The Year Ahead for HIM: Reflecting on HIM's Past Year, and Looking to Its Future in 2014

By Mary Butler

On New Year's Eve, waiting for the Times Square ball to drop, optimistic individuals focus on starting fresh with their resolutions for the new year. Meanwhile, it's easy to get caught up in the boozy lyrics of "Auld Lang Syne" and reflect on the year that was and wait, fatalistically perhaps, for the other shoe to drop.

As health information management (HIM) professionals reflect on the coming of the new year, they have plenty to be proud of for all they accomplished in 2013. But if that optimism is couched with some anxiety about the industry deadlines that await in 2014, that is more than understandable.

The groundwork for success in 2014 needed to be laid in 2013—which is what many HIM professionals have seen over the preceding 12 months. But whether it's getting electronic health record (EHR) systems compliant for stage 2 of the "meaningful use" EHR Incentive Program, complying with the HITECH-HIPAA Omnibus Final Rule, or preparing to meet the ICD-10-CM/PCS implementation date, one year's worth of planning is far from adequate. More work awaits in 2014.

Still, it's not too late to take action and make the most of 2014. The following is a review of the top HIM issues in 2013, and how they will continue to impact the HIM industry and its professionals in the coming year—according to a cross-section of AHIMA and industry experts.

Hard work and attention to detail are required to apply the lessons of 2013 to the successes of 2014. Do this, and savvy HIM professionals will not find themselves dwelling on "Auld Lang Syne's" final verse when it comes time to start attesting and submitting dually-coded claims this year:

> *And surely you will pay for your pint,*
> *And surely I will pay for mine!*
> *And we will take a cup of kindness yet*
> *For times gone by*!

ICD-10 Implementation Deadline Nears

Luckily, coders nursing a New Year's Eve hangover don't have a January 1 implementation date to meet—theirs comes 10 months later. But that doesn't mean there won't be any headaches.

When the Department of Health and Human Services (HHS) pushed the ICD-10-CM/PCS implementation date back a year to October 2014, preparations for the code set switch dropped off the radar for some organizations, several coding consultants have suggested.

"I do think that was the case," says Angie Comfort, RHIT, CDIP, CCS, a director of HIM practice excellence at AHIMA. "When the government issued that statement, I believe a lot of facilities and physicians' offices stopped their preparations. I think they stopped training and they put off starting their steering committees and implementation groups."

While physician groups such as the American Medical Association continue to lobby Congress for ICD-10 delays, hospitals and HIM departments have jumped on the preparation bandwagon, according to Comfort. And for savvy HIM directors, that includes anticipating an estimated 50 percent reduction in coder productivity during the first few months of ICD-10 use. Comfort says many of the vendors she's talked to over 2013 are booked for the rest of 2014 helping hospital and physician offices hire extra coders in anticipation of the shortfall.

It's hard to imagine that a hospital or physician practice could navigate the ICD-10 upgrade without clinical documentation improvement (CDI) programs, Comfort says. She suspects that in HIM departments without CDI programs, HIM directors will quickly start to see that coders will spend a considerable amount of time querying physicians due to the greater specificity ICD-10 requires, and that should be an eye-opener about the need for CDI programs.

"I know there are some hospitals that don't have one and that kind of blows my mind," Comfort says. "Everybody needs improvement on their clinical documentation."

Of particular concern to Comfort is the way that smaller, rural community hospitals will handle the payer denial rates that can be expected when they start submitting claims using the new code set. While big healthcare organizations can afford to hire extra coders and consultants and can better absorb the hit to revenue, critical access hospitals could struggle.

When Comfort was training coders, it was common to hear statements like "I'm retiring when ICD-10 hits" or "I'm becoming a Walmart greeter before ICD-10." But this anxiety can be tempered by keeping coders well educated on all of the code set changes and emphasizing the positives.

"Show them and talk to them about it and present it in not a bad way, but in a 'this is going to be great for us' way," Comfort says.

Big Data Gets Big Talk in 2013

There's no need to pour a champagne toast to Big Data just yet. While the terms "information governance" and "data governance" have transitioned from lofty buzzword to everyday use among HIM professionals, Big Data looks to remain a buzzword in practice for now. But that doesn't mean Big Data shouldn't be taken seriously, according to Karen Boruff, CPIT, CPC, a senior consultant for Hubbert Systems Consulting.

Currently Boruff is working on a project called "Let's Get Healthy California," a 10-year plan to make California the healthiest state in the US that uses Big Data to help measure the state's progress on a number of indicators.

Boruff says that most HIM professionals are three to five years away from handling Big Data on a day-to-day basis, mostly because the US is in a transition mode due to the transition to ICD-10-CM/PCS. Even after the transition, it'll be a couple years before the quality of data generated from ICD-10 will be valuable. But eventually, the granularity of ICD-10 data will bridge a gap between the quality reporting needed and administrative information currently available, according to Boruff.

