CIPA

Consortium of Independent Physician Associations

CIPA NEWSLETTER

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Practice Transformation: Pros and Cons of Telehealth

As you continue to look for ways to improve your patient outreach, consider the Internet. It has transformed modern life and continues to do so. It's probably changed how most people stay in touch with family and friends, purchase goods and services, and even search for information about health problems.

How your practice communicates about health care should be evolving too. A variety of telehealth tools are available to help you stay in touch with your patients and even promote your services. Are you taking advantage of them?

What is telehealth?

The Mayo Clinic defines telehealth as the use of digital information and communication technologies, such as computers and mobile devices, for patients to access health care services remotely and manage their health care. These may be technologies patients use from home or that providers use to improve or support health care services.

According to the Mayo Clinic, telehealth, also called e-health or mobile health (m-health), is designed to make health care accessible to people who live in rural or isolated communities; make services more readily available and convenient for people with limited mobility or transportation options; provide access to medical specialists; improve communication and coordination of care among members of a health care team and a patient; and provide support for self-management of health care.

Potential

The Mayo Clinic states technology has the potential to improve the quality of health care and to make it accessible to more people. Telehealth may provide opportunities to make health care more efficient, better coordinated, and closer to home.

For example, a 2016 review of studies found both telephone-based support and telemonitoring of vital signs of people with heart failure reduced the risk of death and hospitalization for heart failure and improved quality of life.

Limitations

While telehealth has potential for better coordinated care, it also runs the risk of fragmenting health care, the Mayo Clinic states. Fragmented care may lead to gaps in care, overuse of medical care, inappropriate use of medications, or unnecessary or overlapping care.

Potential benefits of telehealth services may also be limited by other factors, such as the ability of patients to pay for them. Insurance reimbursement for telehealth still varies by state and type of insurance. In addition, people who would benefit most from improved access to care may be limited because of Internet availability or the cost of mobile devices.

Future

Telehealth is a good example of an efficient way of using care more effectively. Social factors should also influence the growth as people get more comfortable with the technology on both the provider side and the patient side of the transaction. As the technology advances and the patient community becomes more comfortable with the technology, expect telehealth to continue to grow.

Sources: http://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878?pg=1

MARKET FOCUS

Three Ways to Avoid MACRA Penalty You Can Do Today

It is not too late to begin collecting minimal information to submit starting January 2018 and be compliant with Medicare Access and CHIP Reauthorization Act (MACRA). You can easily avoid the 2019 payment penalty by completing:

1. One Quality measure, or
2. One Improvement Activity, or
3. Four to five base measures of the Advancing Care Information (ACI)

Assess where you are

If your practice hasn't done anything to date to prepare for MACRA, your first step is to look at the Improvement Activities to see if there are any you are already doing. If yes, you can attest to that activity and avoid the penalty. If you are currently considered a Patient-Centered Medical Home (PCMH) through an approved program (such as NCQA, URAC, or other), you can receive credit in the Improvement Activity category.

If you are not already doing one of the Improvement Activities, it is too late for you to use this strategy, as the Improvement Activities need to be completed for a minimum of 90 days, and the last 90-day period has officially started.

However, ANY practice can still collect one Quality Measure data on one patient seen between now and December 31, 2017, to avoid the penalty. Submission begins January 1, 2018.

What you need to do today

By reporting a minimal amount of information in just one of the Merit-based Incentive Payment System (MIPS) categories, you will protect yourself against a negative 4 percent penalty in 2019. Here are the minimum requirements for each category:

- Quality—submit one clinical quality measure with at least one patient in the numerator.
- Improvement Activities—complete and attest to one of the 92 approved Improvement Activities.
- ACI—report on the four required measures of the 2017 Transition Objectives and Measures list.

If you have previously reported to the PQRS, you should have processes in place to collect and report on at least one Quality measure. Verify that your previously reported measures are on the list of approved MIPS quality measures for 2017, and select your submission method.

If you previously attested for Modified Stage 2 of the EHR Incentive Program, you should have the processes in place to meet the four required measures on the 2017 Advancing Care Information Transition Objectives and Measures list. Be sure that you can meet the Health Information Exchange measure on at least one patient if you have been excluded from this measure in the past.

