Accommodating a Patient's Request to Access and Amend the health record.

Michael J. Warner, DO, CPC, CPMA
Patient Advocacy Initiatives

"Control Your Future"
Physician's Computer Company (PCC) Users' Conference
July 21, 2017

Patient Advocacy Initiatives
501(c)(3)
Johnstown, PA

Michael Warner, D.O., CPC, CPMA

Osteopathic physician – dual board certified family medicine & neuromusculoskeletal medicine

Certified professional coder

Certified professional medical auditor

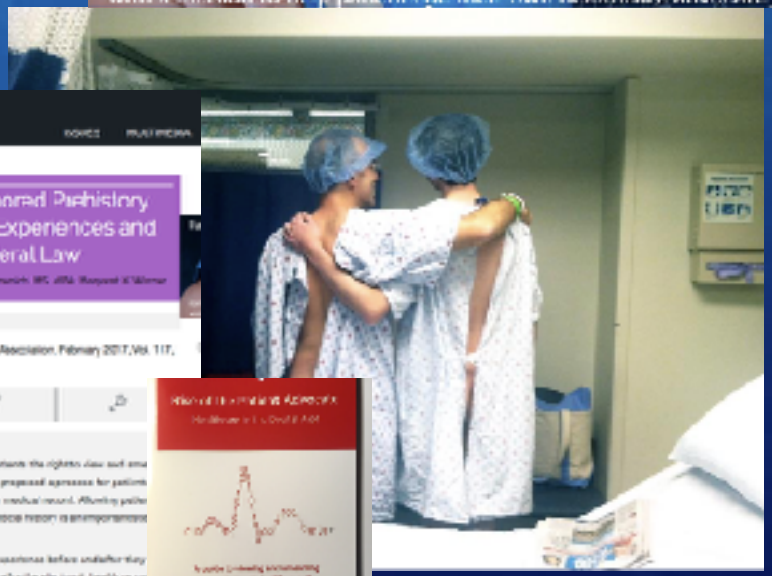
Caretaker and patient

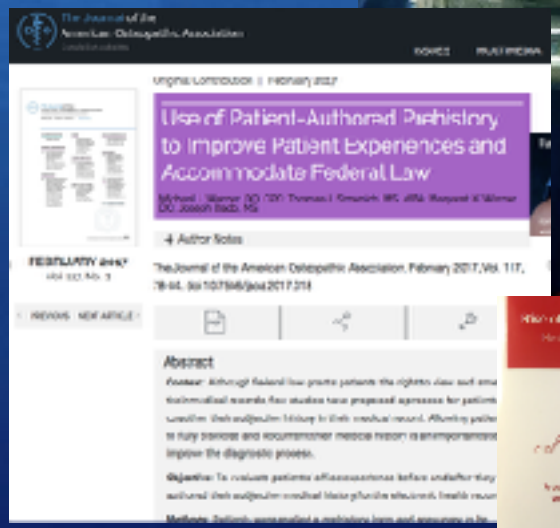
Author

Researcher

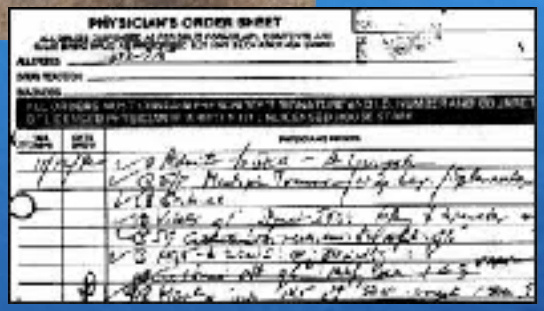
Head of non-profit

2017 AACOM Health Policy Fellow





Patient Access/Amend EHR

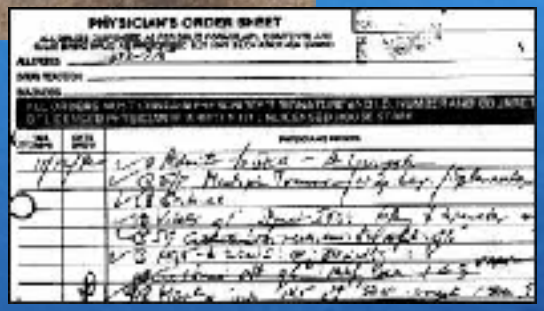


Healthcare is about to radically change as patients routinely access and amend their health record.

Patient Access/Amend EHR

Objectives:

- learn laws governing patient EHR access/amend
- anticipate what it will look like for patients to routinely access/ amend their health record.



Digital Age of Healthcare


PHYSICIAN'S ORDER SHEET

ALL DRUGS DISPENSED AS PER DRUG FORMULARY. CONTENTS ARE SAME BASIC DRUG AS PRESCRIBED BUT MAY BE OF ANOTHER BRAND.

ALLERGIES:

DRUG REACTION:

DIAGNOSIS:

ALL ORDERS MUST CONTAIN PRESCRIBER'S SIGNATURE AND I.D. NUMBER AND COUNTER OF LICENSED PHYSICIAN IF WRITTEN BY UNLICENSED HOUSE STAFF.

