Is 2016 the Year for PA/LTC EHR Connectivity?

My last column (see Caring for the Ages, December 2015, “So You Give Great Care; Do You Have Data To Back That Up?”), online at www.caringfortheages.com/article/S1526-4114(15)00433-3/fulltext focused on the overwhelming importance of data in all future Centers for Medicare & Medicaid Services payment schemes. That article left one question unanswered: where does all that data come from?

Here’s the practical problem: When CMS and The Office of the National Coordinator for Health Information Technology (ONC) developed the programs that are now the Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) meaningful use, the assumptions were that the physician worked in a fixed location (clinic or institution) with a dedicated support staff. Patients arriving for treatment were cognitively intact, or accompanied by a responsible party. Set-up data were captured by a combination of office professionals and allied health staff; the physician’s role was limited to documenting assessments, plans, and treatments. Other team members completed the balance of the activities needed for operations.

In contrast, the typical PA/LTC medical group comprises physicians who spend their days treating patients in the field at multiple LTC facilities. There is usually a small central office with a core administrative support staff. More often than not, the billing for the practice is managed from a different location.

This arrangement is effective at keeping overhead low but requires the medical professionals working in the field to be the primary source for data entry. What made sense for PQRS and meaningful use capture in a clinic or hospital setting is woefully misguided for PA/LTC medicine. The workload on the physician becomes overwhelming; necessary data are skipped, productivity drops, and burnout begins. Often we see all three of these negative results occurring simultaneously.

PQRS+EHR Connectivity Necessary

While that physician is struggling to mimic all the roles of the missing clinic staff, the nursing facility is capturing much of these data for their own facility’s EHR. Reusing these nursing facility data in the physician’s EHR and practice management software allows the facility staff to become virtual staff members of the medical practice.

For readers who may wonder why the need for EHR connectivity is so important to some of us, let me remind you: 2016 is the first year that the force of penalties for not reporting PQRS reaches all the way down to the very smallest medical groups. Failure to report PQRS is an automatic 2% penalty, along with an additional 2% or 4% value-based purchasing penalty. That means small groups that fail to participate will suffer a combined 4% cut in Medicare Part B payments; larger groups (10 or more practitioners) receive an automatic 6% cut.

What is the link between PQRS and EHR connectivity? Plenty! There are 198 individual PQRS measures and 26 measures groups. In addition, there are 64 ambulatory EHR clinical quality measures (eCQMs) that can serve as PQRS measures.

Did you know a significant number of those PQRS measures focus on tasks already being done by the staff in the SNF/NF? Further, those quality activities are documented in the facility’s EHR. In many cases, it is perfectly legitimate for a physician to use patient data from the facility’s record to answer PQRS questions about the same patient. The challenge is transferring that information into the physicians’ record-keeping system so it can be reused.

The IMPACT Act (Improving Medicare Post-Acute Care Transformation Act) for PA/LTC health providers, and MACRA (Medicare Access and CHIP Reauthorization Act) for medical groups, support the alignment of quality measures and reporting across facility locations and with physician groups. At the same time, the complexity and quantity of quality measures are increasing. The only way providers can successfully manage these complex quality activities is through collaboration, and sharing the data is required to document that quality — which brings me to this year’s AMDA annual conference.

Conference Connection

There are three major opportunities at the conference to explore the ways your practice or facility can benefit from data integration:

▶ On Thursday, March 17, a full-day educational track entitled Models of Care will explore the changing system of reimbursement (bundled payments, ACOs, CJR) and the Health Information Technology (HIT) infrastructure needed to support those programs. In the afternoon, a panel discussion will describe the technologies that exist, and those that are on the horizon to support these new patient-centered payment models.

▶ The exhibit hall will be open on Thursday, March 17, and Friday, March 18. More facility EHR vendors are exhibiting on the exhibit floor than ever before (there are currently three, and possibly a few more). We’ll also have repeat visits from SNF/NF-focused data analytics vendors who specialize in Minimum Data Set analysis; those vendors can be an invaluable source of a facility’s quality data for medical practices. Each of the vendors already registered is exhibiting new and sophisticated physician interfaces. These can be simple, such as providing a patient list and enabling e-signing of orders, or sophisticated enough to e-prescribe controlled substances.

▶ On Saturday, March 19, AMDA leadership will provide an update on the top policy issues of 2016, including legislative advocacy, communications with government agencies, updates on health care reform implementation efforts, and on proposed changes to PA/LTC facilities requirements for participation.

I encourage readers to attend these events and get involved. If you don’t have the opportunity to participate in the AMDA annual conference, the next best alternative is to talk with your facilities or medical practices, depending on your role. Sharing data takes time, effort, and probably some expense. Each facility or practice should identify a leader who supports the need for data exchange. Identify the EHR and practice management systems used by other partnering entities, then contact those vendors and ask for help with connectivity.

Apply Now for EHR Meaningful Use Hardship Exemption

The Centers for Medicare & Medicaid Services has released the applications for meaningful use hardship exemptions.

Physicians who qualify for a hardship exemption must apply by March 15; hospitals must apply by April 1 to avoid being penalized in 2017. Exemptions may be granted for those facing infrastructure-related problems, unforeseen circumstances, lack of face-to-face interactions, or lack of available certified electronic health record systems.

As part of the Patient Access and Medicare Protection Act, passed in December 2015, CMS will be able to process blocks of applications instead of processing on a case-by-case basis, as CMS was required to do prior to the new law. Applications and instructions are available at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/paymentadj_hardship.html.

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