

## Improving Accuracy in Healthcare Documents

*How to develop a comprehensive, integrated document management strategy that can reduce the risk of administrative errors, eliminate points of exposure, and optimize the delivery of patient care in acute and ambulatory healthcare environments*

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## Table of Contents

1.0	Executive Summary
2.0	Introduction
3.0	The Challenge of Maintaining Accuracy
4.0	Assessing Current Performance
5.0	Strategies for Improving Accuracy
6.0	Critical Success Factors
7.0	Conclusion

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## Executive Summary

According to a recent study of family care offices,<sup>1</sup> 86% of mistakes in these environments were administrative in nature. Administrative errors — and knowledge errors related to information access and delivery — are among the most preventable of all medical errors.

This white paper explores how a sensible document management strategy can reduce the risk of administrative and other document-related errors, eliminate points of exposure in healthcare organizations, and improve patient care in both acute and ambulatory environments.

With respect to document management, healthcare organizations are evaluating electronic medical records (EMR) systems, computerized physician order entry (CPOE) systems and other IT-related solutions as ways to reduce the frequency of errors. Unfortunately, available offerings can be too complex, may disrupt current operations, and are too expensive to implement. All of these reasons make management teams for hospitals and other medical practitioners apprehensive about moving forward and placing the success of everyday operations at risk. However, more cost-effective and less intrusive strategies are available and can be implemented effectively as long as healthcare organizations meet five critical factors:

1. Challenge solution providers to maximize your existing assets.
2. Do not sacrifice ease of use.
3. Remember that a solution is more than a product.
4. Focus on cost-efficiency.
5. Choose the right partner.

When selecting a document management partner, providers should look for a company that can facilitate the initial assessment and strategic planning as well as deliver a wide range of affordable solutions and handle ongoing support.

<sup>1</sup>“A Preliminary Taxonomy of Medical Errors in Family Practice,” published by Quality and Safety in Healthcare, September 2002

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## Introduction

*“Care delivery organizations need to reduce preventable medical errors by at least 50% during the next five years ... but they must also contend with limited financial resources.”*

— Gartner Research, “Top 10 Healthcare Issues for 2003”

In 1999, an Institute of Medicine Report estimated that preventable medical errors in hospitals account for at least 44,000 — and as many as 98,000 — deaths each year in the United States. This number becomes even more astounding when compared to annual deaths from motor vehicle accidents (42,000), breast cancer (41,500) and homicide (16,800):<sup>2</sup>

Although the data may seem surprising, the prevalence of medical errors is well known in the healthcare industry. According to a 2001 survey,<sup>3</sup> 95% of doctors, 89% of nurses and 82% of healthcare executives confirmed they have witnessed serious medical errors. In addition, nearly half of all patients in a 2000 study<sup>4</sup> had grave concerns about experiencing medical errors.

Medical errors can be classified into two categories, process errors and knowledge errors. Process errors include those related to administrative tasks, initial investigation, treatment delivery, communication, and payment. Knowledge errors include those that relate to a lack of access to clinical knowledge or skills, such as a doctor prescribing the wrong medication due to incorrect information in the patient’s chart.

In physician offices and other ambulatory care centers, process errors are far more prevalent than knowledge errors. According to a recent study of family care offices,<sup>5</sup> 86% of mistakes in these environments were administrative in nature, such as misfiling patient information, prescribing the wrong medication, and ordering incorrect or duplicate tests.

Administrative errors — and knowledge errors related to information access and delivery — are among the most preventable of all medical errors. What all of these errors share is a direct relationship to healthcare documents, including patient records, physician orders, prescriptions, test results, insurance forms and many others. Typically, administrative errors can be traced back to an inaccurate source document.

This white paper explores how a sensible document management strategy can reduce the risk of administrative and other process errors (especially with respect to information access); eliminate points of exposure in healthcare organizations; and improve patient care in both acute and ambulatory healthcare environments. We will examine the challenges organizations face, the potential impacts of inaccuracy and medical errors, how to begin the assessment process, strategies for improving the accuracy of healthcare documents, and critical factors for success.