PHYSICIAN'S ORDERS

History of Time

Pre Digital Age

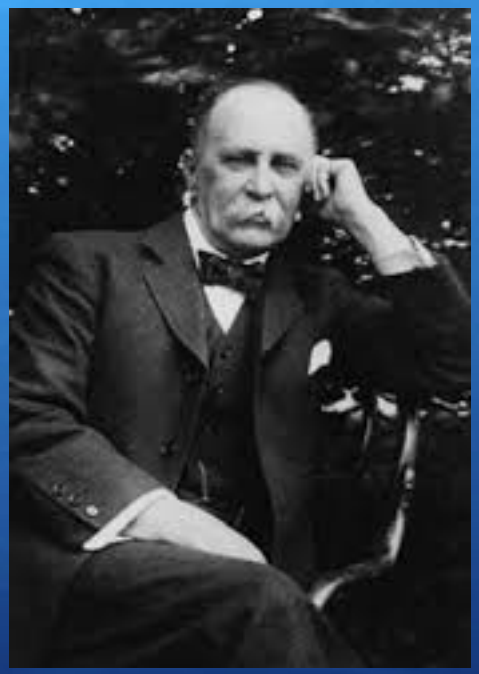
Digital Age

We are currently in transition

Healthcare documentation

Egyptian stone carvings

up to 3,000 B.C.



Sir William Osler

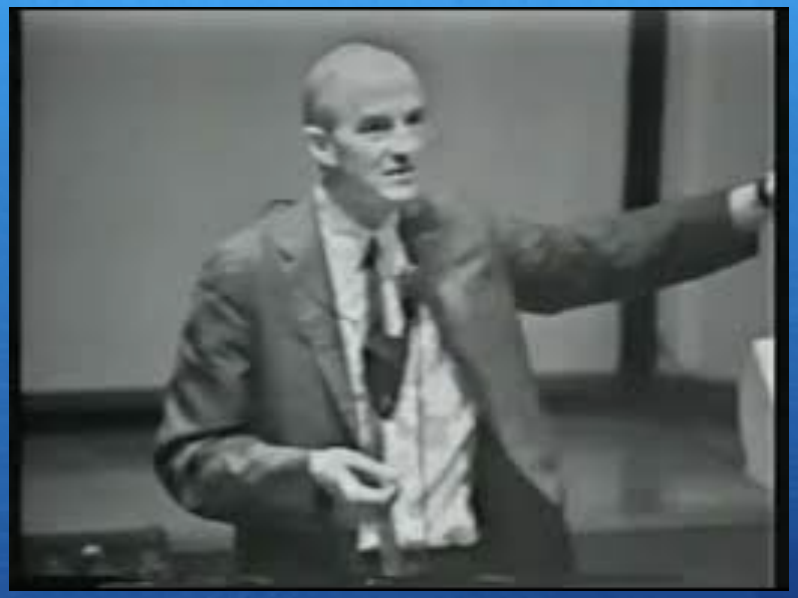
William Osler, M.D.

"Father of Modern Medicine"

1849-1919

"Listen to the patient, he is telling you the diagnosis."

Healthcare documentation



Lawrence Weed, M.D.
(1923-2017)
Father of the Problem-Oriented Medical Record

S.O.A.P. note

S = subjective
O = objective
A = assessment
P = plan

Standardize medical documentation late 1960's

Healthcare documentation

S.O.A.P. note

S = subjective
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P = plan

Standardize medical documentation late 1960's

CMS medical encounter

History
Examination
Medical Decision Making

1995 & 1997 E/M Guidelines
CMS = Centers for Medicare and Medicaid Services

Data collection focus for billing and analytics

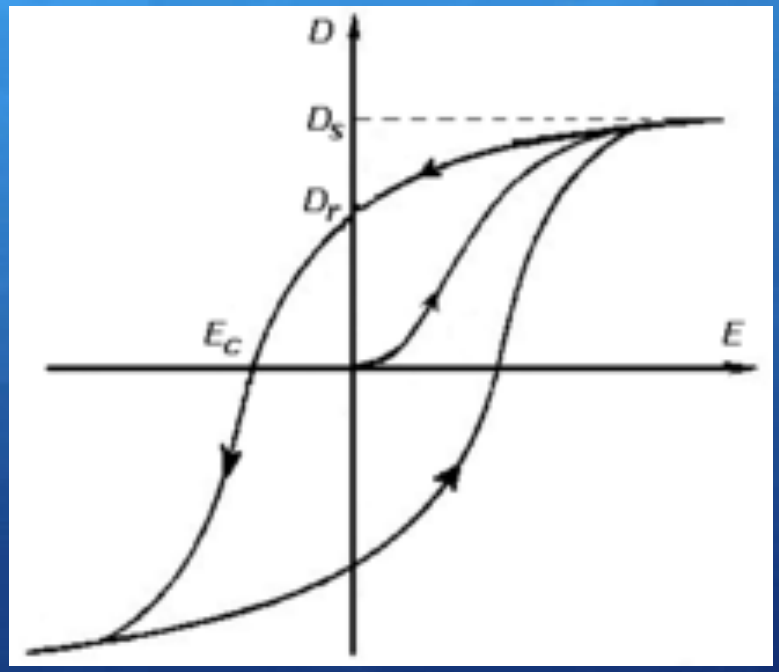
The Digital Age

Prof. Charles Proteus Steinmetz

"Father of the US electrical grid"

"Wizard of General Electric"

1865-1923



Coined "hysteresis"

