Maximizing EHRs under Value-based Care

By Mary K. Pratt

Like many physicians, Abdul Kabir, MD, is watching as the healthcare industry moves from a strictly fee-for-service reimbursement model to value-based care.

Kabir, an internist in a solo practice in Monroe, Michigan, is already part of the trend. One of his commercial payer contracts includes reimbursement rates based on quality outcomes. He’s also participating in Comprehensive Primary Care Plus (CPC+), a national primary care medical home model under the auspices of the Centers for Medicare & Medicaid Services (CMS). Participation in the model means close collaboration with his electronic health record (EHR) vendor.

“You cannot do this [type of care] without your EHR,” Kabir says. “The idea is to use technology to increase efficiencies in workflow and capture, analyze and validate data and use it in our practice in a way that’s meaningful to us and brings value. And by improving quality, you can reduce cost.”

MACRA ushers in changes

This is the first year for physicians to participate in The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), with their 2019 reimbursement based on how well they perform on a series of quality metrics. CMS allowed physicians to avoid a reimbursement penalty by simply submitting one piece of data for 2017.

Plan now

Although much of the discussion around value-based care has centered on clinical best practices and patient outcomes, both health policy leaders and IT experts say physicians need to learn to maximize technology—particularly their EHRs—in order to be successful in an industry that increasingly will pay for positive outcomes. And conversely, penalize for excessive, overly expensive care.

Clinicians, instead, generally find that their EHRs require at least some configuration and customization in order to work well within their practices and to meet staff needs, health experts say. At the same time, those in medical practices find that they, too, need to adjust some of their work processes to optimize the value of their EHRs and related systems.

All of that takes time, which is why clinicians need to prepare now for the changes to Medicare payments and other reimbursement models—including in the private insurer markets—that are expected to come next year and beyond.

Implementing the right software

The importance of implementing certified EHRs and other, related applications goes well beyond meeting government requirements, health IT experts say.
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“Technology is a critical element in practice success,” says Robert M. Tennant, MA, director of health information technology policy for the Medical Group Management Association. “So it’s important for physicians to really understand what their requirements are, the potential impact on their workflows, the impact on their patients and how technology can help or hinder them in the move toward value-based care.”

Internist Kabir can attest to that.

His EHR groups his patients by risk, with the risk stratification running from 1 for minimal risk to 5 for highest. A bed-bound patient with a chronic condition such as renal disease who might also face food insecurity and other social problems would fall into the latter category.

Because higher-risk patients need more care and use a disproportionate amount of healthcare dollars, Kabir says they need higher levels of management to stay as healthy as possible and thus keep costs in check.

Kabir says his EHR and other technologies help him better manage these patients through various functions. For instance, the EHR flags appointment requests for high-risk patients so staff know they have to be seen as soon as possible. He can use his EHR to identify diabetic patients who have A1C blood test results indicating their condition isn’t well controlled, allowing him to proactively work with those patients rather than wait for them to reach a crisis point. And he uses a secure messaging app to communicate with specialists, who can access the patients’ records while Kabir can easily receive reports on which patients made it to the specialists, the results of the visit and which ones were not seen.

“Technology increases efficiency but it also helps us improve patient outcomes,” Kabir says.

However, Kabir, other physicians and health IT experts acknowledge that poorly designed or poorly implemented software can create more work for physicians, disrupt the physician-patient relationship and fail to deliver quality care to patients.

Consider this example from Tennant: A primary care physician orders an MRI for a patient and decides to send the patient to an orthopedist. But the orthopedist can’t access the MRI results and then sends the patient for another MRI—adding unnecessary costs and time to the entire process.

Physicians should note, too, that such technical deficiencies will cost them reimbursement under value-based care.

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“You’ll be judged on maximizing care while minimizing costs,” says Randi Terry, MBA, director of information services at Munson Healthcare in Traverse City, Michigan.

