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Proem

Expecting an error-free medical record seems unreasonable - too many opportunities, too many forces, too many players, too many perspectives. Not having error prevention and correction hardwired into our workflow and documentation processes also seem unreasonable. Last week we spoke with Virginia Lorenzi about technical solutions to correcting errors in medical documentation. Virginia talked about information system solutions to aid human problems and solutions and understanding the different types of errors. This week I read an article in the Washington Post about mining records for outdated data to enhance billing. Another level of error.

As with any concern, the more you discover, the less you know. I do know that the endpoint is best health. Going upstream – best health includes community and personal habits, which comprise care, treatment, and policy decisions. Upstream from that is analysis and interpretation of data and at the source is data itself, the more accurate, the better. Or moving back downstream – accurate, relevant, accessible data with analysis and interpretation of that data, finally, informing action for best health.

Introducing Peter Elias 01:41

Today, Peter Elias, a family practice doc, joins us to discuss his documentation journey. Peter is retired from active primary care after 38 years as a family physician in Maine. We met at the Society for Participatory Medicine, working on several projects together.

Medical documentation over the years 02:42

Health Hats: Peter, what I wanted to talk to you about is three things. I wanted an all related to documentation errors in the EHR. The risk of errors, preventing and fixing errors for patients and clinicians. So that's huge, and I'm not looking to be comprehensive. More to think about just talking with you about your take on those and how you manage those in your experience as a physician. So, start anywhere.

Peter Elias: I'm part of the cohort that did my medical document on paper for a long time and then switched to digital. And medical areas are very different in those two circumstances. I don't think many people are doing it on paper purely anymore. I won't talk much about that unless it comes up personally. The computers are trade-offs. The digital records provide certain scaling and efficiency at the cost of flexibility and individuality. So, in the paper world, you can write down pretty much any word you want for a diagnosis or symptom. And in the digital world, we're often stuck picking a checkbox or a number from a predetermined list. So, the system is based on some artificial, external constraints that a background error it's it would be as if you were told to go grocery shopping and give it a list of fruits that only had four fruits on it. And if you wanted one of those four fruits, you were all set, but if you wanted a fruit that wasn't on the list, you were stuck. So that's one part. Another part is that the documentation has been done over time, mainly after the visit.

Health Hats: Okay. So, I see my doctor. We do what we do. And then, at the end of the day, they're documenting.

Peter Elias: Yes. Okay. And for several years in the old paper world, I would take a pile of charts home at the end of the day with my little handheld Dictaphone, lock myself in a small room, and sit down with the charts and some I took and dictate notes. Then somebody would transcribe and put them; very few systems ask the clinician to review the transcription. So, I dictated mistakes, and the transcriptionist misunderstood what I said, and it got pasted into the chart, and it didn't show up again until it was a problem.

Records go from paper to electronic 05:55

Peter Elias: Nobody I knew was counting or paying attention. It changed a little bit when documentation became part of the reimbursement system. But I am old. So, when I started, we decided what we charged and whether the patient or the insurance company paid or they didn't. And nobody ever looked at their chart to see, and with the electronic record, The documentation is a huge factor in reimbursement. And so that number one that's pressure, if you don't use the right terms, the reimbursement goes down. So obviously, there's some pressure to use the most remunerative terms that you can imagine, or to check three boxes, because you mentioned one of those three things, not because you dealt with it. There is that pressure. I liked to consider myself immune to that pressure, but I'm human. So, I doubt that I was as immune as I pretended. For me, a transformative thing happened two-thirds of the way through my practicing era. It changed the way I approached documentation. It was named primarily at error. But it had a huge impact on accuracy and errors.

