7 for 11: Health Information Management and Technology Stories to Watch in 2011

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By Chris Dimick

Seven stories unfolding in 2011 illustrate the sweeping changes under way in what will be an active and sometimes tumultuous year in health information management.

Each year brings change to HIM, whether it is coding modifications, compliance changes, or new technology. But 2011 promises change unlike any year before it. Large-scale EHR implementation programs; sweeping privacy, security, and quality measure regulation reforms; and the transition on to ICD-10-CM/PCS will drastically affect how HIM professions conduct business.

"We have dealt with major change before-DRGs and new payment models, HIPAA, et cetera-but I think it is different this time because there seem to be fundamental, systemic changes occurring on a scale and pace I haven't seen in 35-plus years of doing HIM," says Lydia Washington, MS, RHIA, CPHIMS, a director of practice leadership at AHIMA.

Seven events coming this year personify the sweeping changes under way. These are some of the stories that Washington and other AHIMA HIM experts will be following in 2011.

Meaningful Use

First providers report for incentive payments

After two years of rulemaking and discussion, 2011 will mark the first time the HITECH EHR incentive program is put to the test. The first group of eligible hospitals and professionals will report their "meaningful use" of certified EHR technology to the Centers for Medicare and Medicaid Services (CMS) for the 90-day period ending in March. Reporting is expected in April, and CMS expects to issue the first incentive payments in May.

Those first reports, and the 90 days of experience behind them, should provide some answers to long-held questions surrounding the program. These include whether the stage 1 requirements were too lofty, how many healthcare facilities were poised to jump into the program at its start, and the impact meaningful use had on clinical care.

Another question likely to be answered in 2011 is whether the health IT and clinical quality measures included in the meaningful use rule are appropriate, says Allison Viola, MBA, RHIA, director of federal relations at AHIMA.

The true amount of work it takes to meet and report meaningful use will also become clearer as more providers implement EHRs and analyze their performance against the program's specifications.

"ONC knows it is going to be hard, but you don't actually know how hard until you go through the process," Viola says. She expects the feedback from physician groups will be especially telling-whether they found the criteria too difficult to meet or whether they came through the first test without too much difficulty.

If many providers initially report, Viola says another story to watch is whether CMS can handle the influx of paperwork and issue incentive payments in a timely manner. In past incentive initiatives offered by CMS, like the Physician Quality Reporting Initiative, many incentive checks were issued 18 months late due to backlogs, Viola says.

Meanwhile, work on stage 2 criteria will continue throughout this year.

Regional Extension Centers

Extension centers reach midpoint of initial funding

The health IT regional extension centers will face their first true test of effectiveness in 2011. Nearly all of the 62 nationwide RECs will be well into efforts to transition providers' health information systems from paper to electronic. Mid-2011 marks the RECs' halfway point through their first two-year government grant. The RECs impact on the national push toward EHRs, however big or small, should be evident this year.

The RECs were formed through the HITECH Act in 2010 in order to assist providers with the implementation and meaningful use of EHR systems. Lingering questions regarding the solvency of the REC system and their effectiveness will likely be answered this year, Viola says.

RECs receive 90 percent of their federal funding in the initial two-year contract. If deemed successful after two years, a REC will then enter a second two-year agreement. However, it will receive only the final 10 percent of the funding, requiring them to be self-sustaining by this point. RECs will be determining their business models for future operations this year, which could include charging providers for resources or instituting a membership model for IT support, Viola says.

This will be a make-or-break year for many RECs. If they can't find stability by the end of 2011 under government funding, there is little hope of doing so when that funding slows to a trickle in mid-2012.

A REC's success will also depend on how many physician offices seek out their services. Even with assistance from RECs and federal incentives, many practices will face a shortage of the time and money required to implement an EHR.

ICD-10

Coders start A&P training

The transition to ICD-10-CM/PCS will ramp up in 2011, with part of the implementation focus shifting to initial training for coders.