If you have not previously reported to the PQRS or the EHR Incentive Program, review the 92 approved Improvement Activities to see if there is one that you are already doing in your office. You can download an Excel spreadsheet with more information on each activity, including required actions and suggested documentation, by clicking on the MIPS Data Validation Criteria link at qpp.cms.gov/about/resource-library. (You must complete your selected Improvement Activity for at least 90 days, so if there is not already an Improvement Activity that applies to you, this option won't work for you.)

If you have never reported to the PQRS or the EHR Incentive Program, and you are not already doing one of the approved Improvement Activities, your easiest and least expensive option is to report at least one quality measure via claims submission by the end of the year. You can download claims measure specifications at: https://qpp.cms.gov/docs/QPP_quality_measure_specifications.zip.

Resources

Centers for Medicare and Medicaid Services (CMS) has created the Quality Payment Program (QPP) website, which contains a wealth of information about both tracks of MACRA: the Advanced Alternate Payment Model (APMs) and MIPS. If you have not visited this site yet, it should be your first step to learning more.

Second, CMS has developed technical assistance programs in every state to offer high-quality, no-cost direct support to help providers plan and implement their MACRA strategies. Visit the QPP_Technical_Assistance_Resource_Guide to determine which program best fits your practice circumstances and needs, and then follow-up with the designated organization in your area to learn more.

Overwhelmed?

Medical Advantage Group is here to help! We offer a MACRA Solution to walk you through the process of completing at least the minimum amount of information in just one of the MIPS.

COMPLIANCE CONNECTION

Equifax Data Breach Serves as an Important Reminder about HIPAA Compliance

Consumers across the U. S. are experiencing a collective sense of insecurity around their personal data since Equifax announced it had been the victim of potentially one of the largest cybersecurity attacks in history.

The company reported criminals had exploited a U.S. website application vulnerability to gain access to files housing data for millions of consumers. The information included names, social security numbers, birth dates, and addresses. The cyber thieves were also able to access credit card numbers for approximately 209,000 consumers.

This is not the first time an organization entrusted to protect confidential data has been violated. And it certainly won't be the last. In the health care industry, HIPAA rules govern the use, disclosure and unauthorized access to protected health information. Not only do health care providers possess similar information as financial institutions, such as names, addresses, birth dates and social security numbers, but they also have access to highly sensitive health information such as diagnoses and test results. If this data were to be released into the wrong hands, the effects could be disastrous.

How to Protect Your Data

While these data breach incidents may seem random and impossible to predict, there are ways for health care providers to protect confidential data. It is critical to understand the flow of protected health information within your systems, including data entry, incoming and outgoing file transfers, data storage, and so much more. Providers with internal information technology expertise may be able to perform a security audit in- house. There are also many external partners that can perform an audit, provide a written assessment and action plan.

Some providers may choose to delegate data storage and file transfers to a third-party vendor, or in some cases, to multiple vendors. This approach may be convenient, but it also has its drawbacks. It is important to periodically audit vendors to ensure they are keeping their systems up-to-date and protecting their data centers from cyber thieves. Ultimately, health care providers are held responsible for any data breaches, even those breaches of a business associate, such as a data center.

What to Do if You Experience a Security Breach

In the event of a data breach, here are a few important reminders about HIPAA reporting: \

- Covered entities have 60 days to notify affected individuals. This is typically done by mail.
- If the breach occurred at a business associate's site, the covered entity may request the business
- associate to provide individual notices.
- Covered entities must notify the Secretary of Health and Human Services (HHS) of the breach. The time frame for notification depends on the number of individuals affected.
  - o If the breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and no later than 60 days following a breach.
  - o If the breach affects fewer than 500 individuals, the covered entity may notify the Secretary on an annual basis. The annual report must be submitted within 60 days of the end of the calendar year in which the breach is discovered.
- For breaches affecting more than 500 individuals, the covered entity must also provide notice to prominent media outlets. This is typically done in the form of a press release.

In addition to the media reporting, HHS also maintains a list of data breaches on its website. This list only includes breaches impacting more than 500 individuals. These types of data breaches are becoming more common in the health care industry. From July 1, 2017 through August 31, 2017, there were 58 reported breaches on the HHS website, as opposed to only 24 reported breaches for the same two-month time period in 2016.

