MILLE LACS BAND OF OJIBWE
HEALTH AND HUMAN SERVICES POLICY & PROCEDURE

Department: Administrative Services-Health Information Management

Policy Number: HHS-ADM-HIM 3407

Policy Title: Clinical Document Scanning

Attachments: Approved Documents for HIM (clinical) Scanning, Scanning Document Error Form

Revision History:

Reviewed Date/ by: Stacy Hopkins/Holly Hunter, 11/2019

Approved by: Jan Manary

Jan Manary, Executive Director of HHS

Date: 12.2.2019

Approved by:

Nicole Anderson, Commissioner of HHS

Date: 12-3-2019

POLICY STATEMENT: Mille Lacs Band Health and Human Services is committed to creating an environment that promotes and fosters the use of the Resource Patient Management System (RPMS) Electronic Health Record (EHR) by defining policies, objectives, and responsibilities for the scanning of documents related to patient care. The VistA Imaging portion of the EHR is designed to supplement the patient record with documents from outside the EHR system.

PURPOSE: The purpose of this policy is to set for the procedures for the scanning of clinical documents in the RPMS.

RESPONSIBILITIES: The Health Information Management (HIM) Coordinator or designee and the medical records review committee are responsible for forming policies, procedures and managing the list of approved documents.

The HIM Coordinator or designee and scanning specialists are responsible for the day-to-day operations of scanning documents and monitoring image quality.

The HIM Coordinator or designee will ensure all scanning specialists are properly trained to scan and use the scanning equipment. Accuracy is extremely important in all facets of medical record management and will continue to be emphasized as scanning is accomplished. Accuracy will be stressed.

Documents will be *attached* to the correct patient and the appropriate progress note title. Images will be checked for quality and will meet necessary standards. During the first 3 months 100% of scanning will be monitored for quality. If quality is greater than 95%, quality monitoring will be reduced to 75% documents checked for 3 months. After the first 6 months and thereafter 25% will be checked as long as accuracy is maintained at 95%. All new scanning specialists will have 100% checks until they achieve 95% accuracy for 3 months.

The HIM Coordinator or designee will be responsible for tracking and monitoring quality/quantity of scanned documents into the EHR according to facility policy.

The HIM Coordinator or designee and the Director of Quality and Compliance will be the only facility staff member with the functionality to delete a scanned image. In the event a document is scanned to the incorrect chart, it will be reported to the HIM Coordinator or designee following the established process.

PROCEDURE: Documents which originate within the clinic but which cannot be found within RPMS EHR will be scanned or imported into the clinical portion of VistA by authorized employees. After scanning quality assurance, the document is placed in the patient Medical Record according to date for retrievable purposes. These documents include, but are not limited to: consent forms, advance directives, visual field forms, audiology ear charts, mammograms, patient care component forms generated during computer down time, progress notes generated during any computer down time.

Clinical documents originating from other facilities will be scanned or imported into the clinical portion of VistA by authorized employees. After scanning quality assurance, the document is placed in the patient Medical Record according to date for retrievable purposes. These documents include, but are not limited to: discharge summaries, H&P, significant consult reports, operation reports, pathology, cytology, significant lab reports, radiology reports, EKG's, and other diagnostic tests.

All scanned documents will be made available to all clinical and support staff who have access to the RPMS EHR.

PROCEDURE FOR SCANNING:

1. Any document received by a scanning specialist will be checked against the list of approved documents for appropriateness before scanning the documents (See attached list of approved documents).
2. If the scanning specialist encounters a document that is not listed on the approved scanning list or questions a document he/she receives, the form will be referred to the HIM Coordinator or designee for a decision on whether the document is appropriate for scanning.
3. The scanning specialist will review each document for legibility and completeness before scanning.
4. If the document being scanned is of poor quality, the scanning specialist will attempt to attain a better copy by requesting this from the original source. If this is not possible, the image will be enhanced as best as possible with the tools available, within the VistA Imaging System.
5. If a legible replacement is not obtainable, all illegible areas will be stamped "Original Illegible" in the margin as close as possible to each affected area.
6. Any blank pages that are numbered will be stamped "Page intentionally left blank."
7. When the scanning specialist scans a document into the RPMS EHR, the "progress note" title will be as designated on the attached listing. When consent forms are scanned, the document image will be linked to the "operative report" note. Written documentation completed during the down time will be scanned into the record with a progress note signed by the scanning specialist that describes the reason for the scanned documents.
8. The document/image date is the date the document is scanned into the RPMS EHR.
9. The note date is the date a sample was collected, the procedure was performed or the date of discharge.
10. Quality checks of the scanned image will be conducted by the document scanning specialist at the time of scanning for adjustment of image resolution, review positioning and legibility.
11. Once scanned the original document will be stamped as "Scanned," dated, and initialed by the scanning specialist and placed in the area designated for quality assurance review by the HIM Coordinator or designee.

