INTRODUCTION

COLLEGE OF OSTEOPATHIC MEDICINE, VALLEJO, CA

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TOUC-DG
TOURO UNIVERSITY CALIFORNIA DOCUMENTATION GUIDELINES
a guide for medical students in light of drastic 2021 health record documentation policy changes
Introduction

The Guidelines

6-17 Health records must contain accurate information
13-18 Patients should answer all history questions in preparation for every medical encounter
19 Ancillary medical staff members should assist patients in authoring the history component of a medical encounter note in the health record
20 Medical providers should first read the patient authored history, then ask additional questions
21 Medical providers and ancillary medical staff members should view the blocking of a patient-authored history as a HIPAA violation
22 Patients should routinely read their entire health record note (history, exam, medical decision making) after every medical encounter
23-24 Medical students, as well as all healthcare professionals, should be trained to view health record documentation through the lens of core competencies: Systems-Based Practice, Practice-Based Learning & Improvement, Professionalism, Interpersonal & Communication Skills, Patient Care, Medical Knowledge, Osteopathic Principles & Practice

PreHx Public Access

Investigator concerns

a. Overcoming language barriers when considering medical interview/Hx questions
b. Providing “How to” training videos on YouTube
c. Community Outreach/Education as a Second Language (ESL) Prepare for a Medical Encounter Class
d. Community Outreach/Health Education for K-12 Students
e. Community Outreach through existing programs (DPP, Pharm2Home)
f. Inclusive Identification in Profile and top of PreHx document
g. Members of the LGBTQ IA+ community face high anxiety when seeking medical care.
h. Recognition of Social Determinants of Health (SDOH)

EHRs and Burnout

COVID-19 Pandemic Implications

Limitations

Conclusion

Compliance Manual Considerations

About the Authors

Sample PreHx
Our society is about to enter a new era of medicine: the digital age of healthcare. Dreams set forth by Erica Topol, M.D.\(^1\) and Robert Wachter, M.D.\(^2\) will soon become reality. What some may consider science fiction today, could become commonplace in a few years. Imagine patients with mysterious symptoms? As individual case presentations, each could appear elusive to definitive diagnosis. Together, referenced to a robust database, advice could be displayed to help providers quickly determine an accurate diagnosis. With outcomes based on each patient’s individual profile, treatment options could be considered with a predicted percentage of success. Electronic health records (EHRs) will soon leverage the power of computerization. Continuous data mining will uncover best practices for diagnosis and treatment of disease, as well as pathways to health. It will revolutionize healthcare delivery and benefit everyone on the planet.

In order to qualify for this next era of medicine, our input data needs to be accurate and detailed.

To date, health record accuracy is poor. Published audits of parts of the History/medical interview potion of health records show accuracy rates around 40%, 37% with scribe.\(^3\) A separate clinical study compared patient reports in the waiting room to what was documented, moments later, into the health record while in the examination room. The study found suboptimal correlation and concluded health records to be a “poor source for patient care or big data analysis.” If a patient reported 3 or more concerns, zero charts in the entire study listed all 3 complaints.\(^4\) From a data analytics perspective, it is a “Garbage in, Garbage out” situation. Very often, health record data are useless, if not misleading.

Poor correlation between what happens at medical encounters and what is documented in health records underscores the integrity of medical providers, such as physicians, nurse practitioners and physician assistants. Though superficial blame can be directed to these professionals to improve documentation, closer analysis reveals a problem with the documentation system: it is unnecessarily burdensome and not practical.

Providers take care of patients and do their best to fulfill health record documentation obligations in order to get paid. Pressed for time and overwhelmed by an ever-growing demand of documentation tasks, most providers resort to utilizing computer auto-population features, such as templates, copy & paste, and copy-forward. Entering enough volume of information into health records fulfills payment obligations in accordance with 1995/1997 Evaluation and Management (E/M) Documentation Guidelines. The result, however, is health records that appear to report highly detailed information, but riddled with false information.

Though documentation from EHR auto-population features result in health records that pass checklist audits, they fail to capture details of the individual patient. Donald Rucker, M.D., National Coordinator for the Office of the National Coordinator (ONC) describes what it is like to read health records as a clinician: searching through pages of words seeking for something meaningful. Due to template abuse, he calls health record documentation “anti-matter” and “clutter.” Again, rather than blame providers, he calls to repair the system.

In 2017, CMS formed the ‘Patients over Paperwork’ initiative to reduce unnecessary regulatory burden

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Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again

2 Wachter, R “The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age,” 2017
The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age

Concordance Between Electronic Clinical Documentation and Physicians’ Observed Behavior

4 Valikodath, NG, et al “Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records,” JAMA Ophth, March 2017
Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records
and improve documentation accuracy. A series of policy changes have, and are, creating a pathway for improvement. In June 2020, CMS created the Office of Burden Reduction and Health Informatics to focus on how health data can be harnessed for more efficient healthcare and improved patient experience.\(^5\)

This report highlights a set of guidelines to follow as our health record documentation duties shift due to CMS policy changes. The first guideline, “Health records must contain accurate information”, seems simplistic and obvious. ‘Why’ this is necessary and “how” it can be accomplished will be detailed in this report. For each of the 7 guidelines, we will analyze for intended/unintended consequences and offer practical solutions based on research and logic.

Everything we recommend, such as online tools and forms, are offered free of charge and without intellectual property. For providers and ancillary medical staff members, we invite you to update your Compliance Manual, reference TUC-DG and use this document as a guide. For individuals, including patient advocates, we encourage you to be your own advocate as outlined by these guidelines and tell your story. For medical and health profession students, we urge you to prepare and accommodate new policies. We need you to lead as our next generation of providers and staff.

We thank the editors of AAPC’s Healthcare Business Monthly magazine for publishing our article, “Guidelines for Clinical Documentation Improvement” September 2020. We consider this AAPC publication to be an Executive Summary to this report.

Computerization has revolutionized most sectors of our economy. Many people in the world carry smartphones that outperform “communicators” from the 1966-1969 Star Trek series. Computer advancements allow us to view inside the body (MRI/CT) and perform robotic surgery. Unfortunately, we have not fully unleashed technology to revolutionize our abilities to practice and deliver healthcare. As you will see in this report, we believe new federal policies are paving the way to a new era of medicine. We support our guidelines as a basic framework to “flip the switch” and enter the digital age of healthcare.

Sincerely,

Michael Warner,
DO, CPC, CPCO, CPMA, AAPC Fellow

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\(^5\) Miliard, M “CMS created new Office of Burden Reduction and Health Informatics,” Healthcare IT News, June 24, 2020

“In addition to reducing the hours and costs clinicians and providers incur for CMS-mandated compliance, the office will also focus on how health data can be harnessed for more efficient healthcare and improved patient experience.”

CMS creates new Office of Burden Reduction and Health Informatics
1. Health records must contain accurate information.

2. Patients should answer all history questions in preparation for every medical encounter.

3. Ancillary medical staff members should assist patients in authoring the history component of a medical encounter note in the health record.

4. Medical providers should first read the patient-authored history, then ask additional questions.

5. Medical providers and ancillary medical staff members should view the blocking of a patient-authored history as a HIPAA violation.

6. Patients should routinely read their entire health record note (history, exam, medical decision making) after every medical encounter.

7. Medical students, as well as all healthcare professionals, should be trained to view health record documentation through the lens of core competencies:
   a. Systems-Based Practice (SBP)
   b. Practice-Based Learning and Improvement (PBLI)
   c. Professionalism
   d. Interpersonal and Communication Skills
   e. Patient Care
   f. Medical Knowledge
   g. Osteopathic Principles & Practice
Health records, just like bank accounts and credit card statements, must contain accurate information. If a person deposits $50 into a checking account, the bank teller cannot enter only $5. Similarly, if a countertop needs to be ordered at 92.5 inches in length, an order change to a different size may not fit or properly function. Health record accuracy is important because it serves as a resource for individual patient care and a database for societal care. Accuracy matters.

Once upon a time, health record documentation was simple. “05/10/1976 L OM Amoxil” meant on that date, a patient was diagnosed with Left Otitis Media and was prescribed Amoxil (Amoxicillin) antibiotic. These 19 characters, written on an index card in a medical office, represented high signal, low noise data. Fast forward to 2020, where documentation requirements have cumbersomely expanded resulting in health records with high noise and low signal. The Centers for Medicare and Medicaid Services (CMS) recognizes this problem and has made a series of policy changes to reduce unnecessary tasks and improve the health record documentation system.

Background

Health record documentation was standardized by the efforts of Lawrence Weed, M.D. (1923-2017). Dr. Weed found great variability in medical chart documentation. His goal was to make it easy for any professional to pick up a chart and figure out what was going on. Since the 1960’s, Dr. Weed promoted the Problem Oriented Medical Record, which included the S.O.A.P. format: Subjective (S) represented the patient’s subjective story, concerns and needs. Objective (O) captured objective data such as the provider’s physical examination findings and laboratory results. Assessment (A) reported diagnoses with Plan (P) as the treatment plan.

In 1995, new documentation guidelines restructured health record documentation with three key components: History (Hx), Examination (Ex) and Medical Decision Making (MDM). A series of scoring grids allow providers/coders/auditors to determine an Evaluation and Management (E/M) level of service for new and established patients in various clinical settings, such as outpatient/office, inpatient/hospital, emergency department, nursing facilities, domiciliary, rest home, custodial care services and home care. The scoring grids created a checklist approach counting the number of documented items to fulfill a particular level of service.

The History of Present Illness (HPI), part of the History, is composed of 8 elements (location, duration, severity, duration, timing, context, modifying factors, associated signs & symptoms). According to 1995/1997 documentation guidelines (1995/1997 DG), documenting 1-3 of these elements qualifies for a Brief HPI, while 4 or more justifies an Extended HPI.

Review of Systems (ROS) is a head-to-toe/mind-body checklist with 14 systems from Constitutional to Allergy/immunologic. When auditing there may be no ROS. 1 ROS counts as Problem Pertinent. 2-9 systems count as an Extended ROS. 10 systems or more count as a Complete ROS. Per 1997 DG, ancillary medical staff members were permitted to document the ROS in health records for E/M services. As of CY2019, staff members can now document the entire Hx.

Past Family Social History is composed of three areas: Past, Family and Social. Documentation of 1 fact pertinent to the HPI for 1 of the areas counts as a Pertinent PFSH. Documentation of at least 1 fact in 2 of the 3 areas counts as a complete PFSH for an established patient. For a new patient, at least 1 fact for each of the 3 areas is required for a Complete PFSH.

