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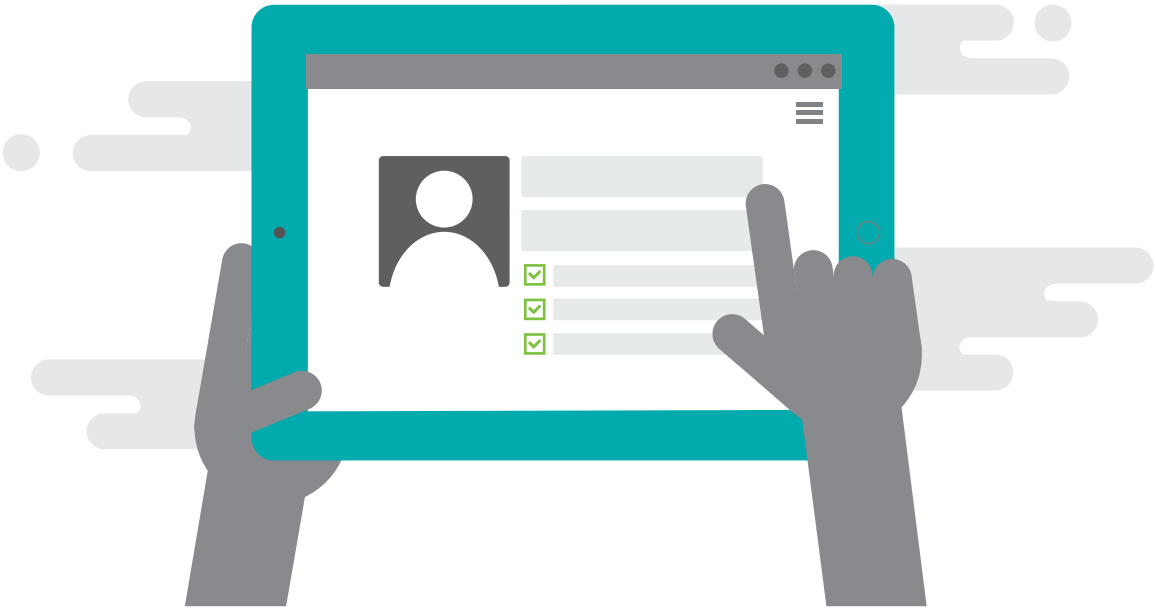

STREAMLINING PATIENT HISTORY COLLECTION

HOW TO MAKE HEALTH RECORDS COMPREHENSIVE, ACCURATE, AND ACTIONABLE

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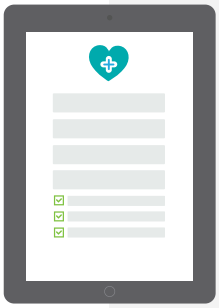
EXPERTISE & SERVICES: Providers

Understanding the medical, surgical, social and even family history of a patient is a fundamental component of enabling the most accurate treatment plan. This comprehensive review can ensure treatment plans are most effective and have the highest likelihood of patient adherence once the patient goes home. A significant challenge for clinical staff is how to most efficiently collect this vital data across a health system. Too often, clinicians and providers collect patient history on paper, which then needs to be transcribed into the electronic health record (EHR) in order to be leveraged across clinical care teams along with the patient's current EHR data for comprehensive analysis.



There are several recognized barriers to history taking during a patient encounter:

- Patients can be inconsistent in their recollection of events, due to difficulties in comprehension, recall, evaluation and verbal communication
- Respondents may provide misleading face-to-face reports because of fear or embarrassment
- Physicians may use medical jargon that can intimidate or confuse patients, leading to incomplete problem presentation and reticence to offer details.[1]

The most efficient and lean approach to collecting patient history is for patients to complete the questionnaires themselves electronically via smartphones, tablets and computers prior to a visit. This information can then be pulled into the EHR by the provider prior to or during the visit, allowing for more "quality" time that have patients to think and accurately document their history, including talking with family members. Studies have shown that patients who provided their history via electronic devices including computers, tablets and smartphones provided *"40 percent more important new information, and this information led to improved communication with 22 percent of patients."*[2] Collecting patient history electronically also saves providers documentation time in the clinic and allows for more focused discussion between the provider and patient in developing the treatment plan.

