

D.13 HEALTH RECORD DOCUMENT SCANNING POLICY (CM 136-10, SEPTEMBER 1, 2017)

VA WESTERN NEW YORK HEALTHCARE SYSTEM

September 1, 2017

CENTER MEMORANDUM NO. 136-10

HEALTH RECORD DOCUMENT SCANNING POLICY

1. **PURPOSE:** To establish policy and procedure for health record document scanning and/or importing of documents/images related to patient care into VistA Imaging. This policy applies to administrative and clinical documents and covers all organizational entities, including Community Based Outpatient Clinics (CBOC).
2. **POLICY:** Health Record documents/images will be scanned or imported into the Computerized Patient Record System (CPRS).
 - A. It is the policy of the Western New York VAMC that only those documents that cannot be created in or interfaced with CPRS must be scanned. The documents must contain sufficient information to identify the patient (i.e. name, date of birth, and last 4 of the Social Security number). Those documents that are not in an electronically signed (complete) status in VistA or CPRS will not be scanned solely to meet the signature requirement. Paper documents that cannot be created electronically will be scanned and stored according to the direction of the VISN 2 Forms Subcommittee and local Medical Records Committee.
 - B. External source health documents (excluding Non-VA Purchased Care) supplied by a Veteran or clinical provider will be scanned into Doc Manager or VistA Imaging after review by a VA practitioner review and completion of a "Request to Scan Non-VA Documents" form (*Appendix A*) to determine which documents are to be scanned. Only pertinent authenticated external health information will be included in the scanned file. This includes, but is not limited to: History & Physical, Discharge Summary, Operative Report, Pathology, Consults and Diagnostic procedures. A summary progress note written by an appropriate clinician after a review of the external source health documents may be used in lieu of scanning any external source documents. Once the clinician enters the progress note, the pertinent external source documents should be destroyed as per MCM 600-136E-136, Medical Record Management.
 - C. In accordance with VHA Handbook 1907.01, Health Information Management and Health Records, Non-VA Purchased Care (Fee Basis) health records, copies of reports submitted by physicians and other reports (laboratory, X-ray, etc.) must be filed in the health record or captured into VistA Imaging within the locally established time frame. See the Non-VA Care Vista Imaging Capture Fact Sheet for more information regarding Non-VA Purchased Care (Fee, contract, sharing agreement, etc.) documentation.
 - D. System generated documents will not be scanned unless otherwise approved. Decentralized scanning will be considered and approved based on the type and urgency of the reports for patient care. A list of those departments or persons allowed to scan, other than centralized scanning staff, will be maintained by the File Room Supervisor and provided to the HIMS Manager.
3. **PROCEDURES:**
 - A. **DEFINITIONS:**
 1. **Health Record:** A health record includes the electronic health record and the paper record, combined, and is also known as the legal health record. A health record can be comprised of two divisions, which are the:

- a. **Clinical Health Record:** The clinical health record is the documentation of all types of health care services provided to an individual, in any aspect of health care delivery. A clinical health record includes: individually identifiable data, in any medium, collected and directly used in or for documenting health care. The term includes records of care in any health-related setting used by health care professionals, while providing patient care services, to review patient data or document their own observations, actions, or instructions. The clinical health record includes all handwritten and computerized components of the documentation.
 - b. **Administrative Health Record:** The administrative health record is an official record pertaining to the administrative aspects involved in the care of a patient, including: demographics, eligibility, billing, correspondence, and other business-related aspects.
2. **Scanning.** Scanning is the digitalization of documents and data using imaging or pictorial technology. Document scanning, or document imaging, is a process by which a paper document is converted to an electronic file.
 3. **Scanned Documents.** Documents that are indexed, scanned, or imported into the VistA Imaging System and accessed via Vista Imaging Display under the CPRS tool drop down box.
- B. All requests to create, develop and approve paper non-electronic facility generated documents to be scanned will be submitted to the local Medical Records committee. This request will include justification for creation of the paper based document and the proposed title that the document is to be scanned under. All requests for facility generated new or revised paper documents must be approved by the Health Information and Medical Records Committee before they can be scanned/imported and indexed in VistA Imaging.
- C. Facility generated and Non-VA paper documents and digital images must include: the patient identifiers (full name, last four digits of the social security number (SSN) and date of birth (DOB)) on the first or cover page. Each subsequent page should contain, at a minimum, the patient's name and last four digits of the SSN. Facility personnel will scan all health records designated by HIMS as "priority" within 48 hours of receipt.
- D. External health record documentation furnished by the veteran will be reviewed by the VA practitioner to determine which documents are to be scanned. External paper documentation must be authenticated prior to document scanning with either an electronic or wet signature. The document must clearly indicate that this is an electronic signature and not a typed signature block, such as transcription typing a physician's name at the bottom of a paper discharge summary. Only those outside health records that are authenticated may be incorporated into the patient's VA health record. Authentication includes a written signature or written initials or an electronic signature. The facility that provided the unauthenticated documents should be contacted and requested to provide authenticated documents for scanning.
- E. If the reviewing practitioner determines that an outside health record document should be available for on-going patient care, the practitioner can either:
- a. Enter a "Review of Outside Health Records" CPRS progress note; or
 - b. Place a notation to an existing clinic note or add an addendum to state "document(s) from (Facility Name) was read". A "Request to Scan Non-VA Documents" form (*Appendix A*) will be completed and forwarded to HIMS personnel with a notation of what progress note to use to attach the records. It is scanned as the first page of the scanned documents and acts as an index as to what is included. NOTE: Only information that is required for continued care is to be included in the health record.

