Are We There Yet?

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Evaluating Whether EHRs are Meeting the Needs of Value-Based Care

By Mary Butler

The “meaningful use” Electronic Health Record (EHR) Incentive Program successfully brought the vast majority of healthcare providers into the computer age and transitioned the industry from a paper-based world to a digital one. That much isn’t up for dispute. What’s less certain is whether all the data generated by these electronic systems is being used effectively to improve patient care, drive down costs, and deliver value-based care.

While it’s still too soon to know whether the meaningful use program and its successor, the Medicare Access and CHIP Reauthorization Act (MACRA), are succeeding in moving the country away from fee-for-service and toward a reimbursement model that rewards quality, there are some early signs of progress.

Melanie Meyer, PhD, RHIA, CPHQ, CCS, performance improvement leader at EVOSCALE Health in Redwood City, CA, pointed to a recent survey from the Society of Actuaries (SOA) as one indication of EHR systems’ success with analytics and value-based care. The SOA found that 60 percent of healthcare executives are using predictive analytics within their organizations. Furthermore, 60 percent of payers and providers expect to invest 15 percent or more of their spending on predictive analytics tools. Predictive analytics tools are a crucial part of helping providers meet the Quality Payment Program and Merit-based Incentive Program (MIPS) under MACRA and advancing population health initiatives.

Meyer adds that organizations lucky enough to have integrated EHRs—or those that hold an organization’s clinical and financial data—are more successful with MIPS and similar efforts.

“Value-based care requires reporting and analysis based on the integration of multiple types of data. EHRs that can do this provide value,” Meyer says. “Having an EHR also provides the foundation to do predictive analytics, and clinical-decision support—which also support value-based care.”

The success of accountable care organizations (ACOs), which are based on a payment model that emphasizes technology and shared risk to improve outcomes, has been mixed. Research by Leavitt Partners found that 74 of Medicare’s 561 ACOs left the program between 2018 and 2019. However, Aledade—a firm cofounded by Farzad Mostashari, MD, former National Coordinator for Health IT (ONC) under President Obama—recently reported great success in helping its ACO partners reach key MIPS benchmarks.

“In performance year 2018, 80 percent of Aledade’s ACOs received perfect MIPS scores and every Aledade ACO with a 2017 score maintained or improved its quality scores from the prior year. More than 70 percent of Aledade’s ACOs improved their quality score by two percentage points or more,” the firm reported in a statement.

In a more tangible sign that value-based care is taking hold, the state of North Carolina—which resisted the Affordable Care Act’s Medicaid expansion—is now taking concrete steps to move past fee-for-service care through several state-based initiatives. North Carolina’s Department of Health and Human Services, as well as Blue Cross and Blue Shield of North Carolina, are starting to pay primary care providers higher rates on preventive care services and care episodes that don’t involve hospital stays, according to a report by the New York Times. The state is also forming ACOs, using government funding to implement social determinants of health (SDOH) pilot programs, and enacting a state-wide data-sharing network for referral services and appointment reminders, the Times reported.

But much of the nitty gritty of carrying out value-based care programs falls on health information management (HIM) professionals. They’re the ones facilitating data requests from payers, incorporating analytics tools into EHRs, customizing

EHR workflows, nudging physicians to capture CCs and MCCs properly, pushing out care management messages to patient portals, and keeping a constant eye on the rulemaking processes in Washington, DC, that will impact their work.

Through their interaction with regulations, health information exchanges (HIEs), physicians, vendors, and IT and finance departments, HIM holds the key to unlocking value-based care and offering insight on how it's progressing.

Smooth Sailing for Some

When it comes to deciding if all the investment in extensive health IT systems and sophisticated analytics tools are worth it, the truth it still sometimes in the eye of the beholder. Susan Hatem, MSM, RHIA, CRCR, HIM director for Wake Forest Baptist Health in Winston-Salem, NC, works for an academic medical center comprising five hospitals and more than 200 physician clinics in the metropolitan area. Hatem says her system takes its academic and teaching approach to medicine seriously—and that means educating patients about their conditions as well as the nurses and physicians in training. For Hatem, value-based care entails entering value-based care contracts with private insurers and ACOs, in addition to making sure patients get the best possible information about themselves.

Accomplishing all of this was much more difficult in a paper-based world. For example, Hatem says a payer recently requested 20,000 records for review in a very short period of time—a request that would've been nearly impossible to accommodate before EHRs. Wake Forest's EHR vendor was able to provide all those records to the payer swiftly through a portal.

"Earlier in my career, pulling even 50 records for an audit was burdensome—now 50 charts is no problem. With all the stuff we review charts for, EHRs have definitely been a godsend. The only thing I worry about is that physicians get all this extraneous information that's scanned into the records and we get a lot of junk, for lack of a better word," Hatem says. "On the flip side, I think some of that is good because we get more data on the patient because it's easier to put in there, and the more information you have, the better."

