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SETMA's Policy on Completion of Medical Records

The medical record is a by-product of the health care experience. The evolution of medical records can roughly be categorized into three iterations at their best:

- 19th Century records which were pencil and paper.
- 20th Century records which were dictation and transcription.
- 21st Century electronic health records.

Records reflect the care received by persons and can be characterized as silhouettes or portraits. The silhouette is a depiction of a person but with such little detail as to give very little information about a person. As picture of a human the silhouette can be charming but as a medical record, it leaves a great deal to be desired. A portrait is greatly desired as a picture as it reveals great detail about the person. As a medical record, a portrait grows with each encounter and communicates a great deal about the person.

19th and 20th Century medical records most were silhouettes of a person's healthcare needs and history. However, beginning with excellence in dictation and expanded in the 21st Century with EHR, medical records increasingly portrayed a detailed, granular documentation of a person's heath status and health needs, along with the care they have received. The capabilities of EHR allowed providers to go beyond "what had happened to" and "what had been done for," a person, to where it is possible for the record to reflect what should happened in the care the person will receive and what the patient can expect as a result of the care they receive.

In addition, as in SETMA, the EHR can simultaneously be available in many different locations. All of this was discussed in a booklet published by SETMA in May, 1999, entitled ***More Than a Transcription Service: Revolutionizing the Practice of Medicine: And Meeting the Challenge of Managed Care With Electronic Medical Records (EMR) which Evolves into Electronic Patient Management.*** **(**This article can be read at http://www.jameslhollymd.com/your-life-your- health/medical-records-more-than-a-transcription-service**)**

Medical Record Policy

Policy should always flow from philosophy, in which case medical records are a by-product of healthcare and not the object. The object of care is the fulfillment of the Triple Aim, i.e.

improved health, improved population health and decreasing of the cost of that care so that it becomes sustainable. It is imperative that this conceptual point not be lost. Many tools are used today to produce excellence in healthcare delivery. EHR is one of those, but it must not be forgotten that the object of that care is not a record but a patient who is healthier and who lives in a healthier community.

Patient-Centered Conversation

As a result, the content and nature of the patient encounter is much more important than the record. In a patient-centered medical home that care should be "patient-centered." It should be founded upon patient-centered communication which is explained in Dr. Carlos Jaén's article, *Patient-Centered Communication*, which was published in *Family Practice Management (*www.aafp.org/fpm March 2008 Ronald M. Epstein, MD, Larry Mauksch, MEd, Jennifer Carroll, MD, MPH, and Carlos Roberto Jaén, MD, PhD) and which was included in SETMA's monthly provider training at http://www.jameslhollymd.com/Presentations/What-is-patient-centered- communication.

Patient Activation and Engagement via a Shared-Decision Making Encounter

The effect of the patient encounter, which is to be guided by an EHR and which will result in a record of that encounter, is that the patient will be activated and engaged in a process which is identified as shared-decision making. That process is defined, described and detailed in: http://www.jameslhollymd.com/your-life-your-health/patient-activation-and-engagement.

Timing of the Completion of the record

In the day of EHR, the timing of the completion of the medical record is more complicated than it once was. First, the details of the encounter as to chief complaint, history of present illness, review of systems, physical examination, assessment and plan of care, should be completed at the time of the patient visit.

To maintain the integrity of the record and to allow for all of the information and medical decision making from a particularly encounter being included in that visit's record, SETMA does not "lock" a visit until seven days after the visit. During that time, laboratory values, procedure results and other data is collected and can be included in the patient encounter. At the end of the seven days, the visit is locked. After that any changes or addenda to the visit will be done in an addendum which will be attached to the visit to which it applies but will be data as of the date the addendum is created.

Note: The limitation to this is that if a challenge to the patent's care is made in the interim, any further additions to the record after that will be done as a dated-addendum so that the date that the addition is indicated. No record will be changed after a question is raised by the patient about their care, but an addition can be made to the record as long as the date of the addendum and the fact that it is an addendum is documented.

Second, the completion of most risk assessment tools and disease management tools can be completed during a regular visit; new data from the tests ordered during the visit can increase the value of the encounter if the new data is incorporated into the visit. This requires waiting a day or sometimes 2-5 days for the test results to return and to be incorporated into the visit.

Third, the result of this second step often will suggest or require another set of evaluations and that can be documented in this encounter before it is locked. Fourth, when the patient is contacted the next day or several days later when the evaluation results are available, delaying the locking of the visit allows for the reporting of results of the visit to be incorporated into the encounter record. Of course, unlike paper records where the only timing and dating is done by hand, the computer time and date stamps every addition to the record, increasing the integrity of the record.

An Example of the Evaluation Process which continues after the Patient Visit

Another reason for delaying the locking of a visit is so that analysis can be done, and the patient's plan of care and treatment plan can reflect the analysis and data which has been developed and/or gathered in the mean time. An example of this can be seen at the following link: http://www.jameslhollymd.com/medical-home/teaching-tool-for-pc-mh-course. This is an analysis of the care of a real patient encounter with all identifying information removed.

Because SETMA has a ***Patient-Centered Medical Home Senior Medical Study and Primary Care Resident training program***, we have developed a syllabus which can be reviewed at: http://www.jameslhollymd.com/senior-medical-student-externship/SETMAs-MS4-Patient-Center- Medical-Home-Selective-Syllabus. The above medical record teaching tool illustrates the analysis and detailed plan of care which can be developed after a patient encounter.