Solutions for maximizing the EHR

Physicians often complain about the challenges they have using their EHRs, saying the systems get in the way of their interactions with patients and take too much time to navigate. Health IT advisors acknowledge that these applications aren’t perfect, but physicians can take steps to optimize their systems, such as:

• Align your EHR and workflows

Terry says too often physicians have processes that differ from how the same processes move through their EHRs. Such

### MIPS Percentages in 2017

Eligible providers operating under MIPS will be paid based on three categories, with those scoring 100% able to receive the maximum payment amount plus a bonus:

- Quality measures will count for 60%; this replaces the Physician Quality Reporting System (PQRS).
- Advancing care information is 25%; this replaces Meaningful Use. To earn full credit, physicians must fulfill required measures for a minimum of 90 days. Those measures including targets for work in the following areas:
  - security risk analysis
  - e-prescribing
  - patient success
  - sending summary of care documents
  - requesting and accepting summary of care documents
  - submit up to nine measures for a minimum of 90 days for additional credit

For bonus credit, physicians can:

- report public health and clinical data registry reporting measures
- use certified EHR technology to complete certain improvement activities in the improvement activities performance category

Physicians for whom the measures don’t apply may not need to submit advancing care information, according to CMS.

- Clinical practice improvement activities count for 15%.
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discrepancies cause frustrations and inefficiencies; worse still, practice workers may look for workarounds and stop inputting important information rather than go through the steps outlined by their system. The better option, Terry says, is to either adapt your workflow to the EHR or tweak the system to meet how you want to operate.

• Get your EHR to work with HIEs

Nearly all health IT experts list interoperability as one of the most critical elements for physician success under value-based care to ensure physician access to labs, tests, notes and data needed to make decisions about patients without having to repeat any work already done.

Although getting EHRs, particularly those from different vendors, to seamlessly share such data doesn’t come easily, experts say physicians can take steps to enable data exchange.

Physicians can use health information exchanges (HIEs), which allow healthcare providers and patients to securely access and share medical information electronically. HIEs establish the protocols and technologies to enable such sharing, along with the procedures for participating in them.

Moreover, physicians need to configure their own EHRs so that the data they’re receiving from other clinicians moves into the patient’s records where the physician can see and use it, says Marc Chasin, MD, CHCIO, vice president and chief information officer of St. Luke’s Health System in Boise, Idaho.

Chasin warns against data coming into the EHR and remaining in a PDF or similar static form. Data that remains in such formats can’t be searched or easily referenced, and if it’s not incorporated into the EHR where the physician can easily access it and incorporate it into dashboards and other processes, then the information does not support more efficient, effective care. In fact, Chasin says, it can do the opposite by leading to redundancies and slower responses.

• Implement clinical decision support

Clinical decision support systems pull information from EHRs as well as other data sources and then use analytics to guide or prompt physicians during exams, diagnoses or treatment plans.

These systems (which can be added onto EHRs but sometimes come as part of them) automate accepted protocols to ensure physicians follow best practices.

“I think one of the biggest tools and best bang for the buck is clinical decision support,” says Jon Vanderpool, MBA, regulatory program manager at St. Luke’s Health System. These systems can intake more information than any individual can scan or memorize and can keep track of the latest treatment protocols, thereby providing immediate, easily accessible guidance to physicians right there in the exam room.

• Enable secure messaging

Kabir uses secure messaging when he can. For example, when he refers patients to an ophthalmologist, they both use a secure messaging app that works within their EHRs. And because it works within their EHRs, the information in their messages remain in the patients’ records.

• Turn on alerts

EHRs have or support as an add-on feature alerts that notify clinicians to various conditions, warnings or requirements that can impact their patients’ health and well-being.

Gabriel R. Guardarramas, MD, a solo practitioner at Physicians Family Health Service in New York City, says he

Pick Your Pace

CMS created a pick-your-pace option for 2017, a transition year for physicians. This approach allows physicians participating in MIPS to choose from several options:

1. Nothing (not participating in the Quality Payment Program): For physicians who don’t send in any 2017 data, they’ll receive a 4% payment penalty.

2. Test: Physicians can submit a minimum amount of 2017 data, such as one quality measure or one improvement activity, and avoid a payment penalty.

3. Partial: Submit 90 days of 2017 data to Medicare and physicians may earn a neutral or positive payment adjustment, or even potentially earn the max adjustment.

