Road Map to 2013: A Guide through Exciting but Unfamiliar HIM Territory and Times

By Genna Rollins

The preparation for any great journey usually begins with reflection on lessons learned and research on just how those lessons can be utilized down the unpredictable road. The paradigm shift of electronic health records has caused HIM professionals to steer their work and career into promising but unfamiliar territory. Change is a constant in any profession, but HIM has seen more than the usual share during recent travels.

"Rollercoaster," "tsunami," and "revolution" are some of the terms AHIMA staff members have used to capture the dramatic scope of what's currently happening in the healthcare industry and the HIM profession. Some changes have been imposed by legislation or regulations, like the extended implementation date for ICD-10-CM/PCS compliance. But many others, such as the flurry of emerging mobile health technologies, represent a confluence of divergent forces.

Looming over much of the healthcare landscape is a great unknown in the federal budget crisis and how its resolution (or lack thereof) will affect a wide range of HIM programs and initiatives. It's clear the healthcare industry is in the midst of a grand evolution and the HIM profession is in the express lane of the action. The road through 2013 is filled with promise and hazards for HIM professionals.

"We're looking at continued transformation. The mechanisms for delivering and reimbursing care are changing, and there's a recognition growing of the importance of data that was not as predominant in the past, including patient access to information and how to use the information," says Dan Rode, MBA, CHPS, FHFMA, vice president of advocacy and policy at AHIMA. "It's a groundswell of change and disruption, but there's been a lot of uncertainty because all these changes are not occurring uniformly, and some are even being resisted."

With so much up in the air, AHIMA's expert staff plan to stay informed and vigilant throughout 2013 to help guide members through the year's rewarding milestones and rocky potholes of change. HIM experts have weighed in on the top five hot topics facing HIM and healthcare along the 2013 highway. And because those who recognize their past can better control their future, staff have summarized the top five topics of 2012 that will continue to change healthcare in 2013 and for years to come. Welcome to your roadmap for what was and what will be in HIM.

Video Extra: The Road Ahead for HIM
journal.ahima.org

AHIMA Director of HIM Solutions Karen Kostick, RHIT, CCS, CCS-P, discusses HIM's path to computer-assisted coding, along with other hot topics facing HIM in 2013.

The Year in Review Top Five Topics of 2012

ICD-10 Deadline Delayed

The decision in August by the Department of Health and Human Services (HHS) to delay the transition to ICD-10-CM and ICD-10-PCS from October 1, 2013 to October 1, 2014 was frustrating to some healthcare providers and a relief to others. The delay came after months of uncertainty and contention, particularly by physician groups, that a 2013 implementation would create an undue administrative burden.

While HHS concluded that the one-year delay would cost the healthcare industry an estimated $1 billion to $6 billion, the agency also calculated that it would lead to $3.6 billion to $8 billion in cost avoidance-since unprepared health plans and providers would not resort to submitting manual claims, and smaller providers would not have to take out loans or lines of credit to continue providing care in light of payment delays, according to Department of Health and Human Services research.

For organizations that were further along in planning for the implementation, the new start date presented various downsides, according to Theresa Rihanek, MHA, RHIA, CCS, director of HIM solutions at AHIMA. “The delay requires providers to maintain both ICD-9-CM and ICD-10-CM/PCS code sets for one more year,” Rihanek says. “Many organizations took a wait-and-see approach, reassessed their ICD-10-CM/PCS implementation budgets, and used implementation funds on other initiatives. The HIM academic community was also impacted by the delay, as many had already integrated new curriculum to accommodate ICD-10-CM/PCS for their students.”

Despite these negative aspects, the delay gives those providers that held off on starting implementation some breathing room to catch up. “They have a chance now to reassess their implementation plan or use the time to bring their implementation process up to where it should be if they have fallen behind or didn’t really get a good start,” Rihanek observes.

At Last, Stage 2
Meaningful Use Final Rules Released

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) in August released the final rules and requirements for the stage 2 “meaningful use” EHR Incentive Program, marking an important step in advancing the secure exchange of information between providers and patients. After some provider groups raised concerns about the difficulty of the program, the final rule scaled back some proposed rule requirements, such as provisions involving the percentage of patients who must electronically access their health records.