PROCEDURE FOR INACTIVE OR RESCINDED ADVANCED DIRECTIVES:

1. Once an advanced directive is no longer active or the patient has rescinded the document, the HIM Coordinator, or designee, will be contacted immediately.
2. The HIM Coordinator, or designee, will add an addendum to the note to include revocation date and time.
3. The HIM Coordinator, or designee, will change the title of the note to "Rescinded Advance Directive."
   a. This will make the note inaccessible to clinical staff, but accessible to the HIM Coordinator or designee.
   b. This will remove the note from the CWAD button or postings window on the coversheet.

PROCEDURE FOR DOCUMENT SCANNING ERRORS:

1. The person identifying any scanning error will document the error on a VistA Document Error Form and attach a copy of the document in question.
2. The person identifying any scanning error will contact the HIM Coordinator or designee to correct the error as soon as possible.
3. The HIM Coordinator or designee will delete the image(s).
4. The HIM Coordinator or designee will document that the image has been deleted in the unsigned note or add an addendum to a signed note.
5. The HIM Coordinator or designee will retract the signed progress note.
6. The scanning error form will be completed by the HIM Coordinator or designee.
7. The completed error form will be filed per HIM policy.
8. All scanning errors will be tracked as a part of the scanning quality assurance protocol.

PROCEDURAL NOTES:

1. It is recognized that while the steps for the actual document scanning are simple, it takes a great deal of attention to detail to be accurate and produce a quality image. For this reason, scanning specialists will work in an area where distractions and interruptions are minimized.
2. All scanning specialists will begin working with a very limited variety of documents until they are proficient. Additional document types will be added as staff competency increases.
3. All Mille Lacs Band Health and Human Services staff members are responsible for the integrity and completeness of the data in the patient medical record. Errors in the VistA package must be reported and corrected immediately to prevent patient endangerment or adverse reactions.

Internal and/or External References	IHS Health Manual, Chapter 3 HIM
Compliance - Posting Date	12/3/2019
Next Review - Due Date	12/3/2022

Document Type	Configuration Button Title	Attach to Progress Note Title	Signed or e-filed
Audiology Referral	REFERRAL_AUDIOLOGY	REFERRAL_AUDIOLOGY	e-filed
Cardiology Referral	REFERRAL_CARDIOLOGY	REFERRAL_CARDIOLOGY	e-filed
Dermatology Referral	REFERRAL_AUDIOLOGY	REFERRAL_AIDOLOGY	e-filed
Endocrinology Referral	REFERRAL_ENDOCRINOLOGY	REFERRAL_ENDOCRINOLOGY	e-filed
ENT Referral	REFERRAL_ENT	REFERRAL_ENT	e-filed
Gastroenterology Referral	REFERRAL_GASTROENTEROLOGY	REFERRAL_GASTROENTEROLOGY	e-filed
General Surgery Referral	REFERRAL_GENERAL SURGERY	REFERRAL_GENERAL SURGERY	e-filed
Hematology Referral	REFERRAL_HEMATOLOGY	REFERRAL_HEMATOLOGY	e-filed
Infectious Disease Referral	REFERRAL_INFECTIOUS DISEASE	REFERRAL_INFECTIOUS DISEASE	e-filed
Mental Health Referral	REFERRAL_MENTAL HEALTH	REFERRAL_MENTAL HEALTH	e-filed
Nephrology Referral	REFERRAL_NEPHROLOGY	REFERRAL_NEPHROLOGY	e-filed
Neurology Referral	REFERRAL_NEUROLOGY	REFERRAL_NEUROLOGY	e-filed
OBGYN Referral	REFERRAL_OBGYN	REFERRAL_OBGYN	e-filed
Oncology Referral	REFERRAL_ONCOLOGY	REFERRAL_ONCOLOGY	e-filed
Ophthalmology Referral	REFERRAL_OPHTHALMOLOGY	REFERRAL_OPHTHALMOLOGY	e-filed
Optometry Referral	REFERRAL_OPTOMETRY	REFERRAL_OPTOMETRY	e-filed
Orthopedics Referral	REFERRAL_ORHTOPEDICS	REFERRAL_ORTHOPEDICS	e-filed
Pain Management Referral	REFERRAL_PAIN MANAGEMENT	REFERRAL_PAIN MANAGEMENT	e-filed
PT/OT Referral	REFERRAL_PT/OT	REFERRAL_PT/OT	e-filed
Podiatry Referral	REFERRAL_PODIATRY	REFERRAL_PODIATRY	e-filed
Psychology Referral	REFERRAL_PSYCHOLOGY	REFERRAL_PSYCHOLOGY	e-filed
Pulmonology Referral	REFERRAL_PULMONOLOGY	REFERRAL_PULMONOLOGY	e-filed
Rheumatology Referral	REFERRAL_RHEUMATOLOGY	REFERRAL_RHEUMATOLOGY	e-filed
Sleep Study Referral	REFERRAL_SLEEP STUDY	REFERRAL_SLEEP STUDY	e-filed
Surgeon Referral	REFERRAL_SURGEON	REFERRAL_SURGEON	e-filed
Urology Referral	REFERRAL_UROLOGY	REFERRAL_UROLOGY	e-filed
CT Image	IMAGING_CT	IMAGING_CT	e-filed
Dexa Scan Image	IMAGING_DEXA SCAN	IMAGING_DEXA_SCAN	e-filed
Echo Image	IMAGING_ECHO	IMAGING_ECHO	e-filed
Mammogram Image	IMAGING_MAMMOGRAM	IMAGING_MAMMOGRAM	e-filed
MRI Image	IMAGING_MRI	IMAGING_MRI	e-filed

