EHRs: Moving Past the Mandate

Yes, adoption of an EHR is mandated by the government, but here's how to use your system to better improve practice operations, patient care, and even your bottom line.

BY STEPH WEBER

Passed in 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act introduced specific government mandates designed to increase the "adoption and meaningful use of health information technology." Subsequently, CMS announced their respective incentive programs, encouraging the implementation and utilization of EHRs. As of May 2015, more than 468,000 providers have participated in the programs, according to CMS.

This industry-wide endeavor has come at a tremendous cost though; providers, feeling pressure to meet meaningful use guidelines, have invested significant intellectual, human, and financial resources towards the development of infrastructure, software testing, and staff education. And as more physicians implement EHR systems, the information technology cost is rising. In 2012, a primary-care practice spent $8,026 per full-time equivalent physician, according to data from the Medical Group Management Association (MGMA). By 2013, that cost grew to $9,323.

Despite these considerable investments, Medicare and Medicaid EHR Incentive Program payments will sunset in 2016 and 2021, respectively, leaving physicians to wonder if the relevancy of EHRs remains. However, the newly passed Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) points to a shift towards value-based, quality-of-care metrics to evaluate provider proficiencies. The tools and applications within existing EHRs are then, arguably, even more relevant now and into the future in meeting these measures.

No longer devoted solely to their initial task of meaningful use compliance, the EHR's data capabilities provide ample opportunities for physicians to attain operational efficiencies, deeper patient engagement, and increased revenues — all well above and beyond the federal mandate.

Transitioning to Value-Based Care

Historically, CMS has relied on quality-based measures, at least in part, to formulate provider reimbursements. Going forward, it is expected these measures will become even more integral to the calculation of provider payments.

The passage of MACRA, which repealed the sustainable growth rate (SGR), only further confirms the transition to a value-based payment system centered on improving quality metrics. The controversial SGR allowed Medicare payment adjustments based on a physician's ability to stay within economic spending targets.

Under the new legislation, another incentive program — the Merit-Based Incentive Payment System (MIPS) — begins in 2019 and offers supplemental income to quality-focused, high-performing physicians.

In an effort to streamline initiatives, MIPS combines three former incentive programs: 1) the Physician Quality Reporting System (PQRS); 2) the Value-Based Modifier (VBM); and 3) Medicare and Medicaid EHR Incentives Programs.

Although the ultimate details of the program are not yet finalized, John Sawyer, an internal medicine physician at West Mountain Primary Care in Queensbury, N.Y., says the merit-based program builds upon current approaches.

"MIPS mirrors the kinds of plans [physicians] are working on already and I suspect it will evaluate the same kinds of metrics," he says. "Almost certainly, it would be measuring things like utilization of care, disease specific metrics, and access to care." Undoubtedly, the continuation of current EHR methodologies that have been contributory to effective meaningful use compliance will also prove instrumental in satisfying the forthcoming metrics.

Patient List Formulation

EHRs are designed with numerous tools, which can be utilized by practices in their transition to a value-based environment.

Customizable patient lists, currently used to verify insurance eligibility, is one such feature that can offer tremendous advantages.

According to Jeffery Daigrepont, senior vice president of the national healthcare advisory firm, Coker Group, lists are excellent visual cues of physician productivity. "Lists allow doctors to get a sense of their productivity," he says. "The visibility into what their day looks like helps them to eliminate any gaps in the schedule and plan and budget time accordingly." Physicians are able to create room in the schedule and accommodate more patients, which has a direct and obvious positive effect on revenues.

Daigrepont, who has no financial ties or conflicts of interest with any vendors or suppliers, notes that reports must be accessible to all key caregivers though, as many times, only front-desk or registration staff have access to the documents.

While lists can be manipulated to show a number of different categories, the main benefit ultimately remains: Physicians gain a better sense of who and what they are treating most often. This information helps to balance scheduling and staffing needs as well as organize additional patient care.

For example, consider the healthcare organization that has multiple clinics or office locations. If one location is consistently overscheduled, to the point that patients seek treatment elsewhere, while another location is only operating at 50 percent capacity, a potential for a significant revenue loss is created. But, by querying the EHR data and formulating those schedules within a list, the organization quickly identifies and implements necessary money-saving adjustments.

Or, a small practice physician queries data and finds that a large percentage of its panel is diabetes patients. Rosemarie Nelson, an independent healthcare operations and technology consultant, says that conducting a quick diagnosis code analysis of the patient panel is ideal for measuring the demand for additional patient services. "The queries help to identify if services should be expanded," she says. "If the data shows that a physician is treating a lot of diabetes patients, then perhaps bringing in a diabetes educator makes sense. It's also a great patient satisfier."

High-risk patient lists, ideal for care manager reference, are compiled from EHR data as well. "Care managers are actively working to try and improve utilization patterns by making more frequent patient contact and setting up social services and other programs as needed," says Sawyer. "They try to coordinate care so people get the help they need, and in the end, eliminate unnecessary emergency room visits and hospitalizations."