But before coders learn the new code sets, many will require refresher training on anatomy and physiology, says Anita Majerowicz, MS, RHIA, the director of clinical coding and reimbursement at AHIMA. With the October 2013 implementation date coming closer, this year marks the point when coders should start seeking A&P training, either through their employers, association training materials, or colleges.

Many coders have not studied the anatomy and physiology of the body since their first months in college, which for some was decades ago. However, the increased detail and specificity of ICD-10 requires sharper A&P skills in order to properly use the new code set, says June Bronnert, RHIA, CCS, CCS-P, the director of clinical data standards at AHIMA.

"Especially when you get into ICD-10-PCS, looking at how the procedures are performed, you have to know where in the body you are and what is being done," Bronnert says. "And it has that granular detail that current ICD-9 coding professionals didn't have to know."

The final rule that established the ICD-10 switch estimated that coders will require 50 hours of training to use ICD-10-CM/PCS. But that estimate does not account for background training such as A&P.

Coding managers should take caution in assuming how much A&P, medical terminology, and biomedical sciences knowledge their coders have, Majerowicz says. Assessing individual training needs will be an important first step in designing appropriate training. If coding staff are at various knowledge levels, a training program that dives into advanced cases risks leaving some staff behind, she says.

Many healthcare facilities will begin evaluating coders' knowledge through assessment tests this year and then use the results to design their A&P training programs. Several state AHIMA associations are working with local community colleges to offer classes tailored to current coding professionals.

Attention to scheduling will help minimize disruption. Training will take place while coders are working to fulfill their usual duties, so spacing out educational sessions over time will minimize the impact to coder productivity, Majerowicz says.

Health Information Exchange

Direct Project launches exchange pilots

Electronic health information exchange will be a major story to watch in 2011 as the federal government expands access to the Nationwide Health Information Network and tests a simplified version intended to aid the meaningful use program.

This summer the Office of the National Coordinator is expected to release NHIN governance rulemaking, which will allow healthcare organizations and HIEs the ability to use the Internet-based information exchange network without a formal government contract. The rulemaking will dictate the way participants must use the NHIN. This includes developing privacy and security governance, interoperability technical requirements, and general NHIN oversight mechanisms, Viola says.

A simplified version of NHIN, called the Direct Project (formerly NHIN Direct), begins pilot-testing this month. The version allows providers to securely share clinical information in one-to-one exchanges with other providers.

While NHIN is considered for use in larger and more complex exchanges, the Direct Project allows providers to do the simpler health data exchanges required under the first stage of meaningful use.

Add in the infusion of federal funding to state-level health information exchanges, and 2011 will be a big year for information exchange.

As more providers move away from fax and mail and begin using NHIN, Direct, and other HIE systems in 2011, HIM professionals must still ensure incoming and outgoing records meet privacy, security, patient consent, and data quality standards, says Harry Rhodes, MBA, RHIA, CHPS, CPHIMS, FAHIMA, director of practice leadership at AHIMA.

"The ability to exchange information is going to create new uses and new requests for use that you are not familiar with, and you will have to test the legitimacy of the use," Rhodes says. "[HIE] is going to test current thinking."

The Direct Project is expected to simplify HIE, even create the ability to set up a direct feed of exchanged data between healthcare entities. But the exchanges won't be successful and secure without traditional data integrity vigilance, Rhodes says. HIM will also need to consider how to integrate exchanged records into the system in a way that actually improves healthcare delivery.

The use of HIEs, NHIN, and Direct in 2011 will mean the start of new and adapted forms of information exchange quality assurance for HIM professionals.

"You are still going to be concerned with the quality and integrity of that data," Rhodes says. "Even though it is coming to you in this Direct [Project] link, it is not like you turn on Direct and forget about it. You are still going to have to run some algorithms to make sure the data are not getting corrupted and that the record is actually being delivered."

