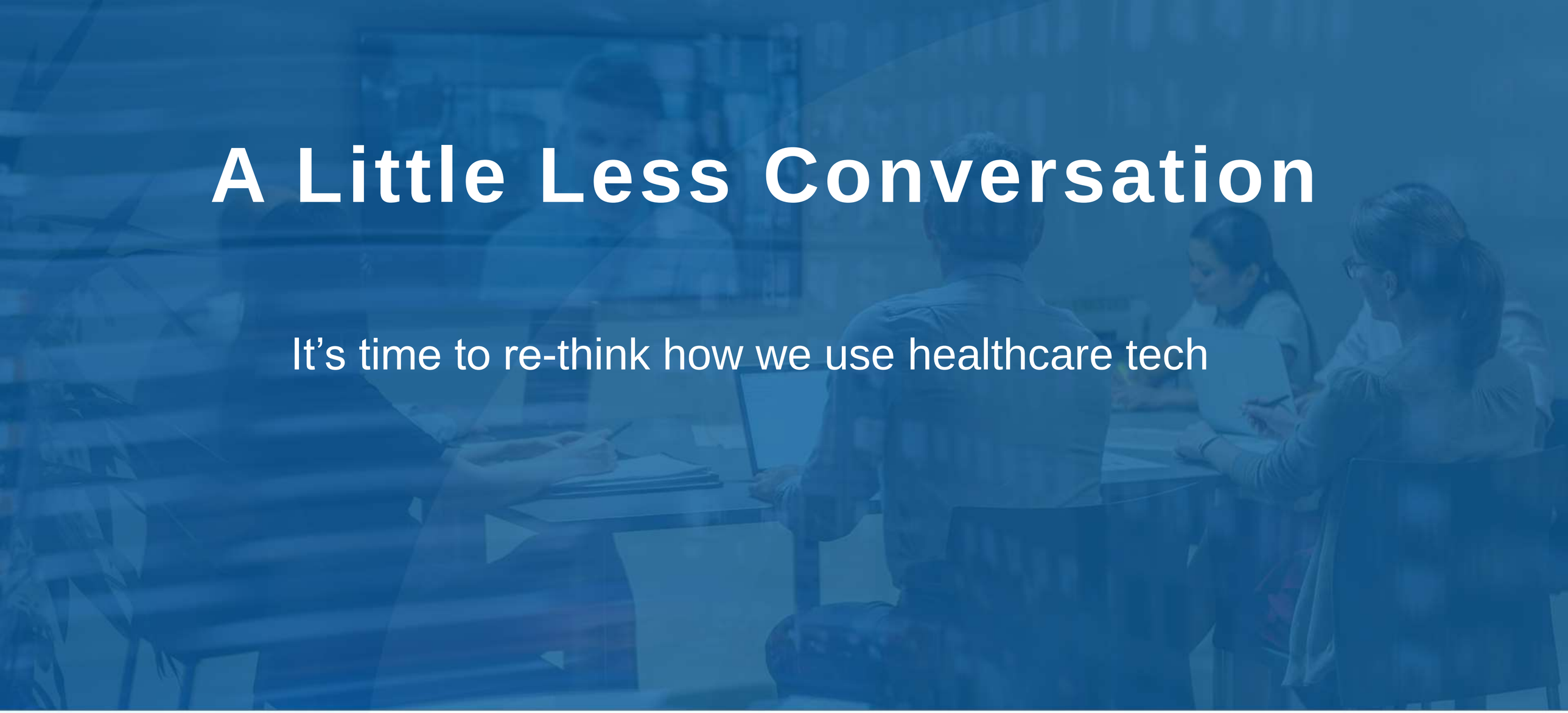


A Little Less Conversation

It’s time to re-think how we use healthcare tech

Karen R. Clark, MBA, CPHIMS.FHIMSS

Chief Information Officer

OrthoTennessee

Physician burnout

It's a battle out there – and it's not a fair fight

- 2009 HITECH Act (part of ACA)
- 2011 First participation year for Meaningful Use
- 2013 MU Stage 2
- 2014 MU Stage 3
- 2015 MACRA replaces MU with MIPS
- 2016 Last payment year for MU
- 2017 First year of MIPS
- 2018 Proposed Rule changes to MACRA
- 2019 Finalized changes to MIPS

How did we get here?

