Converting paper charts to electronic medical records tips

by Peter J. Polack, MD |

We are a little over two years into our electronic medical records implementation at the time of this writing. Since we have been performing a gradual rollout, the entire process has been relatively uneventful. Most of the credit for this goes to our chief information officer (technospeak for the head of our IT department) and our practice administrator.

One of the biggest challenges we have been facing is how to convert all of the paper records into electronic ones.

Since we started our EMR implementation with just new patients, we initially were entering brand-new data on those patients and there wasn't anything to convert. But as we started adding established patients – those patients that had an existing paper chart – we had to deal with two issues: how much of the paper chart do we convert to a digital format and how do we make the majority of the existing clinical history available to the physician? Before I tell you what we did, let's discuss some options for dealing with conversion of paper records to electronic records.

1. **All patient charts are scanned into the electronic medical records (EMR) system.** If your practice is running out of physical office space, as we were, this is an attractive option. Unfortunately, it is easy to underestimate the cost in terms of man-hours. Note also that while the actual scanning of medical records can be performed by an unskilled temporary worker, a more highly-skilled employee is needed to actually file each of the scanned records into the file of the appropriate patient
2. **Partial scanning of patient charts into the EMR system.** Employees will pull all the charts that are due for the coming week or the next workday. Then they will scan only the clinical information that is pertinent to their upcoming appointment. The physicians will need to decide what they consider pertinent: last three visits, the first comprehensive exam, a problem list, past medical histories, medication list, latest lab results, etc. Then when the doctor sees that patient in the EMR system, he or she can view all of the relevant scanned paper records right then and there. This is what we had been doing until recently.
3. **Scan every patient's summary page into the EMR system.** This is most useful if your practice has a lot of patients who are worked into your schedule or if you receive a lot of calls regarding patient questions or pharmacy refills. In this way, more patients start to have an electronic track record established sooner. Additional information can then be entered as they are seen in the office.
4. **Hiring an outside firm to scan all your charts into the EMR system.** Yes, there are companies that will come on-site and scan and organize all of your paper records. But although they will usually have a lot of experience doing this, there

might still be much work on your part or your staff's to ensure that the records are being filed appropriately. If your practice has decided that scanning all of the records is a must, this option may be the most cost-effective in the long run. Nevertheless, it will still probably cost you a pretty penny up front.

5. **Don't scan any old information into the EMR system.** Start seeing all patients in the EMR system going forward and have the paper record pulled and available to the physicians for as many visits as they are comfortable with. New patients will need all of their information typed into the EMR system and established patients will need only their current visit entered (apart from their basic problem list, demographics, and medications for example). At some point, the doctors will no longer need to consult the paper chart and the umbilical cord can be cut. There may be exceptions to the no-scanning rule, such as important documents, labs, or imaging, and that's okay. The goal is to minimize the amount of work spent on scanning information that is unlikely to be seen anyway.

OK, so going back to what we were doing: we were having the charts pulled beforehand, basic information scanned, last three visits scanned, last comprehensive exam, last couple of specialty exams (in our case, visual field tests and optic nerve imaging tests) as well as some other paperwork, and the chart was available to the doctor to view when the patient was seen.

When our CIO, Warren Brown, asked us whether or not we were looking at all of that scanned paperwork, our reply was, "No, because we can see it there in the paper chart." As soon as we answered his question, we realized what a waste of time we were creating having our staff scan and file so much information that we were not even viewing in the EMR system. And although one could argue that this was not really wasted effort, we were creating a backlog of scanning and filing of more important, current information that we really needed to have scanned into the EMR system.

Now every practice is different, and what information needs to be converted into EMR may vary depending on your specialty. But hopefully this will get you thinking ahead of time so you can develop a proper plan to convert your paper records into digital ones in the most efficient and cost-effective manner possible.

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