With data breaches on the rise and health care providers becoming more dependent on technology and information systems to store data, it is a critical time to focus on protecting patients' health information and preserving their trust.

Sources:

https://www.nbcnews.com/tech/security/massive-equifax-data-breach-could-impact-half-u-s-population-n799686#ampshare=https://www.nbcnews.com/tech/security/massive-equifax-data-breach-could-impact-half-u-s-population-n799686

https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

DISEASE OF THE MONTH

Reach Out to Your Diabetic Patients This Month to Promote Good Health!

November is recognized as National Diabetes Month. It is a great time to evaluate how your practice is managing the diabetic population and consider what improvements you can make to ensure high quality care for your diabetic patients.

Diabetes affects millions of Americans and its incidence is on the rise. In 2012, approximately 29 million Americans had diabetes, an increase of nearly 3 million people from 2010[1] Although it is a common disease in the United States, there is a lack of understanding among the general population about the severity and impact of this deadly disease. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death.

Diabetes is the seventh leading cause of death in the United States[2]. And it places a significant cost burden on the health care system. People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes[3]. The national costs are staggering. Diabetes cost the nation $245 billion in 2012, which is comprised of $176 billion in direct medical expenses and $69 billion in disability, unemployment and premature deaths.

Proper diabetes management is essential to control blood glucose, reduce risk of complications and prolong life. Physicians have a key role in diabetes management, not only by providing required tests and screenings, but also through educating patients about self-management. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.

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[1] Centers for Disease Control and Prevention (CDC). 2011. "National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011." Atlanta, GA: U.S. Department of Health and Human Services. (June 11, 2014)

[2] Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services. (May 15, 2015)

[3] Dall, et al., "The Economic Burden of Elevated Blood Glucose Levels in 2012", Diabetes Care, December 2014, vol. 37.

HEDIS Diabetes Measure

The HEDIS measure for Comprehensive Diabetes Care offers guidelines for the required tests and screenings that should be completed each year. This measure evaluates the percentage of adults 18–75 years of age with Type 1 and Type 2 Diabetes who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%), for commercial and Medicaid populations only
- Retinal or dilated eye exam performed
- Medical attention for nephropathy
- Blood pressure control (<140/90 mm Hg)

Focus on Outreach to Maximize Quality Performance

It can be challenging for diabetic patients to keep track of all the tests that are needed. A robust and consistent outreach program is one of the most important factors in successful management of diabetes across your patient population. By offering reminders, you can make sure each diabetic patient is getting the necessary tests and services. The measurement year for HEDIS reporting ends on December 31, 2016.

Now is the time to make your final outreach efforts to get members in for needed tests and services before the end of the year and maximize your performance on value-based contracts.

Diabetes Planned Visit

Pre-Visit Plan for Diabetic Patients

Diabetes care can be organized into three phases: pre-visit, intra-visit, and post-visit. Opportunities exist during each phase to introduce practice changes that can help engage and support patients in their diabetes care and management.

Here are some examples of pre-visit planning activities that will benefit your practice and the patient:

1. Proactively identify patients who are due for diabetes visits. Many electronic medical record (EMR) and practice management systems have the capability to pull lists of patients based on their diagnosis.
2. Reach out to patients and provide clear instructions on what is needed and schedule planned visits. Inform them about which tests are due and the timeline for when they should be completed (either before or during the next visit). Outreach can be provided via a letter, e-mail, text message, or phone call, depending on your office's capabilities and the patient's preferred contact method.
3. Encourage patients and their caregivers to be active participants in their diabetes visits. Perhaps you might include a checklist or diabetes assessment tool that the patient can discuss with their physician.

4. Use standardized encounter forms to organize lab results and other pertinent information prior to the visit. This will minimize the amount of information that the physician must gather during the diabetes visit, allowing the physician to focus on the patient's key issues.
5. Integrate strategies for relaying information to practice team members prior to patient encounters, such as a brief team meeting or a case conference for complex patients.