Who is eligible for MIPS?

MIPS will apply to doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2019.

Are any other professionals eligible?
Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2021, provided there are viable performance metrics available.

What is measured?
Positive and negative adjustments will be applied to items and services furnished beginning January 1, 2019 based on providers meeting a performance threshold four performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology.

Is there a cap on adjustments?
Adjustments will be capped at 4 percent in 2019; 5 percent in 2020; 7 percent in 2021; and 9 percent in 2022 and future years.

Will scores be publicly posted?
Measures implemented in MIPS may be available for public reporting on Physician Compare [Medicare's physician directory].

What 2015 data will be available on Physician Compare?
At the group practice level, all 2015 PQRS Group Practice Reporting Option measures reported via the Web Interface, registry, or EHR are available for public reporting. In addition, the 12 summary survey 2015 Consumer Assessment of Healthcare Providers and Symptoms [CAHPS] for PQRS and CAHPS for ACO measures are available for public reporting for group practices of 2 or more EPs and ACOs reporting via a CMS-approved certified survey vendor. At the individual EP level, all 2015 PQRS measures reported via registry, EHR, or claims are available for public reporting. In addition, individual EP-level 2015 Qualified Clinical Data Registry (QCDR) measures, which include PQRS and non-PQRS data, will be available for public reporting on Physician Compare in late 2016.

Source: "2015 Measures under Consideration List Program Specific Measure Priorities and Needs." Centers for Medicare and Medicaid Services; Center for Clinical Standards and Quality, May 5, 2015, 14-17.

Peer-to-Peer Benchmarking

EHRs have made nearly instantaneous peer-to-peer benchmarking possible. "That which gets measured, gets managed," says Nelson. "Benchmarking helps providers look at continuous quality improvements and pushes them to get to the next level."

Sawyer's practice also uses EHR data for benchmarking. "We do measurement of disease processes and outcome measures," he says. "For example, we measure the blood sugars for our patients with diabetes and also how well controlled the blood pressures are for our patients with hypertension." Those results are then posted by provider, so that each provider within the group can assess where he or she stands — within individual patient panels, as well as compared to peers and the group's target.

Boosting Patient Engagement

The emergence of initiatives, like the Patient-Centered Medical Home (PCMH), not only signals the shift to higher quality, lower cost care, but also to developing deeper patient engagement. With PCMHs, patients are involved in multiple levels of the healthcare process, including:

1. Decision-making at the clinical encounter;
2. Quality improvement feedback at the practice level;
3. Utilization of local healthcare resources at the community level; and
4. Influencing local, regional, and national policymakers at the policy level.

Improvements in engagement are further strengthened and supported through several EHR applications.

Patient Portals and Communications

A 2014 Xerox survey found that 57 percent of Americans would be more proactive and interested in their personal care if they had online medical record access. Furthermore, 64 percent currently do not use an online portal and of that group, 31 percent said their physician never discussed the portal with them.

Despite the growth of patient portals on both the provider and patient side, a supply and demand issue remains readily apparent. "There's still a gap between the providers offering portals

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Patient Lists and Payer Mix

A patient list may be helpful in looking at payer mix also. "How many patients do you have belonging to Aetna vs Cigna, for example?" says Daigrepont. "You can then prioritize those bigger payers when negotiating [contracts]."

If only one or two payers dominate the entire patient panel, it is an acute indication that more diversification is needed. If a practice loses one of those large payers, it will be disastrous for revenues.

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and the number of patients who want that functionality. Patients actually want more portal usage," says Derek Kosiorek, a principal consultant for MGMA's Healthcare Consulting Group.

While patient demand exists, physicians must also ensure continued education is a top priority. "Providers have to create awareness by handing out flyers, displaying posters in the waiting room and exam room, and reminding patients to sign up and download the app," Daigrepont says. "And it has to be ongoing education, because as new patients come in, they need to be made aware also."

Once patients receive the necessary education, medical practices have multiple opportunities to engage the portal. Below is an introductory list of portal communication capabilities for both patients and providers:

For Patients	For Providers
• Submit "New patient" paperwork	• Send appointment reminders
• Ask pertinent questions	• Communicate test results
• Request an appointment	• Answer patient questions

Sawyer says the patient portal is a vital component of his overall patient communication strategy, with about 55 percent of his patient panel identified as active portal users. "I use the portal to communicate results electronically to patients, while patients communicate messages to me electronically as well." The ease of access for both patients and providers alike may be the primary reason for the growing popularity.

"It's quick and easy. Patients can post questions and expect to get an answer back in a reasonable amount of time, and physicians can send off a message without getting tied up on the phone," says Sawyer. "Just the same way that messaging and e-mail have changed business communications, the same thing is happening on the healthcare side."

