Optimizing Quality Management with Your EHR: Getting Paid More for What You Do Best
Executive Summary
Physicians have always been dedicated to finding the best methods of patient care, implementing them, and sharing them with other physicians. In recent years, insurers, private quality organizations, and the government have standardized some of these methods and developed programs that reward physicians for implementing them. These programs are also aimed at cutting health care costs. At a time when practices are facing declining income, the rewards for participation can contribute significantly to your bottom line. But the rewards are only worth seeking if the cost—in time and money—of collecting data for, and reporting it to, quality programs doesn’t outrun the potential gain, as many physicians fear it will. This is where your EHR and the services provided by your EHR vendor can make a significant difference. EHR capabilities and EHR vendor services should include:

1. Notice of, and enrollment in, quality programs appropriate to your practice, as well as continuous tracking, monitoring, and incorporation of new programs and opportunities;

2. Tools that make it easier to deliver and monitor quality care as prescribed by those programs;

3. Population management tools that make it easy to close the care gap for patient populations targeted by quality programs; and,

4. Electronic capabilities and support that remove the administrative burden of collecting and submitting quality data to the programs.

With these four capabilities in place, your practice can not only maintain or improve the quality of patient care, but also reap the financial benefits of delivering high quality care. And you’ll be well-positioned as health care reform moves the industry toward quality-based reimbursement.
No physician needs to be told that quality care produces better outcomes. Nor do you need to be told that sharing best practices for treatment across the health care system is important. Physicians have been doing this since the inception of modern medicine. What is new is the increasing number of quality programs seeking to improve outcomes and lower costs by financially rewarding physicians for applying evidence-based medicine to health care delivery. These programs—sponsored by insurance companies, quality organizations, and state and federal governments—provide a significant opportunity for practices to reap rewards for doing what they do best: providing quality care.

But there is a fly in the ointment. Many practices, small and large, have found—and studies support—that the time and money they invest in finding and enrolling in appropriate quality programs, changing their workflow to follow program procedures, monitoring compliance with quality measures, and reporting data to the programs can outweigh the financial and outcome benefits of participation.

This whitepaper examines the opportunity provided by quality programs, the challenges inherent in finding appropriate programs and participating in them, and the solution for overcoming these challenges and profiting from participation.

The Opportunity: Better Outcomes and Reporting Can Boost Revenue

For starters, what is actually meant by “quality management”? In the health care industry, quality management is simply the process of measuring quality performance to identify gaps in care and areas for improvement. This information is used to develop processes to enhance patient care and improve the efficiency of health care delivery. There are multiple steps and organizations involved in the formal creation of a quality program:

1. A clinical guideline is developed by a physician or disease organization such as the American Academy of Family Physicians (AAFP), American Diabetes Association (ADA), or American Academy of Neurology (AAN) (e.g., studies have shown that diabetics should receive at least two A1C tests per year).

2. Clinical quality organizations such as the Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), and National Committee for Quality Assurance (NCQA) work with physician organizations to develop measures based on guidelines (e.g., the rate of patients between 18 and 75 with diabetes that had A1C tests twice during the year).

3. Program sponsors (such as insurers, quality organizations, and government agencies) adopt measures (e.g., the percentage of patients between 18 and 75 with diabetes who received an A1C test once per year) and create programs that financially reward physicians for following the guidelines.
The benefit of following well-established clinical guidelines is obvious: better outcomes. Patients who get regular, well-vetted treatments are more likely to remain healthy, which benefits the organization sponsoring the program as well as the patient.

In these times of declining physician reimbursement, when many physicians are struggling with more mandates and less income, the financial rewards for following clinical guidelines and participating in ACOs could be significant. For example, Pay-for-Performance (P4P) programs are becoming an important part of the reimbursement environment. (There is also evidence that P4P programs can improve the performance of the lowest-performing providers in a practice.) Payments from P4P programs average 7% of physician compensation, though they can be as high as 30%. Figure 1 shows the variety of P4P programs available.

The quality program that many practices will have to attend to first, if they’re not already doing so, is the CMS EHR Incentive Program created as part of the HITECH Act. This Act provides federal stimulus money to physicians who implement and demonstrate “Meaningful Use” of a certified EHR as defined by CMS in July 2010. (For more information, see “What is the HITECH Act?” at http://www.athenahealth.com/hitech.php.)