Patient Visit

Once the patient is in the office, the diabetes visit should be guided by the physician. The focus of the visit is to make sure that the patient's concerns and needs are addressed, and relevant clinical and behavioral data are obtained. By having test results available at the visit, the physician can discuss such things as the A1C values with the patient and make any medication adjustments that are needed. At the end of each visit, the patient should receive a summary that includes their care plan and goals, as well as detailed instructions related to any prescribed medications. The office staff should also ensure that the patient schedules any follow-up visits, which will reduce the need for time-consuming outreach efforts in the future.

Post-Visit Plan for Diabetic Patients

After the office visit, the process of managing diabetic patients continues. A system should also be in place for ongoing communication with patients between visits. This may include reminders about lab tests, review of lab results if they were not available during the last visit, and follow-up calls to assess how patients are doing with their self-management goals. These types of communications may be offered to all patients with diabetes, or providers may choose to focus specifically on patients who are not at goal for a particular clinical value (e.g., elevated A1C, lipids, or blood pressure). If your office has an EMR system, there are many ways to automate these types of communications. Talk to your EMR vendor about available reports and other care management features.

Payer Program Support for Managing Diabetic Population

Health plans and payers can also be great partners in managing your diabetic population. As we approach the end of the measurement year for HEDIS reporting, health plans will be making a final push to reach out to their diabetic population and remind them to obtain necessary tests and services. Many payers also have disease management programs that provide education and outreach to diabetic patients throughout the year. Contact your largest payers and ask what assistance they can provide. Many payers have template letters and other outreach materials that can be customized to your practice. Some payers may even be willing to cover the costs of postage.

If you want to ensure successful results for your pay-for-value contracts, be sure to include data capture as part of your overall plan for reaching your diabetic population. Office visits, lab tests, and lab results are all critical data components that should be included in your medical record system. All of these efforts will ensure the best quality care for your patients, and maximize reimbursement for your practice

Sources:
Comprehensive Diabetes Care
The Three Phases of the Diabestes Care: Pre-visit, Intra-visit, Post-visit
It's Your Life. Treat Your Diabetes Well.

November 2017

Close Patient Gaps with these End-of-Year Review Strategies

With less than two months until the end of the year, what should you do to ensure your patient gaps are closed? Here are some tips to get you to the finish line:

- Pull your Blue Cross Blue Shield of Michigan (BCBSM) patient gaps list from Carespective™ (exporting the report to excel will give you multiple report options to best customize your approach to fit your practice), Health eBlue or an all patient/all payer list from your EHR or Registry.
- Identify those patients that have gaps that need an appointment and schedule them before the end of the year, allowing enough time to reschedule for cancelations. Add a note in the schedule so staff know to not allow patient to just cancel.
- From the above list, identify patients that can be scheduled for a nurse visit if they need labs done, etc.
- Identify measures that need Healthy Blue (HeB) entry such as blood pressure control and enter that data into HeB.
- From the patient list, identify measures that just need follow up calls for services not completed, such as colorectal cancer screening, mammograms or labs. Follow up with both facilities and patients. Encourage patients to complete services and provide education on importance. Assist patients in scheduling services before the end of the year.

If you would like assistance on how to pull reports from Carespective, contact your practice transition consultant.

All patient-centered medical home (PCMH) capabilities are reported to BCBSM twice a year, December and June. Practice transition consultants will be contacting offices to arrange an appointment to verify current and new PCMH capabilities. You can start preparing now by reviewing your PCMH binder, marking what needs to be updated, and following up on any outstanding items discussed in previous meetings. Below are just a few suggestions to get you started:

Annual training on the chronic care model & PCMH (new PowerPoints are available in Carespective's Learning Center, titled "Path to Transformation".) This is required for all new and seasoned staff. Consider combining this with other annual training requirements such as OSHA, CPR, HIPAA, etc.

- Review the practice's test tracking and specialist referral policies.
- Gather any team meeting minutes or outside presentations on health promotion, community resources and/or education done in 2017.
- Review your community resources directory for current information. Do a "community resource" hunt by matching patient needs with local resources. This is a fun activity to do during a team meeting or lunch.
- Note your most recent patient provider agreement counts for your active patients.