Hatem says she's currently seeing more audits and requests for data than at any other point in her career—audits from payers, DRG reviews, payment integrity reviews—and being able to pull the various data collections and collapse them into a PDF is much easier with EHRs. Wake Forest also has a large population health department that helps payers and physician offices with "roster management," which includes making phone calls and pushing patient portal messages to patients who might be missing appointments or failing to schedule needed follow-up visits.

While there are still many benefits of having more data on any given patient at any point in time, there's an unavoidable human element in managing the care of populations.

"We still need to be able to get through to the patients and make sure that we've done what we can do to get them in here and be able to share their data," Hatem says. "And that way, if they end up in the emergency room, their doctor can look at their record and say 'Oh, they were just at their doctor's office last week' or 'They haven't seen their doctor in three months.' That's good information to have since you can treat them then and there, rather than going in blind even if the patient had been seen in your facility."

NorthShore University Health System, which serves suburban Chicago, IL, went live with its EHR system in 2003 and has had ample time to find out if EHRs are a valuable tool for value-based care.

Lakshmi Halasyamani, MD, chief quality and transformation officer at NorthShore, joined the organization in 2016 to help improve its clinical performance across the continuum, from acute care settings to ambulatory settings. That work involves employing a range of tactics to improve care for people with chronic conditions, such as collecting quality and outcomes data from the EHRs' analytics tools, communicating with patients through their portals, and using that data at the point of care in acute settings.

"We were an early adopter and what we did in our adoption—our goal was to promote use," Halasyamani says. "So when you do that, you tolerate a lot of variation and optimization for a single type of provider or population instead of thinking about 'How does this system need to connect the dots across providers, across settings of care, and across populations that might share similar risk?'"

While the vendor does what NorthShore needs it to do in terms of functionality and optimizing care for a single episode, Halasyamani admits that encompassing multiple episodes is more of a challenge. “If I go to the doctor and get admitted, they’re not as well designed to work across all the places I’ve gone to get my healthcare,” she says. “So I would say right now that the current EHRs are not the solution for that. I know many are working on it, but part of the challenge in a population health environment is that you need to have connections into all of those sites of care and now they don’t all talk to each other in ways that are useful.”

Value-Based Care Growing Pains Persist

One of the lingering legacies of meaningful use is that many health systems use more than one EHR vendor across their care settings. Physician clinics and inpatient floors might have one vendor while ambulatory and emergency departments might share another. This creates additional data siloes, a problematic situation that’s only compounded during mergers and acquisitions.

“It really creates a challenge when you’re trying to tie the patient story together” for the sake of value-based care initiatives, explains Sally Beahan, MHA, RHIA, senior director, enterprise records and health information at University of Washington Medicine (UW Medicine) in Seattle, WA. “And some of the reasons why we still struggle is because of decisions we’ve made around systems or not having governance around documentation.”

As part of an effort to simplify their processes, UW Medicine will be transitioning to a single vendor systemwide in 2020, which Beahan believes will help a great deal. Even though EHRs can capture the specificity of the documentation needed to participate in quality-based care initiatives, reaching those patients is a labor-intensive process since it requires phone calls and manual portal messages.

“During HEDIS [Healthcare Effectiveness Data and Information Set] season we were able to greatly reduce the amount of paper documents we sent to payers and we’ve gained efficiencies and reduced our costs from a staffing perspective, but there are other areas where we have all these requirements to meet and it’s just been really challenging,” Beahan says.

For example, different payers have different sets of quality indicators they’re looking for and providers must show documented proof that these indicators are being actively monitored to be eligible for incentives.

“And so that’s a little bit different than the MIPS and all that, but it’s just our reality here—and it has added to the administrative burden because each of the payers have different portals of their own,” Beahan says. “And we’re responsible for logging into their portal, uploading documentation, and closing what I call a care gap in order to get credit for managing that patient’s health … If you talk to a health system that has a fully integrated EHR, their story might be different than ours, but it’s been challenging.”

Melissa Swanfeldt, associate vice president for the EHR vendor Meditech, has heard these frustrations from her clients.

“At Meditech we have developed standard content along with best practice guidelines to assist our customers with compliance for their reporting needs,” Swanfeldt says. “The challenge is that each value-based care initiative has different data and reporting requirements, so although standards are maturing there is still a very wide range of requirements placed on hospitals and providers. For example, their ACO may have different reporting requirements than their state Medicaid, insurers with HEDIS measures, etc. One customer I spoke to recently said they have over 250 different quality measurements that they need to submit for the different agencies including payers, ACOs, Joint Commission, and meaningful use. Although there is overlap, many of the agencies have different requirements for data.”

Like numerous other providers, Beahan’s system provides care to underserved communities with a substantial number of homeless and uninsured individuals as part of its mission. This has a major impact on reimbursement due to high readmission rates when compared to other hospitals in Massachusetts where rates of homelessness are lower.

