Documenting Patient Histories

Chairperson: Dr. Abe Timmons

Monday, April 30th

1:35 – 2:15 pm

Getting the Details Right: Properly Documenting Patient Histories

Hon. Phyllis G. Phillips
Vermont Department of Labor
Montpelier, VT
Phyllis.phillips@Vermont.gov

Work Related Injuries Workshop
April 30th & May 1st, 2018

Words matter.

"I consider looseness with words no less of a defect than looseness of the bowels."

-- John Calvin

Go Sox.

- **Beware legal terms of art.**
  - "Aggravation (or exacerbation) of a recurrent injury"
  - "Curative" versus "palliative" treatment
- **Beware value-laden statements.**
  - "The patient *is not interested in* returning to work," versus "The patient *is fearful of* returning to work."
- **Beware stating facts about which you have no personal knowledge.**
  - "The employer has no modified-duty work available," versus "Patient reports the employer has no modified duty work available."

Play your part, know your boundaries.

- **Don't play lawyer.**
  - Legal citations have no place in a medical record.

- **Too much patient advocacy detracts from your credibility.**
  - Doctor who insists patient requires skilled nursing care, but cannot identify any medical basis for this conclusion.
  - Chiropractor who insists patient requires ongoing chiropractic treatment, *but only from him*.

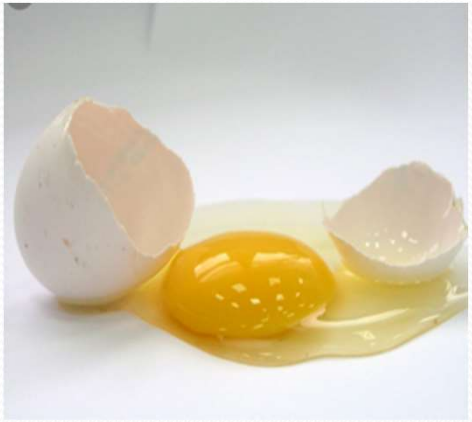
In workers' comp, causation matters.

- **Accurately reporting the mechanism of injury *really matters*.**
  - Did the injury occur while lifting? If yes, how much weight? Bending? For what purpose? Twisting? By itself or while lifting or bending? Slip and fall? Landing on which side? What body parts? Etc. etc.
- **Timing *really matters*.**
  - Did the patient complain *just of* neck pain, or neck *and* shoulder pain? *Just* low back or low back *and* hip pain?

Inaccuracies persist.

- "Words are like eggs dropped from great heights; you can no more call them back than ignore the mess they leave when they fall."

  -- Jodie Picoult



Decoding the Medical Record: How to Find Information in the EMR

Karen L. Huyck, MD, PhD, MPH, FACOEM
Assistant Professor
Section of Occupational and Environmental Medicine
Department of Medicine
Geisel School of Medicine at Dartmouth
Dartmouth-Hitchcock Medical Center
Karen.L.Huyck@Dartmouth.edu

Work Related Injuries Workshop
April 30th & May 1st, 2018

A very brief history of the EMR

- Originally office notes were tools for doctors to remind them what they did at the last visit
- Evolved into a communication tool among providers
- Now distorted primarily into a payment device

A very brief history of the EMR

Even for a person with medical training, documentation in the EMR has become gibberish…

Types of issues:

Copying and pasting
Authorship attribution
Unknown provider type
Typos
Voice dictation errors
Meaningless information/"note bloat"
Missing information
Wrong information
Templated information
Non-standard headers
Lack of assessment
Internal inconsistency (i.e., ROS contradicts history)
Privileging of the system
Prepopulated data
Linking to automated data in the system that can't be changed
Information in other tabs not integrated
Scanned documents not well labeled or organized
Patients can read all their notes

A very brief history of the EMR

For these and many more reasons, the gold compared to the straw in the EMR is very low, making it almost entirely impossible to follow what has happened.

Typos and voice dictation

This is a 47 year old male referred by her outside orthopedics for an onion about his lift need pain…

Assessment/Plan: Size 9 shoe

Plan: Patient Wilbur buy tomorrow

Copying and pasting

Sometimes there are only one or two words different between notes…or none at all!

In addition, copying the work of others instead of obtaining the patient's historical data themselves raises serious concerns about honesty and quality of care. At a minimum, attribution of authorship to copied text allows readers to distinguish between information obtained by the note writer and that which was simply copied.