- If your practice performs patient satisfaction surveys, have the most recent results and improvement activities available to discuss.
- As you gather information for patient gap outreach, keep the worksheets of the work performed, such as patient call lists or sample letter.
- Ensure all new "core capabilities" are in place.

There are numerous resources in the Learning Center to keep you moving forward in your PCMH journey. Contact your practice transition coach with any questions. They are available to help you reach your designation goals.

November 2017

CODING CORNER

Depression Screening: Start the Conversation Today

Depression is sometimes difficult to talk about. It is normal to feel sad from time to time, but some people experience feelings of sadness, loneliness, and isolation on a regular basis for no obvious reason. When these symptoms occur frequently and affect a person's ability to carry on with his or her normal every day activities, depression may be the cause.

Depression is one of the most common mental disorders in the United States, impacting more than 15 million people age 12 years and older. It can affect the way a person thinks, feels, behaves and functions. Depression can cause suffering for individuals and for the people closest to them. It can also lead to missed days at school or work and increased health care costs. The estimated economic burden of depression, including workplace costs, health care costs and suicide-related costs, was more than $210 billion in 2010.

Because patients may be hesitant to discuss their symptoms with a health care provider, it is important for providers to initiate the conversation. Many providers are more comfortable discussing physical symptoms with patients, as opposed to discussing their emotional health. It is important to recognize physical symptoms, such as pain, can be associated with depression. There can be a significant overlap between physical health and mental health symptoms.

The following are some signs and symptoms of depression. Not all people will experience every symptom on this list, but these are the most common. Generally, the person must experience some of these symptoms every day, or nearly every day, for a period of two weeks or longer to be diagnosed with depression:

- Feelings of sadness, hopelessness, depressed mood
- Loss of interest or pleasure in activities that used to be enjoyable
- Increase or decrease in weight or appetite
- Change in activity level
- Difficulty sleeping or sleeping too much
- Feeling tired or not having any energy
- Feelings of guilt or worthlessness
- Difficulties concentrating and paying attention
- Thoughts of death or suicide

Depression Screening Tool

One of the most commonly used screening tools for depression is called the Patient Health Questionnaire, or PHQ-9. It is a brief 10-question survey that can be administered during an office visit. The tool evaluates the degree to which a patient is experiencing symptoms of depression and the degree to which those symptoms impact his or her life. The provider can easily score the tool and determine whether the patient has minimal symptoms or is suffering from mild or major depression. Armed with this information, the physician can then discuss appropriate treatment options.

Risk factors for depression may include a personal or family history of depression or recent major life change, trauma or stress. In addition, patients with a chronic illness, such as diabetes or heart disease, are more likely to experience depression. In some cases, certain medications may also contribute to depression. Patients with these risk factors should be screened for depression. However, screening can be beneficial for all patients.

The National Committee for Quality Assurance (NCQA) has incorporated screening for depression into its HEDIS measures using data from electronic clinical data systems (ECDS). They have added a new depression-related measure each year for the past three years. The current measures are as follows:

Depression Screening and Follow-up for Adolescents and Adults

This measure evaluates the percentage of patients age 12 or older who were screened for clinical depression using a standardized tool and, if screened positive, received follow-up care within 30 days.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

This measure evaluates the percentage of patients age 12 and older with a diagnosis of depression that had an outpatient visit, along with a PHQ-9 score present in their medical record during the same assessment period as the outpatient visit.

Depression Remission or Response for Adolescents and Adults

- This measure evaluates the percentage of patients age 12 and older with a diagnosis of depression and an elevated PHQ-9 score, who showed evidence of response or remission within four to eight months after the initial elevated PHQ-9 score.
- Response or remission is defined as a 50 percent reduction in the PHQ-9 score.

Remember to add the diagnosis to the condition list and include all findings in the documentation so appropriate follow-up can occur.

The most important step in diagnosing depression is to initiate the conversation. Look for signs that a patient's physical symptoms may be caused by underlying depression and take time to perform a depression screening using the PHQ-9. Post information about depression in exam rooms and restrooms to encourage patients to open up about it when they talk with their provider.

The following codes are considered compliant with the HEDIS specifications for any health plan to close gaps. Because coding guidelines change frequently, please check with your billing and coding staff, and current coding manuals, for the most up-to-date requirements.