<sup>2</sup>National Vital Statistics Report, “Deaths: Final Data for 1999,” published September 2001

<sup>3</sup>Robert Wood Johnson Foundation survey, published 2001

<sup>4</sup>AHRQ and Kaiser Family Foundation patient survey, published 2000

<sup>5</sup>“A Preliminary Taxonomy of Medical Errors in Family Practice,” published by Quality and Safety in Healthcare, September 2002

Document management will only be one part of any healthcare organization's effort to improve accuracy and reduce medical errors, both administrative and otherwise. However, as this white paper will show, improving document management can be one of the easiest and most cost-effective strategies to implement. It can also help correct many typical nuisance errors, allowing organizations to focus resources on preventing more critical knowledge errors.

Lanier Worldwide is a leading provider of document management solutions. We have served customers in healthcare for more than 50 years, and our experience in document management spans seven decades. Because we have been involved in the healthcare industry for such an extended period, we are uniquely positioned to assess how document management issues in healthcare are changing, and how they are likely to evolve. We developed this white paper to share our knowledge and experience with you.

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## The Challenge of Maintaining Accuracy

The excerpt from Gartner Research (see Section 2.0) readily summarizes the dilemma healthcare organizations face with respect to medical errors. Of course, physicians, executives and other healthcare professionals understand that errors are unacceptable and reducing their frequency and severity is a critical challenge. However, medical errors represent just one of a host of other critical challenges, including the rising cost of service delivery, a chronic nursing shortage, and compliance with the HIPAA privacy rule. At the same time, healthcare operating budgets are not growing at a pace that easily accommodates funding for new large-scale initiatives.

With respect to document management, healthcare organizations agree that electronic medical records (EMR) systems, Web-based information systems, computerized physician order entry (CPOE) systems and other IT-related solutions may be able to reduce the frequency of errors and improve overall accuracy. Unfortunately, available offerings are often too complex, pose too great a risk to disrupting current operations, and are too expensive to implement.

This is particularly true for smaller physician offices, which see more than 12 times as many patients as hospitals. The vast majority of these offices do not have computerized medical records or Web access, and most can't afford the IT infrastructure and support these systems require. IT companies acknowledge the technological disparity, and as a result have focused on selling EMR and CPOE systems almost exclusively to hospitals and larger physician groups.

Even in these larger and better funded environments, IT-oriented solutions do not receive the same internal support as in other industries. In banking and finance, for example, IT costs typically represent between 8 and 10% of the organization's revenue. In healthcare, the figure is closer to 2 or 3% of revenue.

### **Additional roadblocks to accuracy**

In addition to the primary issues of too many critical factors to address and too few dollars to go around, the average doctor's office faces a number of other challenges — all of which help explain why document-related errors can occur on a daily basis, and why document management solutions are not being installed.

**1. Paper documents.** Paper is still the standard for record-keeping, and these documents maximize opportunities for inaccuracy. With paper, documents usually live in a filing cabinet. Everyone in the office has access to these files, including physicians, nurses, assistants, and receptionists. Yet everyone does not have the same level of experience with the filing system, nor the same degree of accountability. Paper records are physically transported to the lab, a medical imaging center, or a specialist's office, and each point of transfer creates an opportunity for error. Paper records are subject to errors from poor or misinterpreted handwriting, and confusion arising from differences in what the physician says, what the nurse or administrative assistant hears, and what is actually written on the piece of paper. Also, physicians are frequently unaware that new information has been added to an existing paper record. This can lead to duplicate lab tests, delays in treatment and adverse drug interactions.

**2. Solutions do not match workflow.** While 13 to 15% of hospitals have some form of computerized medication order entry in place, physicians in these organizations enter fewer than 25% of their orders using the electronic system. The bottom line is that physicians and other healthcare professionals will not use any solution that does not fit their existing workflow. Physician offices are complex environments that must adapt quickly to new information and manage patient traffic throughout the day. Every minute must be accounted for, and the office depends on consistent procedures and protocol to maintain maximum productivity. When these processes are rearranged to accommodate technology, the risk of errors increases. If IT companies fail to realize this, their offerings will lie dormant while the organization works around them.

**3. Distrust of technology.** When IT companies pitch new systems for document capture, storage, reporting and output, they frequently use terms like “enterprise integration” and “seamless connectivity.” Healthcare organizations frequently have misgivings about these buzzwords, because they realize there are enough workflow issues to deal with in a busy office without adding IT uptime to the mix. Although paper-based files have their own risks, they do have the advantage of easy access without help from IT professionals — especially in the event of an emergency. IT-dependent solutions are often seen as creating more problems than they solve, especially in terms of office productivity.