1892

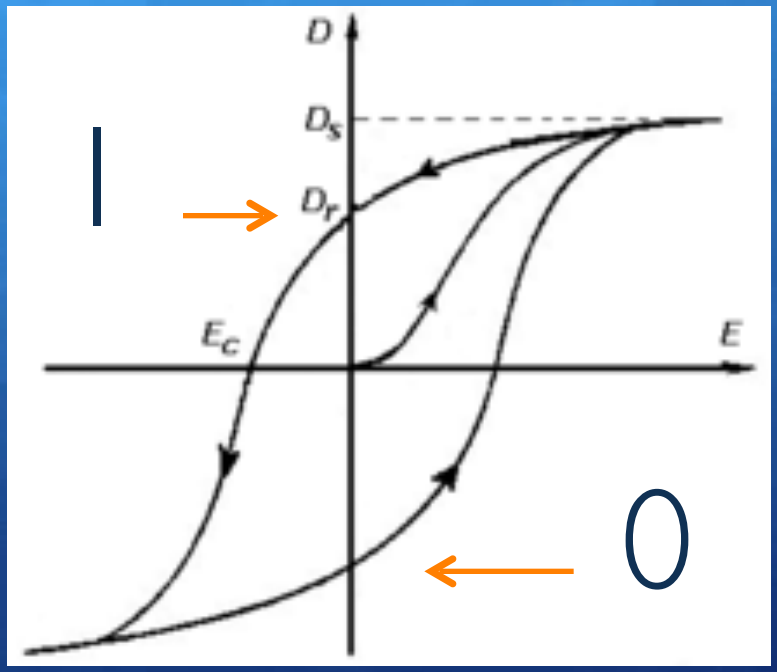
"retentivity" on ordinate

The Digital Age

Prof. Charles Proteus Steinmetz

"Father of the US electrical grid"
"Wizard of General Electric"
1865-1923

Retained values above and below the abscissa enabled the future birth of binary code



Coined "hysteresis"

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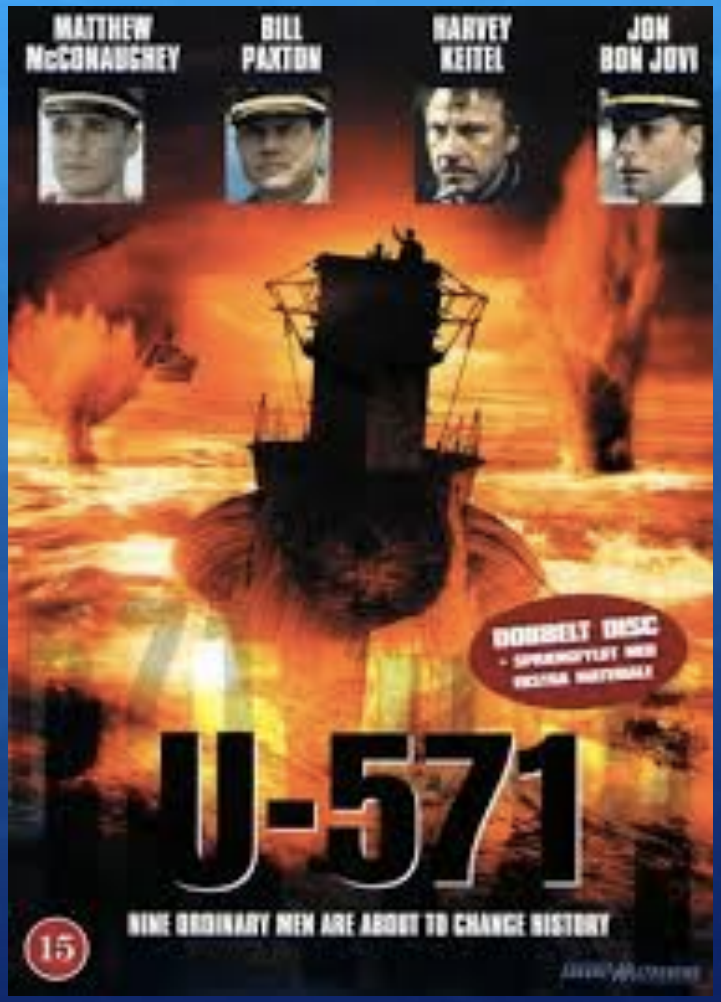
"retentivity" on ordinate

World War II



Movie 2000

Nazi Enigma Machine

Rotors and plug board

= 159 quintillion (10^{18}) combinations

The Digital Age

British child math genius

1936 “On Computable Numbers…” paper

1938 Ph.D. Princeton University

1939 joined Bletchley Park “Ultra” (declassified 1974)

Cracked Nazi Enigma code

Alan Turing, Ph.D.
“Father of theoretical computation and artificial intelligence”
1912-1954

“The Imitation Game”
2014 movie
Benedict Cumberbatch
as Alan Turing.