- HCPCS
    - G0444 - annual depression screening; 15 minutes. This screening is available to Medicare beneficiaries in the primary care settings equipped with staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.
    - Deductibles and coinsurance do not apply to this service
    - See G8431 - G8433 defining documentation
- CPT
    - Not separately identifiable – part of the E/M service
- CPT II
    - 3725F – Depression Screening1040F – Major depressive disorder (MDD) documented at initial evaluation
- ICD-10
    - F32.0-F32.4, F32.9, F33.0 – F33.3, F33.41, F33.9

Sources
https://www.nimh.nih.gov/health/topics/depression/index.shtml
https://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm
https://adaa.org/understanding-anxiety/depression
https://www.ncqa.org/hedis-quality-measurement/hedis-learning-collaborative/hedis-depression-measures
http://www.agencymeddirectors.wa.gov/Files/depressoverview.p

New Physical Activity Counseling Code

Blue Cross Blue Shield of Michigan (BCBSM) accepts the use of diagnosis code Z71.82 on claims to close the physical activity counseling gap for dates of service starting 10/1/2017. The current codes that the practice teams were trained on during the CIPA billing and coding events were G0447, S9451, and Z02.5. You may continue to use these codes as well.

Remember that *three components* are needed to receive credit for the HEDIS measure: weight assessment and counseling for nutrition and physical activity; BMI percentile counseling for nutrition; and counseling for physical activity.

Codes to Identify Weight Assessment:

Codes to Identify BMI Percentile

ICD-10: Z68.51 – Z68.54

Codes to Identify Nutrition Counseling

CPT: 97802-97804 (RD services)

HCPCS: G0270, G0271, G0447, S9449 & S9452 (non-physician provider), S9470 (RD service)

ICD-10: Z71.3 (Dietary counseling and surveillance)

Codes to Identify Physical Activity Counseling

HCPCS: G0447

S9451: (non-physician provider)

ICD-10: Z71.82 NEW 10-1.2017(Exercise counseling)

Z02.5 (Examination to participate in sports)

November 2017

Benefits of a Patient Portal

What is a patient portal? It is a system that supports two-way, secure compliant communication between the practice and the patient.

The goal of the patient portal is for patients to have access to a secure and HIPAA compliant web portal. The portal enables patients to access medical information and facilitates electronic communication with their providers.

Patient portals are applicable to primary care physicians and specialists. A patient portal can save both the practice and patient time.

A patient portal offers many options. Patients can request and/or schedule an appointment, graph results of self-administered tests (such as daily blood glucose levels), participate in an e-visit, request prescription refills, view test results and much more all electronically. Practices can also send automated care reminders, send health education materials, and confirm appointments. This can decrease outreach calls and save staff time.

As part of the Blue Cross Blue Shield of Michigan Patient Centered Medical Home (PCMH) initiative, patient portal is a domain under the PCMH program criteria. To meet the intent of this initiative, the practice should routinely track what portal functions the patients are using. All staff must be trained in proper use of the portal and have knowledge of safety and security issues related to electronic communication.

For more details on BCBSM PCMH Domain 12 - Patient Portal, please review the *BCBSM Interpretive Guidelines* or contact your PCMH practice transformation coach.

November 2017

Five Ways to Optimize Your EHR System

How to Demonstrate Quality Outcomes in the Pay-For-Value Market

What most providers and health systems have learned in this new, pay-for-value health care world is meaningful use of electronic health records (EHR) is necessary for success under value-based incentive programs. Getting to a point where EHRs increase efficiency rather than detract from it is something many providers struggle with today.

Nevertheless, providers need to stick with EHRs and take full advantage of its technological capabilities. Why? Because EHRs can provide more opportunity to manage patient populations and health outcomes through a better understanding of critical care points and associated risks. EHRs also improve data sharing with other partners in the medical chain, enhancing coordinated patient care.

EHRs are the key to getting ahead of quality issues that can lead to financial penalties under value-based care. Health care providers without staff well-versed in technology or adept in the process improvement expertise that makes it possible to optimize an EHR system may need to work with a consultant. Partnering with a consultant experienced in helping health care practices and facilities take full advantage of EHR systems is a good way for providers to get the support they need to improve care coordination and clinical outcomes.

