



Physicians Practice. Vol. 20 No. 1

Can Technology Make P4P Easier?

By Sara Michael | January 1, 2010

Here are tools that can help you manage the complex reporting requirements of pay-for-performance programs

Pop quiz. Can you list all of your male patients who have PSA levels greater than four, who are between the ages of 50 and 75 and have not had a urology consult?

What about your diabetic patients with hemoglobin A1c levels over nine who are due for a foot exam? Or your female patients overdue for a mammogram?

It's data like this that your practice must have at the ready for pay-for-performance program reporting. Medicare and private payers are increasingly developing programs to reward physicians based on clinical benchmarks, marking a move away from visit-based service delivery to one of population management. As more payers embrace this approach, practices are looking to technology to help them manage the complex reporting requirements.

Imagine the time and energy it would take to comb through hundreds of paper charts, flipping through each one looking for test results and visit details, and then calling each patient for appointments.

"It's virtually impossible to readily comply with a P4P program without technology," says management consultant Bruce Kleaveland. "It's very, very difficult to get your arms around the parameters and manage it."

Most EHRs can be configured to run such reports, as long as you have the system fully implemented and are prepared to tailor your work flow accordingly.

But some practices are finding the standard EHRs limiting. Practices and vendors are taking the technology to the next level, adding additional management tools and databases — one doc dubbed the approach "EMR 2.0" — to meet the requirements and become P4P champs.

First stop: EHRs

At Valley Medical Associates in Springfield, Mass., the four physicians and three nurse practitioners are using the practice's Allscripts EHR to meet the requirements of the Medicare Care Management Performance (MCMP) demonstration, a pilot program for reporting on different measures for Medicare

patients.

They are able to run reports based on the program's requirements, generating lists and reminders.

"We are using our electronic record to be able to document when things are being done and then pull reports off and contact patients to make sure they get [the procedures] done," says family practitioner P.J. Helmuth.

EHRs allow practices to take an otherwise essentially impossible task — one that would involve endless hours weeding through paper records — and convert it into a two- or three-hour job. "It allows you to take a more proactive disease management and preventive care management approach to the delivery of healthcare," Kleaveland says.

EHRs can help practices in two major ways, according to Kleaveland. The first is in setting a basic metric by which to track patients' progress, such as blood sugar levels for diabetics. An EHR can generate reminders and notifications for the physician while the patient is in the office. (Mrs. Jones, have you had your foot exam?)

Second, physicians can tailor the EHR's templates based on the particular pay-for-performance program. This modification is necessary, considering that each program has different requirements and the metrics continue to evolve. Most CCHIT-certified systems will allow practices to tailor the templates for the program's criteria, Kleaveland says. He adds "A given provider might have relationships with multiple insurance companies, and the multiple insurance companies don't always have the same P4P programs. One very legitimate challenge for doctors in complying is their ability to understand the specifics of each program."

At Helmuth's office, they've had to add a few extra steps to be able to generate reports. Much patient care happens outside of their office — mammograms and colonoscopies, for starters — so his staff has to enter those results into the system (rather than scan them in) so they can become reportable, Helmuth explains. "We have made some changes to work flow to improve numbers and accommodate that," he says. For the most part, their EHR accommodates their needs, or they can create work-arounds to get the job done.

Another option: registries

Clearly, some practices are finding that EHRs aren't without their limitations.

EHR systems tend to be more focused on visit documentation, Helmuth says, rather than reporting and disease management functions. "It's not just being able to run a report; it's also disease management, and how easy it is to find out which diabetic has not had an eye exam and how to communicate with patients," he says.

Not all EHRs have those capabilities, and many have limited configuration abilities for each program, says Jonathan Niloff, a physician and CEO of MedVentive Inc., which provides quality measurement software.

Further, not all EHRs are networked together (hence Helmuth's added steps of input), and lab results are a key piece of the reporting requirements, Niloff says.

Enter the clinical decision support system, more broadly known as a patient registry.

A disease or patient registry is a tool that collects the data on patients with a similar condition, such as diabetes or those who need mammograms.

The information can come from the practice's EHR, claims, manual entry, or even lab reports, depending on the practice and the software used.

Practices eyeing this type of software should understand what data sources it can take, as well as what communication functions it has, Niloff says, adding that registry systems have different features and capabilities.

"The key thing is a good registry is not just a collection of information, but has built-in rules and logic and can send reminders to the physicians or the patients in an automated way." Niloff says.

Many registry systems can communicate across multiple practices, because they are not platform-specific and can share information across EHRs or even in the absence of an EHR. Although the registry program would ideally connect with your EHR for patient data, Niloff adds, practices without EHRs can opt for these systems as a less expensive and less disruptive alternative.

"Because [registries] are so focused on P4P programs and quality improvement, the good systems are very configurable, have a lot of flexibility, and can match the guidelines to P4P programs on a payer-specific basis," he says.

