Clinic Notes: Helpful and Hurtful

For Veterans enrolled in VHA, information documented in their “chart” (CPRS, Cerner) is integral to the care they receive. For justice-involved Veterans and others in stigmatized groups this can be complicated by prejudice.

1. Documentation Awareness

- Medical documentation is necessary for VHA (or any health care system) to provide good care; what is documented must always balance the need to share information with Veteran privacy. Remember that in VHA all providers have access to the Veteran’s medical record.
- For justice-involved Veterans (who often have other stigmatized life situations, identities, or conditions), the wording and specificity of information about their legal involvement in clinical documentation runs a high risk of activating conscious or unconscious negative biases in people reading that documentation. Once activated, these affect providers’ beliefs, feelings, and behavior towards the Veteran. This can lead to sub-par care.
- Therefore it is important to include only clinically relevant information, no more detail than needed, and to word documentation to minimize setting off stereotypes. Overdocumenting incurs steep costs.

2. Unintentional Consequences of Overdocumentation

Activating negative stereotypes leads to associated emotions (worry) and attitudes (desire to avoid) both before and after a provider meets the Veteran as a person.

A health provider sees details of criminal charge in a Veteran’s medical record, feels worried about safety, nervous about meeting with the Veteran, and wishes they didn’t have to, but of course is willing to.

These feed into behavior patterns that can lead to health disparities in care and outcomes for justice-involved Veterans (and other Veterans for whom stigmatizing detail is included in documentation).

The provider is reserved or nervous when meeting with the Veteran, does not develop much rapport, and may perceive the Veteran (behavior, symptoms, coping) thru a lens in keeping with their biases.

In addition to affecting interpersonal interactions toward the Veteran, biases can impact diagnosis, the health care (tests, prescriptions, interventions) offered or suggested, treatment decisions, and provider support and follow up.

The Veteran may conclude the provider has little interest in them or is irritated at them. The Veteran may feel wary, irritated, or uncared for and may not disclose relevant symptoms or questions, further hampering care. Care, coordination, process, and outcomes may suffer.

Veterans perceive these attitudes, actions, and aversions from providers. This impacts their engagement, communications, treatment adherence, and access to care.

Veteran skepticism about VHA and negative self-beliefs (such as not feeling worthy of care) can be reinforced. The Veteran may decide that VHA does not care about them and may not show up for their follow-up appointments.

3. Real Life Examples

A Veteran gave details about his criminal history to a primary care provider in confidence during treatment, which the provider then included in his CPRS problem list without the Veteran knowing. The Veteran is then puzzled and wary when another provider asks probing questions about these details; the Veteran does not return to care.
A Veterans Justice Programs (VJP) Specialist tried to educate medical personnel that including charges in CPRS (e.g., “Veteran was arrested for XX,”) is unwise especially since it’s not a conviction. They are ignored. “And then you see it in all the charting that comes after that, but that person’s never been convicted of that” and was acquitted.

A Specialist described working with a housing program that openly excludes all Veterans with any criminal charges (even if dropped or acquitted) no matter how old. When the asked, the Housing Program worker said it is policy because of “risk” and because such Veterans will be “more work,” due to court dates or probation.

A VJP specialist tried to advocate for a Veteran who was denied a housing program due to past criminal conviction the program read about in detail in their chart. The housing program told them to, “pick [their] battles because it [complaining] could jeopardize future referrals.”

4. How Providers Can Avoid Overdocumentation

4A. Be conscious, cautious, and conservative in what and how we document Veteran justice-involvement, life situations, health conditions, and social identities that are commonly stigmatized.

“VA’s Office of General Counsel has offered the opinion that a Veteran’s legal history and charges should not be documented in detail in the medical record unless they have direct bearing on clinical treatment.”

-- VHA Directive 1162.06

4B. Make careful choices in wording and detail of CPRS notes (or other documentation) as these greatly impact the associations activated in readers. For example:

- Is it necessary to describe a specific crime? Or is “chronic health condition exacerbated by a history of incarceration,” enough to inform the Veteran’s care?
- Use first person language: avoid terms like “a felon,” “a convicted criminal” “an addict”
- Use wording that activates fewer prejudicial associations: “Legal issues” rather than “criminal charges” or “completed the Veteran court plan” rather than “avoided prison”
- Remember that charges don’t equal conviction, initial charges are often more severe than final ones, and the charges’ language doesn’t give a clear picture of underlying behavior or clinically relevant information.
- Discuss details by phone or in person instead of in the chart; CPRS is not a communication tool.

4C. Consult with your local VJP Specialist(s) who may have more context, expertise, and more familiarity with the intersection of a given Veteran’s clinical and legal history.

Both legitimate concerns and prejudice can make deciding what is necessary to document a contentious issue.

5. Additional Resources

Full text here: https://link.springer.com/content/pdf/10.1007/s11524-019-00382-0.pdf

Full text here: https://psycnet.apa.org/fulltext/2021-90442-001.pdf?auth_token=411c2a1436214d1ac05c94ee442dd9894b50068