**4. Mix of vendors.** Healthcare organizations that embrace the opportunity to go digital with their documents may still be wary of engaging with separate vendors for physician order entry, billing and medical records systems, along with individual vendors for printers, copiers and fax machines. In these situations, it takes longer to identify problems. If the printer can’t print the EMR file, is it the hardware? The software? The printer driver? The application interface? This may trigger finger-pointing while the system sits idle and information can’t be accessed. For this reason, many healthcare organizations and practitioners have no desire to implement proprietary systems that may make it more difficult to receive fast, responsive technical support.

**5. Inaccessible information.** Sharing healthcare documents among providers, payers, clearinghouses and others can be complicated — and the risk of error increased — when documents lack standard formatting, use inconsistent terminology and abbreviations for common terms, and place important information in different locations in each type of document.

**6. Size and scope of assessment.** In many instances, healthcare organizations may feel overwhelmed by the complexity of improving accuracy in document management. Analyzing the current state, considering options, planning improvements, and rolling out new systems for managing healthcare documents seems too daunting, and there is not a single trusted partner that organizations can turn to for help.

### Classifying the consequences

Whether healthcare organizations address document management immediately or in the future, ignoring the issue is not a realistic option. The consequences are simply too dire:

- **Compromised patient care.** Errors in prescriptions, physician orders and patient records are the most serious. Mistakes in these areas — such as unforeseen drug interactions — can have a wide range of negative consequences, including patients who become ill, do not regain health, are admitted to the hospital, or in some very rare cases, die.
- **Exposure to liability.** Errors in healthcare documents, when they result in compromised patient care or unauthorized release of private patient information, can lead to allegations of misconduct, malpractice and fraud.
- **Eroded professional reputation.** Patients that experience the consequences of medical documentation errors experience emotional distress, even if the end result is not serious. More important, these patients can lose trust in their primary care physician, in the physician's entire practice, or in the hospital itself.
- **Delayed reimbursement.** Healthcare organizations must provide accurate and detailed documentation of patient care in order to receive timely and correct reimbursement from managed care and insurance companies.
- **Lower productivity.** Dealing with inaccurate documents adds unnecessary steps to every administrative process and document-related task. Delays during admission, patient history, issuance of physician orders and other frequent tasks can slow down the entire office or workgroup.

By the same token, healthcare organizations that make a commitment to improve the accuracy of their documents can expect to see significant benefits in both the short- and long-term, including:

- **Higher efficiency.** Healthcare organizations with intuitive, easy-to-access electronic resources for managing information and documents will be able to eliminate duplication of effort and administrative delays.
- **Increased patient satisfaction.** Just as patient trust can be shaken by any error, regardless of the outcome, it can be regained through error-free creation, management, and distribution of healthcare documents. When patients see a demonstrated commitment to improvement, the end result is higher satisfaction.
- **Higher quality of care.** Improving the accuracy of healthcare documents decreases opportunities for mistakes and mishandled information, enabling healthcare providers to meet a higher standard for quality patient care.

For many healthcare organizations, the first step toward higher accuracy will be evaluating current procedures for creating, managing, and distributing documents. This process does not have to be an arduous one. Although a complete analysis will likely require outside assistance, there are very basic, fundamental questions you can ask — about documents, workflow, and technology. Your organization can then use this data to discover where document-related efficiencies can make the greatest impact on accuracy and error reduction, and provide the strongest return on investment (ROI).