But many optional quality measures from stage 1 were moved to the required set in stage 2, and many stage 1 measure hold-overs were amped up in difficutly. For example, stage 1 required providers to give patients an electronic copy of their health information upon request within three business days. In stage 2, this measure was modified to require providers to give patients the ability to view online, download, and transmit their health information within 36 hours of discharge from the hospital. The change increased the difficulty for HIM professionals working to release medical records.

The final rule also set the stage for long-anticipated interoperability by specifying uniform formats for structured and coded data shared with patients or transmitted during transitions in care. The adoption of additional stage 2 meaningful use clinical vocabulary standards including SNOMED CT, LOINC, and RxNORM were finalized for the purpose of representing electronic health information, according to Karen Kostick, RHIT, CCS, CCS-P, director of HIM solutions at AHIMA.

“HIM coding specialists are very proficient in the administrative code sets, such as ICD-9-CM and CPT, but now what’s happening-and it’s happening very fast-is that SNOMED CT and other clinical terminologies are being integrated for use within EHRs,” she explains. “This means now is the time for HIM professionals to expand their knowledge in these additional clinical terminologies and classifications and become familiar with their purpose within the EHR.”

This additional expertise will be valuable when HIM professionals are working with IT and EHR vendors during EHR implementation as well as position the HIM professional into a leadership role within the organization. Knowledge in EHR clinical vocabulary standards will continue to be in demand.

Spotlight on Patient Rights and Engagement Brightens

The past year was all about the healthcare patient, with several federal initiatives working to get patients more involved in their healthcare. If the implementation of stage 2 meaningful use edges healthcare records closer to an all-electronic format, it also amps up the meaningful choice concept for patients. “Patient education is embedded in meaningful use stage 2,” says Julie Dooling, RHIT, director of HIM solutions at AHIMA.

Patient-centered decisions need to be made by providers when personal health information is being exchanged. It is the provider’s responsibility to make sure patients are educated in order to have a meaningful choice. Education on patient rights

and health information exchange (HIE) initiatives will be important because patients need to know where their information is going, Dooling says.

She cites as an example the stage 2 measure that requires providers to enable patients to view online, download, and transmit their health information-a change from stage 1 meaningful use where providers were only required to offer patients electronic copies of their health information. "We had been automating and standardizing a lot of the data, and now we're moving to the level of communicating with patients, but it's not just a matter of putting things up on a web page," she adds. "Patients need to be educated about what a portal is, what happens to their information."

Much progress has been made with regard to the technology behind patient portals and personal health records (PHRs). But patients need to understand how these technologies enable the creation and management of their health information, Dooling says.

Part and parcel to engaging patients and making them aware of their rights and choices is the element of trust, according to Harry Rhodes, MBA, RHIA, CHPS, CPHIMS, FAHIMA, director of HIM solutions at AHIMA. The increasing development of health information exchanges gives patients the ability to exchange their records, but also creates the need for higher privacy education. "Providers will be explaining the uses for and value of the information as well as what their privacy practices are so that patients will make a choice to share rather than not share information," Rhodes says. "This process is all about gaining trust. Consumer trust is more important than all the technology in the world."

To spark conversation and thought in this important area, AHIMA has established its first Consumer Engagement Practice Council this year and reached out to national consumer groups to discuss the role of HIM in health information access and privacy and security.

The Rise of Big Data

The advance toward all providers using EHRs and participating in HIE has put industry focus on the vast amounts of health data being collected-and the daunting challenge of managing and analyzing it.

"Data weaves through everything we do, and more emphasis will be placed now on data governance and stewardship," Dooling says. "The conversation has started but questions of who owns it, what's its life cycle, and who controls it have still to be addressed."