Past History includes prior major illnesses and injuries, prior operations, prior hospitalizations, current medications, allergies, age appropriate immunization status, age appropriate feeding/dietary status.

Guideline 1 | Health records must contain accurate information

Guideline 1 | Health records must contain accurate information

Papier, A “Remembering Larry Weed, MD,” MedPage Today, June 18, 2017

1995 Documentation Guidelines for Evaluation and Management Services, CMS.gov
Family History may include age of death or living status of immediate family members.

Social History includes social status or living arrangements (if child, social status of patients), employment status, occupational history, use of drugs/to tobacco/alcohol (if child exposure to secondhand smoke), educational level, sexual history, any social event/occurrence impacting a patient’s condition.

Similar to ROS, 1997 DG permitted ancillary medical staff members to document PFSH into the health record for E/M services. As of CY2019, staff members can now document the entire Hx.

Shortcut approaches to gaining a Complete PFSH could include documenting: “Appendectomy age 12, Father with glaucoma, Non-smoker of tobacco.” While this short sentence captures a ‘Complete’ PFSH, it underscores the patient’s true PFSH. Patients should be given the opportunity to explain their PFSH in detail.

Multiple grids create a final score for the Hx, which can then be compared grid scores from Ex and MDM, to ultimately determine the E/M level of service. For a new patient or any patient in the emergency department, information from all 3 key elements (Hx/Ex/MDM) is required. For an established patient, someone receiving care within the past 3 years, only 2 of 3 key components are required.

In 1997, a new set of E/M documentation guidelines emerged with major modifications to Ex scoring and an additional HPI option. 1995 documentation guidelines (1995 DG), nearly required a head-to-toe Ex to capture enough body areas or systems to qualify for a Detailed or Comprehensive examination. An ophthalmologist, for example, could perform an extensive eye examination and be consistently undervalued by the 1995 DG. 1997 DG added single organ examinations, such as cardiovascular and eyes. The eye exam criteria, for example, allows any provider to complete an Ex with focus on the eye. A provider may choose 1995 or 1997 DG options when performing and recording an E/M encounter and selecting a level of service.

1997 DG added “Status of Chronic Condition/Disease” as an alternative HPI subset. Rather than document HPI “duration” each time seeing a patient with Diabetes mellitus, ‘Status’ allows for a description of the person’s experience with the chronic condition/disease. A patient with Diabetes, for example, may share home glucometer readings, tolerance to medications, as well as updates to dietary and exercise efforts. As of September 10, 2013, CMS expanded Status to be credited under both 1997 and 1995 DG’s, thus making Hx criteria identical for both sets of guidelines.

Conversion from Paper Medical Charts to Electronic Health Records (EHR)

Electronic health records (EHRs) have numerous advantages over paper medical charts. Ideally, records can be easily accessed by any professional with a few keystrokes on a computer. Ideally, patient records can be shared and with the construction of predictive algorithms, make accurate diagnosis and effective treatment plans. Digital records also leverage information technology to data mine for best practice identification. Your medical provider may not know the answer, but your provider plus a database of millions of patients should result in a brilliant diagnosis with a spectacular treatment outcome.

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) allocated over $25 billion to be paid to doctors and health systems for the adoption and meaningful use of electronic health records. In 2008, when the Act was introduced, only 10% of hospitals had adopted EHRs. As a result of this legislation, EHR system use rapidly grew. By 2017, 80% of office-based physicians had adopted a certified EHR with 96% of all non-federal acute care hospitals possessing certified health IT. By 2015, CMS imposed a

8 1997 Documentation Guidelines, CMS.gov, retrieved 21july2020
9 Abel, K “Medical Coding Training: CPC 2014,” AAPC, 2013, p. 619
10 Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), HHS.gov, retrieved 21july2020
12 What is the HITECH Act?, HIPAA Journal, retrieved 21july2020
13 Quick Stats, Health IT Dashboard, The Office of the National Coordinator for Health Information Technology, retrieved 20aug2020

Medicare Physician Guide
HITECH Act Enforcement Interim Final Rule
THE HITECH ACT: An Overview
What is the HITECH Act
Health IT Quick Stats
GUIDELINE 1: HEALTH RECORDS MUST CONTAIN ACCURATE INFORMATION

financial penalty for providers not using certified EHR technology. Substituting paper charts with digital format is only part of the process. Though you may see computer stations in nearly all medical settings, we have not made the transition from paper to digital health records. To date, we have not learned to harness and exploit health record accuracy to power computer technology.

Templates, Copy & Paste, Copy-forward EHR functions:

Though EHR adoption and meaningful use grew, documentation tasks mounted for medical providers. In order to make it through a clinical day, providers have been forced to find ways to fulfill cumbersome documentation requirements. Some of these habits have jeopardized the accuracy of health records.

Templates, copy & paste and copy-forward EHR functions can be used appropriately. A template for Diabetes mellitus chronic care may be 797 characters. Such a template gives a provider the opportunity to add previous and current Hemoglobin A1C values and customize treatment plans. Three of such templates, employed for patients with Diabetes mellitus, Hypertension and Hypercholesterolemia could result in over 3,000 characters. With an average typing speed of 190-200 characters per minute, these three packages of information would take 15 minutes to type into the health record. With a few keystrokes, all three templates can be entered in moments. With an additional 30 seconds, key information can be added to customize the message for the individual patient. This is a good use of templates and EHR auto-population features.

Bad uses of auto-population features occur when information is added to the health record that never occurred. A provider could, when learning a of a patient’s chief complaint of sinus pressure, auto-populate the entire note (Hx, Ex, MDM) with a “sinusitis” template. Though this speeds up the documentation process, it creates a diagnosis/treatment bias based on the chief complaint. What if the diagnosis is not sinusitis? What if the template inserts a Review of Systems response “No shortness of breath”, but the patient reports feeling short of breath?

An EHR Report article in Family Practice News September 2016 showcased the dangers of poor health record accuracy. The authors describe attending a hospital case presentation where a patient, with an I.V. pole and wearing a hospital gown told the story of her 4-month history of symptoms. She described a coherent story of being active, then very sick. She told of numerous medical encounters where she did her best to tell her subjective story.

“Encounter after encounter, a new plan was devised to address the presumed diagnosis. But the patient’s telling of the history barely mentioned any symptoms related to that diagnosis. Her version focused more on how her life was affected, how she could no longer take care of her daughter, how she could no longer exercise (which she did avidly), and how she was sinking deeper into despair and losing hope. Woven through all of this were the historical details and seemingly obvious physical manifestations that might easily disclose the real cause of her symptoms. A few basic questions about her family history would also reveal multiple immediate family members who suffered from the same disease! But even if these questions had been asked, and even if the story had been heard, the image in the mirror – her chart – did not reflect an accurate understanding of the patient.”

Imagine a patient who develops ovarian cancer with vague symptoms of abdominal cramping and
fatigue? An EHR template for fatigue may entertain overcoming depression as a treatment plan. Worse than not documenting two immediate female relatives with ovarian cancer, templates may perpetuate a family history of “no cancer.” Sir William Osler (1849-1919), over 100 years ago reportedly said, “Listen to the patient, he is telling you the diagnosis.” Dr. Osler’s words still ring true today. Bad patient outcomes occur when providers do not listen. Similarly, as with this hospital case presentation, bad outcomes occur when the health record is not accurate.

**EHR documentation ≠ Reality:**

A clinical research study performed in a university eye clinic tested the ability of health records to accurately capture patient concerns. Investigators approached patients in the eye center’s waiting room and asked them to voluntarily complete a one-page form to capture the presence/severity of 8 eye concerns from “blurry vision” to “eye pain.” The questions mimicked a screenshot from the provider’s EHR, which listed each concern.

Patients answered the form and submitted it to investigators prior to leaving the waiting room to enter an examination room with the provider. At a later date, researchers compared the patient’s report with EHR documentation. The correlation was poor. If a patient reported ‘eye pain’ in the waiting room, researchers found ‘eye pain’ nowhere in the health record over a quarter of the time (26.5%). If a patient reported 3 or more concerns, zero charts in the entire study successfully captured all three concerns. The authors concluded, “Our results suggest that documentation of symptoms based on medical record data may not provide a comprehensive resource for clinical practice or ‘big data’ research.”

The research team’s assessment at the eye center is powerful. Health record data needs to be a comprehensive resource for clinical practice. Fulfilling documentation requirements for billing/coding/payment should be done simultaneously as documenting the patient’s subjective story (Hx), clinical examination findings (Ex) and medical decision making (MDM) efforts.

A study in the emergency department took this type of study to the next level. Investigators, composed of a team of 12 observers, watched patient care for 180 patient encounters and recorded what they saw with checklists and video cameras. They then audited health record documentation by emergency room resident physicians to make a comparison. The study found parts of the documented History (Review of Systems – ROS) to be accurate only 40.1% of the time, 36.7% with medical scribe. The documented examination was accurate only 52.8% of the time, 53.6% with scribe. Researchers concluded, “payers should consider removing financial incentives to generate lengthy documentation.”

**Recognizing a Problem with the System:**

CMS could have blamed providers for failing to properly document information into health records. They could have cited use of auto-population features as “willing and knowing acts to create materials in order to seek higher payment from the government,” which is fraud. Instead, they focused on the root cause: the current 1995/1997 Documentation Guidelines system.

A Presidential Executive Order 13771, signed January 2017, prompted regulatory agencies to ‘cut the red tape.’ CMS Administrator Seema Verma, MPH responded in 2017 by creating the ‘Patients Over Paperwork’ (PoP) initiative. PoP goals are to reduce unnecessary burden, increase efficiencies, improve the

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18 Valikodath, NG, et al “Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records,” JAMA Ophth, March 2017 (Conclusion: The History component of medical records is not a trusted source for patient care or ‘big data’ analytics)
beneficiary experience. In July 2018, CMS revealed plans to dramatically change health record documentation requirement and alter E/M scoring for provider payment. These proposed changes included removing Hx and Ex from the scoring criteria, beginning with outpatient/office E/M services starting January 1, 2021.

