Managing Patient-provided Information in EHRs

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Ensuring correct and complete patient health information is an ongoing challenge for healthcare organizations. Patient-provided health information can help organizations gain a more complete view of a patient's health, and electronic health records (EHRs) provide multiple tools that allow patients to review and update their personal health information and add information to their health record.

Healthcare organizations must ensure the information patients provide is accurate and easily accessible to physicians, while also maintaining the integrity and validity of the legal health record.

Providing a Complete Patient History

Patients often can provide current, relevant health information, including:

- Clinically relevant family history
- Social history
- Surgical history
- Allergies
- Current medications (prescription and over the counter)
- Other health information, including immunizations, test results, history of present illness, and review of systems

Such information can fill gaps in the patient record. Clinically relevant family history is frequently missing or not readily available in the EHR.[1] Medications are often not up to date, and over-the-counter medications are often missing.

Methods for Obtaining Patient Health Information

An important factor in ensuring that health information is recorded into the EHR in a usable format is the method in which it is provided. The information needs to be entered and updated in the EHR in a manner that easily allows physicians to locate and review it.

In the paper world, physicians often rely on the patient interview during the appointment. However, this has proven to be an ineffective method to garner all pertinent clinical information. Appointments often focus on the current reason for the visit. For this reason, the information from traditional history taking is often incomplete as well as time-consuming to collect and document.

Many healthcare organizations have developed paper health assessment forms. Although these forms provide structure to an interview, they are not comprehensive or personalized. Many times, the form is scanned after the patient has filled out the form and turned it in. However, if there is no method to extract the pertinent information into the EHR, the physician may never see the information on the form again.

With the advent of the EHR and patient portal technology, there are more opportunities for the patient to review, update, and correct information. Patients are now able to e-mail or send electronic messages with relevant family history or medications to physicians. The physician can then add this information to the EHR.

Often the e-mail is copied into a note and saved. However, the information is no longer readily available for patient care because it is imbedded in a note and not entered into the appropriate section in the EHR. Physicians should be trained on the different sections of the EHR in order to save relevant information from the e-mail to the appropriate section in the EHR. This will ensure the information is available for patient care.

Portals also provide patients with the ability to enter the relevant information through online data entry. Personal health information can be entered as both discrete data and free text.

Whether paper or digital, patient-reported data should be considered a viable method of enhancing documentation, though it is not likely to be as complete and accurate as more comprehensive data exchange between providers. Medical personnel should use their medical judgment to oversee the integration of patient-reported medical information into the EHR to ensure the information is correct and complete.

Barriers to Patient-entered Data

The design of the EHR tool patients use to enter their medical history, whether electronic messaging or a Web portal, is important. If it is difficult to understand, patients will not use it consistently. The use of medical terminology may be a significant obstacle for participants if they do not understand what they are entering.

The navigation's design is also important. If patients get lost in the tool, they will not want to take the time to add additional information. Other barriers include lack of patient familiarity with digital media and concerns with security and privacy of data.

There are also literacy concerns with patient computer entry. The average American reads at an eighth- or ninth-grade level, and one out of five Americans reads at a fifth-grade level or below. However, most healthcare materials are written above a tenth-grade level.[2] Finally, there are patients who just do not want to use a computer.

Physicians may be concerned with the accuracy of the information recorded if there is no oversight by medical personnel. Physicians may have concerns about the patient's interest in editing his or her record. In turn, patient autonomy may threaten the control and authority of some physicians, based on traditional provider-patient roles.

Benefits of Patient-entered Data

Organizations that use EHR tools to allow patients to provide data will reap benefits for patients and providers.

EHRs that allow patients to enter their own health information may improve patient quality of care and patient satisfaction. Patients can in turn leverage this access to improve their health and manage their diseases. These types of EHRs can also provide an ongoing connection between patients and physicians, changing encounters from episodic to continuous.

These EHRs allow patients to proceed at their pace. Patients who are deaf or have other special needs may find using the computer helps them update their histories. The computer does not replace the physician, but it does initiate the process for collecting a complete history.

Patients entering data into their health records can submit the data into their clinicians' EHRs, providing a more complete and accurate patient history. The more information a patient provides, the better a physician's ability to make the best care decisions.

Patient-entered data may provide a conduit for improving health information exchange. All providers have access to the updated patient-entered information.

Patients Taking the Reins with PHRs

Patients are taking greater control over their health information. One way they are doing this is by maintaining personal health records (PHRs). AHIMA's Web site www.myPHR.com provides a list of some of the available PHR products on the market today.

Unfortunately, the reliability and validity of the end product can cause it to be of limited value to a provider. Information entered by the patient may be incomplete or inaccurate. As with the other tools, medical personnel should use their medical judgment when integrating this information into their systems.

HIM's Role in Maintaining Patient-entered Data

The HIM department is responsible for maintaining a complete and accurate record of care and a legally sound business record. As such, the HIM department must outline policies for patient-entered information and tie it to the organization's legal health record policy.

This process should include key disciplines in the organization. An organization's legal health record definition should include externally generated information that is used to make clinical decisions about patient care and treatment. Organizations will also require workflows that ensure patient-entered data are reviewed and validated by clinicians.

As more patients provide clinical information, the HIM department will find itself working with patients more frequently. HIM professionals will be responsible for educating consumers about the management of their health information.

HIM professionals can provide expertise regarding information acquisition, storage, and exchange methods and tools in personal health information management. Patients may identify corrections or amendments to the information they entered. HIM professionals in conjunction with the healthcare provider must ensure the patient data are corrected and updated when the information has been recorded incorrectly.

Notes

1. Staroselsky. M., et al. "Improving Electronic Health Record (EHR) Accuracy and Increasing Compliance with Health Maintenance Clinical Guidelines through Patient Access and Input." *International Journal of Medical Informatics* 75, no. 10-11 (Oct.–Nov. 2006): 693–700.
2. Doak, C.C., L.G. Doak, and J.H. Root. "The Literacy Problem." *In Teaching Patients with Low Literacy Skills*, 2d ed. Philadelphia, PA: J.B. Lippincott Co., 1996.

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