### Documents

Key questions start with the healthcare documents in your organization:

- 1. What document formats do you use?** This refers to the current mix of paper and electronic documents in your facility. Although most ambulatory care centers depend on paper-based patient records, some also use computer-based systems for admissions or billing. Understanding how much your organization depends on paper — and how many systems are already converted to electronic documents — provides a baseline for any document management strategy.
- 2. Which document format do you prefer?** Gauging preference for paper or electronic documents helps reveal where the physical format of the document either improves or hinders productivity. For example, if physicians indicate a strong preference for paper-based patient records, then any transition to computer-based patient record keeping must include a way to print a paper copy of the patient's updated file prior to each visit. Staff preference will also help set priorities for implementation, once the range of possible solutions is considered.
- 3. What document types do you handle?** These answers will vary widely within the organization. Document types may include patient records, prescriptions, physician orders and notes, insurance forms, admissions forms, communications among physicians, lab tests, transcriptions, medical images, and many others. For each type, it will be helpful to note whether they are handwritten, created electronically and printed for storage, or created electronically and stored electronically. Documents might also contain a mix of electronic information and handwritten notes.
- 4. Which documents do you handle most often?** Every time a team member accesses a document, it creates an opportunity for error. Identifying which documents are handled most often — and by the most people — will help set priorities for your document management strategy.
- 5. Which documents seem most error-prone?** Again, perhaps the most important analytical tool is the collective observational power of your staff. Employees should be able to recite from experience which documents are most prone to errors, as well as the types of errors they include.

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## Assessing Current Performance

### Workflow

Examining the path healthcare documents take inside and outside your organization helps identify points of exposure — where the process breaks down and raises the risk of error.

**1. What methods do you use for document capture, retrieval, storage, and delivery?** The scope of this question seems large, but it can be broken down easily. For each of the four processes listed, identify the person or people involved, then describe their tasks. Next, list these tasks in the order they typically occur. This basic information provides the outline for further review of current workflow, and will help establish a starting point for any realistic and cost-effective improvement strategy.

**2. How is information transmitted inside and outside your organization?** If paper documents physically leave your facility, you will need to identify when and where the transfer occurs and who is accountable for supervising the process. It will also be helpful to identify who has access to the documents while they are off-site, and who is authorized to change the information in the file. If electronic files are exchanged with payers, laboratories, medical imaging centers, or other healthcare facilities, you will need to examine how the transmission occurs, who is authorized to complete the transaction, and what kind of audit trail exists.

**3. What security measures are in place?** During every exchange of information (both inside and outside your organization) there is the potential for a breach of security. This question is intended to identify your preferred methods for data protection, including personal supervision, password protection, global monitoring, system redundancy, or data encryption. Once the list is complete, indicate which methods are auditable. For example, can you prove a certain document was viewed (or not viewed), handled (or not), or received (or not) by the intended recipient?

### Technology

More than 90% of the estimated 30 billion health transactions conducted each year are done by phone, fax or mail. These questions are designed to help you determine if this ratio describes your organization accurately, and take an inventory of the technology assets your teams depend on to create, duplicate, store and manage healthcare documents.

**1. What technology do you use for document input?** These may include manual data entry, electronic data entry, or scanning hardcopy documents for digital conversion.

**2. What technology do you use for document output?** Equipment may include desktop laser printers, network printers, host printing or production printing systems, analog copiers, digital copiers, and digital duplicators.

**3. What technology do you use for document management?** Management systems include those your organization uses to capture, store, retrieve, and exchange documents, including fax and email.

After your organization answers the broad-brush, get-started questions of self-assessment, you will be well positioned to consider available options for improving the accuracy of healthcare documents. In this section, we examine six cost-effective document management strategies healthcare organizations can employ to make an immediate impact on document accuracy — without compromising your budget. Many of these strategies can also help your organization improve overall document productivity, which alleviates the strain on overworked staff, especially during peak periods when the risk of human error is highest.

### **Automated storage and retrieval**

Recent studies indicate that 10% of paper documents will either be lost permanently or temporarily misplaced at some point during their life cycle.<sup>6</sup> At minimum, this means your staff likely spends a significant amount of time locating, storing, and tracking paper documents. This portion of time is a major cost driver for administrative supplies, information services, building storage, and staffing — a combination that comprises more than 70% of the average medical group's operating costs.

In these situations, one of the most cost-effective strategies you can implement is an automated storage and retrieval system. These systems are easier to use and less expensive than EMR technology, but they provide many of the same benefits. Typically, the solution includes hardware and software that enable secure capture, printing, scanning, electronic storage, and tracking of medical documents — including sensitive files that contain protected health information (PHI) — as well as report generation. Once implemented, these systems require little IT support, yet they can store large volumes of documents.

