Patient Education, Engagement, and Interactivity Tools Help Hospitals Achieve Stage 2 Meaningful Use Compliance

Part one 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.

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With final Stage 2 rules for satisfying meaningful use requirements issued by The Centers for Medicare and Medicaid Services (CMS) last week, several of these initiatives focus on the importance of patient education and engagement. The requirements for the adoption of certified technology enable the capture and sharing of health-related information to advance clinical processes and drive improved patient outcomes, and many of these criteria actually are driven by patient engagement initiatives.

Beyond improved clinical outcomes and patient satisfaction, the incentive currently driving meaningful use is government subsidies for implementing the technology and compliance changes. Non-compliance in the future will be penalized through withheld reimbursements for hospitals, healthcare organizations, and physicians who fail to achieve meaningful use in the required timeframe.

Under the rules for Stage 2, all Stage 1 items will become mandatory, the scope of many Stage 1 measures will be increased, and providers will be responsible for meeting a number of new requirements, particularly around care coordination and patient engagement. Under the current Stage 2 rule, providers have more time to meet the Stage 2 criteria. A provider that attested to Stage 1 of meaningful use in 2011 would attest to Stage 2 in 2014, instead of in 2013, as was outlined in the original timeline from CMS. Therefore, providers are not required to meet Stage 2 meaningful use before 2014.

However, in preparation for meeting the rules for Stage 2, hospitals need to prepare for these evolving compliance requirements as soon as possible. Those who resist or do not take quick action face the risk of having only a few months to achieve the deadline by which hospitals are responsible for actually initiating Stage 2 requirements. That makes them vulnerable to penalties for non-compliance if unforeseen issues or delays prevent requirements from being implemented on time.

The Nature of New Requirements for Stage 2

Many of the entirely new measures for Stage 2 put greater emphasis on care coordination. The new measures also require additional capabilities and processes related to patient engagement. For hospitals, Stage 1 measures related to patient engagement were limited to patients who asked for an electronic copy of their health information or discharge instructions. In Stage 2, hospitals are responsible for an entirely new measure requiring that hospitals make electronic access to health information available to more than 50 percent of their patients and that more than 10 percent of patients actually view information about their hospital admission.

Another important aspect of meaningful use involves healthcare IT implementation, which generates useful information and translates that information into knowledge. This, theoretically, leads to improved clinical outcomes that result in reduced readmissions, shortened length of stay, improved patient satisfaction, clinical efficiencies, and other processes that help keep the patient engaged in his or her recovery and continued health and wellness.

Stage 2 quality measurement segments include:
- Population and public health
- Patient safety
- Patient and family engagement
- Efficiency
- Care coordination
- Clinical process
According to CMS, providers have earned more than $5 billion in incentive payments for voluntary Stage 1 meaningful use compliance involving electronic health records. Prior to its release of Stage 2 requirements, The American Hospital Association (AHA) warned CMS that the proposed requirements for Stage 2 were not feasible, especially in light of the fact that more than 80 percent of hospitals had not attained Stage 1. The College of Healthcare Information Management Executives (CHIME) also had said the preliminary Stage 2 criteria were "overly ambitious."

Focus On – and Fund – What is Already Working

As the debate continues, many hospitals already are using patient education, engagement, and interactivity tools to increase compliance and understanding, enhance care coordination, measure service responsiveness, and improve clinical outcomes. These outcomes include reduced readmissions, better post-discharge planning, and improved patient satisfaction ratings. However, while these practices are proving beneficial to patients, their families, and hospitals’ bottom lines, they often are not properly coordinated or tracked, nor are they provided needed resources.

Diane C. Moyer, MS, RN, is president of the Health Care Education Association (HCEA), a national non-profit, multi-disciplinary professional organization of healthcare educators. She also serves as associate director of Health System Patient Education for The Ohio State University Wexner Medical Center, in Columbus, Ohio. HCEA, she explains, is dedicated to improving healthcare through evidence-based education, resource development, and communication.

"Everyone has similar standards for patient education, but we use a variety of different resources, vendors, customized in-house, and off-the-shelf third-party solutions for educating patients, and different tools for documentation," Moyer says. “Our intentions are good and the information is useful and valued, but this 'mish mosh' of execution makes it difficult – if not impossible – to measure effectiveness, share best practices, and demonstrate a clear return on investment.”

This lack of consistency, Moyer explains, becomes more complex when you consider the assortment of specialists who all share responsibility for patient education. That includes nurses – who, she says, are the primary educators – as well as physicians, dedicated patient educators, therapists, pharmacists, dietitians, social workers, and more.

"In some ways," Moyer reflects, "we have taken a step back because our systems are not flexible enough to capture all the needed data without extensive documentation by clinicians and time to find and review the notes across disciplines. For example, some hospitals capture patient education participation electronically, and even use simple interactive bedside or online tests to verify comprehension. Often this information is not easily or automatically retrievable, is not connected to a primary resource like an electronic medical record, and is not shared among those educating the patients. This disconnection," she adds, "includes gaps involving patient education and discharge information, particularly as they relate to inpatient and outpatient care."

By "patient education participation," Moyer is referring to how hospitals assign specific educational information and on-demand videos or digitized broadcasts to patients, based on their identified learning needs. For instance, a patient who is in the hospital for heart surgery may be assigned videos detailing specific aspects of his or her disease, as well as programming on medications, exercise, nutrition, rehabilitation, relaxation, and related subjects. Both the patient and the family can view this information, which helps them better understand their challenges and plan appropriate post-discharge care. At the same time, these patient engagement efforts support other clinical initiatives and help the organization meet compliance requirements.

Moyer credits these types of tools, as well as follow-up questioning and additional evaluation by nurses, physicians, and other clinicians, as critical for helping patients comprehend their medical issues and take better care of themselves after they have been discharged. Most patients, Moyer stresses, are not "at their best" when in the hospital. They are frightened, anxious, sedated, and often afraid to ask questions or admit they do not understand the complexities of their illness or what is expected of them. The ability to duplicate their curriculum at home, she adds, is a nice advantage to these systems.

But providing the resources is not the same as providing good education, she stresses, and in the rush to get things done, educational materials may be given to patients with little explanation or opportunity to ask questions or practice the care. Health literacy
issues also play a big role in patients’ understanding of their care, and not all providers simplify the communication or check that the patient really does understand what needs to be done when they go home.

Ensuring that comprehensive print and video materials are available, particularly in languages specific to the community being served, can be expensive and time consuming. Often there are no take-home resources in non-English languages. More worrisome, Moyer points out, is that there are no federal funds for reimbursement of interpretation or translation fees, so these materials and services add significant costs to doing business, even though it is the right – and smart – thing to do for patient safety and quality care.

“Detailed, coordinated patient education involving patients and their families in understanding their roles in recovery and long-term health is essential,” Moyer reflects. “Most patient education specialists would advocate for evaluation of patient/family learning.

Can they show you how to change the dressing? Can they tell you what they would do if the tube fell out? Who would they call if they had a problem? Do they understand warning signs before it escalates to the point where that patient is back in the emergency room?”

“Interactive learning tools that inform patients and their families on these scenarios or skills and check comprehension are absolutely critical, but they require resources to implement,” explains Moyer. “Providers of interactive patient education tools can offer a scalable solution to aid hospitals in their integration, thus providing immediate value, a manageable installation, and a sustained return on investment. As technology improves, enhanced connectivity and better ways to guide patients to credible, plain language health resources outside the hospital will be invaluable.

“That,” she adds with a smile, “would truly be meaningful use.”