On July 18, 2018, CMS Administrator Seema Verma, MPH held a Twitter podcast with a panel of experts. A question was posed to Donald Rucker, M.D., National Coordinator for Health Information Technology: “In light of technology’s thirst for data to identify best practices and construct predictive algorithms, is it possible that eliminating History and Examination documentation will undermine patient care and big data efforts?” Dr. Rucker replied the opposite should occur. These proposed health record policies will actually improve patient care and data mining efforts. He described what it is like to review a medical record as a clinician; searching through pages of auto-populated content for something meaningful. Citing the consequences of templates, he used terms “antimatter” and “clutter” to describe health record documentation. The Federal Register, in July 2018 proposed new E/M policy changes and in November made them Final Rule.

Unreasonably Cumbersome System

A Stanford Medicine EHR National Symposium, June 4, 2018, showcased a Harris Poll of primary care providers. On average, these medical providers spend 31 minutes attending to each patient. Of this time, 12 minutes are spent interacting with the patient and 8 minutes are spent interacting with the patient during the encounter. Of interest, an additional 11 minutes were spent–per patient–interacting with the EHR after hours. Imagine having to spend 11 minutes per patient after hours working on the EHR? If a provider has a face-to-face encounter with 20 patients during the course of a workday, this results in over 3½ hours of afterhours work. Some of this time may be to review patient information, but some is also spent on documentation catch up. How much of the patient’s subjective story or examination findings is a clinician likely to remember when faced with hours of work and a long list of patient health records?

An October 2018 American Osteopathic Association presentation, “Evaluation and Management Scoring Webinar,” showcases all of the steps necessary to score an E/M service. The 32-minute video demonstrates what a provider must consider when documenting in the health record and scoring every E/M level of service. For a new patient, the History is derived from separate scoring from History of Present Illness (HPI)/Status of Chronic Condition/Disease (Status), Review of Systems (ROS) and Past Family Social History (PFSH). Examination is scored based on criteria either from 1995 or 1997 DG. Medical Decision Making (MDM) is determined based on results from 3 separate scoring grids. Once determination of Hx, Ex and MDM is made, then a final grid determines the E/M level of service.

Tabulating all of the points - to determine the proper level of Hx, then Ex, then MDM with a series of grids to finally determine the E/M level of service - is an onerous task. A certified professional coder or medical auditor, presented with an encounter note and an audit sheet, can do this with confidence. A medical provider, in the middle of caring for a patient, is overwhelmed and overburdened.

Streamlined System with new 2021 MDM grid and 2021 Total Time definitions

Along with Proposed Rules in the Federal Register, July 2018, CMS reached out to the American Medical Association’s CPT® Editorial Panel and RUC to form a new Medical Decision Making grid to meet 2021
policy expectations. A CPT/RUC Workgroup on E/M met many hours during the fall/winter of 2018 to produce the new 1-page MDM grid. In the spring of 2019, CMS accepted this grid for use in the outpatient/office setting for E/M services starting 2021.26

In anticipation for 2021, all medical providers, professional students, and ancillary medical staff members should review this document and become familiar with its use in preparation for January 1, 2021.

The new AMA 2021 MDM grid is composed of 3 elements represented in 3 columns:

- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

To score an outpatient/office E/M level of service starting 2021, the provider will choose the best 2 of 3. This one-page grid addresses both new and established patient care the same. There is not one grid for new patients and a separate for established patients. This grid replaces all of the grids used in per 1995/1997 DG starting next year in for E/M services in the outpatient/office setting.

Key words in the new 2021 AMA MDM grid include “addressed, reviewed, and analyzed.” Just because a patient has 10 diagnoses on a list in the health record does not necessarily qualify a high E/M level of service. To be considered, each of these conditions needs to be addressed. Similarly, the amount and/or complexity of data needs to be reviewed and analyzed.

Care for a patient with status migrane headaches non-retractable without aura (G43.001) and a kidney transplant (ICD-10-CM Z94.0) will need to be addressed if both conditions are counted to select the E/M level. This is plausible, since long-term transplant medications can be associated with headache symptoms. In addition, treatment options require special consideration since many medications may cause harm to the transplanted kidney or the immunosuppressed patient. It will be the responsibility of the medical provider to do more than simply list both conditions. She will need to explain why the status transplant diagnosis is addressed: “Tacrolimus level 9.5 could be a factor in causing headaches. Spoke with the transplant team (Dr. Z) to lower the dose of this immunosuppressant with a goal of serum level of 7 in hopes of reducing headaches. No NSAID Rx at this time due to potential harm to kidney function.” Such documentation makes it clear that both conditions were addressed.

In addition to the new AMA MDM grid, E/M services in the outpatient/office setting starting 2021 will also allow Total Time on the date of service as a determinant for level of service. Per 1997 DG, time can be used to determine the level of E/M service, but “50% or more of the encounter time must be spent counseling and/or coordinating care.” For 2021, Total time will be counted for all time spent by the provider, both face-to-face and non-face-to-face, from midnight to midnight on the date of the encounter. Imagine a medical provider who spends 7 minutes on the phone discussing a MRI with a radiologist at 8am and then sees that patient at 2pm. Those 7 minutes will be added to the total time.

As far as total time on the date of service for 2021, new patients and established patients are treated differently. An established patient is generally a person who has received care within the past 3 years.27

New Time Only specifications for outpatient/office E/M services effective January 1, 2021

<table>
<thead>
<tr>
<th>New patients:</th>
<th>Established patients:</th>
</tr>
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<tbody>
<tr>
<td>99201 (code deleted)</td>
<td>99211 7 min</td>
</tr>
<tr>
<td>99202 15-29 min</td>
<td>99212 10-19 min</td>
</tr>
<tr>
<td>99203 30-44 min</td>
<td>99213 20-29 min</td>
</tr>
<tr>
<td>99204 45-59 min</td>
<td>99214 30-39 min</td>
</tr>
<tr>
<td>99205 60-74 min</td>
<td>99215 40-54 min</td>
</tr>
</tbody>
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For 2021, Total Time is restricted to work performed by the provider. If the provider is on the phone from 5:15pm-5:50pm working to obtain authorization

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26 New Medical Decision Making (MDM) grid for outpatient/office setting E/M services starting January 1, 2021
27 Hill, P “Understanding When to Use the New Patient E/M Codes,” Family Practice Management, AAFP, September 2003
28 CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes effective January 1, 2021, AMA, 2019
for an established patient’s care, then the extra 35 minutes can be added to a 15 min encounter from 2:05pm-2:20pm for a total time of 50 minutes (99215). If, instead of the provider, an ancillary medical staff member is on the phone gaining prior authorization for 35 minutes, then this time cannot be counted toward total time of E/M service.

A top priority for 2021 outpatient/office E/M services is to create a MDM +/- Total Time mindset because it will determine how providers and health systems will be paid. Some health systems may function in a risk model, which may place little emphasis on documentation. This report recommends using MDM +/- Time because it creates metrics that can be used to improve healthcare delivery, improve patient outcomes and identify provider value and utilization.

**Activity 1 [A1] Practice Using the new AMA 2021 Outpatient/Office E/M MDM grid**

Download: CPT E/M Office Revisions | AMA

Try applying to clinical cases and learn the details of this 1-page form

**Activity 2 [A2]**

*Keep track of time spent delivering patient care*

Document in the record your start and stop times. If you spend additional time working to help a patient outside of the encounter, but on the same date of service, consider how you will document this time and appropriately adjust your E/M level of service. Record your observations, discuss them with your team and document what you have done into your Compliance Manual.

**Medical Necessity – the Overarching Criterion:**

CMS Manual System, Pub. 100-04, Chapter 12, Subsection 30.6.1 A in the Medicare Claims Manual, May 14, 2004 states the following when addressing the selection of Level of Evaluation and Management Service: “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

This should cause providers to reflect, “Does this documentation support medical necessity?”

New 2021 E/M outpatient/office health record policies invite clinicians to express their MDM mindset. Working at the top of their license, clinicians will have the freedom and opportunity to convey the diagnostic process and treatment development. New Total Time policies will give clinicians the ability to capture a time inside and outside of the encounter.

Though some may view elimination of Hx and Ex from the outpatient/office E/M payment process as disengaging from patient care, this guideline will explain how new policies may free clinicians to literally place patients over paperwork.

**Urgency for Accurate Health Records:**

Now is the time to accommodate emerging policies and make health records accurate. The 2020 Federal Trustees Report reports asset depletion of federal healthcare funds in 2026. Under high-cost assumptions, depletion of funds could occur in 2026.

Due to the impact of COVID-19, a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania now estimates fund insolvency as early as 2022 or 2023.

Achieving health record accuracy is our ticket into the next era of medicine. The digital age of healthcare promises to improve our diagnostic and therapeutic abilities. Efficiency is a logical step toward better outcomes, improved satisfaction for all stakeholders, and reasonable costs.

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CMS Manual System

When addressing the selection of Level of Evaluation and Management Service; “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”


2020 Medicare Trustees Report


Another Problem on the Health Horizon: Medicare Is Running Out of Money
Guideline 2 | Patients should answer all history questions in preparation for every medical encounter

Answering healthcare questions is nothing new to medical practices. Often, patients complete a form in the waiting room or are sent a form to complete in advance of a medical encounter. If patients are not able to answer questions on their own, the provider is always able to ask questions and clarify during the encounter. Encouraging patients to complete answers to all of the Hx questions in preparation for every medical encounter, however, is worth addressing.

Clinical research, where patients answered all questions and authored the Hx in the health record at a family doctor visit, showcased advantages of reporting a complete story. For the provider, it meant entering the examination room with the entire Hx documented in the health record. Reading the whole Hx took an average of 30 seconds. This left plenty of time to ask a few higher order questions and record patient responses. It also helped direct a pertinent Ex. Because both patient and provider were highly engaged, the format readily transformed MDM into Shared Decision Making. Of time keeping interest, the study was conducted within a 15-minute office schedule. Efficiencies in patient data gathering permitted all provider documentation duties to be completed by the end of the face-to-face visit.

For the patient, telling the entire story and having it documented in the Hx component of the encounter note, resulted in high satisfaction (97%). Patients felt better heard and understood. They also appreciated being given the chance to represent themselves. At the checkout window, all patient participants received a printed copy of their entire health record encounter note (Hx, Ex, MDM). They were instructed to go home, read their health record and score their experience with an anonymous survey per research protocol.

