

The case of the missing patient charts

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Size of practice: Four physicians and one midlevel provider at two locations. Physicians collectively see about 250 patients per day

Challenge: Missing patient charts and misfiled information within charts.

Background: Staff members were accessing thousands of paper medical records each week. The ongoing chart management process became a labor-intensive, time-consuming and costly task, ripe for error. In addition, charts were transported between sites, sometimes on the same day. The goal was to have the medical record in the provider's hand at the time of the appointment or when the provider spoke with the patient on the telephone – but charts were often missing or contained incorrect information.

Action: Implemented computerized patient records with scanned document images as the core component.

The practice first tried some partial solutions, which did not address the real problem and created more administrative work:

- Scheduling a courier three times a day instead of transporting records haphazardly and supplementing with faxes. Staff members still spent time managing paperwork. Transferring charts and faxing created additional paper management;
- Consolidating chart information at the patient's primary care site. Again, this process created more paperwork management without solving the problem; and
- Transcribing visit notes directly into the practice management system. No one wanted to view files in the system's generic green-screened data-entry format, so staff members still printed out documents for physicians. Additionally, the records were incomplete because they did not incorporate past paper documents or ancillaries such as lab data.

The practice then considered full electronic medical records but found that option too costly as well as impractical. Staff members and physicians were averse to switching to a complex computer system, which would radically alter their daily routines. Instead, the practice used a hybrid approach: it purchased scanners to transform existing paperwork into computerized images. For a time the practice printed out daily mini-charts for appointments, but physicians gradually became comfortable calling up the images on computers available in each exam room. Physicians still make handwritten patient notes, but in a template that staff members scan at the end of the day and add to existing electronic files.

Results: Chart problems were eliminated after an intense six-week scanning period. One year after implementation, the space used to store documents was converted to offices. After two years, savings from discontinuing the transcription service, eliminating paper charts and several paper-handling positions – approximately \$100,000 – offset the initial set-up costs. In addition, turnover and overhead as a percent of revenue both decreased.