Five ways providers can optimize their EHR systems to improve patient outcomes:

1. Identifying at-risk and risk-stratified populations – EHR data can be accessed to find such populations rapidly. The provider can build a patient registry of identified patients for better care coordination and proactive intervention.
2. Using clinical decision support – By combining EHR data with clinical decision support, providers can ensure safer care by eliminating drug-to-drug and drug-allergy interactions. Also, sending medical reminders through the patient portal can eliminate gaps in care or gaps in needed prevention care services.
3. Scheduling medical appointments – When patients use the patient portal to set up appointments and request prescription refills, this saves office staff members' time. If configured, the system also can issue reminders to patients prior to scheduled appointments for added confirmation.
4. Retrieving lab results – Providing access to normal lab results through the patient portal allows patients to get answers they are looking for as soon as the results become available. As abnormal test results cannot be posted, the portal can be used to remind patients to call a medical staff member.
5. Maintaining a patient education record – To better support patients in their health self-management and ongoing treatment, providers can use the EHR to identify patient-specific educational resources and share them with patients, if appropriate.

Sources:

http://electronichealthreporter.com/value-based-reimbursements-depend-optimized-ehrs/
http://qioprogram.org/qionews/articles/five-key-ways-optimize-ehrs-better-patient-health

Improving Patient Experience of Care Impacts Quality of Care

Patient experiences encompass a range of interactions within a health system, including health plans, doctors, nurses, staff in hospitals, physician practices, and other health care facilities. Many of you have seen the following equation:

Value = Patient Experience + Quality of Care

As providers of health care, we have a solid understanding of how we can impact the quality of care our patients receive. However, we are less certain about how to impact the experience of the patient. Every patient we care for is an individual with different experiences and expectations. We understand being respectful, kind, and compassionate when we speak with patients greatly impacts their experience but are less certain of how to impact other measures of patient experience.

Blue Cross Blue Shield of Michigan (BCBSM) (and other health plans) survey their members annually about the health care they have received from their contracted health care providers. The survey can highlight performance improvement areas to focus on. For example, after BCBSM Medicare Advantage (MA) PPO's 2016 Patient Experience of Care survey results were reviewed, BCBSM MA PPO identified five questions as areas of focus.

Those five questions are:

1. In the past 12 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office follow-up to give you those results? **Percent of respondents that responded "Always" is the measurement.**

2. In the past 12 months, how often did you and your doctor talk about all the prescription medications you are taking? **Percent of respondents that responded "Always" is the measurement.**

3. In the past 12 months, how often did you see the person you came to see within 15 minutes of your appointment time? **Percent of respondents that responded "Always" or "Usually" is the measurement.**

4. In the past 12 months, did your doctor or other health care provider advise you to start, increase, or maintain your level of exercise or physical activity? **Percent of respondents that responded "Yes" is the measurement.**

5. Have you talked with your doctor or other health care provider about urine leakage? **Percent of respondents that responded "Yes" is the measurement**

CIPA began working with its BCBSM Physician Group Incentive Program (PGIP) practices in June 2017 on interventions to improve patient responses to these five questions. Practices may also go to this website: www.brainshark.com/bcbsm/patientcommunication to watch a 30-minute video about how effective communication with patients can improve a patient's experience of care. After the video, the viewer(s) may sign in on the guestbook page, and request free items that can be ordered for your office to help with patient communication:

- Exam room poster
- Exam room notepad for patients
- Patient survey (physicians can hand out) Survey collection box

Studies show at both the practice and individual provider levels, a positive patient experience with providers directly correlates to processes of care for both prevention and disease management and adherence to treatment recommendations. CIPA encourages your practice team to review the questions through the eyes of your patients. What can be said or done differently to make your interactions more customer focused?

Practices may also request a consultation with a BCBSM staff person who is trained to map out a process for your patient experience survey, and to work with your practice on ways to improve your patients' experiences.

BCBSM PPO MA will survey its members again in November 2017. Survey results will be compared to 2016's annual patient experience of care survey results to see if there is improvement in the responses to those five questions.