Data have become so prominent that futurists have pegged "data analyst" as the healthcare job to have in the coming decades, according to Rhodes. "Someone has to make heads and tails of all this data. Right now the biggest gap that's going to stand in the way of achieving success in managing, organizing, and utilizing all this data is that it will take another 10 years to staff enough data analysts," he contends.

Rhodes also points out that the transition to EHRs and HIE has progressed enough that a new challenge has emerged-data with no immediate purpose. "There's a category of data called dark data. If you go to a healthcare provider and ask why they're collecting all this data, there's a whole category that gets captured and collected but is never used," he says. "There's not enough coordination, standardization, or data analysts right now to utilize and understand the value proposition for this dark data." Eventually, as health data is more commonly analyzed and better frameworks and structures to analyze it are developed, providers will see more benefit.

Reflecting the need for better data stewardship, the Centers for Medicare and Medicaid Services (CMS) in 2012 created the Office of Information Products and Data Analytics to oversee the agency's portfolio of data and information. Big Data is a phrase that will keep buzzing well into 2013 for HIM professionals.

Waiting, and Waiting for HITECH Privacy and Security Final Rules

There was considerable uncertainty in late 2012 about just when the HITECH Act Omnibus privacy and security final rules would be released. As of press time, the rules-which will drastically impact HIM processes-remained on the federal government's shelf.

In addition to changes in privacy and security rules, this omnibus regulation combines three other separate rulemakings, including data breach enforcement and penalty requirements, breach notifications, and changes to HIPAA to incorporate the Genetic Information Nondiscrimination Act.

The wait for this sweeping regulation brought consternation to the industry throughout 2012. The delay in part has been due to regulators grappling with how to implement certain aspects of the rule, according to Rode.

"An example could be the requirement that allows individuals to have the provider hide some of their information [if treatment is paid out of pocket] so it can't be shared with a health plan," Rode says. "That sounds simple, but it's far from simple. I've yet to talk with a computer vendor who has been able to come up with [the] ability to do that."

However, due to the significant delay in the release of the rule, vendors may have already implemented some changes based on their understanding of the proposed rule. "It's really going to be everybody grabbing that final copy of regulation, looking at the compliance dates and trying to figure out the next steps."

Even without the final rule, the Office for Civil Rights (OCR) in 2012 continued its track record of robust investigation of HIPAA privacy and security breaches, according to Angela Dinh Rose, MHA, RHIA, CHPS, director of HIM solutions at AHIMA. Privacy and security compliance audits were prevalent in 2012, though their threat didn't stop information from being released without authorization.

By fall 2012 the total number of individuals impacted by privacy breaches since 2009 reached more than 21 million. "They're [OCR] actively auditing, they're mandated to audit, and they mean business," Dinh Rose says. "We've seen a lot of fines and corrective actions, and chances are, it's a domino effect. If the auditors find one thing, it will lead to something else."

As 2012 came to a close, OCR continued their new pilot audit program to assess 115 covered entities for compliance with HIPAA privacy, security, and breach notification requirements. OCR has indicated that it intends to publish best practice findings from this program in the near future.

ICD-10 Implementation on the Horizon

While the one-year delay in implementing ICD-10-CM/PCS was a disappointment to many in HIM, some saw a silver lining in the postponement. "The delay might have been a good thing, because it gives organizations the opportunity to focus more on training," says Kathy DeVault, RHIA, CCS, CCS-P, director of HIM solutions at AHIMA. "Hopefully most are taking advantage of that, and not just stalling for another year. 2013 should be a busy year of training."

DeVault recommends that organizations use the extension to give coders more time to work in both the ICD-9-CM and ICD-10-CM environments and, crucially, to understand the documentation requirements and increased coding granularity in ICD-10. For example, there are eight code choices in ICD-9-CM for a fractured finger versus about 64 in ICD-10.

"The first reaction of coders when they see the greater detail in ICD-10-CM is, 'I'll never be able to code this and I won't have the documentation,'" she says. "But sometimes we don't know what we don't know because ICD-9-CM doesn't provide us the opportunity for that detail. So we don't look for it in the documentation.

"I'm hoping we'll be pleasantly surprised and discover that some of the documentation we thought we wouldn't have is there all along."