Hardware components may include a digital multifunction product (MFP) where hardcopy documents (such as paper copies of EKGs, consultation letters and release forms) are scanned, a secure electronic filing and retrieval device, and a dedicated backup server for redundancy. Software components may include applications for indexing and retrieving documents, and for generating accountability reports.

Indexing applications are useful for capturing the “metadata” of each transaction — such as the name of the person retrieving the file, the name of the person requesting the file, the date and time of transaction, and the number of copies generated. This information can be captured automatically and retrieved later in a report, creating a verifiable audit trail that may help ensure compliance with HIPAA privacy regulations.

With a single, reliable and searchable location for patient records and other documents, your organization can easily reduce the incidence of lost and misplaced files. Unlike a paper filing system, the user interface for an automatic storage and retrieval system eliminates the risk of employees returning files to the wrong location. If paper copies need to be generated for information sharing, you can automatically create a record of each transaction. Plus, documents can be retrieved from the database using a variety of search criteria, and pulled up for review within seconds. Automated storage and retrieval also increases efficiency by automating manual processes that are not only labor-intensive, but also inherently error-prone. And although the automated process is electronic, it conforms to existing workflows for file capture and retrieval.

<sup>6</sup> PricewaterhouseCoopers

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## Strategies for Improving Accuracy

### **Automated point-to-point order routing**

Distributing physician orders is an ongoing challenge for most healthcare facilities, with respect to document accuracy. The vast majority of errors related to patient medication are on the front end, during ordering and administration, not in the pharmacy. In acute care facilities, orders typically originate from each floor's central nursing unit or sub-unit via legacy fax or tube systems. Due to the high volume of scripts being written, and general lack of accountability built into these older systems, the potential for bottlenecks, illegible transmissions and lost orders is high. All of these outcomes compromise accuracy, impair productivity, and can permanently damage staff morale.

If errors related to prescriptions and physician orders are a critical issue in your organization — but CPOE systems seem too expensive or complicated — you may want to consider automated point-to-point order routing. These rules-based routing systems send orders to the correct department automatically, provide confirmation of receipt, and create a data stream that can be captured for demonstrating accountability. By streamlining the delivery mechanism from physician to pharmacy (or other departments), these systems help improve accuracy and significantly reduce the risk of mistakes, miscommunication, and misplaced orders. They also generally cost less to implement than CPOE.

Particular configurations of hardware and software will vary, depending on the configuration that best suits your existing workflow. Options may include fax-to-fax, fax-to-email, and scan-to-email transmission.

The fax-to-fax configuration may utilize a fax machine and a secure electronic filing and retrieval device. Hardcopy orders are scanned, then routed to another fax machine based on a user-determined rule. If you already have an IP network in place, the fax machines may be able to transmit data over the network instead of via phone lines. Many systems are also capable of creating a backup email version of the document, which can be routed back to the originating station and stored in the database for accountability reporting.

Fax-to-email configurations may include a fax machine, plus routing software. In this scenario, the scanned hardcopy order is automatically converted into an email, which can be routed directly to a printer in the pharmacy or another department. The email is simultaneously printed at the originating station for confirmation.

The scan-to-email configuration may use a digital multifunction product (MFP) instead of a fax machine, as well as routing software and a secure electronic filing and retrieval device. Again, the scanned hardcopy file is converted to an email, then routed to a specific printer while a duplicate is stored in the database for accountability.

**Web-based storage and management**

A growing number of providers realize that some Web-based services can reduce costs without requiring extensive IT infrastructure upgrades or ongoing technical support. Web-based storage and management is one of these services, and it can make a substantial improvement in document accuracy by creating a single access point for all healthcare documents.

Web-based storage and management uses a scanning-enabled digital multifunction product (MFP) to transmit pages directly to a secure Internet site, where they are filed in individual private folders. In healthcare, each patient could have a single folder that holds all related records, including physicians' notes, test results, and other files. Authorized users can then access these folders through any Web-connected device. Access is usually password protected, and data transmission can be encrypted for added security.

Perhaps the most attractive feature of Web-based storage is the ease of access. For example, if a specialist needs access to a referred patient's medical history, the physician can call up a Web browser, type in the correct log-in information, and then access the file, upload their own files (such as new test results or diagnostic information), and respond to the referring physician via email.