Health IT Workforce

Consortia-trained health IT students enter workforce

The first group of students enrolled in the federally funded health IT training program will complete the program in March. Their entrance into the workforce will be a story to watch throughout 2011. Will these individuals find jobs, and will they speed the implementation of EHRs?

The six-month training program was created by ONC as the Community College Consortia to Educate Information Technology Specialists in Health Care. More than 80 community colleges across the country received nearly $70 million for the program, with a goal of producing thousands of health IT workers that could assist with EHR implementations.

Many of these new health-IT trained workers are expected to be employed by the RECs, who could put the individuals to work helping providers implement EHR systems and meet ARRA's stage 1 meaningful use requirements.

Many RECs can't afford to wait for this workforce to arrive, according to Lou Ann Wiedemann, MS, RHIA, CPEHR, FAHIMA, practice manager with AHIMA. With federal grant money greatly reduced in mid-2012, the RECs have limited time to sign up enough providers to become self-sustainable, she says. They needed an influx of skilled health IT workers back in mid-2010 when they launched, she notes.

Even if REC jobs are available for those who complete consortia training, the RECs have limited funding for salaries and an uncertain future. RECs could still have trouble recruiting employees, Viola says.

In addition, the first group of graduates is untested-the programs and the curricula are new-and Viola notes the training program might take some time to mature and truly produce an informed workforce.

"I think it is going to take a while for those resources to really evolve," she says. "Working with the changes in the workflow and how and when physicians enter data-I think it will take a couple of years for that to flesh out."

This spring RECs and other employers also will begin seeing job seekers burnishing the first health IT competency exam certificates. [*Editor's update (January 2011): In mid-December 2010, a decision was made in conjunction with ONC not to issue a certificate to those that pass the HITPro competency exam.*] The exam, another piece of ONC's workforce plan, is intended to dovetail with the consortia training programs. However, it may be used by any individual who has completed nondegree training in health IT. Successful completion of the exam will help job seekers demonstrate competency to employers.

Privacy and Security

Final rule on privacy and security rules modification

Perhaps the biggest change to HIM operations this year will occur in privacy and security. ARRA included major modifications to the HIPAA privacy and security rules in 2009, and final rules are expected this year. The regulations will describe new accounting of disclosure requirements, changes to electronic record access rules, and new patient rights to restrict release of information, among other issues.

The impact on HIM professionals will be "huge," according to Angela Dinh, MHA, RHIA, CHPS, a practice resources manager at AHIMA.

Chief among the changes is a new requirement that covered entities track medical record disclosures for payment, treatment, and operations. Covered entities that purchased EHR systems on or after January 1, 2009, must begin providing an accounting of all record accesses on January 1, 2011. Entities with older systems have until 2014 to comply.

Tracking all disclosures presents a massive logistical challenge for HIM professionals, says Diana Warner, MS, RHIA, CHPS, professional practice manager. Few organizations covered by this month's deadline likely were ready to comply, she says.

The final rule also will detail new patient rights to an electronic reproduction of their medical record if the facility uses an EHR. HIM departments will have to draw up policies and procedures for reproducing the record electronically, which may require working with vendors to adapt their systems for the task.

More operational challenges are expected in complying with a provision granting patients the ability to restrict disclosure of certain medical records to insurance companies if the patients pay for the services out of pocket.

No one is quite sure how to honor these restrictions within today's EHR systems, Warner says. "Everyone is talking about it, and no one has an answer."

Rhodes notes that managing the restriction in subsequent transactions with third-party payers presents the ultimate challenge. Providers must determine how they will identify the data to prevent inadvertent disclosure later.

Another privacy and security issue to track in 2011 is a final rule on breach notification. The Office for Civil Rights published an interim rule in 2009 that took effect in February 2010 and included a controversial "harm threshold" that allowed providers to report only those breaches it believed could reasonably lead to harm. A final rule is expected this year.