(But again, using a registry without an EHR means an added labor-intensive step to manually enter data into the system, Kleaveland notes. EHR plus registry is a great way to go, and many practices program the EHR to feed data to the registry.)

Ray Fredette, CEO of CentMass Association of Physicians, an Independent Physicians Association, has been using a claims-based registry system to check patients' compliance with Health Plan Employer Data and Information Set (HEDIS) measures, a program developed by the National Committee for Quality Assurance. The MedVentive system CentMass uses tracks patients for 54 primary-care physicians in five managed-care programs.

"We produce packages quarterly for each primary-care physician that include a list of patients who are due for interventions, a chart insert for each patient, and a letter for that physician to send to each patient," Fredette says.

Because it's a claims-based registry system (a paid claim means the test is no longer overdue), there is a two-month lag in data, so patients may receive letters about tests they have already received, he says. "There will be redundancy there, and we are trying to figure out how to deal with that," Fredette says, adding that despite their limitations, EHRs have much more current data. Ideally, EHRs would have preventive modules for pay-for-performance programs, Fredette says, adding, "We are doing the best we can with a claims-based system."

Not all EHRs and registries rely on claims-based reporting, and some say claims-based reporting isn't ideal. Many of those systems don't have the vocabulary to properly code inputted clinical information, says Maria Rudolph, a vice president at e-MDs Inc. and an executive committee member of the EHR Association. So practices are left using ICD-9 and billing codes to report for pay-for-performance programs. With claims data, "you can't easily track why something happened clinically because all you are seeing is the billing code," she says.

EHR vendors, she says, are beginning to incorporate the clinical nomenclature known as SNOMED CT

for clinical coding, but it's not widespread, presenting a technical challenge for practices adopting P4P programs.

Whether you use an EHR or a registry or both, there isn't yet a perfect system for participating in a P4P program, so it's important for practices to work with their vendors to understand the capabilities of each system.

Providers who are considering purchasing an EHR and planning to participate in a P4P program should talk with their vendors to make sure the data is organized in a way that can be more easily exported, Niloff said. Think of it like storing data in an Excel spreadsheet versus several PDF files — one format allows for more meaningful searching and sorting.

Further, practices should make sure their vendors are willing to help them add a registry system on top of the EHR they are using.

“Get a commitment from the vendor that they will help you work with other clinical decision support tools, in being able to extract data in an easy fashion,” Niloff said.

A page from the business book

When faced with the need for quality measurements reporting — and recognizing the shortcomings of his EHR — Simeon Schwartz, president of Westmed Medical Group in White Plains, N.Y., looked to other industries for help.

The buzz, he found, was around business intelligence, a term that basically refers to the approach and the tools used by companies to get a handle on the business landscape. Think decision making supported by data mining and number crunching — just the sort of approach medical practices need for P4P reporting.

The three hallmarks of business intelligence, Schwartz explains, are taking the data out, translating it, and re-indexing it for reporting.

Westmed wanted to participate in a regional medical home pilot that offers \$5,000 to \$10,000 for primary-care physicians who achieve level two or level three medical home status. His practice has 45 pediatricians and internal medicine physicians who agreed to participate.

Eventually, Westmed's physicians would be tracking more than mammograms and colonoscopies. “Ultimately, you need to do this for hundreds of things. Then all of a sudden, you have a management nightmare of trying to coordinate 15 or 20 parameters for 150,000 people,” says Schwartz.

For this, the physicians needed more than the EHR they have been using for seven years, even though he described his group as “a relatively advanced” user of GE Centricity.

P4P requires a completely different data model than EMRs or EHRs (depending on your term of choice), and Westmed needed to move beyond a transaction system to a population-management system, Schwartz says. “None of this stuff is built into any EMR. This is what we would coin as EMR 2.0.”

Taking a page from the business industry, Schwartz acquired a separate business intelligence system: When the patient data from their EHR is fed into it, the system reorganizes it and readies it for reporting. Physicians can interact with it using a Web-based dashboard to slice and dice the data. A separate

system translates, analyzes, and distributes the data based on the chosen quality metrics. Schwartz's organization is ahead of the curve with this business intelligence system, which he said is not yet available for commercial use.

Schwartz is quick to note the challenges of P4P — from ensuring you have reports from referrals and lab results entered into the EHR to changing the culture of primary-care physicians for the new paradigm.

But, he says, payment reform is on the horizon and practices should be ready for the transition. Not only does he expect it to pay off big for physicians, but he also believes it's a necessary shift in patient care. As his organization looked into becoming a medical home, Schwartz realized how important it was to change their paradigm of patient care to one that was focused on quality of care.

“This is really the way people should be taken care of. There is a clear imperative to physicians that responsibility transcends visits,” he says. “As a large healthcare organization that was committed to delivering quality care, we basically needed to not accept the status quo.”

Sara Michael is an associate editor at Physicians Practice. She can be reached at sara.michael@cmpmedica.com.

This article originally appeared in the January 2010 issue of Physicians Practice.