When providers are informed of patients answering all Hx questions and co-authoring the health record, several issues are raised:

a. Is it legal?
b. Will patients bother to provide information?
c. Do patients have the resources to answer all Hx questions?
d. Will patients say too much and overwhelm visit objectives?
e. Will a patient authored Hx create malpractice exposure?
f. How can this be done?
g. What if a provider wishes to not accept the patient’s written submission?

a. Is it legal?
Yes, it is legal. The Standards for Privacy of Individually Identifiable Health Information of 2001 [45 C.F.R. § 164.526], also known as the HIPAA Privacy Rule grants individuals the federal right to amend their health record. For the JAOA PreHx study, where patients authored the Hx component of their health record for an office visit to the family doctor, the HIPAA Privacy Rule was used as the permission to accept the patient’s amendment and co-author the health record.

To submit an amendment to the health record in accordance to the law, the patient must submit the amendment in writing. The provider, once receiving the submission has 60-days to respond with written notification. If the provider needs more time, an additional 30-day extension may be taken. This extension, however, requires the provider to send another written notification to the patient explaining why extra time is needed. At any point, the provider can refuse the patient’s amendment and explain why in the letter.

33 Warner, M “When a Patient Requests to Amend their Medical Record,” Healthcare Business Monthly, December 2017

T U C - D G
For the JAOA PreHx study, rather than wait 60 or 90 days to accept the patient’s amendment, the provider accepted it immediately. This allowed the provider to empower ancillary medical staff members to use the patient’s words to populate Hx fields in the EHR.

Final Rule in the Federal Register November 23, 2018 for CY2019 specifically identified the power of patients to author the Hx component of health record encounters. This Final Rule affirmed and clarified the ability of patients to create their own subjective narrative and have it documented in the health record.

For the JAOA PreHx 2107 study, a PreHistory (PreHx) was created as an exact replica of the near 30 questions as structured and defined by 1995/1997 DG. While any format could have been accepted, replicating DG format for the Hx made it easy to accept, populate into the health record and be understood by the provider. Patients could submit a written letter or a thesis, but such information would likely be stored somewhere out of sight. With Hx/PreHx format, a patient’s discovery of an immediate family member with ovarian cancer has a specific assigned location in the health record universal to providers and medical auditors: (PFSH).

b. Will patients bother to provide information?

In the JAOA PreHx study, 64% of patients responded to a request sent via the United States Postal Service in a regular sized envelope. Responses from participants in a clinical simulation laboratory at TUC indicate patients are eager to be active participants in their care, particularly when it helps providers understand their concerns.

We believe the strong participation rate was achieved because the medical provider endorsed the letters sent to patients and rallied staff members to adopt a receptive culture. Patients need to feel welcomed and invited to share their whole story.

No one age group participated more/less than others in the JAOA PreHx study. Of interest, 60% of participants were male. This rate, however, was believed to reflect the provider’s schedule and the time frame – which was outside of buck season in Pennsylvania.

c. Why should patients answer all Hx questions?

Asking all of the Hx questions, as structured and defined by 1995/1997 DG, tells the whole story. Peripheral leg swelling, causing foot pain in tight shoes, can be due to excessive salt intake and inactivity – if the remainder of the Hx is unremarkable. Gathering the entire story, however, may introduce mild shortness of breath and chest pressure when climbing one set of stairs. The former patient needs less salt and more activity. The latter needs a cardiopulmonary workup.

The hardest part of answering all of the questions from a patient’s perspective is answering the same questions over and over again. PreHx.com was designed so individuals can enter information once and then update successive versions. If a person lists all of her past surgical procedures, then it stays until altered or amended by the patient.

For the most part, the patient’s Past Family Social History (PFSH) does not change much. Medical lists, part of PFSH, need updating. Employment status/position, also part of PFSH, may change. Very often, however, level of education/past illnesses-surgeries/family history stays constant. What does change is the History of Present Illness, particularly for a new problem. Status of Chronic Condition/Disease is subject to continuous updates.

The purpose of health record documentation is to “retell the story.” Patients should answer all of the History questions because it tells the whole story.

d. Will patients say too much and overwhelm visit objectives?

The JAOA PreHx study did see variation in patient Hx length. Some entered more content than others. The overall length difference, however, was not dramatic because of the 1995/1997 DG structure. We promote the current Hx, as structured and defined by 1995/1997 DG, to be the gold standard for patient information gathering even with new policies that no longer link Hx documentation to medical provider payment.

e. Do patients have the resources to answer all Hx questions?

Yes, most patients have the resources to answer all of the Hx questions. The questions are not inherently difficult to answer. For example, HPI element Quality asks, “What does your problem look or feel like?” This is easy for the patient to answer if she is given a moment to consider the question and formulate an answer. What is difficult for patients is to present their entire story verbally during rapid fire questioning during a typical medical encounter.

Some patients will not have the capacity to answer all of the Hx questions. In the JAOA PreHx study, the oldest patient (age 94) suffered from dementia. In this case her granddaughter, who was also her caretaker, completed her PreHx and submitted it on her behalf at the family doctor office visit. In this study, many patients sought assistance from a family member, friend or caregiver. Many people have internet access and the ability to answer the Hx questions as structured and defined by 1995/1997 DG.

To determine best practices for everyone and provide help for vulnerable populations, research at TUC is exploring PreHx guidance in various languages. They are also working to properly represent documentation to best include all groups of our society.


f. What if patients report information in their PreHx that does not make sense?

Patients are not trained to understand medical terminology. They may refer to their “stomach” and mean the entire abdomen. They may report results that seem to confound medical science. They may deny having a condition though objective data says otherwise. They may report bizarre experiences. All of this is fine because the Hx is the patient’s subjective story. In addition, patient details – just as Dr. Osler advised – tell the diagnosis.

A patient with a Hemoglobin A1c (A1C) over 9 for the past two years may deny having Diabetes mellitus. This information is important to know because it indicates a need for education.

A patient who calls their entire abdomen the ‘stomach’ only needs a few additional questions from the provider to clarify and specify.

A patient who reports occasionally seeing ‘elephants in ballerina costumes dancing in the living room’ is not inaccurate. It is, after all, the patient’s subjective story.

A patient may report experiencing horrifically painful skin itching in the legs after taking a shower. This may make no sense and be unresponsive to antihistamines and steroid medication. With real-time feedback from a database, however, the provider would be suggested to consider a Myeloproliferative Neoplasm (MPN) and order a JAK-2 blood test. For such a patient, a JAK-2 inhibitor oral pill could eliminate the cause of pain and allow the patient to shower and bathe.

g. Do providers and health systems have the resources to answer all Hx questions?

Medical practices typically give patients forms to complete in the waiting room. We suggest such forms ask all of the questions instead of a selected few in order to obtain the patient’s whole story. Having a patient answer a long list of questions in a waiting room, however, may be insensitive. The patient may be sick, not feel well, and have trouble formulating appropriate answers on the spot. Also, another person may be sick in the waiting room prompting the patient to minimize time in that location.

During the JAOA PreHx study, patients routinely reported having to return to the PreHx several times due to answers remembered at later times. Patients were given time to reflect on questions and answers. For this study, PreHx forms were sent to patients 1-week in advance of a scheduled office visit.

We expect some type of a pre-History to be a standard part of all health system patient portals. Just as individuals can feel comfortable to use free online products, providers and health systems can use them free of charge.

h. Will a patient authored Hx create a malpractice exposure?

We believe a patient’s full disclosure, allowing them to be heard, will result in less litigation. For the provider, receiving the patient’s complete story, also allows for an understanding of the big picture. Within the typical office visit time frame of 15-minutes, knowing all of the details puts the provider at an advantage compared to spending the visit trying to
~ GUIDELINE 2: PATIENTS SHOULD ANSWER ALL HISTORY QUESTIONS IN PREPARATION FOR EVERY MEDICAL ENCOUNTER ~

gather basic knowledge and completing documentation after hours.

Another advantage to a patient documented Hx is when the patient reads her records, she will see her story. Currently, few patients routinely read all components of their health record encounter note (Hx, Ex, MDM) after visits. Most patient portals only display discharge documents and lab values/reports. Having the patient narrate the Hx at the beginning of the encounter will be advantageous to having patients complain of Hx inaccuracies and prompt amendments afterward. For the JAOA PreHx study, the patient’s written request to amend was accepted immediately at the check-in window and used to populate the Hx component of the office visit note. To confirm accuracy of the health record, all patients in the JAOA PreHx study received a paper copy of their entire encounter note (Hx, Ex, MDM) at the check-out window after the face-to-face service.

Patients who discover something wrong in their health record may request correction, which places a large amount of non-chargeable work on the provider, including “link & notify” obligations associated with the HIPAA Privacy Rule. Say a patient’s Past Family History was inappropriately marked “unremarkable” in the record despite the patient discussing ovarian cancer afflicting 2 immediate family members. In addition to making the amendment, the provider is obligated to check the health record’s access log and consider anyone else who needs to know this new knowledge. If the patient sees a list of other providers, then the provider receiving the request to amend must send written notification to each of them. The note must explain the amendment, ask each provider to consider the new information, and ask the provider to take action if the new information causes a change in diagnosis consideration or current treatment plan. All of this work, by all providers, is free of charge. Far better to let the patient set the story straight the first time – in their own words.

i. How can this be done?

Patients, providers and ancillary medical staff members should view completion of a PreHx as beneficial to patient-provider communication and an accommodation to federal health record documentation policies.

The JAOA PreHx study outlines the protocol, which includes inviting patients to complete a PreHx and creating a practice mindset that welcomes such patient generated health data.

j. What if a patient refuses to participate in authoring a Hx/PreHx?

No one is forced to answer the Hx/medical interview questions. By completing a PreHx, individuals can prepare for a medical encounter and feel comfortable with their answers to a comprehensive list of questions standardized by 1995/1997 DG.

In light of new 2021 health record documentation policies, which eliminate the Hx as a part of the provider payment formula in the outpatient/office setting, how will information be gathered? Providers, rushed for time and overburdened with documentation tasks, have had difficulty gathering Hx data with high accuracy. This leaves it to all of us as individuals to consider ourselves active members of the healthcare delivery team.

Individuals need awareness of their rights to author the Hx component of their health record. This is empowering and stands to correct health record inaccuracy. With accurate health records, which tell the patient’s complete subjective story, we will have data to guide us into the digital age of healthcare.

Every right implies a responsibility,
Every opportunity, an obligation,
Every possession, a duty.

– John D. Rockefeller (1839-1937)35

k. What if a provider wishes to not accept the patient’s written submission?