Providers can more accurately describe a patient’s risk factors when treating this population by reporting ICD-10 codes designated for social determinants of health that help denote factors such as housing instability, food insecurity, and low income. But adding these codes to the claim becomes tricky because these patients tend to be sicker and have more complex conditions which require even more codes to capture their level of severity.

"This takes us back to the conundrum of there's only a certain number of codes that get passed through on the claim, so if they're going to use claims data to determine who has higher admission rates, for example, then it might not help us, depending on how we sequence those codes," Beahan says. "It's just administratively burdensome. I think ultimately there's good intention behind [value-based care documentation requirements], but I think the legislators don't understand the true complexities that we face on the frontlines of trying to manage all of this."

Value-based Care's Chicken and Egg Problem

For all the talk about tearing down the siloes that keep providers and patients from sharing data in beneficial ways, meaningful use ended up creating more; the multitude of EHR vendors and their inability to "talk" to each other remains a problem. Federal health IT officials are working on proposed regulations to limit information blocking, but health data isn't as easy to share as it should be, which hinders value-based care.

David Kendrick, MD, MPH, FACP, CEO of Oklahoma-based HIE MyHealth Access Network, has been working on health IT interoperability issues for several years. In medical school Kendrick founded a small telemedicine company that became a web-based EHR platform. Kendrick was already working with other hospitals and clinics to meet meaningful use requirements when MyHealth Access Network became a Beacon Community under the HITECH Act. He sensed early on in the meaningful use process that interoperability and HIEs were going to be a focus in the future—and he was correct, as the Affordable Care Act created ACOs and other value-based care programs. Kendrick sees HIEs as a vehicle for delivering quality-based care since they are able to cover more individuals in a region and exchange more meaningful data than hospitals whose EHRs can't communicate.

Kendrick notes that the Strategic Health Information Exchange Collaborative (SHIEC), a nonprofit network of HIEs, recently released a report showing that 92 percent of the US population is served by HIEs. It also found that HIEs are delivering more than 1 billion clinical alerts annually, including notifications to providers about hospital admissions, discharges, and transfers.

"So the HIEs have been sort of this quiet thing going on in the background that has just steadily and continually built the corpus of data and the relationships and the trust arrangements and the governance and the policy necessary for communities to interconnect," Kendrick says.

In his mind, the US healthcare system has a "chicken and egg" problem when it comes to value-based care delivery.

"I always say the push for community-based health information exchanges and interoperability should have come after the rollout of value-based payment models instead of before, because when I started, nobody knew why they needed to do these things," Kendrick says.

He is hopeful about the steps ONC and CMS are taking in their proposed information blocking rules to promote the fast healthcare interoperability resource (FHIR) standards for health data exchange. The proposed rules would mandate that covered entities implement technologies that support application programming interfaces (APIs) capable of using the FHIR standards. Health IT developers and policymakers believe the FHIR standards are the key to simplified health data exchange.

Donald Rucker, MD, who leads ONC, tells the Journal of AHIMA that he believes big changes are coming. "Once we have consumer grade technical capabilities with APIs, I think we're going to have a market-based revolution," Rucker says. "That's what our proposed rule is all about."

Rucker envisions a health consumer future in which shopping for healthcare services, and using and sharing one's health information, is as user-friendly as ordering something from Amazon. That assumes that FHIR and other standards make it possible for consumers to experience true price transparency before they see a doctor or undergo a procedure, and that providers find a way to comply with this regulatory mandate.

"You've seen shopping apps that let you see what you ordered, when you ordered it, and what the price was," Rucker says, noting that this should be the case when it comes to acquiring healthcare services. "It's not exactly challenging computer science, right? It's challenging policy. But the computer science part of it is straightforward once the data is made transparent."

As Rucker notes, enabling this kind of data exchange is challenging policy, and—even with the progress that they have made since meaningful use—EHRs may not be the best mechanism for driving down costs and improving the health of populations just yet.

NorthShore's Halasyamani notes that there is a wide distribution of patients who are comfortable using and interacting with information in their portal.

"For our younger patients there's probably greater stickiness with these tools and communications. For our older, more complicated patients who may have cognitive impairments, it's probably not the ideal way to communicate with them," Halasyamani says. "But it still may have utility in connecting people identified as proxies."

That's the paradox of the chicken and egg problem noted by Kendrick. Do you create tools that could go unused by the population who needs them most, and hope they get used? Only time will tell.

Notes

1. Society of Actuaries. "2019 Predictive Analytics in Health Care Trend Forecast." www.soa.org/globalassets/assets/Files/programs/predictive-analytics/2019-health-care-trend.pdf.
2. Strategic Health Information Exchange Collaborative. "First survey of the SHIEC shows HIEs provide critical national infrastructure." August 19, 2019. https://strategichie.com/first-survey-of-the-strategic-health-information-exchange-collaborative-shiec-shows-health-information-exchanges-hies-provide-critical-national-infrastructure.

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Article citation:
Butler, Mary. "Are We There Yet?" *Journal of AHIMA* 90, no.10 (October 2019): 12-15.