In the course of simply surviving the dizzying rate of change while still running a medical practice--we may have missed some significant changes:

- Proposed Rule changes to MACRA, e.g., blended visit code
- Fewer required data elements
- Pushback against canned notes
- Natural language processing that can interpret narrative text
- Zombie workflows
- Disruptive, consumer-focused tech solutions

Why is my EHR so clumsy and onerous to use?

- The HITECH Act required EHR software to be Federally Certified
- Vendors faced “Certify or Die.”
- All development effort went to meeting the thousands of pages of requirements
- Zero focus on User Experience
- Pace of continual change in MU requirements, and changes to Certification requirements kept vendors focused on not losing their certification—not ease of use

The Swiss Army Knife Approach

- EHR software was sold as an “all in one” solution
- Vendors tried to hit all specialties, so did none of them very well
- Practices eager to avoid any additional costs with interfaces or additional licensing
- Patient portal a requirement—not a need or want-a checkbox item

The rules have changed--really

- MACRA/MIPS not only allows flexibility in measure choice, but beginning in 2019, allows flexibility in measure collection and reporting
- Required data elements went from 22 in MU to 6 Quality measures in MIPS
- Fee schedule changes allow for less repetitive documentation

Blended visit codes and telemedicine

2019 Medicare Physician Fee Schedule Proposal Would Overhaul E&M Coding and Documentation

Major reforms to E&M payments including **single blended payment rates** for both new and established patients for office/outpatient E/M level 2 through 5

Streamlining documentation requirements

Expansions to telehealth and virtual care reimbursement, including payment for virtual check-ins and evaluation of patient-submitted photos or recorded video and Medicare-covered telehealth services for prolonged preventative care

Clinician pushback against canned notes (and they're right!)

Narrative: The patient is seen today for reevaluation of her right elbow. She has a chronic radial head dislocation. She relates that she has mild pain in the elbow, no mechanical locking. Symptoms worsen with overuse.

Canned: <Pt name> is a 65 year old female. She presents with pain and weakness on the right side. The pain is described as sharp. She rates her worst pain as 6/10. She rates her current pain as 2/10. The symptoms are aggravated by lifting, and rotation.

Zombie workflows

- Examine every step in your processes, from appointment to check out
- What data is being collected? Why, and by whom?
- Are you a specialist still asking about flu shots? (Bet you are.)
- Family history? Pneumonia vaccination?
- Each data point should be mapped to a) Clinical, b) Billing, c) Regulatory compliance/reporting
- If it can’t be mapped—stop collecting it.

2018 - Transparent technology and the power of Application Programming Interfaces

- Delta airlines app
- Expedia—open API
- Uber
- High-touch, high customization
- Clinicians use these apps in everyday life
- Allows use of apps built for mobile—not bolted-on

Radical idea (not to our docs!)

If a task does not require MD after your name, why are we asking physicians to complete it?

