Proactive Planning, Coordination, and Execution of Patient Education and Engagement Helps Hospitals Achieve Stage 2 Meaningful Use Compliance

Part two of a three-part series on patient education and engagement, their impact on improved clinical outcomes and patient satisfaction, and the connection to meaningful use requirements.

December 2012
By: Jodi DeMarco, Ph.D., Interactive Solutions Advisor, TeleHealth Services

The controversy around meaningful use options and proposed requirements has morphed from spirited debate to reluctant acceptance. Healthcare providers have weighed in with sometimes varying opinions over the many months since Stage 1 was rolled out. The Centers for Medicare and Medicaid Services (CMS) has reviewed input from all sides and affirmed its intentions for Stage 2 compliance. The resulting mandates reflect compromise in breadth and timing, and the healthcare world now has more clearly defined goals and a timetable for achieving compliance and meeting full reimbursement requirements.

Completing the Transition from Stage 1 to Stage 2 - Emphasis on Health Information Exchange

In the Stage 1 meaningful use regulations, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria. This original timeline would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013. However, CMS has delayed the onset of Stage 2 criteria. The earliest that the Stage 2 criteria will be effective for eligible hospitals is in fiscal year 2014.

Providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014. All other providers would meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year.

Stage 2 retains its core and menu structure for meaningful use objectives, although some Stage 1 objectives were either combined or eliminated. A majority of the Stage 1 objectives are now core objectives under the new criteria.

The stage 2 criteria emphasize health information exchange between providers to improve care coordination for patients. Although clinical quality measure (CQM) reporting has been removed as a core objective for eligible hospitals, all providers are required to report on CQMs in order to demonstrate meaningful use. Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way.

Eligible hospitals must report on 16 out of 29 total CQMs. In addition, all providers must select CQMs from at least three of the six key health care policy domains recommended by the Department of Health and Human Services’ National Quality Strategy. These include:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

That the final list includes these six domains is encouraging news. Each domain reflects areas already receiving significant attention and resources. One of the great things about most practitioners is that they don’t need mandates to do the right things, especially when it comes to clinical care and working in their patients’ best interests. That said, cost plays a huge factor in achieving compliance, especially when regulations require enormous capital outlays to achieve sophisticated electronic milestones, and when goals
involving consistency -- though paved with good intentions -- are extremely difficult to achieve.

Although there is consensus in the industry that working toward these CQMs is important and necessary, many go about it in their own way and at their own pace. Some hospitals have made enormous progress, integrating these efforts across multiple disciplines, setting ambitious patient education goals and dedicating resources to ensure consistent outreach and positive patient, family and caregiver engagement. One shining example is the work being done at University of Arkansas for Medical Sciences (UAMS), a health center with colleges of Medicine, Nursing, Pharmacy, Health Related Professions and Public Health; a graduate school; a hospital; a statewide network of regional centers; and seven institutes.

UAMS is the only adult Level 1 trauma center in the state. It has more than 2,800 students and 775 medical residents, and more than 10,000 employees, including approximately 1,000 physicians and other healthcare professionals. Barbara Brunner, RN, is the director of Patient and Family Centered Care for the hospital at UAMS.

“We have integrated healthcare teams taking care of our patients, essentially a comprehensive nurse/clinician partnership that targets educational planning, implementation and measurement, encompassing all aspects of care, including emergency, inpatient, medication and discharge,” Brunner says.

Staff, Brunner explains, practice a “teach back” method to ensure patient understanding of directions and information pertaining to their health and care, particularly involving post-discharge requirements. “Our goal isn’t only to determine what they know, but as importantly, what will that patient do when he or she goes home,” says Brunner.

Empowered Patients and Caregivers Improve Outcomes and Satisfaction

To that end, UAMS uses a customized interactive patient engagement system with wellness programming that delivers customized, condition-specific education care plans to the bedside television. Following viewing, the patient responds via an automated survey conducted over the telephone to simple “yes/no” questions about their care. This feedback is then reviewed by their care team, who then personally consult with the patient to reinforce care and compliance requirements.