Providers, and ancillary medical staff members, must be careful to never ignore a patient’s request to author the Hx in writing. Failing to acknowledge a patient’s federal right and ignoring CMS Final Rule could result in a damaging HIPAA violation.

Providers may refuse a patient’s written request to author the Hx, but must send the patient a written notification explaining why. A patient, for example, could submit a written request to amend a previous note claiming
a neck injury did not occur in a motor vehicle, as reported at the visit, but while sitting on a swing in a city park. The provider can be justified in refusing to make the amendment claiming the record from that date of service needs to reflect the original story as reported by the patient.

Imagine a patient requesting to author the Hx with an explanation of abdominal cramping, bloating and an immediate family member with ovarian cancer? We have great difficulty justifying how a provider could refuse this information submission request.

Rise of the Patient Advocate

At first glance, new CMS policies eliminating both History and Examination as key components of the outpatient/office Evaluation and Management (E/M) physician payment methodologies seem to undermine listening to the patient and observing clinical signs. Deeper evaluation of these policies, however, emphasize the need to value health record capture of the History and Exam in new ways.

E/M Guidelines Changes, posted in a 2019 AMA document, commit a paragraph to History and/or Examination:

“Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (e.g., by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services.”

New policies are not promoting abandonment of the History and/or Examination, but a new mindset. A new way of thinking includes recognition of the patient as an active member of the healthcare team. Old mindsets viewed the patient’s words as anecdotal. In light of research showing poor History and Examination documentation accuracy, old mindsets need to be challenged. Who else can rate the severity of a problem better than the patient herself? Who else can describe what it is like to live with a chronic disease (Status) than the patient himself? These new policies signify a paradigm shift in health record documentation.

While health records are shown to poorly correlate with what actually happens at medical encounters, value needs to be recognized in a patient authored History. For the patient who reports seeing “bears dancing in ballerina outfits in her living room” is not inaccurate. Reflective of the patient’s subjective History, it is 100% accurate.

Not all patients have the means or ability to author their own History, which is why TUC research is focused on studying ways to best empower individuals to be their own patient advocate. Many patients will be able to enlist help from a family member, friend or caregiver. Community outreach research at TUC proposes enlisting the help of health professional students to guide individuals through the PreHx process.

With clinical research used to create the JAOA 2017 PreHx publication, the two oldest participants were not able to complete a PreHx on their own. The oldest patient, age 94, suffered from severe dementia. Her PreHx was completed by her granddaughter, who was also her caregiver. As mentioned earlier, the second oldest participant, age 93, was a retired nurse, who was blind. This patient enlisted the help of her caregiver to ask all of the PreHx questions and record all of her answers. During a home visit by the provider, her PreHx was presented as her written request to amend the health record in accordance with federal law.

The two youngest participants in the JAOA PreHx study were both age 14. From separate families, both of these young people completed a PreHx and authored the History component of their health record without parental assistance. In both instances, parents proudly observed as their child interacted with the family doctor at the medical encounter. When we think of patient advocates, we need to expand our views beyond adults and consider people of all ages.
Not all patients have internet access and not all patients have the ability to read or write in English. Barriers such as these create disparity, inequity, inequality resulting in burden for members of our society who seek healthcare. We recognize these factors and are committed to finding and defining ways to give all individuals the ability to best represent themselves and their needs when seeking healthcare.

New rules, which superficially appear to discount the History, promise hope to empower all individuals to be their own patient advocate. We welcome these rules and embrace the rise of the patient advocate.

**Activity 3 [A3] For providers:** Encourage a few patients to complete a PreHx in preparation for their next medical encounters

**Activity 4 [A4] For individuals:** Complete a PreHx to prepare for your next medical encounter and submit it as a written request to amend your health record per the HIPAA Privacy Rule of 2001 and Final Rule in the Federal Register CY2019

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36 Klein, R, Huang, D “Defining and measuring disparities, inequities, and inequalities in the Healthy People Initiative, Centers for Disease Control and Prevention National Center for Health Statistics, Healthy People 2010


Free audiobook at [www.PatientAdvocacyInitiatives.org](http://www.PatientAdvocacyInitiatives.org)
Guideline 3

Ancillary medical staff members should assist patients in authoring the history component of a medical encounter note in the health record

Per 1997 DG, ancillary medical staff members, such as nurses and medical assistants were limited to documenting only the Review of Systems (ROS) and Past Family Social History (PFSH). Federal Register Final Rules for CY2019 expanded documentation abilities for ancillary medical staff members to allow documentation of the entire Hx. This includes: History of Present Illness (HPI), Status of Chronic Condition/Disease (Status), Review of Systems (ROS), and Past Family Social History (PFSH).

Policies for 2021, which remove Hx as a key component of outpatient/office E/M services, could be interpreted that it is now the job of ancillary medical staff members to conduct and document the Hx into health records. We fear this response will replicate inaccuracies experienced with provider documented Hx’s and expose staff members to malpractice liability.

Ancillary medical staff members are not universally educated and board tested to conduct a Hx on patients. New policies should not be viewed as unloading a previous provider duty to staff members. The best solution is for ancillary medical staff members to assist patients as they author their own subjective Hx’s.

In the JAOA PreHx study, ancillary medical staff members were prepared to receive a patient’s PreHx. At the check-in window, they asked if the patient had completed a PreHx. If yes, then staff members scanned the paper document into the EHR and transcribed content into the appropriate Hx fields of the EHR’s encounter note. This process took an average of 3 minutes. This time, however, was well invested because when the patient was triaged to the examination room, medication and allergy lists were already documented, as well as Review of Systems (ROS).

Some health systems are adding PreHx-type features to their patient portals. Rather than scan a document and transcribe content, the ancillary medical staff role will be as easy as clicking a button to import the patient’s PreHx into the EHR’s encounter note. This will improve the triage process and reduce clerical burden for staff members.

Activity 5 [A5]: Create a mock PreHx and guide ancillary medical staff members to role play on how to accept a patient’s written request to amend the health record.

Activity 6 [A6]: Document PreHx accommodation experiences into your office/health system Compliance Manual.

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39 1997 Documentation Guidelines for Evaluation and Management Services, CMS.gov, retrieved, 20July2020

Medicare Physician Guide:
Guideline 4

Medical providers should first read the patient authored history, then ask additional questions

••• Medical providers interrupt patients within the first 11 seconds when they try to tell their subjective story. This makes providers, such as physicians, appear insensitive and uncaring. The problem with such an assessment is providers are trained to take quick action under emergent circumstances. Interrupting within the first 11 seconds may not be the problem. The problem may be how information is presented.

Imagine a patient presenting to a provider with escalating shortness of breath? Imagine a patient clenching a fist over his chest with horrible pain? Imagine a patient with intense calf pain after a long airplane flight with shortness of breath? These scenarios require immediate attention because the patient could die now.

When a patient tells a story, piece by piece, provider’s pick up on keywords and are compelled to intervene. Clinical research reports patients will generally stop talking after 30 seconds in a primary care setting and 90 seconds in a consultant setting, if not interrupted. These reports instruct clinicians to pause and allow patients to express their concerns. A best practice would be for the provider to read the patient’s attempt to author the Hx first.

During the JAOA PreHx study, the provider entered the room and greeted the patient. The provider thanked the patient for authoring the Hx and then sat and read the patient’s narrative in the health record. This took an average of 30 seconds. The provider re-affirmed what he learned by remarking to the patient, “You are telling me this and this are going on?” The provider then asked a few higher order questions and documented the patient’s responses.

Reviewing the patient authored Hx during the visit demonstrated to the patient that the provider valued the patient’s narrative. Re-affirming what was learned gave confidence to the patient that she was being heard and understood. Asking additional questions was natural for the provider because the story prompted pattern recognition of diseases based on training.

After reading the patient authored Hx and re-affirming the narrative, providers may engage in less than 11 seconds, perhaps 0.1 of a second! This interaction, however, does not interrupt the patient, but engages the provider as a trained clinician in the best interest of the patient.

39 Ospina, NS, Phillips, KA, Rodriguez-Gutierrez et al “Eliciting the Patient’s Agenda - Secondary Analysis of Recorded Clinical Encounters,” Journal of General Internal Medicine, July 2, 2018
41 Ospina, NS, Phillips, KA, Rodriguez-Gutierrez et al “Eliciting the Patient’s Agenda - Secondary Analysis of Recorded Clinical Encounters,” Journal of General Internal Medicine, July 2, 2018
Medical providers and ancillary medical staff members should view the blocking of a patient-authored history as a HIPAA violation.

Patients have a federal right to request to amend their health record in writing per the Standards for Privacy of Individually Identifiable Health Information of 2001, HIPAA Privacy Rule [45 C.F.R. § 164.526]. While a provider can refuse to amend the health record, the provider is obligated by law to respond to the patient with written notification within 60 days. If the provider refuses a patient’s written request to amend and does not offer an explanation why with written notification, then a HIPAA violation occurs. Similarly, if the provider decides to execute an additional 30-day extension to deciding, the provider must send written notification to the patient or be subject to a HIPAA violation.

Escalating a violation is any evidence of retaliation. Providers and staff members must be keen to avoid any perception of retaliation to a patient who attempts to author the History component of an encounter note in the health record. In the case of a bad clinical outcome, refusal of the patient’s attempt to be heard could create additional liability.

While providers may be aware of this potential for a HIPAA violation, ancillary medical staff members must also be aware. A staff member, representing the provider, could refuse a patient’s written request and place the provider in danger of a violation.

Activity 7 [A7] for Providers and Ancillary Medical Staff Members: Review the HIPAA Privacy Rule and create a pathway for patients to submit a written request to amend the health record in accordance with federal law. Log your observations into your practice/health system Compliance Manual.

42 Warner, M “When a Patient Requests to Amend their Medical Record,” Healthcare Business Monthly, December 2017

When a Patient Requests to Amend their Medical Record
Patients should routinely read their entire health record note (history, exam, medical decision making) after every medical encounter.

Accessing health records should be easy for patients and their authorized personal representatives. As Vice-President of the United States, Joe Biden had to influence power in order to access his son’s health records. The Vice-President was very critical of the difficulty he experienced. Per federal law, it should not be that hard.

The Standards for Privacy of Individually Identifiable Health Information of 2001, HIPAA Privacy Rule [45 C.F.R. § 164.524] grants individuals the federal right to access their health records. Per law, providers have 30 days to respond to a patient’s written request with written notification. If needed, the provider may elect to take an additional 30-days to decide in accordance with the law, but must send written notification to the patient explaining why.