Researchers at University of California San Francisco analyzed 23,630 notes written by 460 clinicians over eight months in UCSF Medical Center's inpatient Epic EHR. In a typical note, 18% of the text was manually entered; 46% copied; and 36% imported. Wang MD, et al. Characterizing the Source of Text in Electronic Health Record Progress Notes. *JAMA Intern Med. 2017: 177(8): 1212.*

Non-standard headers and meaningless data

Automated or imported categories appear in no standardized order causing breakdown of note organization…

Problem-based H and P:

- Chief complaint
- History of present illness
- Past medical history
- Medications
- Allergies
- Social history
- Family history
- Review of systems
- Physical exam
- Imaging and studies
- Assessment
- Plan

EMR note:

- Patient identifier
- Active problem list
- Notes from past visits
- Interval history
- Treatment history
- Patient goals
- Pain/Physical/Mental Status
- Care teams data
- Visit treatment teams
- Questionnaire on file
- Doc Flow Sheet Reports
- Orders
- Communication, etc, etc, etc

Missing data

Consult question: I am referring a 35 year-old laborer who sustained a material handling injury resulting in a left shoulder injury.
The patient reports constant right shoulder pain. On exam, the patient has positive cross body test, tenderness at the AC joint and supraspinatus weakness suggesting AC joint and rotator cuff injuries. MRI does not show full thickness tear. She has plateaued with treatment. Please help with diagnosis and further treatment to facilitate return to work.

Specialist assessment and plan: Right shoulder pain.
Discussed options. Patient will follow up as needed.

Missing data

"Symptom reporting was inconsistent between patient self-report on an ESQ and documentation in the EMR, with symptoms more frequently recorded on a questionnaire. These results suggest that documentation of symptoms based on EMR data may not provide a comprehensive resource for clinical practice"

Valikodath, et al. **Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records**
JAMA Ophthalmol. 2017;135(3):225-231.

Help is on the way?

Medicare is working to get rid of medical complexity criteria for billing; they are recognizing the problem and on course to fix it.

Medical errors and EMR

"The data presented in this study confirms that adverse events related to using electronic medical record systems exist, that they are associated with an appreciable incidence of severe harm and death, and that they are encountered across the continuum of healthcare settings."

Graber, et al. **Electronic Health Record–Related Events in Medical Malpractice Claims.** Journal of Patient Safety. 2015.

Cost savings?

JAMA: EHRs fail to reduce administrative billing costs

While EHRs were implemented with the idea that they would reduce administrative costs, Harvard and Duke researchers found primary care services cost providers about $100,000 annually.

Tseng P, et al. **Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System.** *JAMA.* 2018;319(7):691-697. doi:10.1001/jama.2017.19148

"We found no evidence that adoption of these expensive EHR systems reduced billing costs related to physician services."
Kevin Schulman, MD,
Duke Clinical Research Institute and Harvard Business School

How to get information when the information isn't there…

Non-medical users of notes:

- Providers are likely thinking, but in desperation have not written it down. Ask for reasoning.
- Detect if the provider feels uncomfortable and needs someone else to be the bad cop. They may be signaling distress with the plan, but need to get someone else involved while still maintaining their relationship with the patient.
- Read allied health professional and nursing notes to help find consistency in the record.

Medical providers:

- If you have trouble getting treatment authorized then explain what you want to do and why you want to and what it will accomplish (e.g., CBT is needed because fear of movement is getting in the way of rehabilitation)
- Go back to the standard H and P template
- Remember the assessment
- Pain is not a diagnosis
- Be aware that other parties are relying on you to document

References

Phillip Tseng, MEd; Robert S. Kaplan, PhD; Barak D. Richman, JD, PhD; Mahek A. Shah, MD; Kevin A. Schulman, MD. Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System. JAMA. 2018;319(7):691-697.

Michael D. Wang, MD[1]; Raman Khanna, MD[1]; Nader Najafi, MD. **Characterizing the Source of Text in Electronic Health Record Progress Notes.** *JAMA Intern Med. 2017: 177(8): 1212.*

Valikodath, et al. **Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records.** *JAMA Ophthalmol.* 2017;135(3):225-231.

Graber, et al. **Electronic Health Record–Related Events in Medical Malpractice Claims.** Journal of Patient Safety. 2015.

Zahabi M, Kaber DB, Swangnetr M. **Usability and Safety in Electronic Medical Records Interface Design: A Review of Recent Literature and Guideline Formulation.** Hum Factors. 2015 Aug;57(5):805-34.

Weis JM, Levy PC. **Copy, Paste, and Cloned Notes in Electronic Health Records.** Chest. 2014 Mar;145(3):632-638.

Bernat JL. **Ethical and quality pitfalls in electronic health records.** Neurology. 2013 Mar 12;80(11):1057-61.

Acknowledgments

Jennifer Christian, MD
Ross Koppel, PhD
Matthew Huyck, My Fairy God Tech

Red Flags That Treatment is Off the Rails

Dr. Jennifer Christian

Work Related Injuries Workshop
April 30th & May 1st, 2018