The State of the Electronic Health Record

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Perhaps the biggest news in electronic health records recently is that the Meaningful Use program will be discontinued. However, this is not such a big change as it suggests, except for giving us a whole new set of government acronyms to learn.

Last January, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Part of this act was the repealing the Sustainable Growth Rate (SGR) formula that required Congress to pass a "doc fix" bill each year to prevent a progressive cut in Medicare reimbursements. While CMS reimbursement has been tied to EHR adoption since the HITECH act passed and set a goal of 100% EHR adoption by 2015, MACRA tightened the bond between EHR use and Medicare reimbursement. Part of the change to the new system also included giving providers and state Medicaid agencies until 1/18 to comply.

Currently, there are three separate Medicare quality programs: the Physician Quality Reporting System (PQRS), the Value-Based Modifier Program, and the Meaningful Use (MU) Program. The new formula for reimbursement will combine these three programs into one Merit-Based Payment System (MIPS), which will start accruing data in 2017 for impact on 2019 reimbursements for eligible clinicians. The four categories to rate performance are (Wynne, Pahner and Zatorski):

- Quality, which will constitute 50 percent of total score
- Advancing Care Information (ACI), which will constitute 25% of total score
- Clinical Practice Improvement Activities, for 15% of total score
- Cost or Resource Use, calculated based on Medicare claims data, 10% of total score

DATA ANALYTICS

The electronic health record is allowing data analytics that can really be seen in this payment reform. Medicare is the most visible, but many payers are using this aspect of electronic health record information because they have access to multiple settings, which can help them identify gaps in patient care. For instance, because payers have access to patient information from labs, pharmacies and multiple doctors' offices for a single patient, they may be able to identify a patient with a chronic condition who may not be filling medication in a timely manner or may be skipping regular, required lab tests.

ICD-10 data analytics are expected to be even richer because of greater code specificity, but this hasn't fully been explored yet because coding is not yet consistent and, in some cases, hasn't been fully implemented.

PATIENT PORTALS AND SECURITY

Meaningful Use Stage 3, which is now being rolled into MACRA, called for fully functional patient portals, and that is still a goal of the new system. All certified vendors include a patient portal system, and many physician offices have added this functionality to their EHRs. However, installing a patient portal and getting patients to use it are two different things. While providing information in the patient portal for 80% of the patients within 36 hours may be a realistic goal, the requirement that 10% of

unique patients seen in a year must engage with the portal is a stretch, even though it doesn't sound like much (Gottlieb and Weinstein).

There are quite a few boundaries to widespread use of the portals, ranging from apathy to inability to access the portal due to lack of technical knowledge or portals that have complicated sign-on requirements. This particular part of MU may be the most difficult to implement because it relies on a population that the provider can't directly control. It will take some creative techniques, including liaisons, training, and advertisement to encourage patients to participate.

Security is always on the minds of both clinicians and patients when it comes to electronic health records, which is also part of the issue surrounding patient portals. 2015 was called the year of the Health Data Breach. More than 200 breaches that affected 500 or more people (the bar for required reporting of a breach) were reported, and the top five alone affected more than 108 million people (Oncea). According to the Identity Theft Resource Center, "The healthcare sector was single-handedly responsible for 16.6 percent of the 245.2 million records exposing individuals' SSNs—offering low-hanging fruit to identify thieves…" (Identity Theft Resource Center).

The trick with patient portals, and all functionality of an EHR is, of course, how do we provide simple access to those who should have access while locking out, without fail, those who shouldn't? With wearable "health" devices and people accessing the Internet through multiple devices, such as tablets and cell phones, the entry points for valid consumers of healthcare data can be vast, and every entry point is a possible crack for those seeking to steal a medical identity.

INTEROPERABILITY

Electronic Health Record adoption's Holy Grail is, of course, interoperability. And no matter what you've heard, it's not here yet. Lack of true interoperability is what keeps EHRs from being the boon to patient health and safety and the magic pill for real improvement in population health. Without this functionality, EHRs are little better than electronic versions of paper records. Well, OK, they deserve a little more credit than that. Now that the drama over ICD-10 conversion is over, the focus on EHRs is starting to come around to fixing the problems surrounding patient portals, clinical decision support, and yes, interoperability.

As Healthcare Documentation Specialists know very well, standards will fix a host of problems we still have with EHR implementation. In January 2015, the Office of the National Coordinator for Health Information Technology (ONC) unveiled an Interoperability Roadmap, and the American Health Information Management Association (AHIMA) has been working with Integrating the Healthcare Enterprise (IHE) to release a joint white paper called "Health IT Standards for Health Information Management Practices." IHE is "…an international initiative to promote the use of standards to achieve interoperability among health information technology (HIT) systems and effective use of EHRs (Butler 19)."

AHIMA believes there are four essential components of an interoperability framework: functional, technical, workforce development, and semantic. Functional interoperability supports information governance initiatives, technical interoperability supports HIT infrastructure, workforce development is the support of a workforce with eHealth skills educated about standards, and semantics deals with clinical documentation improvement and standards.

Semantics are words. This is how we, as humans, express ourselves. Sometimes those words hold ambiguous meanings. That's the beauty of language and what allows us to play with it. In healthcare, if we are to maintain patient safety and allow anyone who views a patient's record to use it to treat a patient, there can be no ambiguity. And the content must be clear enough to be interpreted in another language, as health information becomes able to be shared internationally.

SNOMED-CT (Systemized Nomenclature of Medicine-Clinical Terms) is one approach to semantics, and the one most often agreed upon for use in standards development. It is what is known as

a concept-based approach to standards. This means that every clinical word is assigned a concept that can be translated (interpreted across languages and machine-readable without losing meaning. Several words may apply to each concept, and all clinical terms are included in the comprehensive set of over 300,000 concepts and more than 1 million terms (Bhattacharyya and Warner).

The paper AHIMA and IHE wrote outlines health information management (HIM) needs and how to align them with the standards that exist, as well as ways to make HIT products use standards to support HIM best practices. Most importantly, HIM professionals must be aware of standards so they can implement them when the HIT products become capable of capturing them. EHRs, in order to provide efficient healthcare support, must provide records in a way that is adequate, accurate and accessible in a timely manner (Bhattacharyya and Warner). HIM professionals are equipped to perform decisions and tasks necessary to make EHRs fully functional, reliable records that have the power to change the effectiveness of healthcare.

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