Field Guide: Seeing the Trees through the Forest in 2012

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By Chris Dimick

A forest of issues crowds the 2012 HIM landscape. AHIMA practice experts offer a guide for the year ahead.

The seedlings of change planted in 2009 by the announcement of the ICD-10 transition and the American Recovery and Reinvestment Act have sprouted into a towering forest of complex initiatives with roots buried deep in HIM principles.

Other initiatives have grown to crowd that forest-accountable care organizations, recovery audit contractors, HIEs, and value-based purchasing, to name a few.

With so many competing interests, it can be difficult for HIM professionals to know just what initiatives to focus on. At times it can be overwhelming, and 2012 will be no exception, says Dan Rode, vice president of policy and governance at AHIMA.

"It is going to be a rough year," Rode says. "There is no magic out there."

However, the new year provides a great chance to cut away the undergrowth and re-evaluate priorities that will have the most impact on HIM.

Following are the top initiatives AHIMA's HIM experts will be monitoring in these challenging times-a guide to seeing the trees through the forest in 2012.

ICD-10

The One-Year Countdown Begins

The "we-have-plenty-of-time-to-prepare" excuse will officially sour this year, as October marks just 12 months till the ICD-10-CM/PCS implementation deadline. While astute facilities have been preparing for ICD-10 for years, 2012 will see an intensification of those efforts and shift to core coding and HIM activities.

The focus this year will move from assessing the impact to beginning modifications to work processes, modeling the reimbursement impact, devising strategies for managing the immediate transition period, and assessing coder staff competency in preparation of intensive coder training.

"All the work you identified in phase 1 of preparation, now you have to do it," says Sue Bowman, RHIA, CCS, director of coding policy and compliance at AHIMA. "Now you have to go in and actually modify the systems and modify reports and forms to be ready for ICD-10."

Facilities who delayed conducting their impact assessments will realize this year how little time is really left-and they will scramble for help. By late 2012, many facilities will find ICD-10 consultants and vendors are already booked through the implementation deadline.

Organizations have been signing advance contracts with vendors and consultants in order to beat the rush, Bowman says. For example, facilities have already signed contracts with outsource coding companies to help in the summer of 2013 while in-house coders train on ICD-10.

Vendor readiness will also be a hot topic in 2012.

As ICD-10 nears, it will become clear that some vendors are not quite as ready as they have led their customers to believe, Bowman says. This same situation unfolded in 2011 as organizations approached the January 2012 implementation deadline for the 5010 HIPAA transaction standards.

"I think we are going to hear a lot more about which vendors are ready and which ones are not this year," Bowman says.

In some facilities actual coder training on ICD-10 will begin in late 2012. Facilities will begin determining their training strategies-stretch training over several months or hold an intense crash course? Offer training in-house or use online and local classrooms? Pay for training or require coders to pay as a professional responsibility?

As facilities consider the impact ICD-10 will have on their operations, more could turn to computer-assisted coding (CAC) in 2012 to help bridge productivity and revenue gaps. Because of ICD-10 and other initiatives, this could be the year that CAC turns into an essential HIM system.

"CAC is really triggering interest in people because they are looking for ways to improve operational efficiencies, reduce costs, keep up with workflow, and improve accuracy and productivity," Bowman says. "And they're recognizing that incorporating those kinds of tools in the coding process, along with ICD-10, may help them have less of an adverse impact on their operations."

Accountable Care Organizations

Program Launches January 3

The traditional pay-for-service reimbursement model will be ratcheted down further this year when the Medicare Accountable Care Organizations (ACO) program begins January 3. While only a minority of healthcare providers are expected to sign up for the voluntary program, independent and private payer ACO networks also are expected to grow in 2012, according to Lydia Washington, MS, RHIA, CPHIMS, director of practice leadership at AHIMA.

ACOs are networks of area providers who band together in order to better coordinate patient care. The goal is higher quality of care at a lower cost. In the Medicare ACO, called the Shared Savings Program, incentives are paid to participating healthcare providers who agree to work together to coordinate patient care.

If the ACO meets a set of 33 quality standards, based on patient outcome measures that should improve care, the ACO participants will share in the cost savings they achieve for the Medicare program. The better coordinated care they deliver, the higher the savings and the more revenue they receive. The private-sector programs are similar.

The push for ACOs puts additional importance on the need for accurate and well-organized health records and improved information flow, Washington says. HIM departments will have to better integrate health information across multiple organizations, pulling and pushing records as the group coordinates patient care. For example, a hospital within an ACO may first check with its partners for lab test results before conducting its own test. Managing such requests could fall to HIM staff.