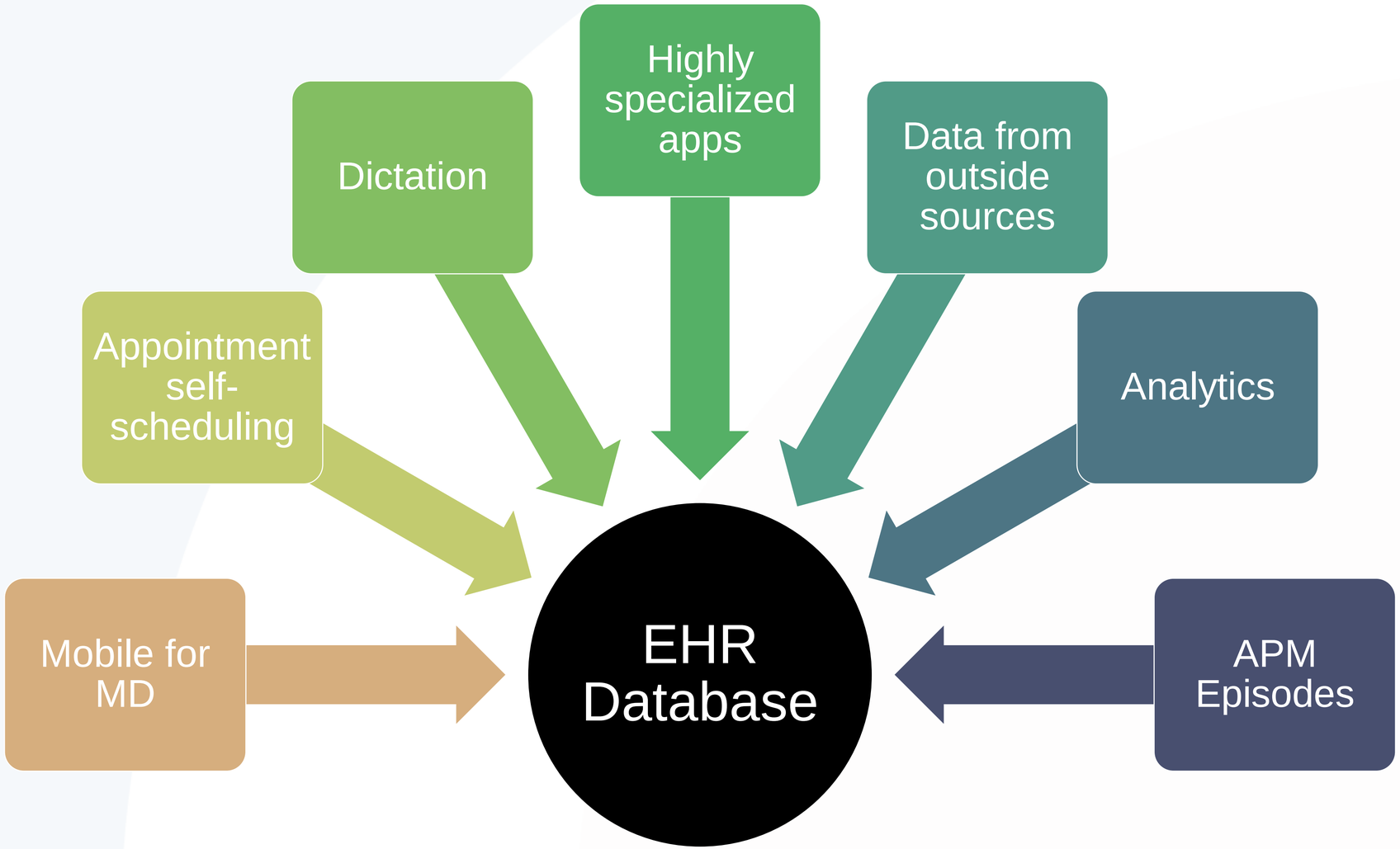
We shouldn’t.

We're moving out of the era of EHR implementation and adoption and into the era of interoperability

Should you change your EHR? (Probably not yet)

- Instead—re-think how you would ideally use tech
  - Mobile for providers
  - Function-specific apps for your mission-critical work
  - Require full interoperability to start—no API-no contract
  - Strip out all unnecessary workflows
  - Our patients want full mobile access also
  - Where is discrete data useful, and where is a narrative best?
  - Use natural language processing

