Treating Healthcare with Health "I"T

Save to myBoK

By Chris Dimick

Patient-Centric Stage 2 Meaningful Use Measures Considered Treatment for Ailing US Health System

---

The US healthcare system is ill. Higher costs, sicker patients, and struggling providers are the symptoms of the disease that has sent industry stakeholders scrambling to find a cure before the entire system expires. Health reform and incentives for implementing health IT have been applied, but a treatment once brushed off by healthcare is now giving renewed hope as a possible cure: Inject the patient into their own care.

“We have tried everything under the sun before to improve the healthcare system that everybody knows is really ailing,” says Christine Bechtel, vice president of the National Partnership for Women & Families and a member of the Office of the National Coordinator for Health IT’s (ONC) Health IT Policy Committee. “What we haven’t done is really put the pedal to the metal on patient-centeredness, and for us what that means is we can’t afford any longer to design a system that does things for patients or to patients. We have to create the system with patients as central partners.”

The US Department of Health and Human Services (HHS) wants to put the “I” back into health IT and is attempting to do so through a variety of patient-centered initiatives that will culminate with the last stage of the “meaningful use” EHR Incentive Program.

Last September HHS held its first Consumer Health IT Summit, where more than 25 healthcare stakeholder organizations such as insurers, providers, and vendors pledged to make it easier for patients to get secure access to their health information.

The summit focused on the benefits of electronic health records, outlined HHS’ plans for a five-year consumer-focused health IT initiative, and highlighted how an informed and empowered patient can help providers manage care and lower costs.

This patient-centric focus extends across HHS to the ONC-developed Stage 2 meaningful use EHR Incentive Program. The proposed stage 2 rule, released in spring, included several patient-focused measures tied to engaging patients in their healthcare through the use of health IT.

The shift from the implementation-heavy focus of stage 1 of the program to the patient-centered use of health IT in stage 2 was a planned transition. Stage 1 was about getting systems implemented, with stages 2 and 3 focused on meaningfully using those systems to improve care delivery, lower costs, and better engage patients in their treatment.

A large part of that engagement is getting health records into the hands of patients, as well as changing the old mindset that patients should be a bystander in the role of their care, Bechtel says.

While the measures in stage 2 more directly engage patients, the processes for meeting these measures have a direct impact on HIM processes and workflow. HIM professionals must maintain a delicate balance between protecting and promoting patient access to health information. If the proposed stage 2 meaningful use measures are finalized, HIM professionals will have to adjust their policies and procedures to ensure that balance remains steady.

Stage 2 Measures and their Impact on HIM

The final rule for the stage 2 meaningful use program is expected to be released by HHS in late summer or early fall 2012. As of press time, the final rule was under the White House’s Office of Management and Budget review, typically the last step before a final rule is issued to the public. If the proposed rule released earlier this year is any indication, many of the new measures will require providers and HIM professionals to interact with patients in new and more direct ways. Patient-centeredness is a key priority of ONC when developing the meaningful use program, Bechtel says.

"Patients need to be central partners in determining what (the healthcare) system looks like, how it operates, and be front and center, side-by-side with providers in doing this," she says.

Online Access, Download, and Transmit Measure

The biggest patient-centric change from stage 1 to stage 2 is the proposed measure requiring participants to allow patients the ability to electronically view, download, and transmit health information online. This addition also has the most potential to impact patient care, Bechtel says. Part of Bechtel's role on the ONC Health IT Policy Committee is to keep patients in mind when helping draw up the proposed EHR Incentive Program meaningful use measures. The measures are then sent from the committee to ONC officials for final approval.

The "view online, download and transmit" measure in stage 2 is a leap from previous requirements. Stage 1 included a measure centering on providing patients online access to their records, but it was an elective "menu" item that could be deferred. It was one of the most frequently deferred items of stage 1, Bechtel says.

The stage 1 measure required providers to allow patients the ability to view information online, through a portal or similar software, but providers could also give patients electronic copies of their records on jump drives and compact discs. The stage 2 requirement bumps this measure to "core," or mandatory, and adds the requirement that patients be able to download and transmit their health records in addition to viewing them online.