Additionally, families and caregivers are invited to attend classes which teach them how to deal with issues and tasks such as IVs and central line maintenance, pre- and post-natal care, diabetes, wound care, pneumonia, congestive heart failure, stroke care and more.

“Our goal is to integrate the patient, along with his or her family and related caregivers, in the recovery process to plan and adjust to life outside of the hospital,” says Jamie Peacock, director of Quality Programs in Nursing. “Additionally, using our patient engagement system we conduct comprehensive satisfaction benchmarking through surveys to ensure that we’re hitting our marks and always raising our levels of care. Results vary, based on traumatic versus chronic needs, but we know that empowering patients in their own care is valuable, improves patient satisfaction, and will reduce readmissions. That is a key focus, especially in this era of cost containment.”

The hospital, Peacock adds, is partnering with two outpatient facilities to continue their educational outreach effort after patients go home, focused initially on congestive heart patients, and patients at risk for central line infections.

Maintaining awareness of population-specific tenets and standards plays an important role at UAMS. All communication and information is available in multiple languages, the hospital has certified interpreters, and offers a language line providing translators fluent in dozens of languages. They also have a patient education database, which helps staff deal effectively with cultural differences relating to areas besides language, such as nutrition, family structure, touch and eye contact.

“While we have not yet implemented an online electronic medical record connection integrating patient education, a solution is being planned,” says Jerri Garland, director of EMR Services.
“Patient education and providing the information patients need at the right time to make informed choices about their health care is a central focus of our initiative. Our interactive patient engagement is one technology that uniquely positions UAMS to extend our health education resources. We’ll get there by enabling direct patient interaction and providing proven tools needed to fulfill Stage 2 criteria, while enhancing the patient experience across the care continuum.”

Every patient receives an educational assessment within 24 hours of being admitted, Garland says, allowing the hospital to quickly determine the best way to teach each individual. “Through this process we identify potential barriers to learning such as language, cognitive, visual or hearing challenges,” Garland explains. “The results of that assessment are documented and available to all staff so it can be used in coordinating care in the hospital, and for subsequent transitional care.”

The hospital, Brunner adds, has an extensive medical library, and its video library is accessible to all patients via the televisions in their rooms. They also feature a Department of Patient Education, with dedicated health educators who integrate care across all clinical areas. Their expertise includes training in care planning, formatting, and adult learning. This benefits everyone, Brunner says, and results in patient education being managed by staff beyond just the physicians and nurses, including nutritionists, respiratory therapists, pharmacists and every medical professional that engages the patient. The hospital also is in the process of establishing advisory councils. These will strengthen ties with the community by enhancing outreach, community wellness, and patient education efforts.

“Ours is a far-reaching, education-oriented, multi-dimensional effort,” Brunner concludes. “Everyone is involved, and every patient and patient family or caregiver benefits from this comprehensive approach.”

Over the coming years, meaningful use will help drive consistency and strengthen links to online record keeping and reporting. That’s good, and welcomed. But the road to enhanced patient satisfaction and improved clinical outcomes begins with stronger care coordination and comprehensive and integrated patient engagement, as demonstrated at UAMS and other forward-thinking, technology savvy hospitals across the country.

In part three, we’ll examine the role of health literacy, multi-culturalism, and post-discharge communication efforts in achieving improved compliance and outcomes, while exploring their impact on meaningful use.

Jodi DeMarco is the interactive solutions advisor for TeleHealth Services. She has spent more than a decade in the hospital/patient setting serving as project manager for patient education at the Cleveland Clinic, and as an adjunct professor at several universities. DeMarco has a bachelor’s degree in community health education, a master’s degree in health science and a doctorate degree in health science. She is a certified health education specialist and a member of Ohio SOPHE.

TeleHealth Services is leading the charge in patient engagement, providing hospitals a range of interactive patient care technologies. These services allow hospitals to provide patient-specific education and facilitate the two-way exchange of multi-cultural information for a variety of needs. Patients, families, and clinicians are responding positively to these efforts to better engage patients in their own recovery. Improved patient engagement is also creating workflow efficiencies, within the hospital, providing new revenue and readmission resources, and playing an important role in helping hospitals achieve Stage 2 meaningful use of compliance.