Patients As Clinical Data Entry Partners

James P. Blasingame, M.D.

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Introduction

Appropriate and thorough documentation of a patient's medical history is a powerful diagnostic tool and an established quality indicator. Public awareness of medical mistakes linked to poor documentation has placed physicians under increasing pressure to improve the quality and legibility of their medical records. At the same time, increased patient loads have cut deeply into the time available for each patient and the associated record keeping. These factors help create an environment of decreased patient satisfaction and increased malpractice risk. Physicians need to solve these problems, which relate both to productivity and quality.

It is the goal of this session to present the argument that patients are an untapped resource of both productivity and quality and to present the means by which they can be enlisted to help the medical practice. The approach is that of improved clinical data capture whereby the patient directly populates appropriate sections of an electronic medical record or similar clinical data repository. HIPAA helps define the environment and general structure for this emerging field of patient data capture.

Background

The capture of a patient's clinical history has traditionally been a two-step process with the physician first gathering the data from the patient and then recording it in the medical record. This session reviews traditional patient data capture by physicians and presents a new, quality-based approach that enlists the patient as a partner in the process. This approach is the use of **structured clinical interviews at the disease or condition level**. Patient data capture using structured clinical interviews replaces much of the traditional two-step process with the direct population of a thorough and legible preliminary medical record before an office visit.

In normal medical practice, a chart note, consultation report, or hospital admission note all contain historical information derived from the patient along with information that can only come from the physician, such as the physical exam and treatment plan. The patient's history makes up about 70% of a comprehensive chart note, as it must cover details of the current problem along

with the patient's allergies, medications, past medical and surgical history, family history, social history, and review of systems. Some physicians employ nurse practitioners, physician assistants, or other trained individuals to help gather this historical information. In addition, the office personnel must obtain the patient's demographic and insurance information.

Most physicians record their notes by either handwriting or dictating, with each method having its own inherent problems and barriers to completeness. Handwritten notes are generally less complete, often illegible, and carry an associated increased malpractice risk. Dictated notes are more legible but the process consumes physician time and generates transcription costs. A small minority of physicians use electronic medical records, which have their own unique problems and barriers to adoption, particularly that of physician data entry.

Compounding these problems, physicians are under increased pressure by government regulators, third party payers, medical malpractice carriers, and general quality concerns to produce more legible and complete notes.

The completeness of a medical record therefore relies on two basic functions:

- Obtaining the appropriate clinical information from the patient and
- Documenting that information in the form of a chart note or record.

Failure to obtain important clinical information may lead to delays in treatment, unnecessary tests, or other medical mistakes. Information gathered from the patient but not documented may as well not have been obtained, as any malpractice defense lawyer would attest.

Any sampling of clinical records from physician offices, hospital admissions, and outpatient surgical centers will demonstrate tremendous variations in completeness, which implies a lack of quality per Deming[1] and other quality experts[2]. The variations occur for many reasons including time constraints, costs, processes, and the individual physician's motivation and skill level. Diminishing these variations around accepted standards of clinical documentation is a mark of improving quality.

Physicians need help with productivity if they are to improve clinical documentation, as most are already short of time and not in a position to spend more resources on skilled assistants and transcription services. This productivity can come from the patient who is, in fact, the source of the necessary information and a willing team member.

1. Deming, WE. *Out of the Crisis.* Center for Advanced Engineering Study, Massachusetts Institute of Technology; Cambridge, MA (1982).
2. Joint Commission on Accreditation of Healthcare Organizations: An Introduction to Quality Improvement in Health Care. Dept. of Publications, l991.