"You could transmit information to another provider and thereby begin facilitating care coordination on your own as a patient," Bechtel says.

This functionality is what patients have been requesting for years, according to Bechtel, and has the ability to vastly change how patients interact with their providers and their health information.

"When we talk to patients and families, over and over again they tell us that their top two problems in the healthcare system are around coordination and communication," she says. "The view, download, and transmit capability is really going to be a huge step forward."

If the function is adopted by a large number of providers, patients will be empowered to use their information in new ways. Computer applications for leveraging health information in the pursuit of improved care will explode in the marketplace, Bechtel predicts.

"I think we are going to see applications doing things we haven't even thought of yet," she says. "So not just letting me track my progress in losing weight or quitting smoking, but developing a collaborative platform for providers and consumers to collaborate on care."

HIM has a large role to play in fulfilling this measure, including helping set up and securely run an electronic record portal, ensuring EHR systems contain the capability for accurately collecting patient records for use in the portal, and revamping record workflow processes to ensure records are ready for patients within the measure-required timeframes.

While facilities with an advanced and well-tested EHR might not have trouble meeting these requirements, smaller or less health IT-experienced providers may run into issues, according to Melissa Martin, RHIA, CCS, chief privacy officer and director of HIM at West Virginia University Hospitals.

Four-Stage Patient Engagement Framework

This document outlines the patient engagement aspects providers should offer patients through the EHR and the three stages of meaningful use-step-by-step, piece-by-piece. The National eHealth Collaborative developed the framework to help healthcare systems assess their patient engagement readiness. Currently in draft form, NeHC plans to adapt the framework into a readiness tool that can be used by healthcare stakeholders to promote collaborative patient care.

Inform Me Give me information	**Engage Me** Inform me and...	**Empower Me** Inform me, Engage me, and...	**Partner with Me** Inform me, Engage me, Empower me, and...
Emerging EHR Patient Education for Every: • Care testing • Medication prescription • Procedure/ Treatment Information for Convenience: • Maps and directions • Services directory • Physician directory • Classes schedule Forms to Print: • HIPAA • Insurance • Advance directives • Informed consent e-Tools: • Symptom checkers • Health encyclopedia • Wellness guidance • Prevention	**EHR: Meaningful Use 1 Certified** Patient Access to Records: • Test results • After-visit summaries • Medication records Patient Reminders for: • Preventive services • Follow-up appointments Patient-Generated Data: • Care experience surveys • Symptom assessments • Self-management diaries Administrative Tools Online: • Patient profile • Register or pay a bill • Register for classes • Email customer service • Schedule a clinic appointment e-Tools: • Pregnancy tracking • Fitness tracking • Healthy eating tracking • Social media links (non-PHI)	**EHR: Meaningful Use 2 Certified** Interactive Tools Online: • Download my record • Transmit my record • Patient-generated data integrated to EHR: Patient Response Quality Improvement: • Quality and safety reports • Patient ratings “Inter-grated” Records: • Summary of care • Referral coordination • Multiple clinician records • Video and photo integrated e-Visits: • Care management • Virtual coaching • Nurse online • Secure messaging Forms Online: • Record correction requests	**EHR: Meaningful Use 3 Certified** Shared Decision Making with Response in the Clinical Record: • Medication decisions • Medical test decisions • Surgical decisions • Care plan decisions • Informed consent/choice Interactive Tools Online: • Care plan management • My wellness plan • Advance care planning • Coordination of care across systems “Extra-grated” Records: • Public health integration • Payer integration • Holistic record, all providers • Registry integration • Preference-sensitive care team decision tools • Long-term care Seamless Integration for All Systems: • CCR updates all participating EMR • EMR updates all CCR • Advanced patient privacy functions e-Tools to Help the Team: • Transitions of care • Condition tracking • Home/Telemetry

	Forms Online: - Records request		- Condition self-management tools - Social media (PHI integrated) Analytics/Quality: - Patient-specific predictive modeling - Patient-specific care coordination review - Patient accountability scores
Desktop…	**and Web…**		**...and Mobile**
Source: National eHealth Collaborative, 2012.			