4. Full: Physicians who submit a full year of 2017 data can earn a positive payment adjustment.

The MIPS payment adjustment is based on the data submitted. The best way to get the maximum MIPS payment adjustment is to participate for a full year. By participating the full year, physicians have the most measures to pick from to submit, more reliable data submissions and the ability to get bonus points. But if physicians only report 90 days, you could still earn the maximum adjustment.
Maxi Mizing has programmed numerous alerts into his EHR. For instance, his system will notify him if he’s seeing a patient who needs a pneumococcal vaccine or a flu shot. This helps his practice better ensure all patients get the treatments they need to stay as healthy as possible.

• Leverage patient portals to boost engagement

“Doctors need to spend a lot more time thinking about how they’re engaging with patients and how they’re allowing them to engage,” says Joel White, executive director of Health IT Now, a coalition of patient groups, provider organizations, employers and payers supporting health IT to improve patient outcome. He notes that Medicare is going to score physicians on how much work they are doing around patient engagement. One way to strengthen patient engagement activities is to leverage patient portals and tie them back into the EHRs, he adds.

“Giving patients complete digital access to their entire EHR record—the notes and everything else—can have a powerful effect both on patient engagement and on improving accuracy of the record, so that it better reflects true quality and so we can learn from the process of care. It may also stimulate entrepreneurs to help people view and benefit from their health record,” says Thomas H. Payne, MD, FACP, board chair of the American Medical Informatics Association and medical director of IT services for the University of Washington’s UW Medicine.

What you need from EHRs to succeed

EHRs today must do more than simply hold electronic versions of patient records, and they must do more than simply offer lots of bells and whistles. They need to have functions and features that work together as effortlessly as possible so that you can use them as easily as you use your stethoscope as your care for your patients. Health IT isn’t quite there yet, but the goal is to find or configure an EHR that gets you as close to that as possible.

Evaluating your current system

Simply put: Not all EHRs are created equal. How much you can customize your existing EHR is only one way to evaluate whether your system will work for you.
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moving forward, health IT experts say. They offer other key questions to ask to help determine how well your EHR, and its developer, can meet the evolving demands of the healthcare industry:

1. **Does your EHR meet your needs?** Does the EHR vendor act as a partner and respond quickly to requests? Health IT experts say it’s worthwhile to ask healthcare colleagues how they feel about their EHRs and compare your experiences with theirs to determine whether your system is competitive.

2. **How much education on evolving requirements does the EHR vendor provide?** “The one thing we’ve seen some EHR vendors do well is offer education and interpretation of the regulations. It’s not just regurgitating what ONC says; they’re teaching you how to do it in their EHR,” Terry says.

3. **How quickly can they meet new rules?** ONC often announces new rules just months before they go into effect, so EHR vendors need to move fast, Vanderpool says. As a result, he suggests asking whether your EHR vendor is nimble enough. “We have experience with multiple vendors and we have found that some are more nimble than others. Some can’t adjust to shifting landscapes, and it has put physicians into position of taking penalties,” he says.

4. **Is my EHR blocking data exchange?** Although the 21st Century Cures Act prohibits this, some EHR vendors may not react quickly enough to meet the new legislation, says Health IT Now’s White. This leaves physicians without access to all the data they need to best coordinate care. “So if I’m a provider who is being held accountable, I could get financially dinged because something is blocked,” he adds.

5. **Do the EHR’s workflow and tools support what my practice needs to do?** EHRs should support much of the physicians’ processes and enable insight into patient data so physicians can manage both patients and patient populations effectively, says Thomson Kuhn, a health IT policy consultant with the American College of Physicians (ACP) and a member of the public policy committee at American Medical Informatics Association.

**Virtual Groups offer new option for solo, small practices**

CMS’ 2018 Quality Payment Program proposed rules allow for some clinicians to participate in MIPS through “virtual groups.” Solo practitioners and practices with 10 or fewer eligible clinicians who are eligible to participate in MIPS can join together virtually for a year with any other physician in the U.S., regardless of specialty or location.

The group will report and be scored on all performance categories, and collectively will have to meet the same quality requirements as others participating in MIPS.

Robert M. Tennant, MA, director of health information technology policy for the Medical Group Management Association, says small and solo practices may want to consider this option, as reporting with a larger patient population could help prevent a small or solo practice from meeting the quality measures because it has a disproportionately large share of chronically ill or underserved patients having a difficult time hitting target health goals.