Now also is the time for HIM professionals to reach out to physicians and assist them in making the change to ICD-10-CM, stresses DeVault. "We don't necessarily need to make physicians [into] coders," she says. "But we want them to be aware of the nuances and specificities of ICD-10-CM so they can begin to adjust their documentation to match what we need in ICD-10-CM."

This year HIM professionals and physicians should start to identify specifics in the documentation that are lacking. This will go a long way for long-term success when the code set becomes a requirement next year. "The more prepared you are and the more time you put into education, the more successful you'll be," DeVault advises.

Health Information Exchange Gains Industry Prominence

Investments made thus far in health information exchange and health information exchange organizations are expected to pay off in 2013 as new models begin to emerge and the value of HIEs becomes more apparent to the broader healthcare community. While 2012 saw a rise in the number of different types of HIE offerings, industry analysts hope this year will mark the first steps toward the integration of the disparate organizations. For the patient, it doesn't matter which type of HIE is exchanging their information-just that all of their information gets exchanged based on their level of permission.

One group hoping to bring together HIEs in 2013 is the Illinois Health Information Exchange Authority. Seeking to become a platform through which vendors and businesses can run specialized applications important to healthcare management, ILHIE Authority has reached out to private HIE companies and vendors interested in developing these products.

"They will be looking for solutions that meet market needs like chronic disease management," Rhodes says. "Diabetics, for example, would have information coming from a lot of different sources, such as primary care physicians and specialists, pharmacies, dieticians, gyms, and grocery stores. So all this information would have to go to a central place and that's what these vendors are aiming for."

Even as new models for using HIEs emerge, efforts still are underway to achieve true interoperability. For example, ONC's EHR/HIE Interoperability Workgroup recently launched an initiative to address the patchwork of interfaces that exist across HIEs despite the existence of standards and testing programs.

Individual organizations are also doing their part to advance HIE, Dooling says. "We're starting to see organizations in the same community or region with the same vendor now working with other vendors and HIEs to help them exchange. We now have a structure forming at the national level, as well as at the private or grassroots level," she says. "This is being driven by accountable care organizations and meaningful use provisions, and we're seeing new energy in this area."

Computer-Assisted Coding Begins Changing the Industry

The increased complexity of ICD-10-CM/PCS is one factor prompting healthcare providers to explore emerging coding technologies, including inpatient computer-assisted coding (CAC) and natural language processing (NLP) products, to boost the efficiency of the coding workflow process. Kostick predicts this trend will continue in 2013 as healthcare organizations continue to prepare for ICD-10-CM/PCS implementation.

In fact, according to a KLAS 2012 report titled "Computer-Assisted Coding: A Glimpse at the Future of HIM Technology," the majority of the providers KLAS interviewed have either already purchased or have plans to purchase an inpatient computer-assisted coding (CAC) solution in the near future.

"Through the expertise and commitment of industry developers the inpatient computer-assisted coding (CAC) and natural language processing (NLP) products are rapidly maturing to meet healthcare providers ICD-10 readiness needs," Kostick says. With the healthcare industry's EHR adoption initiatives and transition to ICD-10-CM/PCS, it is expected that healthcare providers who look towards assessing and establishing CAC and NLP solutions now will be well positioned to ensure an efficient and effective coding workflow process.

In addition to the critical collaboration between HIM management, IT, and the software vendor, it will also be valuable for HIM coding staff to be involved in assessing, planning, and implementing inpatient CAC technology. The coding staff's expertise and input will assist in validating that the coding technology will be used to its fullest capabilities.

Coding professionals shouldn't worry that CAC will spell their demise, according to AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA. "There will always be a need for coders, but these systems will move them from production workers to having editor and quality review roles."

While CAC will impact coders' workflows and responsibilities, Kostick says this new technology will also open new opportunities. "Their coding function will not be as time-consuming as it is today," she says. "The repetitive assignment of codes will be eliminated, and instead they'll be more involved with critical thinking, interpreting and analyzing data and documentation, and creative problem solving.