Your EHR database



Qualities of a 21st century EHR

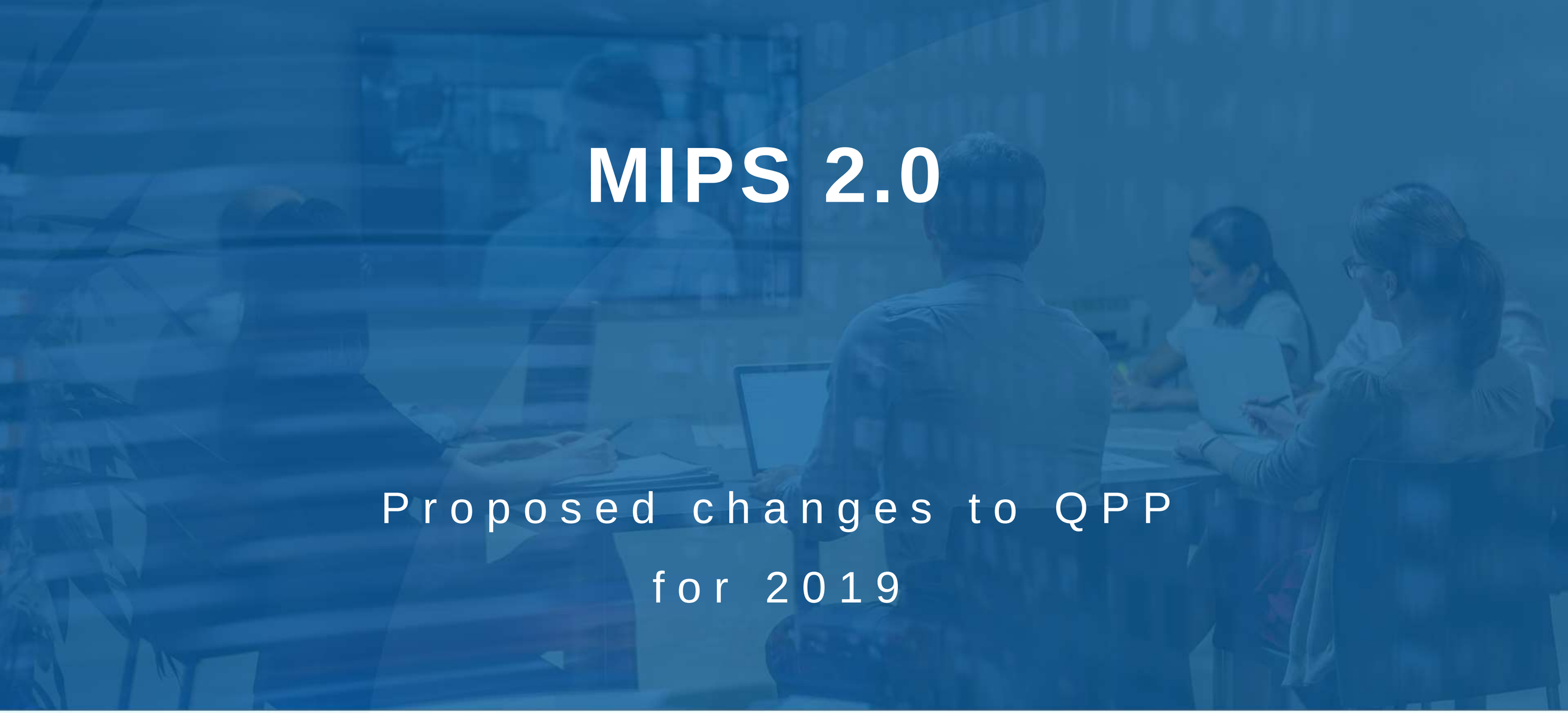
Before the cloud vs. on-prem discussion, look for capabilities that will enable and empower your providers and practice.

- Industry standard database
- Agreements with vendor must include database/interface engine access to allow internal (or outside) integration development
- Open API
- Connectivity with Commonwell and CareEquality and your local HIE

A little more action please

- Let’s ask the right questions
- Let’s help our vendors understand what we need
- Let’s demand excellence in applications for our providers
- Let’s focus on the patient and the process—not the tech

We’ll know we have it right when it becomes invisible.