Web-based storage has significant cost advantages. It eliminates the need to transport paper files via mail or courier, and reduces the need to use fax machines. It can also be used instead of hiring outside firms to manage the storage and retrieval of paper-based archives. Additionally, Web-based storage can be helpful for shortening review time when the reviewers are located in multiple offices worldwide.

Like any form of electronic storage, Web-based storage improves accuracy by minimizing opportunities for human error. It also creates a verifiable audit trail that shows who has accessed a particular file, and whether any new information was uploaded to the folder. Yet it is affordable enough for even small offices to use, because it does not require physician groups to make a substantial investment in Web site development or networking.

**Network scanning and routing**

For healthcare organizations that already use email on a regular basis, network scanning and routing can be an effective strategy for distributing healthcare documents without the normal risks and costs associated with transporting paper files in and out of your facility.

Network scanning software allows you to route scanned documents as email attachments directly from the control panel of a digital MFP. The attachments are sent as TIFF, PDF or other easily transferable file formats. Like Web-based storage, network scanning helps reduce your organization's reliance on couriers and long-distance faxing. With network scanning, you can distribute a patient's record to a specialist in seconds. Data security is ensured through login authentication and encrypted transmission. The login file can be used to associate a specific user with a specific transaction, which improves accountability.

Typically, these software applications can integrate with your existing email servers and encrypt all emails prior to transmission. Compliance with LDAP (Lightweight Directory Access Protocol) is critical, because it allows the application to update its list of available email addresses from the global user directory — which is constantly changing as organizations add employees, change user profiles, and edit email addresses. This way, users always have access to the most recent email addresses in the organization, which reduces the risk of employees sending documents to incorrect addresses or unauthorized users.

### **On-demand printing and forms management**

Healthcare organizations create more than 40 billion pages of pre-printed forms annually. These forms, which represent the majority of document output spending, are outsourced to commercial printers or generated in-house with proprietary host systems and legacy line printers that are slow and expensive to maintain. Either way, your facility absorbs the ongoing costs of printing, storing, and managing large inventories of forms, many of which will become obsolete and need to be discarded prior to use.

In addition to being a considerable drain on your budget, pre-printed forms increase the risk of adding outdated forms to your document workflow. This, in turn, creates opportunities for files to be categorized incorrectly or misplaced (especially if the old file does not conform to new coding standards), or for physicians to overlook new information in a patient record because the form looks unfamiliar.

Distributed and centralized forms management solutions can help your organization print forms on demand, over the network or in a centralized reprographics department. These systems extract host data from legacy mainframe systems, allow users to add graphics and other elements as needed, and create customized forms on demand. Components of the solution may include software for data capture, and a point-of-use printing device, such as a digital multifunction product (MFP).

With print-on-demand systems, users request forms through a PC interface. The software converts host print data to an industry-standard file format (such as PostScript, PCL, PDF or GDI) for output. These files can be printed in exact quantities as needed. In distributed configurations, the forms can be sent directly to another MFP on the network for printing at the point of use. In centralized configurations, forms can be printed in batches on multiple MFPs in a reprographics department.

The financial advantages of on-demand printing are clear. It eliminates the need to print forms in bulk, store them on-site or in a warehouse, and discard them when templates are updated. Instead, healthcare organizations can revise forms as new requirements emerge, such as MICR encoding or barcodes. You can maintain current host printing or production printing hardware, which is typically cost-prohibitive to replace.

On-demand printing also enables your organization to standardize data output and presentation — both of which help improve information access (key information is always in the same place on a form) and overall document accuracy.

**Outsourcing**

Like other large organizations, healthcare providers manage a variety of document-related functions that are essential to daily operations but not part of your core services.

For example, hospitals distribute patient pamphlets, employee handbooks, departmental reports and many other documents. Mailroom operations, convenience copying, commercial offset printing and other business support services also fall into this category.

Facilities management and off-site outsourcing are two strategies for making sure these and many other document-related tasks are accomplished on time and comfortably within your budget requirements — while eliminating the need for your administrators to spend valuable time supervising document production employees and equipment.

