One of the goals of the HITECH act and Meaningful Use is to require vendors to certify that their software meets a minimum standard (certification) and to enable the sharing of data between systems. While these goals are being met, what also has happened is that the HIS vendors are using the certification rules as a way to prevent third party competition. They are using the rules to create monopolies in their market.

How could this be happening? Let's say hypothetical HIS vendor MediSomething sells Admitting, Medical Records, Abstract, and Order Entry modules. If they certified each module separately, then a hospital would be able to buy any or all of these modules and use them for certification. However, if HIS vendor MediSomething only certifies all four modules
However, if HIS vendor MediSomething only certifies all four modules together, and the hospital wanted to use the certified Order Entry module from vendor EpiOrder, then the hospital would need to buy all four modules from MediSomething and then one module from EpiOrder. Yes, that means that to use the certifications, the hospital would need to buy the Order Entry module from MediSomething, never install it, never use it and then buy the Order Entry module from EpiOrder. This is crazy! It's bad for hospitals, bad for third-party vendors, bad for competition, bad for innovation and leads to wasted dollars. What if the Order Entry module from EpiOrder costs half of what the Order Entry module from MediSomething costs or has much better functionality? This is a bad policy for our industry.

I discussed this publicly at the Health 2.0 conference last fall in San Francisco with Farzad Mostashari. He was clearly aware of the issue but really didn’t want to talk about solutions. What’s the answer? Bill O’Toole, former MEDITECH counsel, has suggested a simple solution. His idea is that if a vendor sells any module as a stand alone, then it should be required to be certified separately and not just with a package of modules. I agree. This is a real serious problem for many hospitals today and needs to be addressed immediately. Of course, I can’t see the HIS vendors complaining about it. What they are doing is wrong and encourages the waste of taxpayer dollars for their financial gain. What do you think?

eConnecting with Consumers

Mark Johnson, RN-BC, MHA, CPHIMS

We just wrapped up the HIMSS 2013 annual conference in New Orleans. What an exciting time for healthcare IT! There is a movement towards patient-centric care and healthcare IT is leading the way. Despite the circus tent feel of the exhibit hall and frenetic pace of the conference attendees, you could sense a change afoot. Signs that patient-centric care must be embraced could be heard in Dr. Eric Topol’s keynote address challenging the status quo of the "physician knows best" approach, seen in the Regina Holliday Walking Gallery paintings on the backs of attendees, experienced in the Patient Engagement forum, followed on Twitter via the #PatientEngagement Tweetup, read in the new book Engage! Transforming Healthcare through Digital Patient Engagement or by the fact that HIMSS dubbed Tuesday "Patient Engagement Day." There was a palpable push to make attendees realize that patient engagement must be part of the solutions that providers and vendors are offering.

A few patient engagement announcements at one HIMSS conference will not make any difference without action. We have a long way to go before realizing the true value of making patients and caregivers the primary drivers of healthcare. That’s one of the reasons I joined the eConnecting with Consumers committee at HIMSS last year. The committee has worked to promote the paradigm shift towards the patient and caregivers, following their mission to enable providers with the toolset necessary to successfully engage their patients throughout the care cycle, not just at the point of billing. With ACOs and HIEs dominating the future reimbursement landscape, providers without the tools to engage patients will be left behind. In 2013, our committee plans to continue producing podcasts and blog postings about how providers can use the tools available now and promote emerging and disruptive technologies.

Another role I have is on the Social Media Taskforce responsible for exposing providers to these tools via our social media channels. Our committee was instrumental in getting the new book Engage! Transforming Healthcare through Digital Patient Engagement written and published in time for the annual conference. Our committee is also working to promote better patient-facing health IT solutions that incorporate user interfaces that are intuitive
and easy to use. Our policy advocacy taskforce is helping make sure our
government regulations are not a hurdle to patient engagement. I am
honored to have the chance to work with some of the smartest people in the
industry on this committee; it is a talented group of clinicians, IT leaders and
patient advocacy champions doing great work for HIMSS members via the
eConnecting with Consumers committee.

I am proud of the work Iatric Systems does to help facilitate patient
engagement for our customers. However, there is a lot of work ahead for
everyone involved. For Iatric Systems, the ability to enable providers to truly
integrate patients and families into their care is our ultimate goal. Our patient
portal, PtAccess, is just one tool that helps bring patients and caregivers
into the driver’s seat. By providing the most comprehensive integration to
our customers, we can make patient-centric care happen. It won’t be easy,
but the rewards will be for everyone. I look forward to what the future brings
for true patient-centric care and how healthcare IT and Iatric Systems will be
a part of the solution!

