PHR Effect

Save to myBoK

by Jill Burrington-Brown, MS, RHIA

As part of the Markle and Robert Wood Johnson Foundations Connecting for Health collaborative, a working group on policies for electronic information sharing between doctors and patients was formed. The working group comprised 25 industry leaders, including AHIMA former past president Barbara Odom-Wesley, PhD, RHIA, and AHIMA vice president of practice leadership Don Mon, PhD. The group's purpose was to define the functions of the personal health record (PHR) as well as evaluate the demand for the PHR among patients and physicians. This article gives a brief overview of the group's report, "Connecting Americans to Their Healthcare."

PHR Possibilities

The industry leaders who formed the working group identified the PHR as a key element in the transformation of the US healthcare system. As it develops, the PHR promises to help individuals "be more engaged and successful managers of their own health."[1]

The PHR can be either stored manually (on paper) or electronically. For many people, a paper PHR may be all that is available because of the way their primary clinician maintains health information or because they do not have access to electronic means. Within the e-environment, a PHR could be stored on a personal computer, in a Web-based application, or on a portable device, such as a personal digital assistant or a USB memory device.[2] Information can be updated via data entry, scanning, or uploading as available to the individual.

The data in the PHR can be either patient-sourced (entered by the patient or a representative) or professionally sourced (entered by the treatment or care deliverer). The PHR gains value when both sources of data are employed, although it is more expensive to develop and maintain. There is no short-term incentive for institutions to develop a multisourced PHR, nor does there appear to be evidence of a market of paying customers for such a product.[3] However, some successful models exist within institutions and are accessible within the healthcare delivery of that institution. These PHR models lack the capability to be accessed or used from outside the organization.

PHR functions should include some core personal health information, but at this point in time, there is no one functional definition of a PHR.[4] This year an AHIMA volunteer work group will be developing a definition.

HIM Issues Remain Unchanged

HIM issues are the same no matter how health information is stored or who has custody of the health information.

Privacy: health information needs to be as private as an individual wishes it to be, maintaining a level of confidentiality that all deserve.

Access: health information must be accessible to treatment providers, caregivers, and individuals for efficient, high quality, and safe care.

Administrative Use: appropriate health information must also be able to be used by payers, researchers, and others who need it to complete the administrative work of healthcare, such as payment, statistical reporting, classification, and quality management.

Legal Record: health information must be identifiable in a standard set that will serve as the legal record for an individual and each of the healthcare providers who serve him or her.

Legal and Ethical Issues: health information is used in legal processes to determine liability, injury, and damages when the legal process is used. Health information is also important in the resolution of ethical issues such as fraud and abuse, research and decision support, coding for reimbursement, and quality and resource management.

Working Group Findings

The US should accelerate the development of PHRs. Technology and electronic connectivity can help transform our broken healthcare system, and PHRs can bridge the information gap between patients and health professionals. Most people want access to their health information in a convenient manner.

PHRs will help increase consumer health awareness, activation, and safety. PHRs help individuals understand their health issues and become more engaged in their healthcare. Individuals with chronic conditions would benefit from improvements in the coordination and efficiency of care. PHRs can help transition the health record from an incomplete, retrospective physician-centered record to a complete, current patient-centered record.

There is no single pathway to a universal PHR. PHRs are in the early stages with different models at different junctures. Widespread adoption will require acceptance by the entire industry (payers, providers, individuals, and families). Widespread use will require the adoption of common data sets, methods of patient identification, and privacy and security protections. Patients must be at the center of the PHR, controlling its use and access as well as maintaining responsibility for its content.

Data set commonality is a vital starting point. The PHR must have a set of common data fields, a secure protocol for information exchange, and common clinical vocabularies. The data standards should already exist and be accepted by the medical community and HL7 compliant. The sets and standards must be simple to understand and use.

The American public is receptive toward the idea of a PHR. People have a limited understanding of health IT today though they want access to and control of their health information. Population and age determine preference over the medium of the PHR. People are receptive to the online convenience possible with online PHRs and want to work with their doctors.

Key findings from existing PHRs include:

- Physician promotion and use is key to consumer adoption.
- The PHR should be integrated into the clinical workflow in order to benefit physician practice.
- Consumers find functions such as messaging, online refills, and lab results most useful.
- Patients feel empowered when they have access to their health information.[5]

HIM Challenges for the Future

We still must manage health information within the medium it is produced and maintained. Our challenge is to keep current with the emerging health information mediums and structure.

The PHR offers HIM the opportunity to assist in the development of this new resource from the beginning. HIM professionals should also seek opportunities to offer their expertise to organizations developing PHRs: healthcare delivery systems, health plans, practitioners, and consumer organizations. We can foster understanding of our information management functions, and consumer education will be one of our new roles.

In fact, HIM professionals should go back and review the emerging roles included in the Vision 2006 strategic plan developed by the AHIMA Board of Directors in 1996. It is remarkable that the role of patient information coordinator, a position to help consumers manage their health information, was identified even then.[6] We must be ready to play an important role in this emerging shift.

Notes

1. Connecting for Health. “Connecting Americans to Their Healthcare: Final Report.” July 2004, page 1. Available online at www.connectingforhealth.com.
2. Ibid, 25.
3. Ibid, 26.
4. Ibid, 28.
5. Ibid, 2–5.
6. AHIMA. “Emerging Roles.” 1996.

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