Faster Copies of Records

The “view online, download, and transmit” measure also comes with a time requirement. Participating hospitals would need to provide patients with online access to a determined set of health information within 36 hours of discharge. For physicians, they must provide access to information within four business days.

This requirement would impact HIM professionals’ workflow-specifically, the processes for assembling and approving health records.

Some healthcare stakeholders have said the timeframe called for in the stage 2 proposed rule is too short, and that certain pieces of information just won’t be available for uploading to a portal in the time allotted.

“Sometimes the record is not complete upon discharge even if it is an electronic record,” Martin says. “And then you are met with the challenge of ‘Do you then make the information available to the patient if it hasn’t been signed off by a physician?’”

This concern was raised by the American Hospital Association, who said in their comment letter to the Centers for Medicare and Medicaid Services (CMS) on the stage 2 proposed rule that the timeframe for providing patient records should be pushed out to 30 days to allow ample approval and processing time. While ONC develops the meaningful use program, CMS facilitates provider participation and hands out the incentive payments.

The AHA also stated that most hospitals didn’t have the capability to offer electronic, online portals to health information, and that the stage 2 measures were too ambitious for many providers.

Though meeting the time requirement could mean a change in record processing on HIM’s side, the care benefits outweigh the administrative hardships, Bechtel says.

Starting in October, Medicare will begin issuing financial penalties for patients who are readmitted within 30 days of an initial hospital discharge. One of the biggest reasons for readmissions is that patients don’t receive the follow-up care they are instructed to undergo. Allowing patients the ability to review and transmit their records to caretakers or providers could quickly lead to better treatment following their discharge, and therefore a lower readmission rate, Bechtel says.

This saves hospitals from financial penalties and also leads to cost savings through healthier patients.

“You have got to get it into the hands of patients and families instantly and you have got to get it into the hands of primary care providers because 30 days is a very short window and information is really key to keeping them out of the hospital,” Bechtel says.

The Health IT Policy Committee understood that workflow changes would be necessary to meet this record release measure, Bechtel says. But it was clinicians on the committee who advocated for the 36-hour timeline, not the patient advocacy community.

Just what health records providers will be required to disclose within the measure deadline has not yet been determined, though the final rule is expected to require a general summary of health records connected to the latest patient encounter. The entire patient's medical record would not be required, but instead a collection of key information such as labs, problem lists, medications, and allergies, Bechtel says.

AHIMA supported the 36-hour and four-day timeframes, though it did acknowledge some logistical concerns, specifically the effect the timing would have on the assembly and analysis of patient records and the process to ensure the "correct results on the correct patient have been confirmed," according to AHIMA's written comments to CMS.

The biggest problem in meeting the timeline would occur at those facilities with a hybrid paper-electronic record where staff still scan parts of the patient record, Martin says.

Likely, HIM professionals could get the record ready for release within 36 hours of discharge with the modification of a few workflow processes-some involving speeding up the physician documentation and review sign-off processes, Martin says.

Just because information is being released through a portal doesn't mean standard HIM practices wouldn't apply, Martin says. When working with information in their patient portal, West Virginia University Hospitals has had to make some difficult decisions regarding when and if to release certain information. Martin says the decision is made based on steadfast and tested paper processes.

"We always frame it this way in our department when someone asks, 'Well, should we release it to the portal?" she says. "If (the patient) comes to the front window of our department, which is where our release of information staff sit, and asks for their record, we would release it to them. So why wouldn't we release it to the portal?"

That said, there are still instances where Martin's staff has held off on posting sensitive health information to the portal until a caregiver has had the chance to review it and analyze the impact on the patient. The proposed rule is unclear how providers should handle these situations.

Spotlight: Consumer/Patient Engagement Power Team

ONC formed the Consumer/Patient Engagement Power Team to assess the standards and certification criteria included in the various "meaningful use" EHR Incentive Program's proposed rules. The team, chaired by Leslie Kelly Hall, senior vice president of policy at Healthwise, provides recommendations for strengthening the patient engagement components of the proposed rules.