The Digital Age

1939 Electromechanical Bombe (solved Enigma)

1943 Colossus (first programmable, electronic, digital computer)

Turing Test

Turing Award (Association for Computing Machinery, est. 1966)

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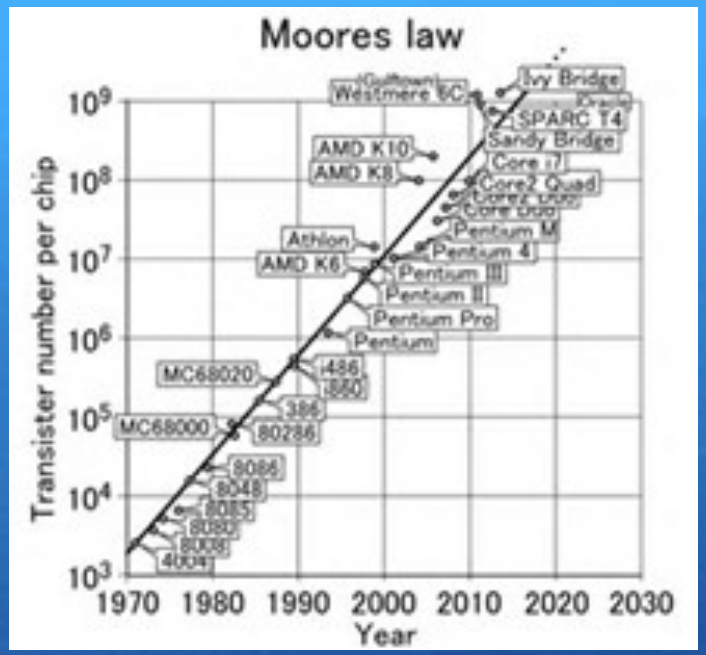
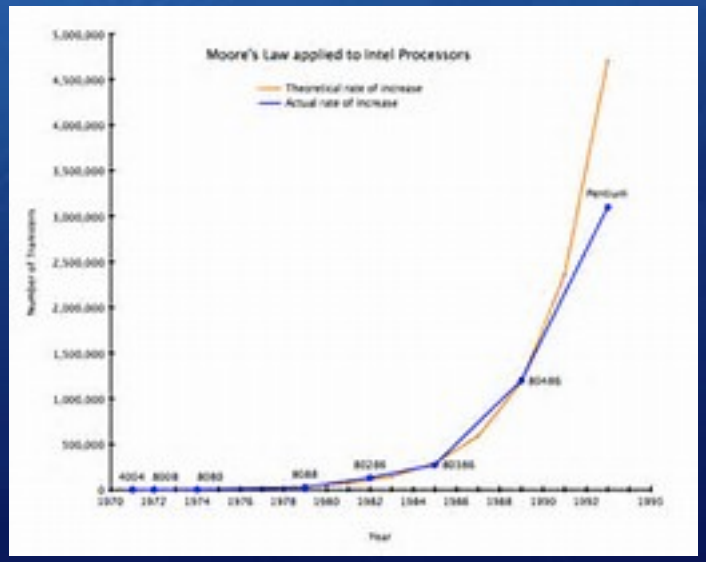
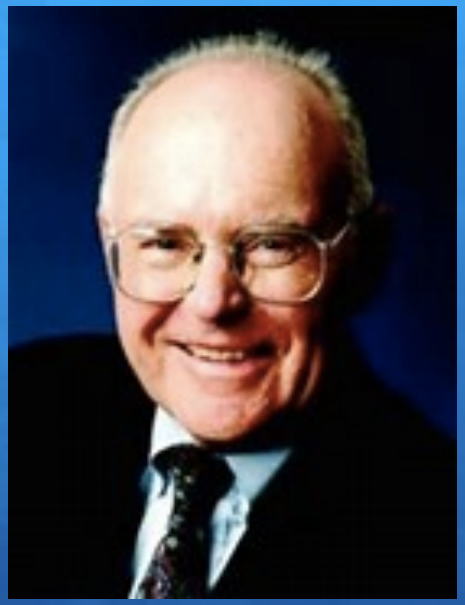
The Digital Age



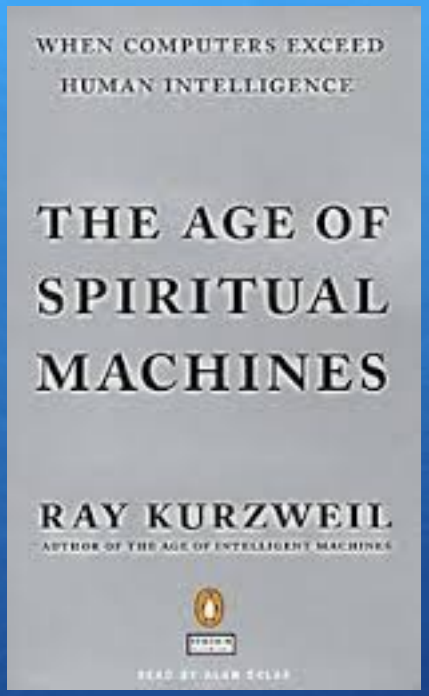




Gordon E. Moore, Ph.D.

born 1929, co-founder Intel Corp. "Moore's Law" coined by Carver Mead, Ph.D. based on 1965 article that questioned his friend about the future of the integrated circuit. Implied processor speed will double every 1-2 years.