MIPS 2.0

Proposed changes to QPP for 2019

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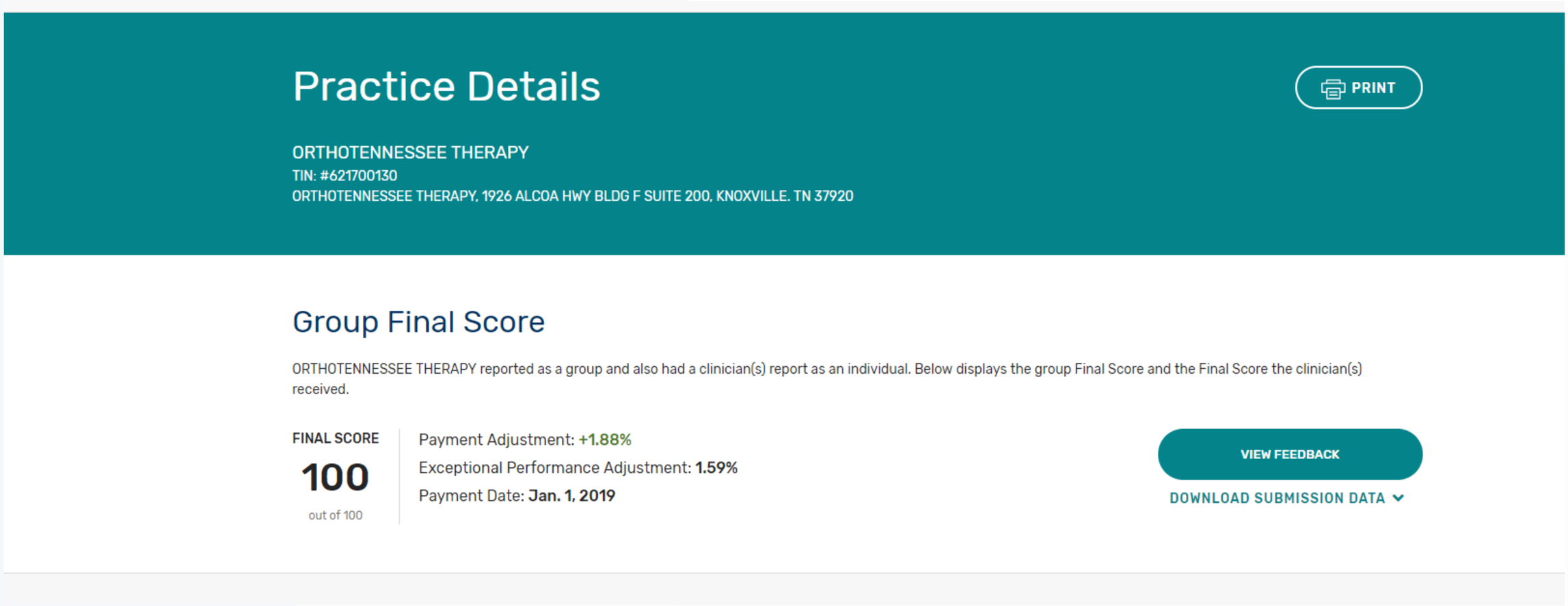
So, was it worth it?



Practice Details

PRINT

ORTHOTENNESSEE THERAPY
TIN: #621700130
ORTHOTENNESSEE THERAPY, 1926 ALCOA HWY BLDG F SUITE 200, KNOXVILLE. TN 37920

Group Final Score

ORTHOTENNESSEE THERAPY reported as a group and also had a clinician(s) report as an individual. Below displays the group Final Score and the Final Score the clinician(s) received.