Individuals are generally accustomed to reviewing receipts after visiting a store. After submitting a report assignment, students routinely review their paper for teacher comments and score. In a similar fashion, we expect individuals to routinely view their health records after every medical encounter.

While most medical settings give patients discharge summaries, it is rare for patients to access the entire note (Hx, Ex, MDM). Discharge summaries offer a list of diagnosis and the treatment plan, but do not allow the patient to assess how their story was entered into the health record.

In a similar fashion, patients should be able to view the documented Ex. Imagine the patient with the worst abdominal pain in their life, curled up on a gurney. If the Ex in the health record reads, “Abdomen non-tender with normal bowel sounds in all four quadrants,” when the patient is actually “severely tender with guarding, rebound and + Rovsing’s sign,” the patient should be aware of the error. Such documentation not only misrepresents the patient’s clinical presentation, but could deny approval for testing, such as a 'stat CT of the Abdomen.'

We suggest patients do whatever they can to assure accuracy at the time of the encounter. “Doing everything,” in accordance with federal law and Final Rules, now means authoring the Hx and reviewing the health record after encounters.

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44 Warner, M “When a Patient Requests Access to their Medical Record,” Healthcare Business Monthly, January 2018
Guideline 7

Medical students, as well as all healthcare professionals, should be trained to view health record documentation through the lens of core competencies: Systems-Based Practice, Practice-Based Learning & Improvement, Professionalism, Interpersonal & Communication Skills, Patient Care, Medical Knowledge, Osteopathic Principles & Practice

Medical students, as well as all healthcare professionals, should be trained to view health record documentation through the lens of core competencies: Systems-based practice, Practice-based learning and improvement, Professionalism, Interpersonal and communication skills, Patient care

When asked in June 2020 of awareness of 2021 polices that eliminate documentation of the Hx and Ex as part of the provider payment formula in the outpatient/office setting, most TUC 3rd year osteopathic medical students were unaware of such policy changes. We feel awareness is crucial to improving healthcare delivery.

Of interest, one of the first policy changes due to the Patients over Paperwork initiative was to empower medical students to document all aspects of E/M services into the health record. MM110412, a revision to the Medicare Claims Processing Manual, defined documentation roles of medical students effective January 1, 2018. With review of the revision’s details, medical student health record documentation can count as attending physician documentation.

Since the advent of the HITECH Act of 2009 and meaningful use payments for EHR adoption, medical students have been routinely kept away from health record documentation. Attending physicians have been left with few options to engage medical students because federal rules needed clarification. With the January 1, 2018 effective date, we need to let medical students be part of the documentation process. Is it not fair for individual students or our healthcare delivery system to suddenly expect documentation/coding proficiency upon graduation. With the CMS revision, medical students should be routinely given access credentials when on service and coders/auditors need to recognize medical student documentation as official.

Core Competencies

The American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) support 7 Core Competencies.

Core Competency: Systems-Based Practice

Systems-based practice is the “why” behind policies. New policy changes are occurring, not because the government does not care about the patient narrative, but because the Hx is valued. New policies emphasizing MDM are emerging because our government recognizes the importance of effectively capturing the clinician’s mindset when making a diagnosis and creating an effective treatment plan.

Core Competency: Practice-Based Learning & Improvement

Practice-based learning & improvement is the “how” behind these new policies. How can we improve health record documentation? How can we encourage patients to take an active role in reporting their story?
How can providers benefit from this information, with a near-future promise of information technology feedback and recommendations? How will ancillary medical staff members accommodate new policies?

**Core Competency: Professionalism**

Professionalism consists of behavior, respect and work ethic. Relative to new health record documentation policies, this competency should bring out the best in our healthcare workforce.

**Core Competency: Interpersonal & Communication Skills**

Communication among a patient and provider is key to a healthy relationship. These guidelines, which superficially appear to discount the patient’s narrative, actually highly regard the Hx. From a patient perspective, we are giving individuals the ability to exercise their federal right to be heard and understood in the healthcare setting.

Communication also means sharing information from one healthcare professional to another. New 2021 policies promise to create health records rich with accurate information. This should improve communication among professionals as well as feed computer technology to deliver best practice feedback.

**Core Competency: Patient Care**

Patient care requires continuous evidence of ongoing awareness of the patient’s condition and progress. Patient care also requires carrying out plans and communicating changes with the patient. We support new policy changes as ways to improve patient care.

**Core Competency: Medical Knowledge**

Medical knowledge is worthless if the patient is not understood or the health record is inaccurate. Medical knowledge is dangerous if the patient is only partially understood. We support new policy changes because it will allow providers to work at the top of their license. A Patients over Paperwork approach should maximize the ability of providers, and all health professionals, to best apply medical knowledge.

**Core Competency: Osteopathic Principles & Practice**

The osteopathic profession differs from other medical professions in adding ‘Osteopathic Principles & Practice’ as a Core Competency. OPP includes hands-on diagnostic maneuvers and treatment procedures, such as Osteopathic Manipulative Treatment (OMT CPT 98925-98929). OPP also includes a philosophical approach to the whole body which recognizes body unity. Understanding patient information, including the patient’s narrative, is important to formulating an accurate diagnosis and delivering effective treatment.

~ GUIDELINE 7: MEDICAL STUDENTS, AS WELL AS ALL HEALTHCARE PROFESSIONALS, SHOULD BE TRAINED TO VIEW HEALTH RECORD DOCUMENTATION THROUGH THE LENS OF CORE COMPETENCIES: SYSTEMS-BASED PRACTICE, PRACTICE-BASED LEARNING & IMPROVEMENT, PROFESSIONALISM, INTERPERSONAL & COMMUNICATION SKILLS, PATIENT CARER ~
A 3-page paper PreHx form is available at www.PatientAdvocacyInitiatives.org. At the 501(c)(3)’s website and directly at www.PreHx.com is a free online patient advocacy tool. This tool is designed to guide individuals through all of the Hx questions as structured and defined by 1995/1997 DG. PreHx.com’s security and legal declarations are posted on PreHx.com. Patient Advocacy Initiatives, operator of the websites, has vowed to never sell, share or read what individuals record while participating with PreHx.com. On purpose, all materials are without intellectual property and are for use by the public domain, for the good of the general public.
Investigator Concerns

Improvements to PreHx.com are being developed by medical and postgraduate students at TUC. The following areas have been identified with proposed solutions.

a. Overcoming language barriers when considering medical interview/Hx questions: Some medical interview/Hx questions, like Duration (How long have you had your problem?), translate well among languages. Some questions, however, translate poorly and cause confusion for the patient. To better understand what each question is actually asking, we propose creating a series of short videos. Currently, PreHx.com shows a thumbnail with a short video to verbally explain each statement and questions. Recordings at TUC include Panjabi with plans to soon expand to Hindi, Spanish and other languages.

b. Providing “How to” training videos on YouTube Online videos, such as ‘How to Complete a PreHx’ to ‘How to answer Past Family History’, can help patients, providers and ancillary medical staff members. For patients, such videos can offer technical advice, such as ‘How to obtain a copy of your PreHx to your email?’ We see such videos as an efficient way to provide guidance and field comments/questions.

c. Community Outreach/Education as a Second Language (ESL) Prepare for a Medical Encounter Class: ‘Preparing for a Medical Visit’ is a fun and meaningful activity for an ESL class. Such a class would inform individuals of their rights to author the health record and assign the class to prepare for a future medical encounter. Participants could utilize the online tool at PreHx.com or download the 3-page paper form at PatientAdvocacyInitiatives.org.

At successive classes, students could offer their experiences as they prepared for a future visit and authored their medical narrative. Classmates could exchange tips, which could include enlisting the help of a family member, friend or caregiver. Ultimately, students could share their experience when they sought medical care and co-authored the health record.

d. Community Outreach/Health Education for K-12 Students: Especially in times of a pandemic and remote learning, teaching young people how to represent themselves at a medical encounter is valuable. Health education, via YouTube videos and live Zoom sessions, can encourage and empower our next generation to recognize merit in the patient narrative and value health record data. Our rising generation will likely expect information technology feedback, recommending best practice options with outcome success percentages, to be a standard feature in the digital age of healthcare.

e. Community Outreach through existing programs (DPP, Pharm2Home) TUC Patient Advocacy Club is currently working on a community outreach research project in conjunction with the Center for Disease Control Diabetes Prevention Program (DPP), which is designed to improve lifestyle health choices to mitigate the onset of Type 2 Diabetes Mellitus for patients diagnosed with pre-diabetes. The community outreach project is intended to enroll DPP participants and help them prepare for an upcoming medical encounter. We plan to guide individuals through all of the Hx questions as structured and defined by 1995/1007 documentation guidelines. We will use paper PreHx 3-page forms and digital PreHx online tool (PatientAdvocacyInitiatives.org) as guides.

At the least, we will help individuals organize their medication and allergy lists. At most, we will help them create a PreHx document that can be submitted to the provider and ancillary medical staff members at the person’s next medical encounter. Our goals are to empower individuals to narrate their own medical health record and work in partnership with their providers to assure the Hx is accurate. In follow-up, we plan to evaluate the process for intended and unintended consequences so reports can be shared with the healthcare delivery community.
TUC researchers and Patient Advocacy Club members hope to continue community outreach projects through a Sutter Community Outreach Program called Pharm2Home.

f. Inclusive Identification in Profile and top of PreHx document: PreHx.com currently allows users to identify themselves based on male/female nomenclature, but plans to soon expand to allow for inclusive profile descriptors, which will show at the top of the final PreHx document.

g. Members of the LGBTQ IA+ community face high anxiety when seeking medical care: According to the U.S. Transgender Survey conducted in 2015, 33% of LGBTQ IA+ patients who saw a health care provider reported at least one negative experience related to being LGBTQ IA+. 23% did not see a doctor when they needed to because of fear of being mistreated. 47

We propose updating PreHx forms to allow for inclusive descriptors that can be chosen, by the individual, to self-identify. Inclusive language will change the online tool to be consistent with Safe Zone and include a wide variety of selection for pronouns such as “he, she, they, ze, any pronouns not listed and no pronoun preference.” Prefix options included, “Miss, Mr., Mrs., Ms., and Mx.” A field that asks for the patient's gender at birth will be expanded beyond two options: “male or female.” A selection will be added to include sexual orientations: “Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex, Asexual, and heterosexual, something else, and decline to answer.” Options will also be added to select gender identity to include: “Male/man, female/woman, Transmale/transman, Transfemale/transwoman, Gender queer/gender non-conforming, something else, and prefer not to answer.”