"And that's a real problem right now. So much of our reporting is based on claims and administrative information, which doesn't have the richness that quality and outcomes reporting needs," Boruff says. "So I think we're going to see that much more in ICD-10, and that's one of the benefits, but that's going to be a transition."

Big Data refers to large volumes of data that incorporates claims data, structured and unstructured EHR data, social media, and patient-centered data, and distills it into information using technology. HIM professionals are well positioned to work with Big Data in the future because they are knowledgeable about both clinical and administrative data.

"There are certifications that are already out there that are great, but a lot of the core skills and knowledge, HIM professionals already have," Boruff says. "That's why it makes them great data stewards and puts them in a position to really manage data and foster best practices for information governance and using Big Data."

Stage 2 Meaningful Use Challenges Providers

Many meaningful use program participants welcomed both a new year and a new opportunity to attest to the "meaningful use" EHR Incentive Program, which offers payments for the use of certified health IT systems.

The October 1, 2013 launch date for stage 2 meaningful use had the misfortune of coinciding with the federal government shutdown, leading to some hiccups with the online attestation portal. However, after two months of attestation for hospitals, participation looks robust, according to Diana Warner, MS, RHIA, CHPS, FAHIMA, a director of HIM practice excellence at

AHIMA. Attestation to stage 2 began in October 2013 for hospitals, and began January 1, 2014 for physicians' practices and other eligible providers.

The Centers for Medicare and Medicaid Services announced in December that the period for stage 2 compliance would be extended by a year.

Warner is concerned that even though EHR adoption under meaningful use is supposed to be incremental, meeting the stage 2 criteria could be a real challenge as written.

"We have to remember, the vendors aren't given that much time to create this code, so they're slamming this into the EHRs and that's a common complaint we're hearing," Warner says.

Other major challenges for providers and vendors relate to the use of patient portals and transitions of care, Warner says. Meaningful use requires that eligible providers who refer patients to other settings of care must provide an electronic summary of care for each transition.

Additionally, meaningful use patient engagement provisions requires organizations to give patients the ability to view online, download, and transmit their health information within four days of their information becoming available from their provider. Providers then must not only create a secured platform by which patients can interact with this information, but also be able to prove that a certain percentage of patients actually do.

"I think the understanding and getting continuity of care documents from transitions of care is going to be difficult," Warner says. "I think getting patients in some areas to access their records, getting the portals [working], especially in rural areas, it's going to be hard even if they do have Internet. But if their patient population is elderly, I think that is going to be a difficult measure to meet."

But if a patient doesn't access their portal, the criteria can't be counted. "It's just a checkmark at that point," Warner says. "I think people think [portals] are a good thing, but I don't think we have the workflows embedded yet to do it well. And how do you engage those patients?"

Patient Matching Efforts Make a Comeback

The task of matching patient identities—a critically important one in 2014—is not a new issue. Long before the first EHR was implemented, HIM professionals have been searching for the best way to ensure health records were properly matched to individual patients.

As the Affordable Care Act continues to push providers toward accountable care organizations (ACOs), and meaningful use standards require providers to have interoperable EHRs, the demand for better patient identity matching technologies has never been greater.

In September 2013, the Office of the National Coordinator for Health IT (ONC) appointed a multi-organizational initiative to identify best practices used by private sector healthcare delivery systems and federal agencies to improve patient matching "across disparate systems."

Micky Tripathi, PhD, chair of the ONC Health IT Policy Committee Health Information Exchange Work Group and CEO and founder of the Massachusetts eHealth Collaborative, says the demand for interoperability is already driving improvement in patient identity matching solutions.

Additionally, because Congress has been adamant about not creating a national patient identifier, "there are processes that are in place now that people use to get what I think is at least adequate, if not robust, patient matching," Tripathi says.

"Those processes and technologies are getting better and better all the time," Tripathi continues. "And if you start to move into a world where we see more bottom-up demand for interoperability across different entities, I think that's going to create more demand-driven improvements in patient matching than over what we have today."

In the absence of a national patient identifier, Tripathi is optimistic about the use of mobile phone numbers as unique identifiers, and the creation of Direct enabled e-mail addresses, which is a secure e-mail standard accepted by stage 2 meaningful use that allows patients and providers to exchange encrypted information end-to-end.

Tripathi thinks the best patient matching results are going to come as providers enter ACOs and pressure vendors for better solutions.

"That's the demand-driven part," Tripathi says. "That's where they start pushing on their vendors and saying 'you need to give us better products.' And I'm much more sanguine about that being the path for better patient matching than anything that would come from a top-down ONC or the Centers for Medicare and Medicaid Services sort of imposition on the market."

Finally a Final HITECH Privacy Rule Released

Privacy and security officers are used to worrying about all the pesky security issues that keep their HIM colleagues up at night, so New Year's Eve is really no different for them this year—though uncertainty looms.

The deadline for healthcare providers and other HIPAA-covered entities to become compliant with the HITECH Omnibus Rule was September 23, 2013. This deadline posed significant new challenges for covered entities.

One challenge of the rule, formally called the "Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act," was that it extended compliance with HIPAA to covered entities' business associates and their subcontractors.

