Print Restrictions in the EHR: Pros, Cons, and Recommended Practices

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The electronic health record's promise of a paperless environment has been around for decades, but it has proven difficult to keep. Regardless of how an EHR is implemented or the phase of implementation, paper remains a staple of the health record for quite some time after conversion and, in most cases, for longer than necessary. However, the need to print may be warranted for legal purposes or patient care, such as providing discharge summaries.

Implementing an EHR and all its components requires a multidisciplinary team, resources, time, and most importantly substantial planning. One important function that must be considered and well planned for is printing records.

Why Print?

Transitioning from paper to electronic can be difficult for any user, from the registration clerk to the orthopedic surgeon. There are many legitimate reasons to print from an EHR, such as for legal purposes (e.g., in response to a subpoena), an insurance claim, or continuity of care. However, there are just as many excuses to print. Examples of excuses include:

- "It's easier to use because I'm used to it."
- "I work faster because I know where to find the information I need."
- "I don't like the new system."

Paper records have been a part of daily operations from the beginning and old habits die hard. However, organizations must address the implications printing poses and outline printing restrictions accordingly.

The Pros and Cons of Printing

The most significant risk of printing involves endangering patient safety. For example, a physician prints a lab report, takes action on a critical value, documents it on the paper, and is called away for an emergency. The physician hurriedly puts the paper in his pocket, heads to the emergency situation, and forgets the lab report is in his pocket. The end result is a health record with incomplete and inaccurate information, jeopardizing the quality of care and overall safety of the patient.

Printing can also delay the progress toward a fully functional EHR because paper is still available and remains a crutch for users. The longer paper is in use, the longer it will take for the EHR to become fully functional and reliable.

Another risk involves version control. Take for example the lab report stuffed into the physician's pocket as he hurried off to the ER. The report falls out of his pocket and is later found by a nurse and sent to the HIM department for processing. An HIM clerk investigates the lab report to discover that a similar order has already been entered responding to the critical value. Which version is correct? Or are they the same?

The goal is to become paperless or as paperless as possible. Implementing and enforcing printing restrictions supports and encourages the overall EHR adoption.

Benefits can also be realized in the cost savings from not printing, such as reducing the amount of paper and ink used. Finally, once the legal health record is defined as the EHR, users can be confident the information contained within the EHR is the most current and accurate for the quality given throughout the continuum of care.

Recommended Printing Practices

Printing is inevitable during an EHR transition and may continue long after the transition is complete. However, there are ways to ensure that printing is done appropriately and minimally.

First, it is important that an organization defines the content required for its legal health record and where the content resides. This applies regardless of the media used to create and store health records-paper, electronic, or hybrid.[1] The legal health record acts as the organization's legal record for business and evidentiary purposes. Defining the legal health record will help identify base guidelines of where printing may or may not be permitted because as part of the process, organizations identify what information resides where. In defining the legal health record, organizations can map out what can be printed from where.

In addition, a well thought-out printing plan, including policies and procedures supported and executed by management, is critical for successful printing and destruction of paper once its purpose is served. The printing plan should include, at a minimum, the following components:

- Documented policies and procedures for who has printing permissions, what information can be printed, where information can be printed (limiting printing stations will decrease risk and increase control), and audit processes for tracking printed documents and persons with printing privileges
- Training and expectations on printing policies and procedures
- Enforcement of policies and procedures (by management), especially timelines for the expected day all printing is expected to cease
- Use of colored paper or a watermark for any information printed from the EHR (e.g., "Unofficial Copy")
- Destruction procedures (e.g., immediate shredding)
- The physician liaison to help execute the policies and procedures and communicate with clinical staff

Regardless of how much printing continues, achieving a paperless state remains the ultimate goal. According to the Office of the National Coordinator, the healthcare industry could save an estimated $300 billion each year by eliminating paper.[2] It is an effort worth working toward.

Notes

1. AHIMA EHR Practice Council. "Developing a Legal Health Record Policy." *Journal of AHIMA* 78, no. 9 (Oct. 2007): 93–97. Available online in the AHIMA Body of Knowledge at www.ahima.org.
2. Kluger, Jeffrey. "Electronic Health Records: What's Taking So Long?" *Time*, March 25, 2009. Available online at www.time.com/time/health/article/0,8599,1887658,00.html.

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Article citation:
Dinh, Angela K.. "Print Restrictions in the EHR: Pros, Cons, and Recommended Practices"
Journal of AHIMA 82, no.1 (January 2011): 38-39.

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