We hypothesize that allowing the individual to self-identify in a PreHx setting has the potential to reduce health encounter anxiety for the patient because they can have the option to self-declare. This should avoid provider awkwardness because such a declaration could be made up front. Take for example a homosexual male who, via a standard form, indicates that he is married? A provider, suspicious of a household upper respiratory viral infection could ask, “How is your wife doing?” This creates a situation in which the patient and the provider may both sense discomfort. While this approach may not reduce all LGBTQ IA+ discrimination, it does create a mechanism for documenting the patient’s identification as part of the legal health record.

h. Recognition of Social Determinants of Health (SDOH): The Status of Chronic Condition/Disease (Status), a subset of the History of Present Illness (HPI) allows patients to describe their healthcare experiences and challenges in free-text. A person with Diabetes mellitus, for example, may not have filled a prescribed medication because the cost was unaffordable. A patient status-post knee replacement surgery may not attend physical therapy because of a lack of transportation to the therapist’s facility. A patient with elevated blood glucose and cholesterol levels may not change dietary intake to a higher portion of vegetables and fruit because of living in a food desert. Status gives patients the opportunity to express limitations due to SDOH. All of these patients may face a significant limitation in diagnostic or treatment efforts because of a SDOH. Health professionals need to be alert for SDOH and not to jump too quickly to conclusions of patient non-adherence or non-compliance.

The new 2021 AMA Medical Decision Making (MDM) grid recognizes SDOH as a factor in determination of an Evaluation and Management (E/M) level of service. 48 Specifically, “Diagnosis or treatment significantly limited by social determinants of health” is printed as an example of “Moderate risk of morbidity from additional diagnostic testing or treatment.” We see opportunities to best guide patients to express SDOH. We hope such recognition will uncover ways to accommodate patient needs and overcome barriers to diagnosis and treatment.

48 CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XX) Code and Guidelines Changes – effective January 1, 2021, AMA, ©2019 Code and Guideline Changes | AMA
Burnout, a symptom of current health record documentation policies

Electronic health records (EHRs) have been linked to physician burnout. The Maslach Burnout Inventory (MBI) assesses burnout risk based on three factors: Emotional exhaustion, Depersonalization, the need for Personal Accomplishment. While physical exhaustion can be overcome with rest and conditioning, emotional exhaustion is more daunting. Consider the Harris Poll described at the 2018 Stanford EHR National Symposium identifying an additional 11 minutes of EHR work per patient after hours? For a provider seeing 20 patients a day, that’s 3.6 hours to be spent after the work shift. New E/M documentation policies promise to reduce provider clerical burden, which should minimize the need for afterhours documentation. In the JAOA PreHx study, all documentation was completed by the end of the encounter visit within the 15-minute office schedule due to the efficiency of patient data gathering.

Depersonalization/cynicism occurs as providers become detached from the patient. Using an auto-population EHR feature to generate the patient’s narrative, rather than the true story, is a material form of depersonalization. Due to 2001 federal law and Final Rules in the Federal Register for CY2019, patients have the right and are authorized to author the History component of an EHR encounter note. Starting January 1, 2021, providers in the outpatient/office setting will not be paid based on History documentation. These policy changes invite a best practice for patients to narrate their own History, which should promote personalized patient-provider communication.

Emotional exhaustion and depersonalization, according to the MBI, pose low risk of burnout if such experiences occur only several times a year. With the current documentation system, providers may experience these elements with every patient encounter.

Resolving interoperability, particularly in accordance with the 21st Century Cures Act, is not part of this guideline. Interoperable or not, health records need to be accurate and should encourage the patient’s subjective narrative.

The final MBI element is the need for Personal Accomplishment. Medical providers need to feel useful and that they are making a positive difference for their patients. To avoid burnout risk due to lack of Personal Accomplishment, providers should experience positive feelings daily. Knowing each patient’s individual story is a highly meaningful honor and privilege for medical providers. New policies give hope for providers to experience fulfillment of accomplishment with every patient encounter.

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49 Devitt, M. “Study: EHRs Contribute to Family Physician Stress, Burnout.” AAFP News, January 2019
49 Study: EHRs Contribute to Family Physician Stress, Burnout
50 EHR National Symposium - setting a bold, new vision for electronic health records, June 4, 2018, Harris Poll discussed during opening remarks by Loyd Minor, MD 2018 Agenda | EHR National Symposium | Stanford Medicine
51 Gardener, RL, Cooper, E, Haskell, J et al. “Physician stress and burnout: the impact of health information technology,” JAMIA, February 2019 Physician stress and burnout: the impact of health information technology
52 Maslash, C. “Burnout: the cost of caring,” 2015
Clinicians report COVID-19 patients can look “fine,” then “suddenly deteriorate.”\(^{53}\) Could information in a patient’s detailed Hx uncover clues to severity and outcome? Imagine if patients routinely and continuously prepared for medical encounters by authoring the Hx in advance of any potential healthcare encounter? Imagine if someone who became sick was able to produce an up to date Hx that included details of disease progression? In regard to COVID-19, imagine if those health records could be reviewed and compared with other COVID-19 patients? What symptoms do patients have with COVID-19? Does symptom presentation serve as an indicator of severity of disease?

COVID-19 pandemic has exposed the extreme of Hx absence. Patients reporting to an emergency department with advanced SARS-Cov-2 symptoms, such as respiratory distress, are taken into the ward without the accompaniment of family members or friends due to infectious disease protocols. In such scenarios, very little Hx information can be obtained. If we were to make health records accurate and encourage patients to report their narrative, we would likely witness greater insight into this novel virus.

Beyond the patient’s story at the time of presentation, information could be analyzed reflective of the patient’s attempts to recover. Among COVID-19 patients who experience good outcomes, are there any patterns? What did they do? For example, we might find combinations of chronic disease medications to be protective.

A growing concern for COVID-19 will be sequelae, also known as late effects.\(^{54}\) To date, the novel virus is being blamed for irreversible damage throughout the body, including the mind.\(^{55}\) Learning of the patient’s detailed story will help the medical profession understand the sequelae and give policymakers information to better allocate resources.

To capture a patient’s experience with a chronic disease or condition, we do not need to invent new protocols. The Status of Chronic Condition/Disease (Status) was introduced with 2017 DG and made part of 2015 DG with a 2013 CMS ruling.\(^{56}\) Status gives patients the opportunity to personally describe their experience.\(^{57}\) Rather than answer standard HPI questions (Duration: how long has the problem been present? Location: where in the body is the problem), Status encourages an open narrative for the patient to describe her experience. A person with COVID-19 sequelae could describe what it is like to live with symptoms after the initial viral infection. Such discovery of sequelae details would serve providers well so they can best manage patient care. Such awareness will also serve individual patients, so they can be heard and understood. Without accurate health record data, the healthcare community is rudderless to maneuver an effective appreciation and response to this novel virus and its sequelae.

The COVID-19 pandemic has been disruptive to human health. Now, more than ever, we need to take active measures to improve healthcare delivery. Nearly 800 years ago, Rumi instructed us, “Raise your words, not voice. It is rain that grows flowers, not thunder.”\(^{58}\) Patients should not need to raise their voice to be heard.

\(^{53}\) Brown, N “From fine to flailing - rapid health declines in COVID-19 patients jar doctors, nurses,” Health News, Reuters, April 8, 2020

\(^{54}\) Grider, D “What We Currently Know about the Sequela Effects of COVID-19,” icd10monitor.com, July 28, 2020

\(^{55}\) Wilson, R "COVID-19 shows signs of long-term harm in some recovered patients," The Hill, May 31, 2020

\(^{56}\) Abel, K “Medical Coding Training: CPC 2014,” AAPC, 2013, p. 619

\(^{57}\) Warner, M “Capture the Patient’s Story - Status of Chronic Condition/Disease provides an opportunity for improved documentation,” AAPC’s Healthcare Business Monthly magazine, March 2020, digital version at AAPC’s Knowledge Center, Capture the Patient's Story

\(^{58}\) “Raise your words, not voice. It is rain that grows flowers, not thunder,” Rumi Quotes, Goodreads.com, retrieved 24aug2020
or understood. Similarly, providers should not need to raise their voices to identify a 1995/1997 system that has not caught up to modern times. Patients have the ability to answer +30 standardized questions before the medical encounter begins. A template, that tells a generic story of “everything normal,” cannot be accepted into health records and analyzed for best practice. We need a system for patients and providers.

Discussions are folly unless they have concrete solutions. We challenge everyone to take the PreHx Challenge. Go to www.PatientAdvocacyInitiatives.org and download the 3-page PreHistory. On the same website, engage with the non-profit’s online tool, or access it directly at www.PreHx.com. Complete a PreHistory (PreHx) on yourself. Experience the consideration of all of the standardize questions and stimulate your mind to formulate appropriate answers. We encourage you to work with your medical providers, not to gather a few facts during a visit, but to understand your entire story.

We wish to empower you to raise your words and be your own patient advocate. For the reasons specified throughout these guidelines, we believe you will receive better care when your story is heard and understood. Who best, but you, knows your story?
Limitations

“It is impossible to improve any process until it is standardized. If the process is shifting from here to there, then any improvement will just be one more variation that is occasionally used and mostly ignored. One must standardize, and thus stabilize the process, before continuous improvement can be made.”

Masaaki Imai, founder of the Kaizen Institute

Fortunately, the structure of the History is highly standardized. As structured and defined by 1995/1997 documentation guidelines, the near 30 questions assemble a comprehensive patient narrative. To date, poor History accuracy in health record documentation has sabotaged our ability to leverage the digitalization of health records. Our greatest limitation, and our greatest challenge, will be to accept a new way of gathering patient information: one that empowers patients to be their own advocate.

59 AZ Quotes, retrieved 18aug2020,
Masaaki Imai Quote
Dr. Osler told us to ‘listen to the patient.” Dr. Weed advised us to structure health records so any professional could pick up the medical chart and figure out what is going on. With changes spearheaded by CMS Administrator Seema Verma, MPH, we are on the brink of a new era of medicine.

We encourage patients, providers and ancillary medical staff members to consider their new roles in light of emerging policy changes. Providers, overburdened with regulatory tasks, should now be freed to concentrate on the patient, not paperwork. Ancillary medical staff members can see themselves as patient advocates, helping to properly populate the patient’s self-constructed narrative into the health record. We also encourage medical students to be leaders in our final transformation from paper medical charts to digital health records.