How to Use Technology to Prepare and Meet the Deadlines for Meaningful Use 2014

To meet Meaningful Use, you need to make plans and decisions now. The
issue is determining exactly how you can meet the requirements by 2014. In
our first document, we’ve worked together to create a guide to look at
specific adjustments required for Stage 1, and how these adjustments impact
your facility. It also addresses the preparations required for Stage 2 and 2014
Edition EHR Technology. To help with your planning, it includes a 9-point
checklist outlining how you can create a model for successful attestation in
2014.

The second part of the guide reviews each Core and Menu Set Objective,
including details on each measure, key areas to remember in your attestation
process, and a glimpse into Stage 3 measures. Planning ahead for Stage 2
Objectives will help you attest successfully regardless of your timeframe.

Read this two-part guide, How to Prepare For and Meet the Deadlines for
Meaningful Use 2014, to get the background, information, and technology
knowledge you will need for your planning and implementation process.

Download Part One: Preparing for Meaningful Use 2014
Download Part Two: Understanding Stage 2 Meaningful Use Core and
Menu Objectives

Privacy and Proactive Compliance

James Lawson and Michael ‘Mac’ McMillan

Healthcare institutions are at greater risk of falling short on patient privacy
compliance than ever before. Both the movement toward a complete
electronic health record and constant changes to patient privacy regulations
are key challenges for everyone in healthcare IT.

Maintaining compliance is difficult for many reasons, such as changing
regulations, manual processes, and limited resources. At the same time,
hospitals face severe penalties for breaches, including financial, criminal, and
harm to reputation. Learn more about how hospitals can maintain compliance with patient privacy laws by implementing an automated auditing system, and what the best practices are for breach incident tracking.

This featured article from Journal of Healthcare Information Management (JHIM), reviews the changes to the Health Insurance Portability and Accountability Act (HIPAA) mandated by the American Recovery and Reinvestment Act (ARRA) and the Health Information Technology for Economic and Clinical Health Act (HITECH), including breach notification rules, penalties, Meaningful Use Stage 2 rules, and the Office for Civil Rights (OCR) HIPAA Audits that started in 2011.

**Download Protecting Patient Privacy in an Ever-changing Environment**

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**Compliance Corner**

Kay Jackson, Manager, Software Certification, and Compliance

**What is the story about Patient Portals?**

This is a question I am asked several times a week. I thought I would summarize the questions I hear most often together with my research. Keep in mind that no matter what reporting period your hospital will be tracking on or after October 1, 2013, a portal solution will be required for your CMS single quarter FY 2014 MU Attestation.

Remember, the Meaningful Use requirement states *unique* patients discharged from the *inpatient or emergency* departments during the EHR *reporting period* have their information available online within *36 hours* of discharge. Your facility needs to prepare for the portal selection process and choose the best portal for your community.

The first step for portal success is to create a marketing plan for adding a portal for your community patient engagement needs. Think of the portal in terms of the advantages it will provide your patients, and not just something you must do to meet Meaningful Use.

Your core team for the portal selection process should include team members from Marketing, clinical areas, Access, physician staff, medical records, CIO, IT, CFO, and PFS. Plan how your whole organization team members will view adding a portal; educate those team members of the value the portal will provide so they can build awareness as well.

Create a workflow plan on how your team will offer access to the portal for both current and past patients, and the process for tracking the access provided. This access provided count is necessary for your team to calculate your percentage for Meaningful Use. In addition, retain that access provided query for returning patients so your team can note access has been provided and encourage adoption and continued reliance on the portal for their complete health information.
Consider the enrollment process during registration, since that is usually the first interaction with your patient. You can verify the identity of the patient prior to creating the access code needed to enable the patient to create a portal account. The marketing plan needs to include how you will build adoption of the portal and continued use for the foreseeable future. Some ideas for marketing your portal include:

- Set up Health Fairs right before and after the portal is live to sign up patients
- Create a policy that states NO ID, no portal access code issued for that patient
- Include the process for parental and custodian access in your organizational plan

Another suggestion is to consider including a portal engagement consulting team that has the knowledge to help you create and market the portal adoption for your community needs and ensure the adoption needed not only for Meaningful Use but to help the patient engage in their own health. Branding of the portal with logos and other items also fosters the united front between patient and hospital.

Next month I will address how patient convenience within the portal can drive adoption and more.

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**Report Writing Tips**

**Joe Cocuzzo, Senior Vice President – Report Writing Services**

**Just Curious: ICD-9 vs ICD-10 – eh?**

As US hospitals are beginning the process of migration from ICD-9 to ICD-10, I wondered how the much larger ICD-10 dictionary might affect the diversity of coding diagnosis and surgical procedures.