Going forward, an evolution in healthcare communications is expected as technology becomes more central to patients' lives. For instance, in 2014, the annual healthcare wearable market (e.g. Apple Watch, FitBit, Google Glass) volume was $2 billion; by 2020, those numbers will balloon to $41 billion, equating to a compounded annual growth rate of 65 percent, according to a Soreon Research report. Additionally, a 2014 PwC report notes that four in five consumers believe wearable technology will make healthcare more convenient. Kosiorek says today's patient portals will likely be adapted; the portals of the future will be able to capture personal health information generated by wearable devices, which will, in turn, flow directly to the EHR. The efficiency of "user-generated" data is promising, as physicians and healthcare workers won't be burdened with manual entry.

Kosiorek also says upcoming generations of the portal will alter how patients predominantly interface with their healthcare providers. "It's going to be a huge growth area because the ability to communicate certain information to patients alleviates so much work in the medical practice itself," he says.

Transition of Care Documentation

Utilizing transition of care (TOC) documentation, now available within EHR platforms, has the potential to increase patient engagement as well as lead to better outcomes. With medication reconciliation, patients should take a central and active role. This is particularly important during the transfer of care that occurs at hospital discharge. A 2013 *Journal of Hospital Medicine* study showed that when patients were contacted by their primary care physicians within 24 hours of discharge, the incidence of medication discrepancies dropped 70 percent. Another report that same year identified lower risk-standardized 30-day readmission rates when a solid plan for the dissemination of TOC documentation was in place.

"Physicians know a lot about their patients, but they don't necessarily share it," says Nelson. Sharing information with all pertinent providers benefits everyone. Receiving providers do not have to manually input the patient's medical history; instead, they can simply review the TOC documentation from the referring provider. "We've always done TOC documentation, but it hasn't been done in concrete data elements that can be transferred from one practice to another," says Nelson. "With today's EHRs, that's a possibility now."

> Organizing and analyzing patient data provides worthwhile outcomes — for physicians, patients, and especially a practice's bottom line.

Population Health Data

The ongoing accumulation of population health data from the EHR realizes multifaceted benefits. First, the searchable diagnostic criteria alerts physicians to the presence of a public health issue, like an outbreak of measles or tuberculosis. The EHR can also be instrumental in identifying unvaccinated patients as well as disseminating pertinent information to healthcare providers and patients in the infected area.

Rapid availability of detailed diagnostic information allows physicians to easily and efficiently report these trends to the proper governmental agency, like their local or state health department offices, for example.

A secondary benefit pertains to the community-at-large. As data mining identifies emerging disease patterns, physicians can take the necessary steps to counteract the process. By implementing additional services, like dietary consultations or bone density screenings, physicians have an unprecedented opportunity to provide targeted preventative measures for patients within the community — all of which leads to a healthier community overall. "Physicians can promote those programs publicly," says Nelson. "They can say they're using the EHR to improve patients' lives as well as [those within the] community because they're screening for necessary services."

Improving Your Bottom Line

With the tremendous amount of resources invested into EHRs, a substantial return on investment is to be expected. Organizing and analyzing patient data provides worthwhile outcomes — for physicians, patients, and especially a practice's bottom line.

Better Define Your Practice

Most physicians see dozens of patients each day. While they may have an idea of their predominant patient base or mix, it's only when reviewing the individualized components of the entire patient panel that similarities or patterns are truly identified. Fortunately, EHRs make this easier.

Performing a diagnosis code analysis provides a visual categorization of the types of patients and/or diseases being treated most often within a practice. But conducting the analysis will not necessarily improve revenues; the next steps are vital.

Consider this example: A physician runs a query of his panel to identify the diabetes patients who have not been seen within the past six months. Based on this list, he then sends a message through the patient portal, asking patients to contact the office to schedule a follow-up visit. Better yet, the portal offers convenient online scheduling and no one — neither the patient nor office staff — has to ever pick up the phone. The efficiencies of a highly automated patient outreach program have the power to substantially boost revenues as well as patient outcomes and satisfaction. "The practices who are doing this are generally doing so when they have a new provider," says Nelson. "It's an excellent way to fill a physician's schedule."

And the process can be repeated for virtually any subset of patients: women over 50 years old who have not had a mammogram in the past five years; asthmatic patients who require an inhaler; or hypertensive patients without recent cholesterol labs. The ability to provide better follow-up care for patients, particularly those who may otherwise be overlooked, is considerable.

EHR data is instrumental to payer contract negotiations too. "If you objectively demonstrate areas or report outcome measures where you're saving the payer money, there's nothing but a benefit there [for physicians]," says Kosiorek.

As EHRs evolve and gain even greater functionality, particularly the ability to accommodate both structured and unstructured data elements, the power of these data-driven systems will increase exponentially. Physicians choosing to invest in continuous EHR education and experimentation now, above and beyond meaningful use requirements, will be well-prepared for this transition. ◆

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