The Power Team's most recent goals are to ensure the program's stage 2 standards meet current opportunities for engaging patients and their families in their care, and to anticipate future policy and technology that can encourage patient engagement.

Below are four questions with Hall about her team and its work on making healthcare more patient-centric.

What is one aspect of the stage 2 meaningful use standards the Consumer/Patient Engagement Power Team contributed to?

One specific principle provided by our patient participants emphasized the patient as a contributing member of the care team. Two major pieces arise from this position: the need to view, download, and transmit information and ensuring that information is usable by the patient.

What do we mean by "usable"? Patient-specific links to education; plain language explanations; the ability to transmit patient data in a secure way; and that necessary metadata is included to make the information actionable.

Why are the patient-centered aspects of the proposed stage 2 measures important?

Putting greater emphasis on the voice of the patient is key to reforming healthcare. There is tremendous momentum for patient engagement within the (meaningful use) requirements. Think of these recommendations as signals for future requirements. “View, download, and transmit,” for example, has significant potential to inform patients and their designees about their care.

What impact will these measures have on patients?

Absolutely there is great impact. But this is a first step. Patients as contributing care team members, and not solely an object of care, is a paradigm shift. This shift is necessary to transform care. We all want better outcomes. Health information technology can help patients do as much as they can for themselves, get the care they need, and say no to the care they don’t need.

What piece of criteria from the stage 2 proposed rules do you feel is the most “patient-centered”?

Today our readmission rates are all over the map. However, what is common is that as much as 40 percent of the unnecessary readmissions resulted from patients not knowing how to care for themselves or how to follow-up with (providers) after hospitalization. Making sure that the patient knows what care they have had, how to care for themselves, and what to do next seems fundamental to patient-centeredness, and meaningful use advances this.

Tracking Portal Use

Another aspect of the “view online, download, and transmit” health information stage 2 measure is the requirement that more than 10 percent of all unique patients seen by participating physicians and hospitals must access their information at least once during the reporting period. This element was added by ONC to ensure providers promoted to patients the benefits of accessing their information through the portal, Bechtel says.

“We know that whether or not patients use online access is highly dependent on the work that the clinical team does to encourage that use,” she says. “It doesn’t make sense to establish a criteria and just sort of hope that it gets used, when the use of it is really critical to delivering value to both patients and providers.”

In its comments to CMS, AHIMA disagreed with the inclusion of the 10 percent use measure, stating that providers should not be punished if patients refuse or are unable to use portal technology.

Martin agrees, saying it is not fair if hospitals and physicians are penalized for patient refusal to take advantage of online record access. However, at Martin’s facility, meeting a 10 percent quota likely would not be a problem-West Virginia University Hospitals’ portal is very popular with patients.

But that might not be the case for all providers, especially those physicians who are providing clinical summaries to patients after each office visit-another measure called for in stage 2 of the program. Some people who receive these summaries might feel they don’t need to visit the portal, which would lead to lower use numbers, Martin says.

The requirement for patient portal engagement is no different than other quality measures that hinge on patient involvement, Bechtel says, like measures calling for patients to change habits in order to improve their blood pressure or blood sugar.

Also, the Health IT Policy Committee felt it wouldn’t be difficult for providers to meet this measure. According to the February 2012 survey “Making IT Meaningful: How Consumers Value and Trust Health IT,” conducted by the National Partnership for Women & Families, 48 percent of patients who have online access to their health information accessed it three times a year or more.

“This is not hard to do if you implement it in a patient-centered way and if you work with patients and families and encourage their use,” she says.

EHR Incentive Program Payments

the more providers take part in the EHR Incentive Program, the faster patient-centric use of health IT will spread, patient advocates say. Below, a summary of the Centers for Medicare and Medicaid Services' stage 1 meaningful use program participants and payments, as of May 2012.