FINAL SCORE
100
out of 100

Payment Adjustment: **+1.88%**
Exceptional Performance Adjustment: **1.59%**
Payment Date: **Jan. 1, 2019**

VIEW FEEDBACK
DOWNLOAD SUBMISSION DATA

Executive Summary for 2019 (Proposed)

- Fee schedule changes come with reduced documentation requirements
- New Eligible Clinicians: PT, OT, CSW, LCP
- Flexibility in method of data collection
- Flexibility in submitter type
- AUC criteria required on claims beginning 2020
- Cost component include episode-based measures (TKA)
- Promoting Interoperability now all performance based
- In 2022 performance threshold will be set to the mean performance of all EC—so each EC will have to be “better than average” in order not to be penalized

Professional Fee Schedule Changes

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Blended visit codes and telemedicine

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Streamlining documentation requirements

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Condensing Visit Payment Amounts

CPT Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99201	$45	$43
99202	$76	$134
99203	$110	
99204	$167	
99205	$211	

CPT Code Est. Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99211	$22	$24
99212	$45	$92
99213	$74	
99214	$109	
99215	$148	

E&M proposals for 2019

CMS originally considered eliminating CPT code for office visits, but logistics with secondary payers led to use existing CPTs

- Physicians **will be allowed to choose method of documentation**:
  - 1. 1995 or 1997 Evaluation and Management Guidelines for history, physical exam and medical decision making (current framework for documentation)
  - 2. Medical decision making only
  - 3. Physician time spent face-to-face with patient

Changes to documentation requirements

In order to report an ***established*** office visit to Medicare, physicians need to document medical necessity and then one of the following:

(1) Two of the three components: (1) problem-focused history that does not include a review of systems or a past, family or social history; (2) a limited examination of the affected body area or organ system; and (3) straightforward medical decision making measured by minimal problems, data review and risk; or

(2) Straightforward medical decision making measured by minimal problems, data review and risk, or

(3) Time personally spent by billing practitioner face-to-face with the patient. CMS is soliciting comment on what time should be required if this is the documentation selection (two options mentioned, 10 minutes (CPT defined typical time) or 16 minutes (weighted average of all established office visits).

Quality Payment Program Proposals

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The rules have changed--really

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Quality Payment Program Proposals

- MIPS Expanded to New Clinician Types
- Quality weight to 45%
- Low-Volume Threshold - $90,000/200
- Performance Threshold is now 30 points
- New Reporting Options
- Remove 34 low-value measures, add 10 new measures

Cost category includes episodes

- Eight new episode-based measures in 2019. All of the measures include both Part A and Part B costs
- Five of the new measures are tied to costs associated with a particular procedure (elective percutaneous coronary intervention, **knee arthroplasty,** revascularization for lower limb ischemia, routine cataract removal with IOL, and screening colonoscopy).
- Cost now 15% of your total score

OPERATIONAL CONSIDERATIONS

PUTTING IT INTO PRACTICE

ORTHO TENNESSEE

So, is it worth it?

- For 2020, CMS predicting a 1.5% for high performers compared to 5% authorized under law
- Alignment of MIPS Promoting Interoperability with Hospital PI
- By removing carrot and stick, CMS has moved from a significant value-based transition tool to a regulatory compliance exercise with little impact on cost or quality

An opportunity to reduce physician burden

We now know it’s not difficult to achieve a high score

Measure flexibility might allow us to choose measure that mean something (like FSAs for total joints)

Reduction in documentation and simplified coding means less data entry

Work with your EHR vendor or registry on a 2019 strategy—minimum effort for maximum score—and nothing extra

Zombie workflows

- Examine every step in your processes, from appointment to check out
- What data is being collected? Why, and by whom?
- Are you a specialist still asking about flu shots? (Bet you are.)
- Family history? Pneumonia vaccination?
- Each data point should be mapped to a) Clinical, b) Billing, c) Regulatory compliance/reporting
- If it can’t be mapped—stop collecting it.

Prepare for 2019

1. **Review** your MIPS performance
2. **Evaluate measure choice**
3. **Eliminate** unnecessary workflows
4. **Identify** your reporting options
5. **Educate** physicians and staff

Thank you

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