Although the rule became effective in September, covered entities have had the time since the rule was published in 2009 to prepare. Yet many may still be struggling to update their policies and procedures as the calendar turns over to 2014.

"I suspect that many organizations have been too overwhelmed by all the other healthcare initiatives to focus on privacy and security compliance with the HIPAA Omnibus Rule. Many may still be out of compliance going into 2014," says Harry Rhodes, MBA, RHIA, CHPS, CDIP, CPHIMS, FAHIMA, a director of HIM practice excellence at AHIMA.

Another provision of the HITECH-HIPAA Omnibus Final Rule that may still have some covered entities scratching their heads is the right for patients to enact a "request for restrictions," allowing them to sequester certain health information from their health record if they pay for a service out of pocket. Rhodes says this is an "emerging protocol" that some HIM professionals have not been able to develop for their EHR systems.

Boruff says many provider networks in California are still struggling to figure out how to manage the requests. Some are implementing homegrown solutions, while others are looking to their vendors to help with compliance. Boruff says one health information exchange organization in California developed a procedure so that when a patient requests a restriction, the system creates an automatic "opt out" so their information is never shared.

"It's a completely all in or all out situation. And because our systems are still not connected—we're connected but we're not interoperable," Boruff says.

New Year's Resolution Redux

These issues sound familiar? The following are topics and issues that many HIM professionals expected would be resolved in 2013, but will pop up again in 2014.

- Even the most diligent HIM professionals face some unknowns in 2014. One of the most troublesome is the fate of regional extension centers (RECs), the small, usually state-run resource centers designed to help rural providers comply with meaningful use. Federal funding for RECs is set to run out in 2014, making their fate uncertain. Diana Warner, MS, RHIA, CHPS, FAHIMA, a director of HIM practice excellence at AHIMA, says she's worried about the RECs' ability to be self-sufficient when the funding runs out. Additionally, Warner is concerned that given the pace at which vendors have had to update EHR code for stage 2, any audits launched will add undue pain for providers.

- Compliance officers are waiting for HHS to finalize HITECH Act changes to the HIPAA Privacy Rule concerning accounting of disclosures. ONC's Health Information Technology Policy Committee approved recommendations in December to adopt the ARRA-HITECH requirement for HIPPA-covered entities to account for disclosures of personal health information for treatment, payment and healthcare operations made through an EHR. However, a timetable has not been set for the Department of Health and Human Services to issue a final rule.
- A bright spot for HIM professionals, particularly those working on patient engagement issues, is the Blue Button Initiative, a federal project launched several years ago but now gaining traction in the healthcare industry since it was widely promoted and opened up to the public. Blue Button helps give patients electronic access to their health information via a patient portal. What originally started as a way to give Veterans Administration and Medicare beneficiaries access to their protected health information is expanding to the private sector and partnering with groups like AHIMA.

ICD-10/RAC Audit Reform Legislation Hits DC

While lawmakers are out celebrating the New Year with their families and constituents, HIM advocates in Washington are celebrating their own advances while keeping their eyes on key players.

As many in the healthcare industry work steadily to prepare for ICD-10-CM/PCS implementation, some lawmakers are still mounting efforts to block it. Margarita Valdez, AHIMA's director of Congressional relations, says she is keeping an eye on Senate bill (S. 972), introduced by Sen. Tom Coburn (R-OK), and its House of Representatives version (H. 1701), sponsored by Rep. Ted Poe (R-TX), both called the "Cutting Costly Codes Act of 2013."

Although Valdez considers the lawmakers' reasoning for advancing this legislation to be weak, the situation warrants monitoring as Congress deals with the fallout of the federal government shutdown agreement. Valdez worries that one of the bills could be inserted into last-minute negotiations over the budget or the debt ceiling—battles Congress is expected to wage in the early months of 2014.

"That's why it's even more critical for our members to write legislators to ensure that even though there's this work happening with the budget and all these other things, that we realign legislators' priorities," Valdez says.

Another key legislative interest for AHIMA members is RAC audit reform. In 2013, AHIMA worked with Rep. Sam Graves (R-MO) and Rep. Adam Schiff (D-CA) to introduce the "Medicare Audit Improvement Act of 2013," which would set a consolidated limit for the number of audit record requests Medicare contractors can submit to providers within a 45-day period. CMS currently limits the number of audit claims to 400 over 45 days, placing an undue burden on many HIM staff members, according to Valdez. Making things worse, some RAC groups aren't even abiding by the current regulation. The bill currently has 161 co-sponsors.

"Having two bills in both chambers of Congress is really a major move in the right direction for our membership," Valdez says. "Going forward in 2014 we are asking for more co-sponsors and then also pushing to have a hearing in both the House and Senate on this bill."

Video Extra. HIMinute: The Emerging Role of Information Governance in HIM

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Last year also saw the emergance of information governance as a hot area for HIM. In this video Linda Kloss discusses why this role will be important to HIM in 2014 and beyond.

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