	Providers Paid Program-To-Date	**Amount Paid** 2011 Program Year	**Amount Paid** 2012 Program Year	**Amount Paid** Program-To-Date
Medicare Eligible Professionals	**58,530**	**$955,483,305**	**$39,510,000**	**$994,993,305**
Doctors of Medicine or Osteopathy	51,879	$851,026,570	$36,414,000	$887,440,570
Dentists	49	$736,280	$18,000	$754,280
Optometrists	2,394	$36,719,687	$846,000	$37,565,687
Podiatrists	2,955	$50,464,968	$2,196,000	$52,660,968
Chiropractors	1,253	$16,535,799	$36,000	$16,571,799
Medicaid Eligible Professionals	**40,700**	**$767,008,220**	**$84,907,974**	**$851,916,194**
Physicians	30,348	$575,368,384	$57,834,057	$633,202,441
Certified Nurse-Midwives	893	$17,425,000	$1,462,000	$18,887,000
Dentists	2,243	$38,207,500	$9,273,500	$47,481,000
Nurse Practitioners	6,865	$129,462,336	$15,552,167	$145,014,503
Physicians Assistants	351	$6,545,000	$786,250	$7,331,250
Eligible Hospitals	**3,150**	**$2,994,558,627**	**$730,120,471**	**$3,724,679,098**
Medicare Only	89	$98,795,824	$34,669,737	$133,465,561
Medicare/Medicaid (Medicare Payment)	958	$1,241,363,021	$511,747,787	$1,753,110,807

Medicaid Only	60	$125,235,521	$11,911,855	$137,147,376
Medicare/Medicaid (Medicaid Payment)	2,043	$1,529,164,262	$171,791,092	$1,700,955,354
Medicare Advantage Organizations For Eligible Professionals	**11,117**	**$189,436,486**	**$0**	**$189,436,486**
Total	**113,497**	**$4,906,486,637**	**$854,538,446**	**$5,761,025,083**

Source: Centers for Medicare and Medicaid Services.

Secure Messaging Requirement

Another patient-centric feature that could raise HIM interest is the stage 2 secure messaging measure. This calls on providers to allow patients the ability to electronically message their physicians to ask questions about their health information or care. Typically this would be done through a feature in the patient portal system and would require strict privacy and security functions in order to first transmit and then store the resulting personal health information.

“Secure messaging is a great way to open up that communication beyond just the seven-minute office visit or the five-minute phone call,” Bechtel says.

HIM professionals would need to determine whether these exchanges are part of the formal health record, and what retention policy should be followed for saving messages.

Standards have been developed for secure messaging that can be utilized for most systems, Bechtel says.

Summary of Care Transferred

Another patient engagement measure that impacts HIM professionals centers on the transfer of records.

The proposed rule states that hospitals must provide care summary records for 65 percent of patients transferred to another setting of care. This is up from 50 percent in stage 1, and the measure has moved from elective to required in stage 2.

If widely adopted, the measure would mean more electronic record assembly and transmission by the HIM department. But it is for a great patient cause, Bechtel says.

“One thing (focus groups) say is ‘I just want my doctors to talk to each other,’” Bechtel says. “It was that simple, and for some patients they are tired of showing up at another doctor’s office when they are referred and having the care team ask yet again ‘What are you here for?’

“There is an expectation that the information will follow them… and that just doesn’t happen today.”

Another measure calls for physicians to provide clinical summaries to 50 percent of patients within 24 hours of their visit.

While record transfer processes would need to be adapted at most facilities, HIM professionals likely wouldn’t have a problem meeting this measure, Martin says, if they had an EHR with health information exchange capabilities or the provider linked to their regional or state health information exchange (HIE).

AHIMA agreed in its comments, writing that while it holds some concern for the HIE aspects of the meaningful use program, it supports "CMS' belief that meaningful use of electronic health records must involve ongoing exchange of health information for care coordination."

Stage 3 in the Works

Work has already begun on the third and final stage of the meaningful use program, and it is on track to be the most patient-centric yet. Workgroups like ONC's Consumer/Patient Engagement Power Team and the Health IT Policy Committee have begun discussing their wish lists for stage 3. The stage 3 program will open up to providers in 2015.

