

Title:

Patient-Clinician Encounter Documentation in the Electronic Medical Record (EMR) by Ambulatory Care Clinicians

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References:

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Abstract Summary:

A poster presentation comparing clinical documentation of ambulatory clinic visit interactions with complex chronic disease patients by ambulatory primary care physicians and nurse practitioners. Qualitative content analysis of audio recordings identifies aspects of the interactions for comparison.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
1. The learner will be able to discuss the importance of documentation of psychosocial aspects of care.	I. Introduction/Background II. Methodology a. Patient-Clinician dyad recruitment b. Patient-Clinician dyad recordings c. Qualitative content analysis III. Results a. Coded data categories b. Physician-NP encounter comparison c. Physician-NP documentation comparison

2. The learner will be able to describe the patient's definition of a successful ambulatory primary care encounter.

d. Patient definition of a successful encounter
e. Patient perception of communication strategies IV. Discussion
a. Implication for clinical practice
b. Implication for clinician education
c. Future research opportunity

Abstract Text:

Background

Clinical documentation in electronic medical records (EMR) provides improved data access across systems, more rapid coding and billing of medical encounters, and opportunities for improved data management. Accurate data stored in the EMR can improve patient safety, quality, and health outcomes. Psychosocial factors such as community resources, patient's family or friend support, and social and financial factors influence health outcomes. Psychosocial information is frequently processed between patients and clinicians in face-to-face encounters. In ambulatory Oncology clinics, patients frequently express psychosocial information to clinicians. Arnold, Tulskey, and colleagues (2011) demonstrated that patients express similar psychosocial or emotional utterances to physician and non-physician clinicians. Often, billing metrics influences clinician documentation. Clinicians perceive documentation of psychosocial factors or conversations as a lower priority due to time constraints or lack of reimbursement (Conrad, 2012). How clinicians document their encounters influences how other clinicians understand patient health priorities, plan of care, and progress of the plan of care. This poster presentation incorporates previous collected physician data examining linguistic strategies used in interactions between complex chronic disease patients and ambulatory primary care physicians, including physician strategies for clinical documentation of the interactions. The purpose of this study is to qualitatively analyze patient-nurse practitioner (NP) encounters for interaction content based on content themes from the patient-physician interactions and compare NP data with physician data for similarities or differences.

Methods

Eleven primary care ambulatory patient-physician dyads were recruited for a linguistic strategies study with the goal of identifying what is best practice for communication between patients and physicians to enhance patient satisfaction and health outcomes. Physician recruitment and analysis is complete while the NP arm of the study is ongoing. Five patient-NP dyads are being recruited to evaluate best practice for communication strategies with complex chronic illness patients. Each dyad has three audio recordings; 1) a recording of the actual patient-NP encounter without the researcher present, 2) a recording of a patient-researcher interview while the patient listens to the replay of the encounter, stopping the recording to make comments or give explanations of specific portions of the encounter, and 3) a recording of a NP-researcher interview while the NP listens to the replay of the encounter, stopping the recording to make comments or give explanations of specific portions of the encounter. During both interviews semi-structured questions help define what specific strategies create a successful patient-NP encounter. Recordings are transcribed, without identifying characteristics, and content qualitatively analyzed and coded by two independent researchers. Qualitative content analysis of interactions and clinical documentation identifies which aspects of the interactions are included or omitted in clinician documentation. Four of Five patient-NP dyads have been recruited.

Results

The patient-physician data was coded into four categories; 1) chronic condition, 2) acute/new problem, 3) disease prevention, and 4) patient care preferences and social determinants of health. Patient care preferences and social determinants of health category were further subdivided into 1) death and dying, 2) barriers, 3) emotions, 4) preferences, and 5) life/relations. Discourse analysis of the patient-physician encounter and playback interview sessions demonstrated that both patients and physicians introduced

clinical symptoms and psychosocial concerns during ambulatory clinic visits. Physicians used a range of verbal and non-verbal strategies to acknowledge patient contributions. Patients perceived physician strategies as showing interest and understanding their perspective to create a successful encounter. Physicians expressed purposeful engagement in psychosocial conversations to promote trust and buy-in for treatment plans. However, review of the EMR produced limited clinician documentation of psychosocial concerns. Going forward, five patient-NP and five patient-physician dyads will be compared for similarities and differences in interaction content and clinical documentation.

Discussion

Providing psychosocial patient information in the EMR may assist in understanding patient preferences and challenges to managing successful health outcomes. More complete EMR documentation may promote improved communication across interdisciplinary teams contributing to efficient, high quality patient care and improved patient satisfaction and health outcomes. Understanding what clinicians include in EMR documentation from patient-clinician encounter interactions may pinpoint areas for improvement in EMR templates, allow consideration of a standard language for accurate documentation of psychosocial aspects of care, and have implications for clinician education. Future research will focus on understanding barriers to documentation of psychosocial aspects of care.