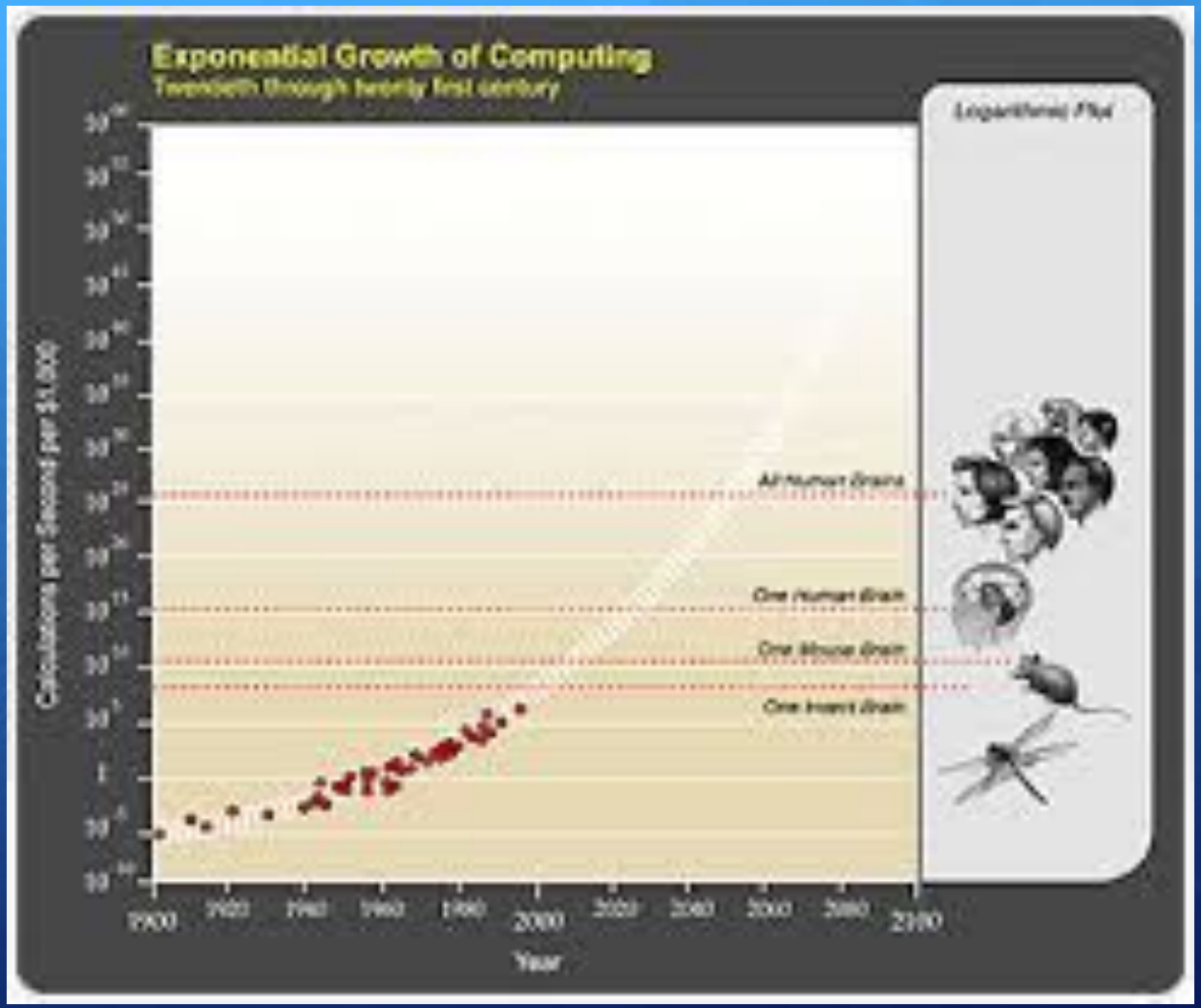
The Digital Age



1999

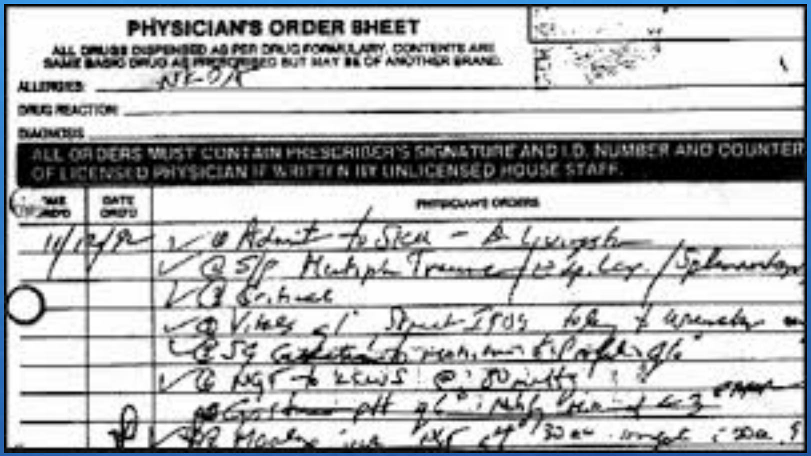
Professor Ray Kurzweil
born 1948
author, inventor, futurist.
Pioneered text and speech recognition.

The Digital Age



The Spiritual Age of Machines –
when computers exceed human intelligence © 1999

Digital Age of Healthcare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PHYSICIAN'S ORDERS

History of Time

Pre Digital Age

Digital Age

More than substituting a keyboard for a pen.