Quality Measures

CMS transitions to value-based purchasing

Big changes in Medicare quality reporting programs will be the talk of 2011, as provisions specified in the 2010 Affordable Care Act are finalized and launched this year. In addition to insurance and Medicare regulations, several "value-based purchasing" programs were included in ACA-initiatives that use quality and cost-reporting data to drive provider selection.

The value-based purchasing changes will make quality data more visible to patients and other payers, and Medicare will increase the link between payment and the quality of care reported.

HIM professionals will need to ensure their organizations' documentation effectively supports quality reporting measures, says Crystal Kallem, RHIA, CPHQ, a director of practice leadership at AHIMA. Not doing so could harm an organization's clinical reputation and eventually cut revenues.

ACA calls for CMS to evaluate transitioning its quality reporting programs to value-based purchasing initiatives. Final regulations on these changes are expected soon, giving providers a clear look in 2011 of requirements for the incentive-based programs. CMS expects the programs to be in full swing by 2015.

"The reporting periods for some of these initiatives would begin as early as January 1, 2012," Kallem says. "In 2011 we are going to prepare and figure out what it is we are going to be reporting, how that is going to be relayed back to providers, how they will be validating that data."

Value-based purchasing initiatives allow patients and payers to use quality measures data to select those providers who offer the highest quality healthcare at the lowest cost. One value-based purchasing initiative created by ACA and expected to launch in 2011 is the CMS Physician Compare Web site. The site, intended for use by the public, will compare quality measures and care costs reported by individual physicians.

Eventually, sites like Physician Compare will transition to a value-based purchasing model, where patients can compare quality measures to cost and find the best healthcare deals.

In the future, CMS is considering offering incentives to patients who use physicians and facilities that excel in value-based purchasing measures, Kallem says. For example, Medicare patients could have their co-pays reduced if they see a physician identified by Physician Compare as offering both high quality and low cost healthcare.

HIM professionals will want to pay close attention to these initiatives, Kallem says, due to the impact on reporting requirements, clinical documentation and data quality, data analytics, and revenue.

"From the clinical documentation improvement perspective, there may need to be changes internally in terms of how physicians document in order to get the appropriate data out for these various value-based purchasing programs," she says. "A physician might be providing an aspect of care but not documenting it. That is a problem."

More Stories to Watch in 2011

- **Stage 2 meaningful use criteria**, with requirements including ICD-10. Final criteria are expected by summer. How much higher will CMS raise the bar?
- **Lowering the red flag for healthcare.** In the last days of 2010, Congress passed legislation exempting many providers from the Red Flags Rule, regulation which required businesses that act as "creditors" to maintain identity theft prevention programs. Hospitals, however, will be determining their status one by one.
- **Final rule on breach notification.** ONC had prepared a final rule last spring but withdrew it prior to publication. Will the harm threshold stand? Will the rule be superseded by a more encompassing federal rule?

- **Clarification and guidance on minimum necessary.** Will the Office for Civil Rights finally clear up the lingering confusion? ARRA called for the office to publish guidance, but none has appeared to date.
- **HIPAA 5010 transaction standards.** The new standards take effect January 1, 2012. How mad will the rush be in the fourth quarter, and did everyone make it time?
- **The final full update to ICD-9.** The 30-year-old code set receives its last regular update in October. Only limited, necessary updates will be made in 2012. (ICD-10-CM/PCS will be under a similar, partial freeze until full updates resume in 2014.)
- **EHR certification for the meaningful use program.** The temporary certification program is in full swing, but it is tentatively scheduled to sunset December 31. A final rule on the permanent program that will replace it is expected early this year.
- **Industry reaction to the PCAST report.** In December, the President's Council of Advisors on Science and Technology released recommendations on the future direction of the federal health IT initiatives, which differ in some ways from HHS's approach. What's the reaction from the healthcare industry? ONC has issued a request for comment by January 17.

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