

PATIENT CARE DOCUMENTATION: COMMON DEFICIENCIES AND EFFECTIVE REMEDIATION

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Background: Documentation deficiencies are cited in many state medical board disciplinary documents and can negatively impact optimal patient care. Since the landmark publication *To Err is Human*, released in 1999 (1), unprecedented efforts have taken place to minimize opportunities for error in patient care in both the inpatient and outpatient setting. Over several decades, patient care documentation has been evolving to adapt to the needs of multiple health care team members, third party payers, and litigation defense. These ongoing forces, combined with the increased attention to patient safety and minimizing health care costs, have resulted in the need for physicians to document efficiently and effectively, and to accept the inevitability of a complete transition to electronic medical records.

CPEP, the Center for Personalized Education for Physicians, has provided an intensive interactive patient care documentation seminar with an optional follow-up component since 2001. This continuing medical education (CME) seminar was developed to meet the needs of physicians for whom remediation of documentation deficiencies would likely require more than the typical self-study and/or traditional CME options.

Purpose: The purposes of this study are to identify the most common documentation deficiencies in the patient care records of physicians referred to the CPEP Patient Care Documentation seminar and to evaluate the ability of referred physicians to successfully remediate their deficiencies and integrate positive changes into their documentation.

Methods: Participants in the CPEP Patient Care Documentation seminar submitted medical records for review prior the educational seminar (all participants) and at two, four, and six months *after* participation (follow-up participants only). CPEP physician reviewers provided personalized and individualized feedback regarding the quality of documents reviewed, and areas in need of improvement, after each record review through a written feedback form as well as an optional telephone conference. The feedback forms were reviewed for the incidence of certain specific deficiencies. Participants in the follow-up component and their referring organizations received a Final Report indicating whether the participant successfully integrated the necessary improvements over time. Final Reports were reviewed to evaluate the percentage of participants who successfully completed the follow-up component.

Results: The frequencies of specific documentation deficiencies were calculated to determine the most common deficiencies in this referred physician population. The majority of participants who enrolled in the follow-up component were able to successfully achieve acceptable quality in their patient care documentation.

Conclusions: While legibility is often generally considered to be the most common documentation deficiency in the general physician population, the incidences of deficiencies found in this analysis indicate that other deficiencies are as common or more common in this referral population. The information gained from the follow-up component data reflects that

physicians are able to improve their documentation when provided personalized and intensive feedback about their medical records. The format of this CME activity is effective in resulting in improvement in this aspect of physician practice and represents an important resource for state medical boards.

References:

- (1) LT Kohn, JM Corrigan, MS Donaldson, eds: *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 1999