The importance of data

To succeed under value-based care, EHRs need to organize and manage the data it holds. The systems cannot simply be digital filing cabinets. Instead, physicians must have EHRs that collect, store and analyze data in ways that work for them and their payers.

“The doctor needs to capture the quality metrics that each of their payers need,” Tennant says, explaining that Medicare has set quality metrics while private insurers each have their own, too.

To do that, the EHR needs to accurately record what physicians and their staffs do, according to Terry. She has seen practices where physicians take all the required actions each day, yet their EHR reports say otherwise. Terry says sometimes the physicians aren’t checking off the right boxes to reflect all their actions, other times the EHRs aren’t configured to capture the right data. She says EHR upgrades can change workflows just enough to throw off the data collection, which can cause a physician’s quality scores to plunge simply because the right data is no longer being put in.

Given those possibilities, Terry recommends that physicians
run their own reports regularly so they don’t find any surprises when the time comes to submit official reports.

Data requirements extend beyond reporting requirements, though.

EHRs must be able to show physicians and their staff performance metrics that help them provide better care to both individual patients and entire patient populations if they want to succeed under value-based care, says Denette Dresback, MBA, director of data and analytics at St. Luke’s, the Boise, Idaho, healthcare system. Dresback and other health IT leaders say such analytic capabilities can either be built into or added onto their EHRs.

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She and others say an EHR’s ability to create dashboards that allow physicians to see data in ways that are actionable is particularly critical.

Physicians need to see, for instance, how well an individual patient is doing against established measures so they can identify problems and potential solutions as quickly and easily as possible. For instance, the physician should be able to see whether a patient with high-blood pressure is meeting certain targets established for quality care in his or her case.

Similarly, Dresback and other health IT leaders say physicians must be able to use analytics to study how well groups of patients are doing. For example, analytics tools should allow physicians to identify all their diabetic patients as well as identify which ones need an A1C blood test. The better EHRs also have the capability for physicians to generate messages to those patients, automatically send those messages, order the lab tests and even schedule them.

**Conclusion**

Guardarramas, the family physician in New York City, has seen a significant evolution of technology since he first started practicing in 1982.

He acknowledges that the technology has brought many advantages. But, like most physicians, Guardarramas voices frustration with some parts of the new IT environment. For instance, he says his EHR is effective but he still struggles with interoperability issues. He says the alerts notifying him to particular patient needs helpful, but wants to have an easier way to act on them: a button to click that lets him call, text and email the patient, for example.

And he anticipates the time in the future when his system will do that.

“Right now they want us to doctor the computer. I’d rather have the computer help me,” he says. “Let the computer work for the doctor. The computer should be there to help us manage the patient.”

Health IT leaders say that technology is critical for physicians today and, for all its faults, does indeed help them become more effective and efficient and ultimately better manage patients. They expect that will only improve as physicians move into value-based care and need — and expect their technology to do more.

More importantly, health IT experts say physicians don’t have to wait for next-generation technology to reap benefits from their EHRs or to leverage technology to be more efficient and effective in their jobs.

Physicians can incorporate more or all of the existing EHR functions into their practices, implement software designed to work in conjunction with their EHRs and re-engineer their workflows to better align them and their EHRs. Moreover, experts note, physicians have options in the market if they find that they’ve taken those steps and still aren’t able to find the efficiency and effectiveness they want from their existing systems.

EHR software makers offer many different solutions and support services to ensure that physicians can find a system that works best for their needs.

iPatientCare helps physician offices, rural health clinics (RHC), and community/federally qualified health centers (CHC/FQHC) with their needs of medical billing and MACRA/MIPS and CPC+ assistance by delivering an integrated cloud-based EHR & Practice Management System along with a dedicated team comprising of certified billers and coders to help with credentialing, enrollment, eligibility verification, referral authorization, patient fee estimation & collection, claims scrubbing, and denial management.

iPatientCare EHR is certified as 2014 Edition Ambulatory Complete EHR and comes integrated with practice management system, patient portal, ePrescribing, lab & radiology interfaces, patient appointment reminders, iPad/iPhone app, and an EDI clearing house, allowing unlimited claims and eligibility requests. iPatientCare EHR comes with Chronic Care Management, Annual Wellness Visit, and Population Health Management modules.

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