"Stage 2 is the beginning of interconnectivity and interoperability with the patient, and I think stage 3 is what is going to be the main sort of leap to where the patient is really involved with their care," says John Derr, R.Ph., a strategic clinical technology consultant with Golden Living, LLC and a member of the Consumer/Patient Engagement Power Team.

Stage 1 focused on capturing data electronically and implementing health IT. Stage 2 will focus on care coordination and information exchange, and stage 3 is designed to use the data and functionality of an EHR to improve health outcomes for patients, Bechtel says.

An example of patient-centric measures Bechtel would like to see in the program's final stage is more use of patient-generated data, either through telemedicine devices or the integration of patient-submitted medical records. Another wish: more collaborative care coordination between doctor's offices, hospitals, and other care providers who are taking part in the meaningful use program, she says.

"The notion of using information technology as a platform for interactivity and collaboration in a really dynamic way, to me, is very exciting," Bechtel says.

Change in Mentality Needed

It will take more than just the implementation of health IT to make the US healthcare system patient-centric. A vast change in the way providers view patients is necessary.

"This is a culture change. It has been that healthcare was a mystery. The physician didn't really share information with the patient, and now we are saying that healthcare can't be a mystery, in fact the informed patient is part of the culture change," Derr says. "We have to get the physician to understand that the patient wants to have this information to start controlling their own health, then we have to train the patient to want this information."

Patients need to access and use their health information in order for health IT to successfully transform and improve healthcare, Derr says. This will be reflected in meaningful use stages 2 and 3 as the exchange of health information through HIEs and portals will give patients easy access to information and pull the cloak back from their care processes.

Some providers don't trust patient-submitted information or information transferred from other care facilities. This needs to change, Bechtel says. After all, most information comes from the patient anyway through "the dreaded clipboard."

"We really have to get past this notion that patients are not reliable sources of their own health information," she says. "They are the only ones that are present at every single doctor's office and specialist and hospital visit. And they are the ones with the most vested interest in making sure that their care is safe, effective, and coordinated."

Health IT Fosters Patient Partnerships

The benefits of providing patients electronic access to their health records through an EHR go beyond clinical treatment. The move actually impacts patient perceptions of care and health IT.

The National Partnership for Women & Families' February survey also showed that patients with online access to their health records rate the value of EHRs twice as high as those without electronic access. Also, those with electronic access had higher trust in physicians to protect their health information.

Seeing electronic records firsthand leads to more transparency with patients and therefore more trust in EHRs.

“I think for HIM professionals who care deeply about trust in the integrity and security of health information, that is a really important finding,” Bechtel says. “They see (the EHR) and it’s not a mystery anymore.”

Getting patients better access to their records has been a priority for AHIMA and many of its members. Faster access to records could actually make work easier for the HIM department, Martin says.

“The faster we can get patients access to their information, especially those who really want (it), the better their overall care and treatment will be and the less stress on the HIM department,” Martin says. “Honestly, if we can get that information out to the portals quickly then I don’t have to have eight people working in my release of information area kind of just putting out fires.”

While stage 2 does step up HHS’s call to providers to make care more patient-centered, there is still a far distance to walk until the goal is met, Derr says. The program is still about implementing health IT to reach incentives, but by stage 3 Derr hopes it will transition to using health IT for measured quality improvements. Only then will the US healthcare system recover from its debilitating illness.

“(Stage 2) was a baby step. But one thing that is becoming more set now is there is meaningful use the noun, which is the incentive program, and then there is meaningful use the verb, which is providing better care,” he says.

Reference

National Partnership for Women & Families. “Making IT Meaningful: How Consumers Value and Trust Health IT.” February 2012. www.nationalpartnership.org.

Chris Dimick (chris.dimick@ahima.org) is editor-in-chief of the *Journal of AHIMA.*

Article citation:
Dimick, Chris. "Treating Healthcare with Health "I"T" *Journal of AHIMA* 83, no.9 (September 2012): 30-37.

Driving the Power of Knowledge