- F. If a document is not legible, the scanning personnel will make their best efforts to copy the document until legibility is improved or request another copy of the source document. If this cannot be accomplished, the scanner will annotate on the document prior to scanning, "poor original".
- G. Any document received for scanning that does not have a completed "Request to Scan Non-VA Document" form, will be returned to the appropriate clinician for completion. The "Request to Scan Non-VA Document" form must include appropriate indexing instructions to include the full patient name and the patient's last four of the social security number.
- H. The individual performing the original scan must complete an initial quality check on 100% of scanned records. The scanner will ensure the accuracy of linking to correct patient, note title, and/or consult when appropriate; accuracy of indexing by document type, specialty, event/procedure and visit, readability and that all documents belong to the same patient.
- I. Quality assurance reviews will be conducted on all scanning activities as per VHA Handbook 1907.01, Health Information Management and Health Records. The reviews must be conducted by a third party (i.e., supervisor, quality coordinator) with 10% of scanned documents for experienced scanning staff and 100% of documents for new scanning staff for 3 months, after 3 months if quality standards are maintained, quality reviews will be conducted at the 10% rate to ensure compliance. If no inconsistencies or problems with scanning are found, the documents will be destroyed within the facility defined time frame. The National Archives and Records Administration (NARA) disposition authority for electronic health records allows VA to destroy source documents after scanning, but only if health record retention and retrieval requirements can be met, and quality control processes are in place. In accordance with the NARA disposition authority, document imaged records must be retained to satisfy the "75-year after the last episode of care" retention requirement. Paper health records or administrative documents will be retained for no more than 30 days after scanning for quality assurance review.
- J. Scanned documents entered in error in VistA Imaging will be processed and corrected by the Chief, HIMS or designee.

4. **RESPONSIBILITY:**

- a. The Chief, Health Information Management Section (HIMS) or designee is responsible for:
 - 1. Ensuring scanning responsibilities are implemented according to VHA guidelines.
 - 2. Ensuring performance quality assurance and ensuring quality assurance reviews of scanning personnel are completed each month on 10% of the total scanned images.
 - 3. Monitoring image quality and data integrity.
 - 4. Ensuring all appropriate personnel have been trained in scanning and quality control.
- b. Clinicians are responsible for reviewing and completing the "Request to Scan External Source Documents" form (*Appendix A*) and routing documentation for scanning to HIMS for appropriate action.

5. **REFERENCES:**

- a. VHA Handbook 1907.01, Health Information Management and Health Records.
- b. The Joint Commission Accreditation Manuals.
- c. HIM Office of Informatics and Information Governance Fact Sheet Vista Imaging Capture Indexing Reference Guide for Internal and External Documents.

d. Record Control Schedule (RCS) 10-1 Section XLIII – Health Information Management Service (HIM),
Item No. XLIII-2.

6. **RESCISSIONS:** None

7. **FOLLOW-UP RESPONSIBILITY:** Manager, Health Information Management Section

8. **AUTOMATIC REVIEW DATE:** September 1, 2020

//s//

PAUL S. CREWS, MPH, FACHE
Interim Medical Center Director

Department of
Veterans Affairs

Memorandum

Date: _____
From: _____ (Provider's Name & Title)
Subj: External Clinical Records for Scanning or Uploading
To: Scanning (HIMS)

The attached documents pertain to:

- Patient name: _____
- Last four SSN#: _____
- Clinic location: _____

I CERTIFY that I have reviewed the attached medical/administrative information and deem this information as being pertinent to the care of this patient at this VA facility.

If you have any questions, please contact me at _____ (Extension).

(Please check the contents of the Items to be Scanned Below)

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- ☐ External Consultation Report
- ☐ External Correspondence (Administrative Records)
- ☐ External Discharge Summary
- ☐ External Imaging Report
- ☐ External Lab Report
- ☐ External Procedure Note
- ☐ External Progress Note
- ☐ External Advanced Directive / Power of Attorney / DNR / Health Care Proxy / Organ Donor (Circle One)

(Attach to CPRS Note Dated: _____)

Provider Signature: _____