Copies of doctors' notes to patients, sometimes 7:16

Peter Elias: Should I describe that? I saw a couple for a relatively long visit about a new complicated diagnosis. It was going to require that they get specialty care in a couple of different places besides my primary care. And we made a plan. They were young artists, an engaged couple. And at the end of the visit, I reminded them that our medical record system in this country is fractured and not very responsive. And if they needed it to steward their information, I told them to ask for a copy of every test, every x-ray, and every note or letter. And organize it in a binder and bring it to all their visits because that was the only way they would be sure each person saw what the last person did on the way out. My patient's wife smiled at me and nailed me to the wall. She said, how do we get a copy of your note? And until that day, I had never given a patient a copy of their note that I could recall. So that night, when I was making their note At a somewhat different mindset. I was doing the note, knowing I would give it to them the next day. And I realized that my usual phrasing was how I usually made the note. It was my note about my visit. It was entirely my perspective on the interaction, and to the extent that a patient appeared in the note, it was always third person. The patient says, the patient denies, and the patient exhibits, all these medical phrases that clinicians are fine with. And I was uncomfortable with that. And I wrote that note differently. I used we a lot. We decided to do this. We decided this was important, and that felt different. I thought about that and said, okay, I'm going to try to write my notes as if the patient is going to look at them. Of course, as if it's one of those powerful phrases, you can do anything with as if, and then two other things happened that same week. Two days later, one of my trusted, respected, highly competent colleagues came to me unhappy with the fact that I had seen one of his patients and included in the note a phrase about this patient who hasn't had an A1C done in nine months, which is inconsistent with current best care. And he was justifiably upset that if the patient or a litigation attorney looked at that note, I had dug a hole for him. He wasn't apologizing for not having done the A1C. He just would have liked me to have said the last day, once he was on such and such a date, and then a couple of days later, the nurse I worked with who knew I had given a copy of their note asked me to give the note to a patient that I saw that day. Now Tiffany is a great nurse. I trusted her. We were a great team, and I never brushed her suggestions aside, but I did that. I said I gave it to them. You don't have to give it to everybody. And she looked at me. She said, well?

Always 10:28

Peter Elias: And that kind of tipped me over the edge. So, I decided to try to give my notes to everybody, and I had to change my workflow. When I've talked about this, it wasn't that overnight. It didn't mean that the next day was fixed, but a year later, I gave every patient a copy of their note at the end of the visit. We get printed at the front and front desk but give it to them. And as I said, I didn't do that primarily for accuracy. One big thing happened to give them the note. I had to do it during the visit, to document during the visit and still maintain contact with them. I didn't feel comfortable turning away from the patient and typing and then turning back to the patient and then turning away, turning back.

Patients feel reassured 11:21

Peter Elias: So, I had the patient sitting next to me and said, okay, let's document today's visit together. So, they saw what I typed, and I could check with them. And I meant that I had to say out loud what I was typing, which meant that I explained a boatload more stuff to the patient that I might not otherwise. There's stuff in my head.

Health Hats: Yeah.

Peter Elias: And one of my fears going through this was that it would freak patients out if they knew I was ordering a test because I wanted to make sure such and such wasn't happening. They were generally relieved that I was thinking about things like that and doing tests to make sure such and such wasn't happening, that they were already worried about were things that I was right, so I quickly discovered I wasn't alarming patients by thinking out loud, I was reassuring them. That was a surprise. I thought I was doing them a favor by being private with my thoughts and discovered that level of transparency was a tool. Yeah.

Care planning and collaborative notes 12:20

Peter Elias: When we came to do the assessment and the plan, we would generate a list, and I could tell them which parts of this plan looked like? And then, I wrote it down in my chart and tested them when they returned in three months. They're going to be a challenge. Is there anything we need to talk about or problem solve? So, a step wasn't there when we just talked about it.

Challenging conversations 12:46

Peter Elias: What did you do? X, Y, and Z, because we now said we have X, Y, and Z. You will be hard. You talked about. Another thing I learned was that the challenging conversations about abuse or drug abuse, domestic abuse, and onsite environments were more effortless. I thought they'd be harder, but they were easier because it came up, and I would pause. And I'd say the patient, though, this will be a little hard to write about. So how are we going to write this? In a way that both of us understand it and are comfortable with what's written down. And I think that made it a little easier for the patient that distanced them a little bit. Yes. They were talking about it like a screenplay, and it was a little easier to talk about it and come up with less emotional terms and descriptive terms. And I got much less pushback having those conversations, doing it that way. So, that is true with patients with two

psychiatric illnesses, delusional disorder and schizophrenia. I had to be overt about which of the things that they were talking about that I thought were real in my environment and which were only real and theirs, and that facilitated our conversations.

Families, records, getting it right 14:00

Peter Elias: We had common ground for discussing and errors. Errors got filtered out while I was typing. Nope, it wasn't June. It was July. I just said it was July, and they would go home and show it to their spouse, family, parents, or whatever, who would look at it and say, no, you've got it wrong. It wasn't your father who read that. It was your grandfather and stuff. And so, they would write with a lot of additional information or corrected information that happened.

