

History Taking for Dummies

Over the last fifteen years, the “___ for Dummies” series has grown to literally hundreds of titles. According to the company website, www.dummies.com, the series started in 1991 with “DOS for Dummies” and has grown to cover wide-ranging subject matters. However, a review of their website shows no results for a search on “optometric patient history taking.” While I doubt that I could convince the publisher to take on “History Taking for Dummies,” I suspect that the book would sell at least one or two copies. The truth is that with 35,000+ ODs in this country, with probably three or four times that many paraoptometric working with the doctors, the subject would be a good read for hundreds of thousands of optometric care providers.

The goal of this month’s installment is not to review some conventions of history taking that might trigger improved documentation of patient complaints by doctor and staff, not the specific guidelines of documentation of the case history as told by the 1997 Documentation Guidelines for Evaluation and Management Services (they will be covered in a forthcoming installment that will take on the nuances of applying the history to the choice of 99000 codes.) History taking is an art-form that can be practiced and improved with repetition, but also is potentially impossible even for the most motivated individual.

Any doctor or staffperson that is involved in history taking must understand that the history is a key contributor to selecting a proper code for a patient encounter. A minor surgical procedure code should be associated with an office visit that has a very clear reason for the need of the procedure, and a follow-up for a vision therapy session must clearly state the point within the progression of the treatment process, in order for both types of visits to be considered for payment by an insurance company. The history of the case is absolutely critical to demonstrating the need for the care that is provided by the doctor. That leads to our first tip in “History Taking for Dummies.”

TIP #1: Appoint and create a good history taker if you want a good history. A good history taker can be hard to find, as any optometrist who has hired paraoptometric personnel can tell you. It is not a trait that one interviews for, but it is a trait that is notably evident when it is there and painfully evident when it is not there. Optometric technicians are generally in tune with people, more extroverted than introverted. A conversational attitude can be taught to a competent staffperson who might start off with a limited willingness to be engaging. Doctors who delegate history taking must spend time allowing the staffperson to sit in on history taking sessions between the doctor and patient to learn the nuances of the doctor’s expectations for a good history.

REMEMBER! Documentation is everything in a good case history. Studies of medical students taking case histories demonstrate a significant loss of information from patient report to written documentation. To improve the documentation of a case history, use a good exam form or electronic health record that affords the history taker a list of important subject matters. There are a number of “areas” within case history, regardless of the type of patient encounter, that must be addressed at each visit. Perhaps this viewpoint is

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oversimplified, but the more common that history taking is for a multitude of types of patient encounters, the easier the role of the staffperson and the better the documentation.

TECHNICAL STUFF: The areas of a case history should be: 1) The reason for visit (RFV) from both the patient's perspective and the doctor's historical perspective; 2) Review of current problems/issues per patient report or the doctor's historical perspective; and 3) Review of pertinent related matters to the patient's case.

Let's review some very basic examples:

o Case 1: Initial Follow Up to a New Contact Lens Fitting – 1) RFV is "Recommended evaluation after 2 weeks of buildup of lens wearing time"; 2) Issues are "Patient is happy with lenses, worn DW, 12 hours per day"; and 3) "Vision fluctuates at night depending on blinking and drops only help limitedly, using tap water to soak lenses at night."

o Case 2: Medical Evaluation of Contact Lens Complication – 1) RFV is "Patient requests left eye evaluation, c/o irritated left eye for five days"; 2) Issues include but perhaps are not limited to "Wearing continuous wear lenses for thirty days consecutive, symptomless for nine months since fitting, left lens is mislocating off cornea and lens is filmy"; and 3) "Worn glasses once a week this month; using Clear-Eye drops four times a day for relief."

o Case 3: Medical Evaluation of Emergency Visit – 1) RFV is "Patient experiencing extreme left eye pain and photophobia for one day"; 2) History of present illness is "OS experiences deep pain, extreme photophobia, foreign body sensation, and watering since last night; lens was removed last evening and symptoms worsened; Visine instilled twice since lens removal without benefit; patient reports compliance with recommended six night continuous wear cycle and lens replacement prescription"; and 3) "Review of Systems" is negative for 13/14 areas except for Respiratory which is positive for asthma treated with albuterol inhaler prn."

WARNING! This subject matter should not be intimidating. But it should not be overlooked as too simple, either. History taking depends on an accurate patient report, and anyone in health care knows that patients are not accurate reporters. Since the subjects themselves are sources of error, every possible effort should be made to eliminate errors that come from the documentation of the patient report. The best method of improving staff confidence in history taking is to give the staff a useful list of common questions that can be asked in the majority of history taking sessions. OD practices are famous for the "no burning, tearing, itching, redness" and "no flashes, floaters" lists. These are good tools, as long as the primary history takers are trained by the doctor to break away from these lists when the patient case obviously requires more specific documentation of problems that will require attention by the doctor.

TIP #2: Pertinent negatives are important, positives are a must. When a staffperson gets good at history taking, the chart is full of notes about issues that have been asked that resulted in the answer, "no." These include questions like "Do you experience glare at night? Do you have any problems with computer vision?" When a staffperson or doctor

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stumbles upon an issue that is positive, then an entire litany of questions should follow. An excellent example of this is questioning about headaches, which optometry students are trained to pursue with a line of questioning that might be associated with an acronym like "FORDL" which stands for Frequency, Onset, Relief, Duration, and Location; ask questions about each of those matters as they relate to headaches, and the doctor will have a very well-rounded history to consider during the patient's exam.

So there you have it... "History Taking for Dummies." The topic is not the most intense one that could be covered in the Coding Corner, but by staying consistent with the theme of the "for Dummies" series, this lighthearted viewpoint of the importance of good history taking should motivate you to work with your staff to improve your history taking.