Other Image that does not fit into other listed categories	IMAGING_OTHER	IMAGING_OTHER	e-filed
Ultrasound Image	IMAGING_ULTRASOUND	IMAGING_ULTRASOUND	e-filed
X-Ray Image	IMAGING_X-RAY	IMAGING_X_RAY	e-filed
Advanced Directive	ADVANCED DIRECTIVE	ADVANCED DIRECTIVE	e-filed
Anticoagulation Flowsheet	ANTICOAGULATION FLOWSHEET	ANTICOAGULATION FLOWSHEET	e-filed
Ages & Stages Question Form (WCC)	ASQ FORMS	ASQ FORMS	e-filed
Colonoscopy Report	COLONOSCOPY REPORT	COLONOSCOPY REPORT	e-filed
Consent for Treatment/Procedure	CONSENT FOR TREATMENT/PROCEDURE	CONSENT FOR TREATMENT/PROCEDURE	e-filed
Diabetes Related Information	DIABETES MANAGEMENT	DIABETES	e-filed
DOT Physical Form	DOT PHYSICAL	DOT PHYSICAL	e-filed
Notes from ER or Urgent Care	ER/URGENT CARE NOTE	ER_NOTE	e-filed
Hospital Discharge Note	HOSPITAL DISCHARGE	HOSPITAL_DISCHARGE_NOTE	e-filed
Hospital Stay Note	HOSPITAL NOTE	HOSPITAL_NOTE	e-filed
Labs	LABS	LAB	e-filed
MAR related Information	MAR	MAR	e-filed
Medication Agreement	MEDICATION AGREEMENT	MEDICATION AGREEMENT	e-filed
Mental Health Information	MENTAL HEALTH	MENTAL HEALTH	e-filed
Anything that doesn't fit elsewhere	MISC DOCUMENTS	MISC DOCUMENTS	e-filed
Operative Report	OERATIVE REPORT	OPERATIVE_REPORT	e-filed
Orders	ORDERS	ORDER	e-filed
Records from Outside Facilities	OUTSIDE RECORDS	OUTSIDE_RECORDS	e-filed
Progress Note	PROGRESS NOTE	PROGRESS_NOTE	e-filed
Public Health Note	PUBLIC HEALTH NOTE	PUBLIC HEALTH NOTE	e-filed
Sports Physical	SPORTS PHYSICAL	SPORTS PHYSICAL	e-filed
Tests not classified elsewhere	TESTS	TESTS	e-filed
EKG Test	TESTS_EKG	EKG TEST	e-filed
Spirometry Test	TESTS_SPIROMETRY	SPIROMETRY TEST	e-filed
Stress Test	TEST_STRESS TEST	TESTS	e-filed
Pathology	PATHOLOGY	PATHOLOGY	e-filed
Pill Count	PILL COUNT	CONTROLLED SUBSTANCE PILL COUNT	e-filed

SCANNING DOCUMENT ERROR FORM

HRN#: _____

Patient Name(Last,First): _____

Document type: Clinical Administrative
Scanned Document
Digital Photo
.PDF File

Reason for Removal: No Dates with Patient Signature
No Image
Patient didn't complete or sign
Scanned to wrong patient
Image Quality not acceptable
Other: _____

Image #s:			

Requested By: _____ Date: _____

PLEASE ATTACH COY OF ORIGINAL DOCUMENT

**********Do Not write below this line**********

ID#:			
Date & Time:			
Created By:			

Action Taken:
Erased Note Erased Image Index Edit
Other: _____

Corrected By: _____ Date: _____

Clinical Director's Signature: _____

Notes:

SCANNING DOCUMENT ERROR FORM

HRN#: _____

Patient Name(Last,First): _____

Document type: Clinical Administrative
Scanned Document
Digital Photo
.PDF File

Reason for Removal: No Dates with Patient Signature
No Image
Patient didn't complete or sign
Scanned to wrong patient
Image Quality not acceptable
Other: _____

Image #s:			

Requested By: _____ Date: _____

PLEASE ATTACH COY OF ORIGINAL DOCUMENT

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ID#:			
Date & Time:			
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Action Taken:
Erased Note Erased Image Index Edit
Other: _____

Corrected By: _____ Date: _____

Clinical Director's Signature: _____

Notes: