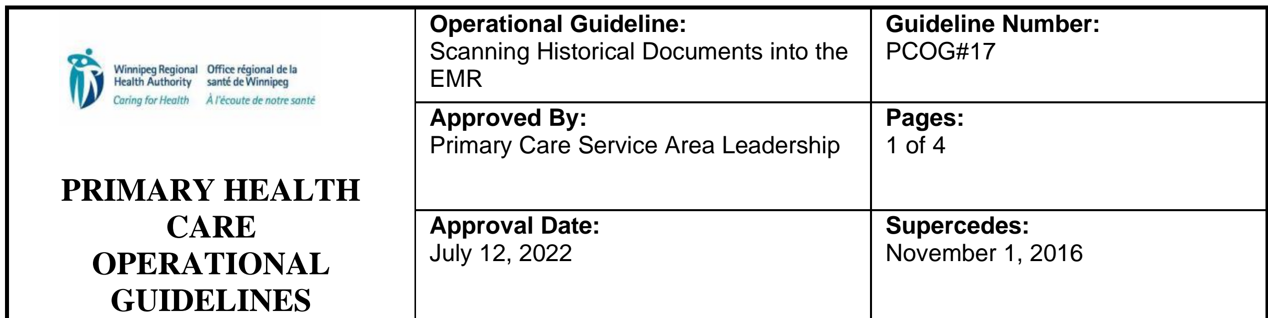


Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé **PRIMARY HEALTH CARE OPERATIONAL GUIDELINES**	**Operational Guideline:** Scanning Historical Documents into the EMR	**Guideline Number:** PCOG#17
	Approved By: Primary Care Service Area Leadership	**Pages:** 1 of 4
	Approval Date: July 12, 2022	**Supercedes:** November 1, 2016

1. INTENT

To provide guidance on the scanning of historical documents from an existing paper or electronic chart (via USB Flash Drive) into the Electronic Medical Record when necessary

2. DEFINITIONS

- **Electronic Medical Record (EMR) -** A secure electronic record of a patient's health care history including, but not limited to, appointment history, medications, laboratory results, diagnostic images and encounter records maintained in the EMR software

- **Historical Paper Document –** Existing paper documentation of patient care prior to the clinic's implementation of EMR software. This may also include paper documentation transferred from a non-EMR clinic to an EMR clinic.

- **Scanning -** Converting of a historical document to an electronic format

- **Date Created** – The true date for historical documents; date of the paper copy, not the date the historical document was scanned into the EMR

- **Date Received** – Also known as date stamped or date received into the clinic

- **Date Reviewed** – Is to be completed by the Primary Care provider for clinical management and documentation of the patient record

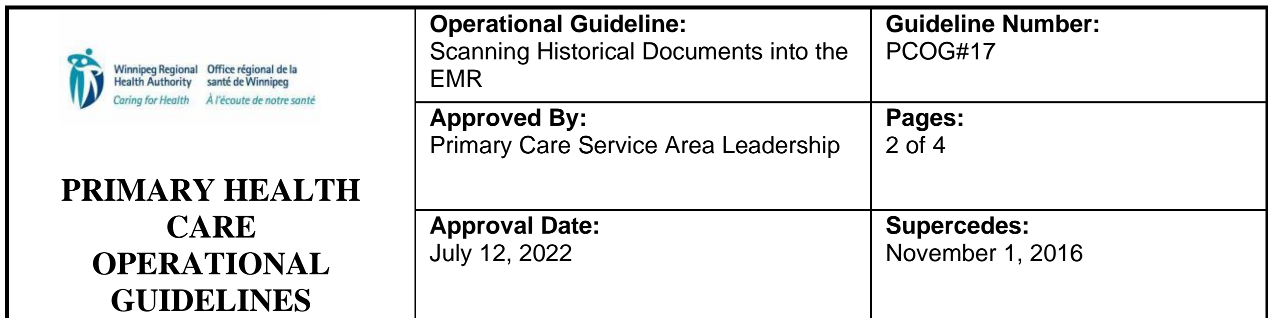
3. GUIDELINE

Internal/External Paper Charts

3.1. While there are typically fewer paper charts in existence today, some clinics do still operate with paper charts alone. If a paper chart does exist for a patient, it will be pulled by the Primary Care Assistant (PCA) and given to the provider in advance of a specific patient appointment only when the provider indicates this is necessary.

3.2. Providers will use discretion in determining which historical paper documents are scanned into the EMR. Consideration will include:
- The need for the patient's information to be in the EMR
- Resource costs of scanning

3.3. There are some historical documents that providers may deem as being a required part of the electronic record. Types of historical information that may fall in this category include:
- Documents relevant to current active care (i.e. insurance claims or consultation reports)
- Relevant and current medical legal reports



- Relevant lab reports

Historical documents scanned into the EMR become the source of truth.

3.4. Providers will identify and flag any documents in the paper record that are pertinent to current patient care and will instruct the PCA to scan the information into the EMR

3.5. Prior to scanning the document(s), the PCA will draw a line through any remaining white space on the document ensuring no further entries can be made. The PCA will then scan the document(s) and convert to a PDF “read only” format that cannot be altered or manipulated after conversion.

3.6. When scanning the document, the PCA will need to change the date created to ensure all scanned documents are dated in the EMR according to their true date (date of the paper copy, not the date they were scanned into the EMR)

3.7. Date received is to be entered into the comments section of the EMR per *APPENDIX D - Documents Screen View*

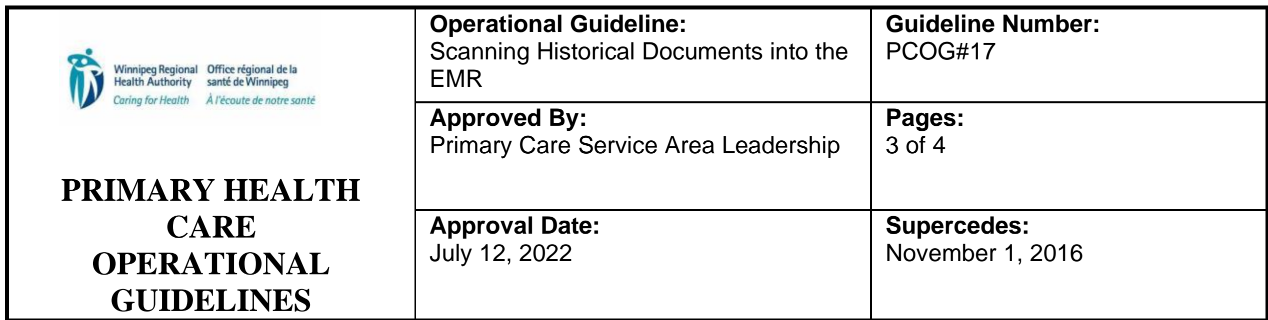
3.8. Scanned or electronically faxed documents should be organized into folders in the correct patient’s record, so they are easier to find and retrieve. Documents should be filed in a standard format by the PCA using *APPENDIX B - Document Folders and Sub Folders.*

3.9. Once scanned and organized, the documents will be sent to the requesting provider for review and final filing within the EMR. Date reviewed is to be completed by the Primary Care provider for clinical management and documentation of the patient record per *APPENDIX D - Documents Screen View*.

3.10. Once the historical document(s) has been scanned into the EMR, the PCA will stamp it (or write in red ink) “Scanned into EMR”. Return the original copy to the identical location within the paper chart from where originally retrieved. Historical documents are not to be destroyed.

3.11. For paper documentation transferred in/received from a non-EMR clinic (i.e. transferred file), place documentation in plain envelope once scanning is complete. On the outside of the envelope record the corresponding Accuro Identification Number generated in EMR. Make note in the comment section of the “Documents Screen View” indicating the file was received from “X” clinic and documentation/chart is now stored in the clinic manual file system.

3.12. The PCA will place yellow neon caution form (*APPENDIX A – Caution Form*) in the patient’s paper record as the top page and will flag/record the documents that have been scanned into the EMR and returned to the paper record. At any point in time, this tracking sheet will provide a summary of all documents from the paper record that have been scanned into the EMR.



3.13. The paper record will remain at the clinic site and be accessible as long as it is needed. If it is deemed by the provider and Team Manager that a specific paper chart is no longer required because all necessary records are now contained within the EMR, the paper chart can be archived per the applicable WRHA Regional Policy.

Internal/External Electronic Charts on USB Flash Drive

3.14. In the event that an electronic historical chart is received on a USB Flash Drive for a new patient to the clinic, all applicable paper chart processes as identified above shall be followed. *APPENDIX E - Importing PDF Documents from Historic Electronic Charts* provides step by step instructions to complete a sort and transfer of an existing medical chart provided on a USB Flash Drive into the Community EMR Chart.

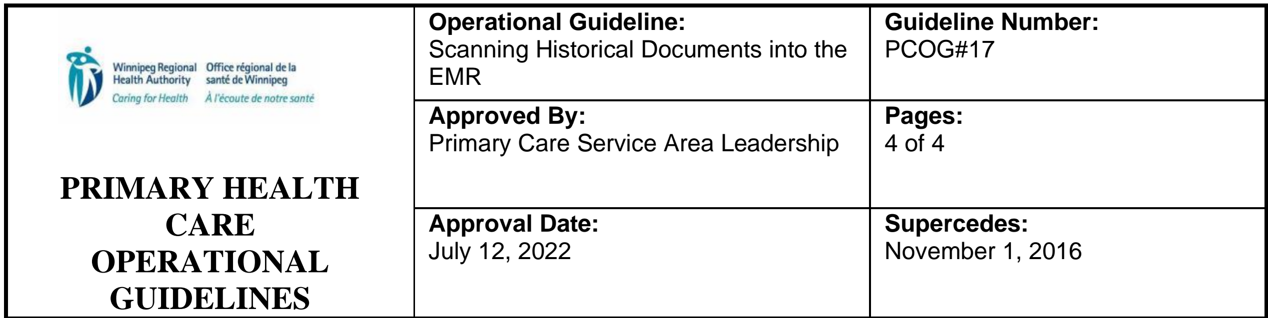
3.15. USB Flash Drives should never be used as a permanent storage of Personal Health Information as they are subject to loss and even with sufficient encryption, may pose a risk if the information on the USB is unique

4. SOURCE/REFERENCES

- Canadian Medical Protective Association (CMPA) (June, 2010). CMPA Perspective: Transitioning to Electronic Medical Records 2/2, 10-12
- Dinh, A.K. et al (December, 2010). Migrating from Paper to EHRs in Physician Practice. Practice Guideline for Managing Health Information. Journal of AHIMA, 81/11, 60 -64
- Hall, T.M. (November-December 2008). Minimizing Hybrid Records: Tips for Reducing Paper Documentation as New Systems Come Online" Journal of Ahima 79/11: 42-45
- Reino, L.; Hyde, C. From Paper to Electronic, and In Between: The Challenges Hospitals Face with the Hybrid Record. AHIMA's 78th National Convention and Exhibit Proceedings, October 2006
- Cottrell, C. Legal Health Record: A Component of Overall EHR Strategy. Journal of AHI<A 78/3 (March 2007): 56-57, 66
- Consultation with Primary Care Service Area Leadership, Community Area Directors, Primary Care Team Managers, Regional Primary Health Care Quality Team and EMR Support Services (June 2022)

5. APPENDICES

- **APPENDIX A** - Caution Form
- **APPENDIX B** - Document Folders and Sub Folders
- **APPENDIX C** - Scanning Historical Documents into the EMR-Workflow
- **APPENDIX D** - Documents Screen View
- **APPENDIX E** – Importing PDF Documents from Historic Electronic Charts



PRIMARY HEALTH CARE OPERATIONAL GUIDELINES	**Operational Guideline:** Scanning Historical Documents into the EMR	**Guideline Number:** PCOG#17
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SCOPE: Applicable to all WRHA Primary Care Direct Operation Clinics (including Walk-In Connected Care Clinics located at Access Winnipeg West, Access Fort Garry and McGregor).

NOTE: While the Funded Community Health Agencies are out of scope of Primary Care Operating Guidelines, it is recommended the content and/or processes be adapted/adopted where applicable.

Questions regarding this or any other Primary Care Operating guideline should be directed to Primary Care Service Area Leadership