Most centric to all focus are patients themselves. As all of us become a patient of our healthcare systems at some points or another, patient focus is people focus. We welcome the new roles of people to be their own patient advocate to power a new era of medicine which will improve healthcare delivery for everyone.
The Office of Inspector General (OIG), through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) recommend 7 fundamental elements of an effective Compliance Program. We recommend following the OIG’s advice word for word.

1. **Implement written policies, procedures and standards of conduct**
   A start to your compliance plan in regard to new 2021 outpatient/office health record documentation policies is to read this report and complete the activities.

2. **Designate a compliance officer and compliance committee**
   Someone in your office/health system needs to be designated as the compliance officer. In addition, a compliance committee needs to exist with active members. Meeting minutes, with observations pertinent to all 7 compliance plan elements, should be documented and stored.

3. **Conduct effective training and education**
   The activities within this guideline offer a pathway of training and education. As we approach and enter 2021, learning how to accommodate new policies will be crucial to maintaining good patient flow work patterns and delivering quality care.

4. **Developing effective lines of communication**
   Your compliance manual should showcase proper lines of communication for patients, staff members and providers. Staff and providers should not be “taken by surprise” should a patient request to amend or access a health record.

5. **Conduct internal monitoring and auditing**
   On a quarterly basis, some entry should be made to the compliance manual with a performance assessment. Has any patient requested to amend or access a health record? What happened? As we approach and pass January 1, 2021, practices should expect to see increased requests by patients to amend and access.

6. **Enforcing standards through well-publicized disciplinary guidelines**
   This guideline offers references to publication specifically addressing standards. Consistent accommodation to standards will reduce risk of violation and liability exposure. On a positive note, accommodations should make the practice of medicine easier for clinicians and more meaningful for patients.

7. **Responding promptly to detect offenses and undertaking corrective action plan**
   A Corrective Action Plan (CAP) identifies a problem and creates a pathway resolution.

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Health Care Compliance Program Tips
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Avleen Gill, OMSI, MS, is a medical and public health student at Touro University College of Osteopathic Medicine in Vallejo, CA. As a dual degree MPH/DO student and member of Patient Advocacy Club as well as the Indian Student Health Association she hopes to work with underserved populations and develop valuable resources for community members. She is Historian for the Patient Advocacy Club.

Jagmeet Singh, MS, is an aspiring osteopathic physician who currently works with TUC Rainbow Health Coalition, TUC Patient Advocacy Club, Translators Without Borders and Sahaita Organization to advocate for equitable and more accessible universal healthcare.

Andrew Antos, MS, will be a student in Touro California’s DO class of 2025. He is currently the Vice President of Finance for the Patient Advocacy Club.

Sean Lim, OMSIII, is a medical student part of the Touro University College of Osteopathic Medicine’s class of 2022. His interests include app development, game design, urban farming, and taking long hikes near the beach.

Heidi Molga, OMSII is a medical student at Touro University College of Osteopathic Medicine in Vallejo, CA. She is the president of both the Touro Student Chapter of the Osteopathic Physicians and Surgeons of California and the Integrative Medicine Club on campus. She also is involved in the Patient Advocacy club.

Ayseha Malik, OMSII, is an osteopathic medical student with a drive to advocate for underserved patient populations in the United States.

Mary Masek, OMSI, is a medical student at Touro University California of Osteopathic Medicine in Vallejo, CA. She is currently Vice-President of Social Affairs for the Patient Advocacy Club.

Pooya Prasad, MS, is an aspiring Osteopathic Physician with a strong passion for patient advocacy, empowerment and education. With a background in clinical research, she believes in bench to bedside translational research that provides solutions to marginalized populations. She is currently working in research and serves as a mentor for youth in the Social Justice space.

Shalaya Yazdi, MPH, is a Masters of Science in Medical Health Science student and an aspiring osteopathic medical physician. Her passion for advocacy and community service is seen through the work she did founding a nonprofit, which serves the homeless communities throughout the Bay Area. Shalaya works with the DREAM Team as a Diabetes Prevention Program Community Outreach Coordinator and participates in the Patient Advocacy Club and Integrative Medicine Club at Touro University.
The following three pages show an example of a PreHx generated by PreHx.com. The cover page highlights the reason for the document and legal references for its use. We encourage all health professionals to work at the top of their license.

Read the last 2 pages, which represents the PreHx, and see how long it takes for you to appreciate this patient’s story. Imagine greeting the patient, sitting down and reading this in the health record?
Dear Medical Provider and staff,

This document is a universal PreHistory (PreHx) assembled through 501(c)(3) non-profit Patient Advocacy Initiatives. **Please use this patient authored information to populate the History component of your health record encounter note.**

Accepting this document and empowering the patient to co-author the medical record is supported Federally in three ways:

1. This PreHx is a patient’s written request to amend the medical records per the Standards for Privacy of Individually Identifiable Health Information of 2001 (HIPAA Privacy Rule) [45 C.F.R. § 164.526].

2. A patient authored History is defined as patient generated health data (PGHD) per the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) as part of the Act’s objective to coordinate care through patient engagement.


Through the “Patients Over Paperwork Initiative”, CMS aims to simplify medical record documentation. New laws and rules empower patients and ancillary medical staff members to populated the History. CMS wants medical providers to focus on the needs of the patient rather than be overwhelmed with clerical duties.

Patient Advocacy Initiatives, Pennsylvania, offers [www.PreHx.com](http://www.PreHx.com) as a free service. All individual entered information is kept confidential and private. PreHx.com is a tool to help people prepare for medical encounters. We guide individuals through all of the near 30 medical interview questions as defined and structured by 1995 and 1997 CMS Evaluation & Management Documentation Guidelines.

This PreHx is intended to:

- Facilitate patient-provider communication
- Reduce medical provider clerical burden
- Improve health record documentation

Ancillary staff members can scan this patient authored PreHistory into your electronic health record (EHR) or enter a copy into your paper medical record. The provider should read the PreHx and document that it was reviewed. Rather than spend much of the visit gathering basic questions, start the visit with a finished History. Work at the top of your license!

Sincerely,

Michael J. Warner, DO, CPC, CPCO, CPMA, AAPC Fellow
President, Patient Advocacy Initiatives
**Patient Name:** First Name Last Name  
**Address:**  
000 Main Street  
Napa, CA 94559 USA  
**Age:** 43  
**Date of Birth:** 5/1/1977  
**Phone Number:** XXX-XXX-XXXX

**Patient Email:** email address

<table>
<thead>
<tr>
<th><strong>Chief complaint</strong></th>
<th>Back pain and pains in right leg</th>
</tr>
</thead>
</table>

**History of Present Illness (HPI)**

<table>
<thead>
<tr>
<th><strong>Location</strong></th>
<th>right low back, right buttocks area, right back of thigh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>burning pain that shoots into my thigh</td>
</tr>
<tr>
<td><strong>Severity</strong></td>
<td>7 out of 10</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>4 days</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>during the day, near constant</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Many hours for multiple months sitting in chair while working on the computer, then I tried to clean out the garage this past weekend</td>
</tr>
<tr>
<td><strong>Modifying factors</strong></td>
<td>Worse: when sitting, certain movements and resting in bed on right side. Better: when resting in bed on left side and when not sitting</td>
</tr>
<tr>
<td><strong>Associated signs and symptoms</strong></td>
<td>Started Aleve (Naproxyn) two days ago with a little relief. Worried about taking this pill with my Diabetes and Hypertension.</td>
</tr>
</tbody>
</table>

**Status of Chronic Disease(s)**  
Diabetes mellitus, Hypertension, High cholesterol. Last office visit for these conditions July 9, 2020 with Dr. St. Pierre. HA1c 7.4, LDL 83. Taking all medications and trying to incorporate daily activity with daily walks - which stopped a few days ago. Home BP's 126/72. I'm doing a good job with my diet with plenty of vegetables. Avoiding sweets.

**Review of Symptoms (ROS)**

<table>
<thead>
<tr>
<th><strong>Constitutional</strong></th>
<th>Bad because of the back/leg pain. If not for that, I would be doing good.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyes</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Ears, nose, mouth, throat</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>No swelling in legs. No chest pain</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>No troubles breathing. Able to walk with no shortness of breath</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>Stomach ok. Long ago, I did experience stomach pain when taking Advil for a few weeks. Bowels ok</td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
<td>Urinating ok</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td>Pain right low back with pain radiating into the back part of my right thigh. Arms and shoulders ok.</td>
</tr>
<tr>
<td>Integumentary</td>
<td>No rashes</td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Pain into right low back with pain into right thigh. No pains in feet. Trouble moving due to the back and thigh pain</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Sleep cycle is not right because the pain wears me out. No increase thirst.</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>My mood is disrupted because of the pain and the pain I experience when I try to get work done on the computer. I do not believe this is depression or anxiety, I just want to get back to normal so I can do my normal activities.</td>
</tr>
<tr>
<td>Hematologic / lymphatic</td>
<td>No bruises, no swollen glands</td>
</tr>
<tr>
<td>Allergy / immunologic</td>
<td>Dust gives me sinus congestion.</td>
</tr>
</tbody>
</table>

**PFSH: Past Family Social History**

| Medication list | Aleve 220mg one pill by mouth twice a day with food for back pain, over the counter, for past 3 days Lisinopril 10mg once every bedtime by mouth for control of Hypertension, Dr. St. Pierre, CVS Napa on Imola Metformin 500mg one by mouth twice a day with food for Diabetes, Dr. St. Pierre, CVS Napa on Imola Atorvastatin 10mg one by mouth at bedtime for Cholesterol, Dr. St. Pierre, CVS Napa on Imola Baby Aspirin 81mg coated one by mouth once a day in the morning with food for heart & stroke protection, over the counter |
| Allergies to medications | No Known Drug Allergies |
| Do you have a non-medication allergy, such as to bee stings, cats or peanuts? | Lobsters - throat swelled 2008 |
| Prior illnesses | Diabetes mellitus (2016), Hypertension (2017), High cholesterol (2016) |
| Prior surgeries | Tonsillectomy (1978), Ingrown toenail removed right big toe (2012) |
| Change in lifestyle | Married to Theresa (1997), employed as Accountant, Quit smoking age 43 (2015) after 25 years of 1 pack per day. Social beer/wine on weekends. |