Using a scribe to assist with documentation 15:16

Health Hats: I appreciate several things about what you're saying, but the one that comes to mind right now is that the more people see data and information, the more they can. It feels like it's theirs. The more it's accurate. My PCP has a scribe who is in the room. Somebody I also know and feel comfortable with, and she's typing, she's like looking stuff up, when we have a question, she'll Google it, and make that available for us to see. And we can talk about what I'm going to do. Not just what I got told to do or what did I, what I did, she'll go back and say, she'll help the two of us, my doctor and I, to this is what we said last time, so that's, part of it

Misdiagnosis and long-standing error 16:24

Health Hats In that scenario, correcting and preventing errors are part of the flow, as you were saying, but then there's stuff that has implications that is hard to fit. Like I have MS. When I finally got diagnosed with MS, the neurologist said I'd had it for 25 years, and my PCP every time, like two or three times a year, I have an episode. Since my dad died when he was 45 of his second heart attack, I would get a cardiac workup, which by the time it was done and negative, my episode would be over. And so I have this long history of cardiac disease that was Ms. Every time I go to a different doctor, I have to say, I don't have cardiac disease, and they believe me. But I can't get it changed. It's like a problem that can't, that doesn't get off the system. And I'm on top of that, and I know that's a problem, but it's upsetting. It's just taking more energy. When I go to the doctor, I pick my doctors who are good doctors and collaborative. But it kills me that my PCP refers me, knows me, and refers me to doctors who I'm sympatico with, but still, I'm going because I got a new problem, and I still got to explain all this, these errors that are in the system.

Preserving data, accurate data, workarounds 18:02

Peter Elias: I talked to my son a little bit about that, who has chronic medical problems and is a computer person and data analyst. He's a Ph.D. in statistics and probability. And he does computer management for educational institutions and health institutions. And we've discussed the challenge of preserving data history's integrity and providing an accurate, current picture. And from his perspective, ultimately, the only way to do a good job of that is to design the system from the ground up, knowing that's going to be a requirement. It's tough to layer that on top of the standard database. My workaround came up with patients more common for me than MS masquerading as cardiac disease. Instead, I saw various medical illnesses labeled as depression or anxiety. And so, I would have patients who'd been on 17 antidepressants and seen four or five psychiatrists before their medical illness was identified and addressed. I couldn't go back in time and erase those code numbers, but I think I can have it right near the top of my problem list, a document I then sent to other places. A fairly plain vanilla code that I would then overwrite the DSM thing and say, a long history of X, misdiagnosed as depression. And then, I could include what was right at the top of the problem list. I could make sure, and patients would remind me, we would have that discussion. They would remind me that I could start with my letter to a consultant, Mrs. Jones, a woman I followed for 15 years, who has a long history of her such and such being misdiagnosed as depression. That doesn't get rid of everything in the past.

Health Hats: But it deals with tomorrow.

Insurance companies 20:24

Peter Elias: Yes. But it's a challenge, and that was not a perfect solution because the insurance company, for example, only sees the number. That's why I would not take the diagnosis, leaving the depression in there, and just rewrite the text that went with that number, which you can do in most medical records. Because the insurance company would only see the number, they would only see depression. Some things you can move to past history. Which is another entire story. We say a past history of pneumonia, and people assume it's over, but you say past history of depression, and people assume it's only in the closet waiting to jump. And if you say past history of cancer, that may not be a smart thing to do because we were never really a hundred percent sure, that sort of stuff. We say cancer, no evidence of disease as opposed to cured.

Open Notes, relationships with clinicians 21:27

Health Hats: So, if there are engaged patients and family members who are trying to build that relationship with their clinician. You're talking about Open Notes. I'm just trying to think about how we, as patients, become more attuned and more collaborative in our relationships with those few important clinicians - I see six or seven physicians. Still, two are key: my PCP and my neurologist. They're my key clinicians.

Not at your best at the doctor's office 22:13

Health Hats: I'm pretty aggressive, but I still find it hard to have those conversations. Unless I got a bug up my butt, I'm angry about it. Then I sort of don't have a problem, but I can get to the doctor. You're

not at your best. You're worried. One of my sponsors is Abridge. One of the reasons that they sponsor me is they have this app that you record the visit, which is a godsend for us because I go home, and I don't know what happened. I don't remember what we did and what we said. And so, I have a recording that we can listen to, and as you said, she can say, wait a minute, that's not right. Why did you tell him that? Or why didn't you say this? That is what errors are made of is not good communication but being sick by definition is not good communication.