THE APPROACH

A three-pronged approach to developing a patient history questionnaire strategy includes:

Proof of Concept

Each specialty within a health system frequently has their own version of a historical questionnaire; the challenge is often how to most efficiently transcribe electronically without overburdening information service resources and approach the build in a way that is easy to modify going forward. The easiest way to approach a proof of concept for an enterprise patient history questionnaire is to form a committee to collect the current versions of patient history questionnaires used across the health system to assess similarities to create a base version. Having a core patient history questionnaire base can enable the expansion of the survey to additional clinics and specialties as well as future updates by assigning an additional specialty-specific questionnaire.

Piloting the Approach

Once a base patient history questionnaire is finalized, the proof of concept can then be piloted to ensure the tool is truly patient friendly and meets the needs of the clinicians leveraging the tool. It is at this point that the questionnaire can also be tested across various technology platforms to ensure the tool integrates appropriately into the EHR, and that the necessary patient and staff and education is created and trained as part of implementations. Often it is best to test with the broadest patient population to account for a wide array of clinical diagnoses, making primary care, internal and family medicine a prime place to pilot such an enterprise-wide initiative. Additionally, the broad approach allows for primary care physicians to encourage specialists they interact with to adopt the approach and for patients to grow accustomed to using tool prior to implementing in the specialty offices.

Deploying and Integrating

Once the base has been designed and implemented, the enterprise will need to consider how frequently the patient completes a history. To align with current clinic operations, it is likely best to have patients complete the base history questionnaire prior to or as part of a new patient visit. It is also necessary to ensure accurately capture the patient's history annually within primary care, potentially as part of the patient's annual physical or the first sick visit after a year from when they completed the questionnaire last. Considerations do need to be made as to how the information is pulled into the EHR and updated to ensure a full view of the patient's history and to ensure duplicate information does not clutter the history view in the EHR, as well as how specialty specific questions will be added or managed as part of the base history questionnaire build.

BUILDING THE BUSINESS CASE

A significant challenge for many organizations is how to advocate for and communicate the business need related to such enterprise projects. Streamlined, efficient and accurate patient history collection is directly aligned to and supports three common strategic priorities:

Patient Engagement

A standard history questionnaire allows patients to simply review and update previously provided patient history, rather than completing the same detailed history information again and again. It communicates to patients the organization's dedication and commitment to leveraging technology in a smart, innovative way to improve their experience and overall care. A recent study found that of 173 patients who provided their patient history electronically in the ED, *"94% felt the technology was easy to hold and handle 97% felt the questions were detailed to fully describe their condition, 98% felt it helped them organize their thoughts and communicate better with their physician, 95% felt it would improve their quality of care and 97% expressed desire to use again in the future."*[1]

One of the biggest fears related to computerizing patient history collection is whether patients will like it, especially for older patients. While this may vary, *"90 percent of patients in most practices can use this sort of system. Elderly patients are slower but more accurate than young people."*[2]

Provider and Staff Satisfaction

Simplified and streamlined clinical workflows such as electronic patient history collection can save typing time and clicks for both staff and providers who previously prepared paper surveys and manually keyed in patient history. When patients complete their history electronically, it is directly integrated into the EHR and providers can simply accept the patient history information without clicking through multiple sections or screens on the chart. By streamlining and automating the patient history collection process, providers can dedicate more of their clinical time to in-depth conversations around symptoms and care plan development, ideally to ensure better adherence and better clinical outcomes.

Interoperability for Population Health

Accurate and complete patient medical history is the foundation for driving population health decision making. This patient history can be further leveraged in conjunction with integration with other patient data through interoperability functionality and partnering with mobile data to develop more custom care plans. Ensuring clinicians have a complete and comprehensive medical, surgical, family and social patient history will better inform predictive health initiatives.

HOW VYNAMIC CAN HELP

Vynamic's purpose is: *We Believe There Is A Better Way.* Our reimagined approach helps clients achieve Actionable Strategy, Operational Intelligence, and Healthy Culture. Our Provider offerings include Strategic Planning & Mobilization, Process Improvement, Lean Transformation, Culture Curation, Values & Behaviors, Change Management, and Application Integration and Transformation, any of which can be applied in a custom way to meet client-specific needs. Our team brings robust healthcare industry perspective that will make an enterprise initiative sustainable, impactful, and one that drives operational and clinical outcomes.

Interested in learning more?

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End Notes:

1. Arora, Sanjay, et al. "Patient Impression and Satisfaction of a Self-Administered, Automated Medical History-Taking Device in the Emergency Department." Advances in Pediatrics., U.S. National Library of Medicine, Feb. 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC3952887/

2. Bachman, John W. "Improving Care With an Automated Patient History." American Family Physician, 1 Aug. 2007, www.aafp.org/fpm/2007/0700/p39.html