HIM staff will also help ensure records from different organizations use the same language and meet the same electronic standards, likely partnering with their IT departments to address the issues.

"You might have a well integrated record that has content from a variety of different sources," Washington says. "We will have to figure out what that means for things like the [individual organization's] legal health record."

ACOs may also increase the use of registries to better manage health populations and the information needed to meet quality measures. HIM professionals may find they need to hone their data quality management skills when working with registries, as well as help redesign EHR systems to feed information to these systems. Even if the processes are not managed within the HIM department, they will require HIM skills, Washington says.

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Meaningful Use

Final Rule for Stage 2 Released

As the new year begins, all eyes are on the proposed rule for stage 2 of the meaningful use program, which at press time was expected in February. A final rule is expected in summer.

This will be a crucial year for the program and its participants, says Allison Viola, director of federal relations at AHIMA. Stage 1 will enter its second year, adoption of the released stage 2 requirements will begin, and discussion on stage 3 will be under way.

In tandem with the release of the stage 2 rule, vendors and providers also will receive a companion regulation dictating the standards, implementation specifications, and certification criteria that EHRs must meet to be used in the program.

While stage 1 was meant to be a relatively easy launching pad for the program, stage 2 is expected to ramp up in difficulty, leading to more extensive changes in the HIM department.

The elective menu set items from stage 1-such as asking patients to complete advance directives-are expected to become requirements in stage 2. Many of the measure thresholds will increase, and some new measures likely will be added.

A stage 1 requirement that will continue to challenge HIM departments this year is providing patients with timely electronic access to certain medical information.

Under HIPAA organizations had up to four weeks to prepare a record for release (with one extension allowed). But stage 1 calls for select information to be released to the patient as an electronic copy within three days of request.

This acceleration creates a need for providers to redesign the entire record creation process, affecting everything from physician documentation to transcription contracts and billing. HIM departments are working with patients in different ways because of meaningful use. Stage 2 will intensify that change with increased patient-centered requirements, Viola says.

One highly anticipated aspect of the stage 2 rule will be the start date.

Throughout 2011, calls increased for the Centers for Medicare and Medicaid Services, the manager of the program, to delay stage 2. With the final rule expected in summer and the phase set to begin in October for hospitals and January 2013 for professionals, many vendors and providers argued they would not have time to prepare.

In November that pressure was relieved for one group, at least, when hospitals and eligible professionals who joined stage 1 in 2011 learned they would receive an extra year to meet stage 2 requirements. They will be on the same 2014 deadline as those providers who join the program in 2012.

The alignment of quality measures across federal programs-including meaningful use, ACOs, IPPS, and PQRI-is another evolving issue with a major impact on HIM.

The hope is that federal programs requiring quality reporting will align their measures to reduce the effort of collecting and reporting them, but that isn't guaranteed, Rode says.

Health Information Exchange

HIEs Still Seeking Sustainability

During the last two years, health information exchanges (HIEs) have launched in every state, funded to varying degrees by federal grant programs like the State Health Information Exchange Cooperative Agreement. That money is being handed out incrementally, with an end date in late 2014.

The state-level HIEs must become self-sufficient before funding runs out, but recent studies conducted by industry groups show many HIEs do not have solid sustainability plans in place. With only two more years of anticipated government funding left, 2012 will be a vital year for HIEs to identify a solid sustainability plan and get it in place.

According to a recent eHealth Initiative study, of the 255 HIEs chartered in 2011, only 24 say they are sustainable. If the promise of private and secure health information exchange isn't enough to pay the bills, HIEs may soon need to offer services that relate to other industry initiatives such as accountable care organizations and meaningful use, according to Harry Rhodes, MBA, RHIA, CHPS, CPHIMS, FAHIMA, director of practice leadership at AHIMA.

"I think HIEs are still trying to find their market," Rhodes says. "The reason they are excited about the ACOs is that the ACOs are potential customers. I think they are having a hard time selling the benefits of health information exchange."

For every active HIE like the Indiana Health Information Exchange, founded in 2004, there is one or more that has folded. CareSpark, the active and high-profile HIE serving northeast Tennessee and southwest Virginia, folded last year despite having received a series of government grants.

While state HIEs work to find their roles, more regional and private health information exchange organizations have sprung up. Many private HIEs offer providers services related to the meaningful use program and ACOs, according to Julie Dooling, RHIT, a professional practice resources manager at AHIMA.

With more networks coming online, more HIM professionals will be addressing the complexities of making their organization's information available and processing the information that pours into their facilities. Data integrity, patient identity checks, and privacy and security all must be addressed when an HIM professional's facility joins an HIE, Dooling says.