Digitalization of medical records is part of the Federal Health IT Strategic Plan


Our government foresaw the digital age of healthcare

Federal Laws paved the way for improvement:

HIPAA 1996

Health Insurance Portability and Accountability Act of 1996

Initial focus: medical record storage and transmission

HIPAA Privacy Rule 2001

Standards for Privacy of Individually Identifiable Health Information

Further defined: individuals right to access and amend the medical record

MACRA 2015

Medicare Access and CHIP Reauthorization Act of 2015

New physician payment system that rewards quality. Data capture started January 2017 to pay 2019. Patient Generated Health Data (PGHD)/amend and patient access count toward physician $ bonus

The Privacy Rule of HIPAA

patient right to request to access and amend the health record

§= section symbol

Part 164

Section 524 access

Section 526 amend

Title 45 Public Welfare

Code of Federal Regulations

"Administrative Law"

45 C.F.R. § 164.524

45 C.F.R. § 164.526

The Privacy Rule: Access

45 C.F.R. § 164.524

- Patient should submit a written request
- Provider has 30 days to respond with written notification
- Provider may deny access if content could "harm the patient"
- Provider may request an additional 30 days with written notification
- HIPAA exempt: psych notes, work comp, MVA
- May charge customary fee for photocopy & postage, CD, thumbdrive
- Nominal fee for search/retrieval (Act 26 in Penna) (18 V.S.A. §9419) =

no charge search/retrieval, access charge $5 flat/$0.50 per page max)

The Privacy Rule: Amend

45 C.F.R. § 164.526

- Patient should submit a written request
- Provider has 60 days to respond with written notification
- Provider may deny
- "link & notify" – check health record activity log to identify who to notify
- Provider who receives notification must review the record to see if Medical Decision Making requires alteration
- Provider must avoid any evidence of retaliation
- Provider may not charge for amendment work

Privacy Rule Enforcement

Office for Civil Rights (OCR)

complaint investigations

www.ocrportal.hhs.gov

800-368-1019

compliance reviews

enforcement of policy

empowered to assign civil money penalties and (with DOJ) criminal prosecution against medical providers. Penalties skyrocket if evidence of retaliation.

MACRA calls for patient access and patient amendment of the health record as part of the physician payment formula.

MACRA promotes PGHD.

Patient Generated Health Data (PGHD), which is defined as including the History, as part of an objective to coordinate care through patient engagement.

MACRA = The Medicare Access & CHIP Reauthorization Act of 2015, data capture starts January 1, 2017

Federal Information Technology Strategic Plan

HITECH Act of 2009

Health Information Technology for Economic and Clinical Health Act

allocated $25.9 billion to be paid to doctors and health systems for the adoption and meaningful use of electronic health records (EHRs)

Doctors using EHR systems rapidly grew

2008 17% to 2012 78%

2015: financial penalty if not using certified EHR

Federal Strategic Information Technology Plan anticipates a return on investment regarding healthcare quality, cost and satisfaction.

Quality: #42 life expectancy/223 for 2011
#169 infant mortality
64/100 National Scorecard 2011
67/100 in 2006 The Commonwealth Fund

Cost: >$3 trillion per year
17.5% GDP 2014, projected 34% by 2040

Satisfaction: 66% of Americans approve of the way the healthcare system works for them

2014 Gallup

Healthcare communication challenges

Patient has an average of **3 concerns** to address at a medical encounter [1]

Interrupted in the first **12 seconds** [2]

Once interrupted, has only **1/52** chance of returning to the three original concerns [3]

77% of interviews documented in the medical record fail to fully elicit why the patient came to see the doctor [4]

1, 3, 4 The Medical Interview, 2014
2 Improving Diagnosis in Health Care, National Academies of Science, 2015