Since Canada implemented ICD-10 in 2001, we can visit our neighbors to the North and see how their coding changed as they converted to the new schema.

The first step is to set up a report to check all "IN" patients for a discharge date range, in a report that has no detail region:

Then we add a computed sort field where we will group patients by the calendar year of their discharge date. The $4 takes the YYYY off of YYYYMMDD discharge date.
We select all the "IN" patients for a dis.date range:

We write a small "detail" macro to execute each record to loop on the diagnoses and operative procedures to create some temporary lists of unique diagnoses and procedures, both for the entire report range, and for each year:

This code makes a list in slash of each code, in four different globals:
/DX[dx] for all dx codes
/PROC[proc] for all procedure codes
/DXY[year,dx] for diagnoses by year
/PROCY[year,proc] for all operative procedures by year

For example, /DXY[dx] looks like this (note the leading alpha in the ICD-10 codes):

To put totals on the report, we can use a computed field to loop on the sort value in the TK region and count the number of diagnosis and procedures for the year. By using the + operator in a "DO" loop and then incrementing the variable TOT by 1 for each unique code in our list, we can count the unique codes per each year in the TK1 region.
The fields in the TR region loop on /DX[dx] and /PROC[proc] to count codes for the entire report date range.

We also create some fields to compare the 1999 patient count, unique diagnosis count, and unique procedure count to the values for each subsequent year. To do this we use a TK1 macro to loop one time thru the values for 1999 to provide a diagnosis count and procedure count that we can then use as the denominator to calculate some percentages.

The macro looks like this:

Since ICD-9 has 13,000 diagnosis codes and ICD-10 has about 68,000, and ICD-9 has 3,000 procedure codes and ICD-10 has about 87,000 codes, we would expect to see more unique codes after the transition from ICD-9 to ICD-10.

In a completely non-scientific survey of two Canadian sites, we see only a slight increase in the diversity of codes between 1999 and >2001. Here is the first hospital:
Here is a second hospital:

<table>
<thead>
<tr>
<th>Discharge Year</th>
<th>Pts</th>
<th>Des</th>
<th>OR Procs</th>
<th>Increase Since 1999 (ICD-9 Yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>1111</td>
<td>3018</td>
<td>847</td>
<td>100.00 100.00 100.00</td>
</tr>
<tr>
<td>2000</td>
<td>11384</td>
<td>2877</td>
<td>826</td>
<td>102.44 95.30 97.50</td>
</tr>
<tr>
<td>2001</td>
<td>11895</td>
<td>2591</td>
<td>844</td>
<td>107.04 85.88 99.60</td>
</tr>
<tr>
<td>2002</td>
<td>11671</td>
<td>2902</td>
<td>1445</td>
<td>105.03 129.20 170.60</td>
</tr>
<tr>
<td>2003</td>
<td>12129</td>
<td>2870</td>
<td>1123</td>
<td>109.15 95.00 132.50</td>
</tr>
<tr>
<td>2004</td>
<td>13688</td>
<td>2979</td>
<td>1112</td>
<td>123.18 98.78 131.20</td>
</tr>
<tr>
<td>2005</td>
<td>13667</td>
<td>3078</td>
<td>1070</td>
<td>122.99 101.90 126.30</td>
</tr>
</tbody>
</table>

A sample (MAGIC) report ABS.PAT.zcus.is.icd9 has been uploaded to our report library. Code for a Client/Server version would be identical.

Search our report library for more Report Writing tips:


Read Joe's blog posts at MEDI-Talk.

To subscribe for email notifications for new Report Writing classes, please follow this link:

For more information, please contact Karen Roemer at 978.805.3142 or email karen.roemer@iatric.com.
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Upcoming Events:

**MUSE Event**
April 3, 2013
Burke Rehabilitation Hospital
(White Plains, New York)

**HCCA Compliance Institute 2013**
April 20 - 24, 2013
Gaylord National
(National Harbor, Maryland)

**MD HIMSS Spring Educational Event**
April 25, 2013
Gaylord National
(National Harbor, Maryland)

**CHOP's 6th Annual Healthcare Informatics Symposium**
April 26, 2013
Sheraton Philadelphia Downtown
(Philadelphia, Pennsylvania)

**Montana HIMSS 2nd Annual Spring Convention and Tradeshow**
May 2 - 3, 2013
Crowne Plaza
(Billings, Montana)

**2013 International MUSE Conference**
May 28 - 31, 2013
Gaylord National
(National Harbor, Maryland)