One HIE story to watch in 2012 is an effort to create a standardized consent process. The Office of the National Coordinator is expected to begin a pilot project this year to develop and test an electronic system allowing patients to consent to share their health data in an HIE.

The six-month ONC E-Consent Pilot Project will be tested at four provider sites within the Western New York Health Information Exchange, with results expected late in 2012. If the pilot is successful, consent authorization processes could change drastically for HIM professionals.

Privacy and Security

HITECH Final Rules Finally Released

The HITECH modifications to HIPAA have been making HIM professionals anxious for nearly three years now. Published in February 2009, they have since been progressing through a slow regulatory process that should resolve this year with publication of final rules.

HIM professionals can expect 2012 to be the year they will finally begin implementing the changes called for in the legislation. Depending on when the rules are published, compliance could begin this year. The impact will be dramatic.

"The final rules will change the practice of privacy and security as we know it today," says Angela Dinh, MHA, RHIA, CHPS, manager of professional practice resources at AHIMA.

Included in the HIPAA changes are modifications that extended covered-entity status to business associates and more closely tie their actions to their contracting facilities and new patient rights for accessing and restricting disclosure of their records, including major changes to the accounting of disclosures rule.

The changes will call on HIM professionals to modify organizational policies and procedures. For example, one HITECH provision requires that patients who pay for care out of their pocket can request the facility not release a record of the treatment to their insurers. Sequestering this information is currently not possible in many EHR systems, says Diana Warner, MS, RHIA, CHPS, FAHIMA, manager of professional practice resources at AHIMA.

"Some of these changes are very difficult to implement," Warner says. In the case of restrictions, she notes, "how do you segregate that out if it is only one test within a whole inpatient stay? How do you track that and what responsibilities do you have when you send that information for continuing care to another provider?"
This restriction will affect coding as well. Since the treatment cannot be added to a comorbidity, it could affect the level of

reimbursement for the entire encounter, Warner says. Policies and procedures not only must be developed but remembered-such requests won't happen every day, Rhodes says.

"People made the rules before technology could catch up," Rhodes notes. "Current systems don't have the functionality to track and remind users of restriction requests on file. Some other 'bolt-on' tracking system will need to be utilized to track and remind staff of a restriction on file."

Organizations have been required to comply with HITECH's breach notification provision since an interim rule took effect in September 2009. A final rule is expected this year, which could alter the so-called harm threshold. The provision allows facilities to assess a breach's potential for harm. If the facility judges that no harm is likely to result, it is not required to notify the individuals whose information was breached.

There has been talk that the harm threshold would be modified or removed from the final rule. Meanwhile, organizations vary in how they determine risk of harm, Rhodes says.

EHRs

Patient Portals on the Rise

Initiatives this year will change how EHRs are used, how their data are shared, and the rules of how their data may be shared. One example is the growing implementation of patient portals.

Portals offer patients secure access to select information maintained in the facility's EHR. More facilities will explore portals to aid their release of information efforts and meet meaningful use requirements related to easing patient access to information.

While patient portals may cut down some manual release of information work, managing the portal and ensuring data remain accurate and confidential will remain an important and time-consuming job for HIM professionals.

The rise in portals is creating the new role of patient portal manager, Warner says. This position, which is expected to grow in 2012, is in charge of managing the information being sent out via the portal, helping patients access their information, and ensuring portals remain private and secure.

Portal managers also respond to patient requests for changes to their records.

When portals are opened to patients, HIM departments typically see an increase in correction requests. Some of the requests are legitimate, such as correcting an incorrectly recorded date of birth or a broken arm mistakenly documented on the left side rather than the right. But other requests can be frivolous or unnecessary, such as a patient claiming he or she weighed five pounds less than recorded during a routine check-up the previous year.

While larger facilities have hired patient portal managers, smaller facilities with fewer resources may roll portal duties into existing HIM roles.

"I do see that being a big management piece because especially in large facilities you could be getting a lot of requests," Dinh says.

HIM professionals at organizations that participate in HIEs and ACOs will also be busy working on EHRs. With more data flowing in and out of EHRs, organizations will be working to make their information less fragmented and more searchable and sortable.

Data governance will become increasingly important as large amounts of internally and externally generated data amasses in systems. Time spent sorting and merging patient records will increase, and organizations will require rules and processes for minimzing the impact.

Following fundamental professional tenets, however, will help make the changes manageable.

"The fundamental rules of health information management are the same at our core. We still need to do what we have always done, it has just changed formats," Warner says.

