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Integrating Patient-reported Symptoms in the Arthritis Care Record

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**Presenter Information**
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For knee and hip arthritis patients, self-assessed pain and physical function are central to treatment decisions as well as to clinical and outcomes research.

Both paper and electronic health records capture the clinician’s summary of the patient symptoms.

Brief patient-reported arthritis symptom assessments have been broadly tested and validated in clinical research, yet have not been integrated into routine office practice.

The introduction of electronic health records offers an opportunity for patient direct-entry and real-time scores of standardized symptom assessments to be included in the routine health record.

The data collection and management system was implemented in the Arthritis and Total Joint Center (TJC) ambulatory clinic at UMass Medical Center.

The host system allows development and delivery of custom web-based surveys and serves as a database archive system with interfaces to hospital information services (HIS) and a data storage location.

The survey data are divided into 21 tables representing clinical categories (e.g., pain, function, clinical diagnoses) with 259 measures, and 66 among them are used for QA reports.

The patient-entered survey data are merged with the clinical data in a structured format, providing comprehensive longitudinal records for individual patients. In addition, real-time symptom trend reports are produced using query, search and analysis functions.

The system implemented in our clinic is a successful model for collecting and integrating patient symptom data with clinical data as part of a patient health record.

This template is the foundation for a newly funded national research registry for comparative effectiveness in total joint replacement surgery (FORCE-TJR).