Peter Elias: I'm a basically healthy person with a lot of medical experience, and I'm not at my best when I go to see my physician for a routine visit. Yeah. I feel at risk walking in there, and that's a certain sense of vulnerability. And if that happens to me in an office where I worked for 40 years with a clinician who was a resident who trained under me when I'm feeling healthy, I can't begin to wrap my head around what it's like for somebody who's in pain or having trouble breathing. Who thinks they're dying of what their uncle died of. So, patients ask me or used to ask me how can I get my other docs or nurse practitioners to do what you're doing?

Health Hats: That's the question?

Peter Elias: And I don't have a magic answer. So, if you were hoping that I had a pat phrase, a bumper sticker, that would always work. Sorry. No.

Health Hats: I wasn't really.

Getting the most out of it 24:10

Peter Elias: But I think I made a difference on some of the time by encouraging them to point out to the other clinician that I don't want to waste your time here today. I want to make sure I get the most out of our visit. Part of that is impacted by the fact that I can't remember when I get home, or my wife couldn't join me today, and she usually helps me stay on task. And so you're, there's this it is taking responsibility for something that is to necessarily, it's saying, it's my fault that isn't working, and I'm a little uncomfortable with the patient having to play that game. So, it will be really useful if I have a copy of the note. It's a small price to pay.

Coaching other docs 25:04

I live in Maine and don't have the same depth of consultant opportunities for my patients that I might if I were in New York, Los Angeles, or Boston. So, I sometimes have to. I couldn't just pick the right person. I had to find somebody and get the consultant to trust them. I have to practice ahead of time. So, I knew I was going to not use red flag words. But I could call or write to consultants to say it would be helpful for this patient and me. I've been doing it with them. They're comfortable with it. It's not a problem. You'll get really good feedback if you do your note while they're watching, and they can fill in some of the blanks. They'll see some stuff and note that will help them remember. And I don't think I had any other clinicians who flipped over to my diving into the deep end of the pool here, but I think I changed

some behaviors. Some. I had a lot of male patients who told me how nice it was to go home and when their spouses asked about the visit, they said, " Here, read this.

Health Hats: Totally. Totally.

Peter Elias: And my partners appreciated the notes because. They knew where the patient and I were literally on the same page. They knew exactly where the patient was. They didn't have to worry about whether the patient knew this or not because it was all there.

Emerging issues 26:40

Peter Elias: I should mention then probably that when patients had additional information or correction, my medical record allowed me to append that visit with a comment note if you will, and then correct or add to the diagnosis, I couldn't erase the old stuff, but I could make sure there was an electronic attachment to that. So, anybody who had access to the first part would also have access to the second part. It's not perfect. And then the other thing I would mention is there's a new problem arising in that transgendered individuals are beginning to find that they are denied procedures or medications because the insurance company only accepts, only approves it, based on what's in their record. And that's an example of how the system constraints get in the way of taking care of an individual.

For other clinicians 27:36

Health Hats: Yes. And what do you think we should have talked about in this

Peter Elias: So, I think there are a couple of the things I like to mention, especially if conditions are going to see any of this. And one is that I had always been proud of how good my charting was that it was organized, accurate, and well documented until I realized what it looked like to others. It was beautiful private notes but didn't pass the publication test. And that's changed when explicitly documenting for publication downs, small audience. So that was one thing. And the other is there was some cost to me in terms of effort. I did spend time every morning looking at the charts and doing a little clean-up, sometimes typing a list of things to talk about and the HPI to make the visit run more smoothly, so I didn't have to do as much housekeeping.

I didn't want to spend time during the visit taking out last year's urinary tract infection from the problem list. I wanted that. But it meant when I went home at the end of the day, I was done, saving me two hours every night. Yeah. Oh, two hours of family time. And that was wonderful. That was wonderful. That was fantastic. And made me happier. And I'm convinced that the error correction, patient engagement, and collaborative workflow. Those alone make it worth doing it is my institution didn't have open notes. I was doing this. I attracted a little attention from the administration. They weren't entirely pleased with what I was doing, but they stopped. You're trying to stop me.

Reflection 29:12

Wouldn't you be delighted to have Dr. Elias as your PCP? A learning individual. So many ways to look at documentation, errors, informed decision making. What has worked for you? Let me know. See you around the block.