Other Hot Topics in 2012

- Medicare **RAC** program expands dramatically: prepayment pilot begins in 11 states, prior authorization for select medical equipment demonstration begins in seven states, and pilot for Part A to Part B rebilling opens to 380 hospitals nationwide. Medicaid RAC audits increase as all state programs must launch by January 1, 2012.
- Demonstrations of CMS's voluntary **Payment Bundling initiative** roll out in 2012, encouraging providers to coordinate care by bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery.
- ONC decides whether to include use of **EHR metadata** in the stage 2 meaningful use rule. The President's Council of Advisors on Science and Technology advocates such standards, but vendors and providers say adopting them in stage 2 is too much too soon.
- **Meaningful use EHR certification** permanent program launches in summer in conjunction with stage 2 rule. Certification organizations approved under the temporary program must re-apply to test or certify products in the permanent program. EHR products must be certified against new stage-2 standards and criteria.
- Enforcement of version 5010 **HIPAA transaction standards** begins March 31. Organizations turn next to adopting operating rules for two transactions by the January 1, 2013, deadline: eligibility for a health plan and healthcare claim status.
- **Clinical documentation improvement** programs gain new importance as facilities look to documentation requirements related to ICD-10, meaningful use, and ACOs. Program focus shifts to educating clinicians on these new documentation needs.
- ICD-9-CM and ICD-10-CM/PCS will receive only limited **code updates** in October, restricted to changes necessary to capture new technologies and diseases. Limiting updates will provide a welcome respite to providers and vendors focused on their ICD-10 implementations.
- ONC releases proposed rule on **NwHIN governance**, defining the standards for secure exchange of health information within NwHIN projects. Laying out the rules may encourage more participation; state and private HIE projects will take a close look at ONC's model. ONC's Direct project, enabling one-to-one provider exchanges, should be ready for widespread use.
- More **physician practices** merge with large hospitals and delivery networks in 2012, due in part to IT challenges, data management needs, and incentives related to meaningful use, ACOs, and ICD-10. Managing legacy records and integrating data management practices will challenge HIM departments.

The New Bottom Line: Data

Each of these trees in the forest share a common connection-they all require reliable data.

Managing data for stewardship, analytics, reporting, and care will be more important than ever this year, AHIMA's experts say. This makes 2012 the "year of data"-creating data, managing data, and using data.

"Data is the new bottom line for organizations," Rode says. "It is taking on a life of its own, and IT doesn't have the background to look at the governance or functional aspects of data. That is HIM's job."

The Centers for Medicare and Medicaid Services' value-based purchasing rules will be released in May and take effect in October. This is just another step in the march healthcare is taking from claims-based reimbursement to pay based on quality measurement-pay that is based essentially on data. The more accurate and managed a facility's data, the better their reimbursement potential.

"People are going to have to leverage the data and use the data that they have available," says Rita Scichilone, MHSA, RHIA, CCS, CCS-P, director of practice leadership at AHIMA. "That is what's going to make the difference between success and failure."

Never before have data been so closely tied to reimbursement. HIM professionals will need to strengthen their data analytic skills in order to handle the pay-for-performance initiatives currently developing, as well as the initiatives sure to come.

"Members will need to understand data analytics and statistics a little better and know how to apply some of these data modeling and data analysis techniques in practice," Scichilone says.

As healthcare leans on data to help solve its problems, it will learn something HIM has known for years-data integrity currently isn't what it should be. Throughout 2012 this problem will get more attention, placing HIM squarely in a position to help find solutions and finally leverage EHR data for a better, cheaper healthcare system, says Michelle Dougherty, MA, RHIA, CHP, director of practice leadership at AHIMA. It will also raise HIM's profile within organizations.

"Maybe, finally, we will have a forum that is interested in hearing and understanding what these data integrity issues are and put some attention to fixing them so the real value [of EHRs] can be addressed," Dougherty says.

With EHRs in place and the implementation bruises healing, healthcare facilities are learning more about how EHR systems can help improve processes and care. Health data are the secret, and some HIM departments have been adding roles like data quality and integrity manager to focus on data.

Throughout this year work will be done to leverage metadata tags to manage patient identity, patient privacy and security, and health data provenance, Rhodes says. Many HIM professionals will be learning more about metadata in the year ahead.

To some degree, everyone will be wrestling with data stewardship questions. In a world of mobile health data, who is responsible for what? Who owns the data?

And everyone will be watching their language. With the need to better integrate health information across organizational boundaries, organizations must come to terms on their terms. Integrating information from different facilities raises information management challenges when multiple terms are used for the same items.

Take for example a hospital with a psychology division that participates in an ACO. The division sends a record named "treatment plan" to another facility, which assumes it is a general health treatment plan and fails to provide the record with the advanced security that behavioral health records require.

"The EHR is now a given. So we have to focus on what are we getting from it in terms of the data and using that to advance the healthcare business," Washington says.

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