"There's absolutely a role for coding professionals with CAC and in the future they'll be transitioned into clinical coding editors."

Mobile Health to Alter Patient Information Collection

Mobile health is the new frontier for consumers wishing to access and interact with their health information. This year the healthcare industry will start thinking more and more about how to manage provider-patient health information exchanges through personal mobile and telemedicine devices, according to Rhodes. A litany of applications for smartphones are due to hit the market over the next two years, including apps that enable users to track their blood pressure, manage chronic diseases, and perform their own eye examinations.

"Consumers are wanting to use their phones for all kinds of purposes, and these apps are coming to healthcare," Rhodes says. "People are going to buy these apps and come to the provider expecting that the provider will be ready, willing, and enthusiastically able to start receiving all the information they're collecting.

"All of this is coming so fast, and I wonder about how we're [healthcare professionals] going to be able to oblige the consumer, collect all this information, and do it in a way that meets regulatory requirements and respects patient choices."

Patty Thierry Sheridan, MBA, RHIA, FAHIMA, AHIMA's past-president, shares Rhodes's anticipation of the coming mobile invasion in healthcare. "We need to look forward to the impact mobile technology will have on healthcare," she says. "How will the connectivity we have with mobile technology in our daily lives be integrated in healthcare? And how will that impact health information and HIM practice?

"And equally important, how will that change how AHIMA delivers services and products?"

A Pew Research Center survey released in November suggests the industry has a closing window of time to devise approaches to mobile healthcare. The poll found that nearly one-third of cell phone owners have used their phones to look for health information, and one-fifth of smartphone owners have downloaded a health app. But while 80 percent of cell phone owners receive and send text messages, just 9 percent say they receive text updates or alerts about medical issues.

HIEs hold enormous power to benefit population-level health as well as individual patients-but the industry is still struggling with how best to educate patients about informed consent for information exchange, according to Dooling. This includes recording and sharing information on a mobile device.

"This is going to continue to be a challenge because as more information is shared outside the four walls of any one facility, patients need clear instructions and they need to know where their information is going when they consent," she said. "Most organizations are looking at opt-out consent models, but not everyone is doing it the same way."

Audits Bring Renewed Attention to Data Stewardship

If data integrity and good data stewardship were not already priorities of HIM professionals, a bevy of public and private audit and performance initiatives will keep these issues in their headlights throughout 2013.

"Data affects every aspect of patient care and quality, and if anything, its importance only keeps increasing due to external auditing," Kostick says. "What will be big in 2013 is Medicare's Hospital Value-based Purchasing Program, which will need good quality data to be readily available and submitted to CMS. That's just one example."

Kostick and her AHIMA colleagues cite a veritable traffic jam of audits HIM can expect to face on the road through 2013. These include:

- Recovery Audit Contractors
- Medicare Administrative Contractors
- Medicaid Integrity Contractors
- Audits by private payers

Whether a lawsuit filed in November 2012 by the American Hospital Association (AHA) against the Department of Health and Human Services over certain RAC practices will have any moderating effect remained to be seen at press time. The AHA filed the suit claiming Medicare is unfairly taking away reimbursement for necessary care provided by hospitals. In the

meantime, HIM professionals can expect to lay on the horn and live with the current audit climate in the coming year as the federal government looks to audits to aid budget repairs.

“There’s increased scrutiny on our coded data across the board, and it’s interesting to see the coding world evolve in the face of all these audits,” DeVault says. “I’ve seen some excellent coders begin to lose their confidence because they’re afraid their coding is going to lead to an audit.”

The process related to audits is an administrative burden unto itself, and it’s a “full time process by one person just to manage,” DeVault says. “But it’s become a way of life in hospitals.”

Genna Rollins (rollinswrites@verizon.net) is a freelance writer specializing in healthcare.

Article citation:
Rollins, Genna. "Road Map to 2013: A Guide through Exciting but Unfamiliar HIM Territory and Times" *Journal of AHIMA* 84, no.1 (January 2013): 22-29.