Are We There Yet? How to Improve Meaningful Use and Gauge Industry Performance

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One of the many benefits of working in the information management field is being a part of healthcare's transformation to the use of electronic health records (EHRs). Everyone has a stake in this transformation, and an opportunity to help determine how the transition is actually proceeding.

In May 2013, the United States passed a significant EHR milestone: Over half of eligible professionals and 80 percent of hospitals had implemented EHR systems certified as capable of meeting the health information technology (HIT) functional requirements stipulated by the "meaningful use" EHR Incentive Program's first stage.[1] Each of those providers received taxpayer dollars as a reward for their achievement.

As a result of these incentives, patient visits to a provider will most likely involve an EHR system. Health data standards are available so that an EHR's electronic health information can be exchanged between organizations. And health information exchange organizations have started to make it easier to connect to other providers. So the question arises, why do patients still get asked repeatedly to share the same information over and over again, detailing medications, allergies, family and personal medical history, every single time they see a healthcare provider? A lot of progress has been made, but sometimes it just does not feel like healthcare has reached its full potential in EHR design and use.

Still on the EHR Journey

Information often lives in a progress note in a text only format, not in a standardized or structured format. When a system is not designed to capture information in a standardized fashion, and in the form of exchangeable data, then it becomes very difficult to exchange. Initiatives are in place to ease this burden. Examples include the Institute of Medicine's initiative to ensure social and behavioral domains are captured in every EHR, and the work being done by the Standards & Interoperability Framework to "facilitate the functional exchange of information."[2]

Another challenge involves the small steps taken by the meaningful use program. Thanks to meaningful use, clinical professionals and hospitals are receiving monetary incentives to make sure workable EHRs are implemented. However, EHRs that qualify for participation in this program are only tested in labs, not out in the real world, to exchange information with other providers or organizations.

Current State of EHR Exchange Capabilities

To start, it helps to understand what a certified EHR must actually do at this point. Achieving stage 1 meaningful use certification requires making only some, not all, clinical summary information available electronically. For example, any meaningful use-certified EHR must be capable of rendering, transmitting, and receiving a standardized electronic document called the patient summary. The patient summary must be standardized to one of two formats called the Continuity of Care Document (CCD), developed by standards organization Health Level Seven, or Continuity of Care Record.

Note that there are differences between the specification for a CCD and the Continuity of Care Record. But, for the purposes of this article, they can be considered approximately the same and will be refered to as the CCD. Both are noted as acceptable in the meaningful use certification test protocols.

Both are standards-based health information summary tools that enable data to be shared across healthcare providers in a meaningful way while ensuring data integrity and consistency. The CCD is intended to represent an exchangeable and useful

clinical summary in a form that will have the same content no matter where it originates. The patient summary must be something the provider can send to another clinician or hospital so that they have the information before a patient arrives there—assuming both facilities are using a meaningful use-certified EHR. This is great for the harried patient who is tired of repeating their health history. Additionally, each facility should be able to give any patient a copy of their records in either a printed or electronic form, or both.[3]

In the early stages of the program, a meaningful use-certified EHR was not actually required to produce or exchange a fully capable version of all the possible CCD content.[4] While the use of standards-based terminologies and data sharing are key to ensuring the portability and integrity of this data, not all data available are required in a meaningful use-required patient summary. The data are not expected to create a longitudinal health record with all the information available everywhere.

The CCD is designed to present a subset of key health data from the most recent information available to that specific doctor or hospital. So, a given CCD may appear wrong because it only represents the information that specific doctor or hospital has provided. This is part of the purpose of simplifying information exchange. Updates using the CCD are supposed to become simpler, faster, and cheaper due to the ease of electronic exchange. Eventually all providers should have the same updated information when all these functions are fully operational.

First, providers should focus on whether a given clinic or hospital can actually give another facility a patient summary, keeping in mind that a given summary may only be up-to-date according to the information available at that time in the EHR system that produces it. Then consider other current limitations for the patient summary. For instance, stage 1 meaningful use has only a minimum content requirement for the patient summary, stating it must include diagnostic test results, a problem list, a medication list, and a medication allergy list.[5]

In sum, it is a very reasonable expectation that if a provider attested for EHR incentive funds they have a system that is capable of sending and receiving a patient summary electronically and a system that can meet the four requirements above. Furthermore, it's reasonable to expect that these same providers are able to provide the same electronic patient summary since their EHR is required to "render" that summary. If the industry can show that this capability actually exists, we will know where we are on our journey to the full adoption, implementation, and utilization of the EHR. At that point patients can quit reporting—and clinicians can quit writing—the same information over and over again.

Table 1: Simple Survey: Electronic Patient Summary Capability

Question	Yes	No	Comments
1. Can you get your patient summary electronically?			
2. Can you get your patient summary in print?			
3. Can your clinician (or hospital) send your patient summary to another one of your clinicians?			

Take Action, Take the Survey

Any provider that has attested that they have met the meaningful use incentive criteria should be able to provide patient summaries with at least the four components listed above. The reality is it's hard to know if the results seen in the certification test lab are achievable in actual practice.

In order to work together to find out the answer to "Where are we?" and to spur more meaningful "meaningful use," the authors of this article are asking readers to take the survey included in Table 1 to your workplace, your doctor's office, and

your hospital. Fill it out based on the responses you receive to your request for a patient summary from their certified EHR system. Provide the survey to your peers, friends, and family members. Then share your results on AHIMA's Engage website, via the event "Complete the Electronic Patient Survey" in the Information Governance and Standards Community. Don't forget to post a short narrative of your experience as well.

Be prepared for a request to give a provider a blank disk or empty USB drive so you can get the information. Depending on the responses you get, you may also want to provide your clinicians or your hospital with a copy of this article.

Working together, health information management professionals can help make "meaningful use" in the US meaningful. It can start with a dialogue on the Engage site, spurred by your posted comments, support, and survey results.

Notes

[1] Department of Health and Human Services. "Doctors and hospitals' use of health IT more than doubles since 2012." May 22, 2013. www.hhs.gov/news/press/2013pres/05/20130522a.html.

[2] Standards & Interoperability Framework. "What is the S&I Framework?" www.siframework.org/whatis.html.

[3] National Institute of Standards and Technology. "Test Procedure for §170.304 (i) Exchange Clinical Information and Patient Summary Record." September 24, 2010. http://healthcare.nist.gov/docs/170.304.i_ExchangeClinicalinfoPatientSummaryRecordAmb_v1.1.pdf.

[4] Corepoint Health. "Understanding the Continuity of Care Record." 2011. www.corepointhealth.com/sites/default/files/whitepapers/understanding-the-continuity-of-care-record-ccr.pdf.

[5] National Institute of Standards and Technology. "Test Procedure for §170.304 (i) Exchange Clinical Information and Patient Summary Record."

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