HIM Innovation

An electronic medical record (EMR) is only as good as the documents captured in it. Follow these six document capture best practices to get the most from your EMR.

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Making Sure Your Electronic Medical Records Practices are "Best Practices"

(*Editor's Note: This is the fourth article in a five-part series examining best practices for implementing and using an electronic medical record [EMR]. In this series, you'll learn about best practices in five key areas: managing the health information management [HIM] department, using an EMR, managing chart deficiencies, capturing documents, and managing the revenue cycle process. Last month, we discussed managing chart deficiencies; this month we turn to document capture.*)

Walk into any health information management (HIM) department that still uses paper-based charts and you'll see an "assembly line" process for chart completion -- not only does a *person* have to put all the pieces together in the right order, by hand, but *each* person has to complete his or her tasks before the chart moves to the next person. Ultimately, the patient chart is completed, signed and permanently filed -- but sometimes not until weeks later.

Once documents are electronically captured in the electronic medical record (EMR), most of that slow, cumbersome work is done for you. And it's done more quickly, with fewer people and allows multiple users to complete their tasks at the same time.

However, an EMR is only as good as the documents captured in it. Follow these six document capture best practices to get the most from your EMR:

1.   Scan and store all patient records for any patient type -- inpatient, ER, outpatient -- in your EMR. While there are some exceptions to *types* of documents that don't lend themselves well to scanning -- fetal monitor strips, for example -- there should be no exceptions to types of patients or visits.

2.   Scan and index all patient records within 24 hours of patient discharge. The faster that documents are captured and made available through the EMR, the more quickly patient records are available for patient care, chart processing, chart completion and review activities.

3.   Redesign your forms to ensure high-quality scanned images. In paper records, document types may be color-coded. For effective scanning into an EMR, redesigned forms should be plain white with very little shading.

4.   Bar-code at least 80 percent of your forms that will be scanned into the EMR. Bar-coding scanned documents is key to your staff's productivity and efficiency because the bar-code contains indexing information the EMR needs to place the form in the correct location in the correct patient visit. Indexing includes identifying the type of document -- such as "physicians orders" -- patient encounter number and facility identifier for health care organizations with multiple facilities. Bar-coded forms reduce or eliminate manual indexing.

5.   Use computer output to laser disk (COLD) technology to capture as many documents as possible. Eighty percent of what *can* be COLD-fed directly into the EMR *should* be. COLD-fed documents, such as laboratory and radiology reports and physicians' dictated notes, require no manual handling. In addition, your EMR can automatically assign signature deficiencies to these documents.

6.   Use the EMR to batch process and automatically index "loose reports." An EMR can solve one of the most vexing problems any medical records department faces -- the capture of "loose reports" that are sent to HIM after discharge. In the paper world, somebody must manually organize the pile of loose reports, find the patient charts

and put the paper in the charts in the right place. With an EMR, the HIM department can simply scan the batch. When the batch is indexed, the EMR will automatically place the reports directly to the applicable charts.

Following these best practices for electronic document capture will result in an online patient record that delivers results. Paradoxically, the road to good electronic document capture begins with paper -- reviewing it, re-designing it, bar-coding it and setting goals for managing it electronically. Then, you can let your EMR do the rest.

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