By transferring basic document management tasks and related services to an outsourcing or facilities management provider, healthcare organizations can accomplish several goals simultaneously. You can consolidate multiple tasks with one provider, instead of handling some requirements in-house and dealing with separate vendors for other services. You acquire a single point of contact for any document-related issue, including special requests during peak periods. Plus, you can free up more time to focus on improving the accuracy of healthcare-specific documents that are more closely tied to ensuring high-quality patient care.

Outsourcing is also a proven strategy for reducing overall operating expenses, simply because outsourcing providers have the specialized knowledge and expertise required to maximize efficiency and minimize the cost of production. Reducing operating expenses allows you to reallocate resources to core activities, including systems that can improve the accuracy of healthcare documents and reduce the risk of human errors.

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## Critical Success Factors

Healthcare organizations will take very different paths to improving the accuracy of documents, depending on your staff, budget, and current technology infrastructure. Ignoring the issue is not a viable option; the potential consequences of inaccurate documents are too severe. However, getting started can be a difficult process, whether your organization includes two physicians or 250 healthcare professionals. In this final section, we offer five critical issues that will play a significant role in determining your short- and long-term success as you implement a document management strategy designed to improve accuracy and reduce costs.

**1. Challenge solution providers to maximize your existing assets.** Many IT providers focus heavily on network-ready solutions, occasionally to the exclusion of stand-alone technologies that are more affordable and make more sense for smaller healthcare providers. When considering your options for managing documents, ask questions about the full range of options, from enterprise-level, network-dependent systems to individual systems that include one or two hardware assets and a single software application. The determining factor in your decision should be how well the solution fits in your particular environment, not how advanced or complex the individual technology components are.

**2. Do not sacrifice ease of use.** Any new solution for improving document management must match the expectations of your staff, in terms of current workflow. Solutions that are difficult to use or disrupt current practices will not only cause confusion — and most likely, backlash — they will be ignored. The capabilities of the technology should remain secondary to ease of use in your decision-making process. Points to consider when evaluating ease of use include the number of steps involved in a given process; the flexibility of the process to accommodate various or changing workflows; and the appearance and navigation of the software interface (if applicable), especially legibility of buttons and menus.

**3. Remember, a solution is more than a product.** Ideally, a solution includes all the hardware, software, and service you need to achieve maximum productivity with a minimum of effort. Too often, solution providers expect customers to take up the slack when it comes to installation, end-user training, ongoing evaluation, and technical support. Or these services are priced separately from the technology, placing the actual solution out of range for your budget. Or maintenance and technical support are offered through a third party with no personal connection to your team or little understanding of critical document issues in healthcare. Look for providers that can take care of all the solution components, so your office can focus on the documents themselves, not IT issues.

**4. Focus on cost-efficiency.** Any solutions you choose to improve document accuracy must be aligned with your budget and spending priorities. Solution providers should be able to demonstrate clearly the ROI of any system, and provide case studies from other healthcare customers as points of reference. Total cost of ownership should also be calculated for the long-term as well as the first year of operation.

**5. Choose the right partner.** The best document management strategy starts with a realistic plan based on actual metrics from your organization. It is important to choose a document management partner that can handle the initial analysis, short- and long-term planning, installation, training, technical support, and ongoing maintenance. You also need a partner that understands healthcare and has experience serving the healthcare industry, and maintains strong expertise in document management technology. Your partner should understand how to balance IT concerns with traditional workflow. And your partner should offer a wide range of document management solutions, so you can consolidate as many vendor relationships as possible and simplify your approach to improving document accuracy.

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## Conclusion

Creating a sensible document management strategy is one of the fastest and easiest ways healthcare facilities and other providers can improve the accuracy of healthcare documents, improve workflow, and reduce the risk of administrative errors. By exploring a wider range of alternatives, hospitals and providers can find an ideal combination of new solutions and other options (such as EMR and CPOE) that matches your workflow and operating budget. When selecting a document management partner, providers should look for a company that can facilitate the initial assessment and strategic planning as well as deliver a wide range of affordable solutions and handle ongoing support.

**For more information**

For more information about healthcare-specific document management solutions from Lanier Worldwide, please contact:

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Debra Williams joined Lanier in 2003 as healthcare marketing manager. She has more than 15 years of experience in the healthcare industry, working with hospitals, payers, and providers. On both the national and local levels, she has been instrumental in the development of strategic products and services designed to address the needs of healthcare professionals. She holds a masters in business administration.

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