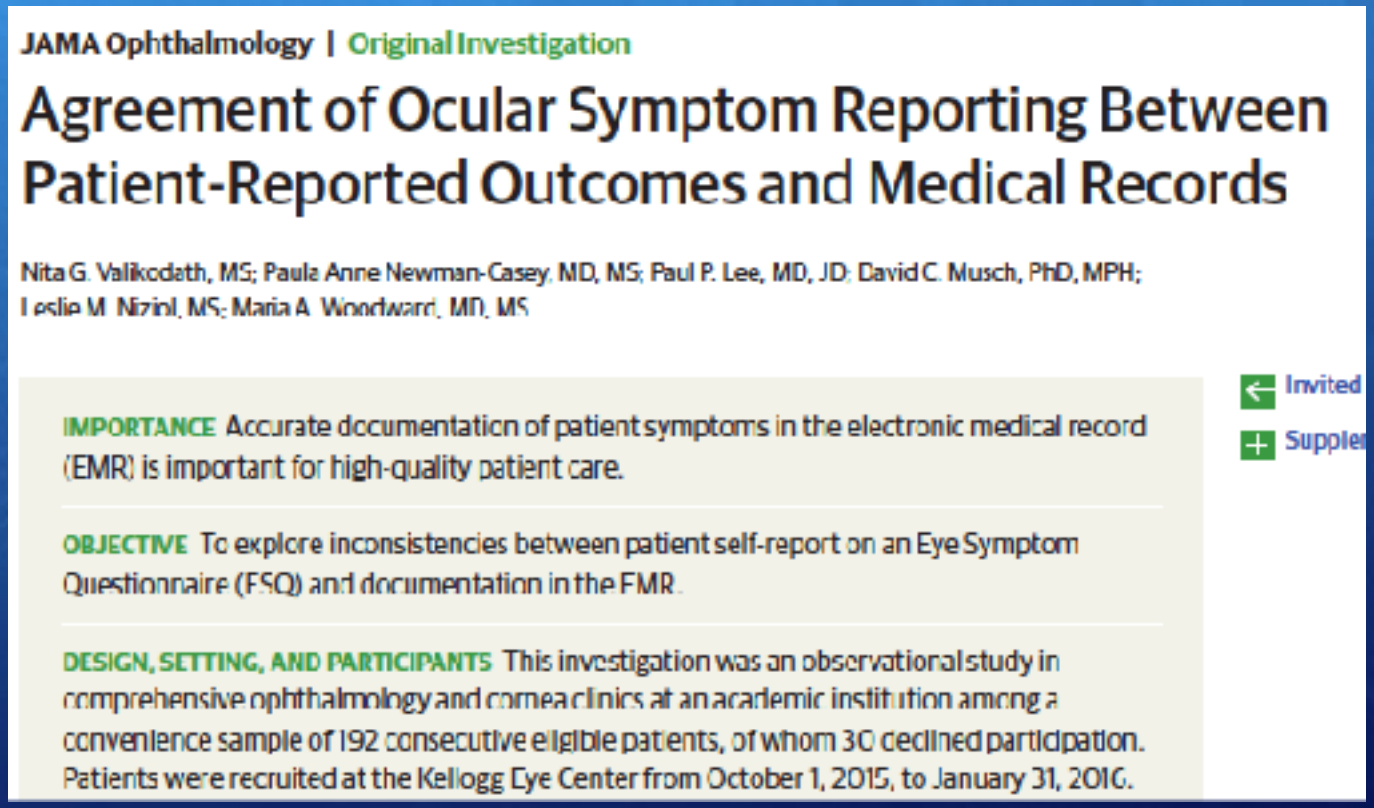
History/Exam/MDM 3 key components

History – about 30 questions, **takes time to ask each question, wait for response and document**

Chief complaint
History of Present Illness
(location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms)
Status of Chronic Disease
Review of Systems
(head to toe, mind body inventory)
Past Family Social History
(includes medication & allergy lists)

JAMA Ophthalmology – Jan 2017

Compared what the patient reported in the waiting room to what the doctor, moments later, documented in the health record. Poor correlation.



JAMA Ophthalmology | Original Investigation

Agreement of Ocular Symptom Reporting Between Patient-Reported Outcomes and Medical Records

Nita G. Valikodath, MS; Paula Anne Newman-Casey, MD, MS; Paul P. Lee, MD, JD; David C. Musch, PhD, MPH; Leslie M. Niziol, MS; Maria A. Woodward, MD, MS

Invited

Suppler

IMPORTANCE Accurate documentation of patient symptoms in the electronic medical record (EMR) is important for high-quality patient care.

OBJECTIVE To explore inconsistencies between patient self-report on an Eye Symptom Questionnaire (ESQ) and documentation in the EMR.

DESIGN, SETTING, AND PARTICIPANTS This investigation was an observational study in comprehensive ophthalmology and cornea clinics at an academic institution among a convenience sample of 192 consecutive eligible patients, of whom 30 declined participation. Patients were recruited at the Kellogg Eye Center from October 1, 2015, to January 31, 2016.

Patient reported “eye pain”, then “eye pain missing 26.5% in EHR.

Watson shows poor medical performance

IBM supercomputer Watson ceased work with MD Anderson Cancer Center at the University of Texas on a "promise to transform cancer care with the help of artificial intelligence." (WSJ 9march2017)

Watson wins on *Jeopardy!*

$62 million 5 years

Investigators cited Watson's trouble "reading relevant information in patient charts."

If the eye center records looked anything like the cancer center records, Watson never stood a chance!

What is the purpose of the medical record?

"Retell the story"

Annuals of Internal Medicine, vol. 162 No. 4, 17feb2015

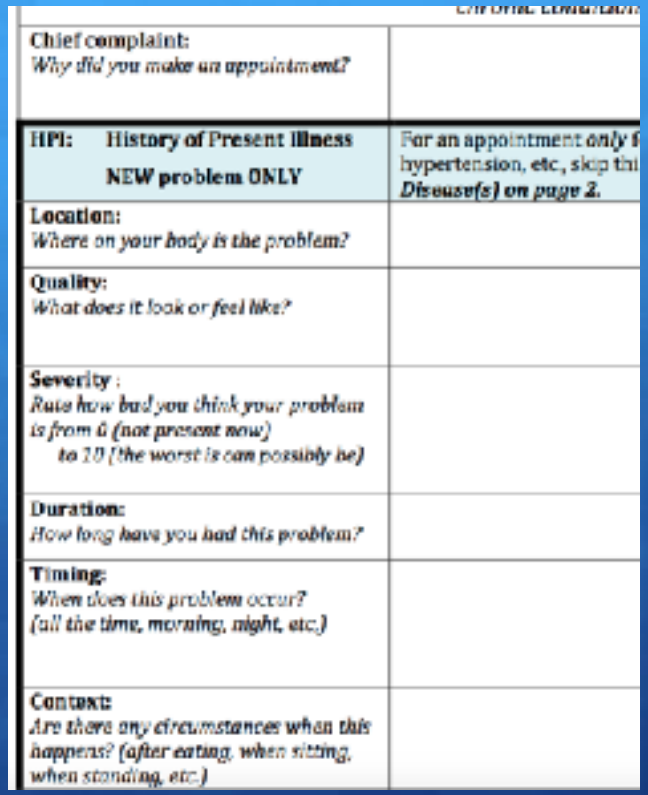
Billing & Coding, Reimbursement for services rendered or supplies utilized, Data for population health, Data to develop personalized health algorithms, Continuity of Care, Assure quality care, Identify best practices, Identify cost effective care

Information technology terms: Exploration (gather information), Exploitation (use information)

However, to be data ready, the information must be accurate and structured.

The History (PreHistory is a replica) asks about 30 questions.

Questions are not difficult, but do take time to reflect upon and answer.



Chief complaint: *Why did you make an appointment?*	
HPI: History of Present Illness **NEW problem ONLY**	For an appointment *only f* hypertension, etc., skip thi *Disease(s) on page 2.*
Location: *Where on your body is the problem?*	
Quality: *What does it look or feel like?*	
Severity: *Rate how bad you think your problem is from 0 (not present now) to 10 (the worst it can possibly be)*	
Duration: *How long have you had this problem?*	
Timing: *When does this problem occur? (all the time, morning, night, etc.)*	
Context: *Are there any circumstances when this happens? (after eating, when sitting, when standing, etc.)*	

www.PatientAdvocacyInitiatives.org

Rather than expect the doctor to ask all 30 questions, wait for an answer for each, then type/dictate response into computer/EHR,

why not let the patient consider and answer these questions in advance?

JAOA – Feb 2017

Invited patients to co-author the History component of the health record by completing a PreHistory. Three page 30 question = History per CMS E/M Guidelines.

Use of Patient-Authored Prehistory to Improve Patient Experiences and Accommodate Federal Law

Michael J. Warner, DO, CPC; Thomas J. Simunich, MS, MBA; Margaret K. Warner, DO; and Joseph Dado, MS

Context: Although federal law grants patients the right to view and amend their medical records, few studies have proposed a process for patients to coauthor their subjective history in their medical record. Allowing patients to fully disclose and document their medical history is an important step to improve the diagnostic process.

Patients submitted the PreHx as a written request to amend their health record per the HIPAA Privacy Rule [45 C.F.R. § 164.526]

Patient authored PreHistory allows for subjective input into the electronic health record, improves the patient experience and accommodates federal law.

JAOA Feb 2017

263 individuals co-authored health record as part of a face-to-face visit with a medical provider

64% participation rate

60% male

Ages 14-94

Often, with the help of a family member, friend, or caretaker

Patient authored PreHistory allows for subjective input into the electronic health record, improves the patient experience and accommodates federal law.

Survey Question	Likert Scale	Time Point	N	Mean	Difference in Means, (Post - Pre)	percent change, (Post-Pre)/ Pre	*p-value*
How satisfied were you with your experience as a patient in this office?	0 - 10	Pre	255	**9.5**	0.2, improved	2%	*.048* [1,2]
		Post	134	**9.7**			
Completing the Pre-History made me feel more empowered in my healthcare.	1 - 5	Pre	249	**2.5**	-0.6, improved	-23%	*<.0005* [1,2]
		Post	131	**2.0**			
I appreciate being given the chance to co-author my medical record.	1 - 5	Pre	260	**2.2**	-0.4, improved	-18%	*<.0005* [1]
		Post	132	**1.8**			
I feel that I will be better heard and understood by having submitted a Pre-History.	1 - 5	Pre	254	**2.4**	-0.4, improved	-18%	*<.0005* [1,2]
		Post	131	**1.9**			

1 Some violation of Normality assumption
2 Unequal variances assumed

JAOA clinical research study focused on patient satisfaction/experience. Efficiency was targeted as all documentation was completed by the end of each patient visit within a 15-min office visit schedule.

The government and health insurance companies already monitor quality and cost.

Provider **Prescribing** Report

HIGHMARK.

MICHAEL J WARNER DO
188 INDUSTRIAL PARK ROAD
STE B
EBINSBERG, PA 15931

Period From: 01/03/2015 To: 07/03/2015
Specialty: FAMILY MEDICINE
Peer Group: Specialty

Practice Summary

Member Profile (Patients

Cost per member per month less than half cost of peers

Patient Request to access/amend drill

Conduct a drill during a meeting with your staff and enter your exericse into to your compliance manual. This will prepare you for specific instances.

- Patient asks for a copy of his/her record
- Authorized personal representative requests access
- Patient with severe and escalating depression requests access
- Patient reads health record and disputes what is written
  - MRI order for wrong shoulder
  - Patient believes story is inaccurate and is angered
- Patient requests to amend health record
  - “Didn’t we discuss my back pain?”
- Doctor approves request to amend, then “link & notify”
- Provider recieves notification of amendment to record

drmichaelwarner@patientadvocacyinitiatives.org

Thank you!

Patient Advocacy Show on YouTube

Pandora's Box

"Craziest System"

Communication

Blind Men & Elephant

Quantified Self

Elaine Benes

Orbitz.com

What Doctors Want

Paradigm Shift Dr. Thomas Kuhn

Empathy