To give another example, the Physician Quality Reporting Initiative (PQRI) program’s rewards will be in effect through 2014. However, the Patient Protection and Affordable Care Act set penalties for nonparticipation in PQRI programs. In 2015, nonparticipating practices will see their Medicare and Medicaid payments reduced by 1.5% and in 2016 and beyond the reduction will be 2%.

In order to benefit financially from quality program participation—and avoid future penalties—practices must find appropriate programs, enroll in them, and then figure out how to provide all the data required to trigger financial rewards without incurring additional costs.
The Challenge: Participating in Quality Programs Costs Money & Time

It is important that a practice have a quality strategy that involves collecting quality information, doing internal reporting on that data for quality improvement purposes, and being able to submit that data to outside organizations for P4P incentives or preferential contracts. An important part of this quality strategy should be taking an assessment of the P4P opportunities that are available and making sure to take part in the programs that are applicable to the practice. In fact, there are more than 150 P4P programs in the U.S., and that number is increasing. Only a program that rewards the procedures your practice performs regularly will be worth participating in, so you may need expert guidance in order to choose wisely from among the programs available.

Once your practice has enrolled in one or more quality programs, the work really begins in earnest. Practices may need to track anywhere from 50-100 quality measures across multiple programs—measures that must be followed, monitored, and reported on in order to receive incentives. And, although there may be similarities in measures, each program has unique quality measure specifications, data collection methods, data submission timeframes, and methods.

A recent study from the University of North Carolina, published in Annals of Family Medicine in late 2009, makes it clear that the cost in time and money for participation in quality programs is real. The study, which looked at the quality participation activities of eight diverse practices, notes that, “across these practices and programs, the major expenses included planning, training, registry maintenance, visit coding, data gathering and entry, and modification of electronic systems. Considerable variability across practices was noted, underscoring the notable challenges to performing quality improvement work.”

Figure 3, reprinted with permission from that study, defines the specific areas where costs were incurred by the practices studied as a result of their participation in the following four quality programs: PQRI, Community Care of North Carolina (CCNC), Bridges to Excellence (BTE), and Improving Performance in Practice (IPIP).

Patient-Centered Medical Home

A quality program often regarded as one that points to the future of medical care coordination is the Patient-Centered Medical Home (PCMH) quality program sponsored by the National Committee for Quality Assurance (NCQA). NCQA defines PCMH as “a health care setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family.

Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. There are nine PPC® standards, including 10 must-pass elements, which can result in one of three levels of recognition. Practices seeking PPC®.PCMH™ use a webbased data collection tool and provide documentation that validates responses.”

This is a demanding program with guidelines covering everything from care management to electronic prescribing to patient access and communications. Gathering and reporting the data required by PCMH without overtaxing a practice’s administrative staff and systems is difficult without the aid of a sophisticated EHR system and an EHR vendor that provides services to take on much of the administrative burden.
### Figure 3. Types of Costs Incurred for Quality Program Participation\(^\text{10}\)

<table>
<thead>
<tr>
<th>Categories of Costs Identified and Estimates for Each Program and Practice</th>
<th>Direct Cost of Personnel Time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category</strong></td>
<td><strong>Non-personnel Costs</strong></td>
</tr>
<tr>
<td>Definition</td>
<td>Cost of hardware, software, program materials, or participation fees(^b)</td>
</tr>
<tr>
<td>Types of costs identified and estimated</td>
<td></td>
</tr>
</tbody>
</table>
|  | • Application fees  
  • Cost of written program materials  
  • Software or software upgrades  
  • Hardware  
  • Data backup (electronic or paper), data security  
  • Legal consultations for agreements  
  • Excess clinical supplies needed to participate | • Personnel time to decide whether to participate in the program  
  • Personnel time to decide on measures to work on within the program  
  • Meeting times (formal and informal) to inform practice staff of program expectations, requirements, changes in staff roles and duties  
  • Regional meetings with other practices or administrators of the program(s)  
  • Staff time devoted to improving information interoperability necessary for data capture, submission, and crosscommunication with different electronic systems  
  • On-site staff time provided and paid for by the program and devoted to educating and/or assisting the practice  
  • Chart audit/data abstraction | • On-site staff time provided and paid for by the program and devoted to extracting data elements  
  • Report generation time, and/or report review time  
  • Data entry and upload  
  • Developing and maintaining a list of active patients for whom a measure applies; work to contact patients who are potentially inactive |

Note: Staff/personnel time costs are calculated as follows: cost = (hours devoted to task) (hourly salary + 22% [for benefits]). Source for benefit rate: http://www.pohly.com/books/mgmacost-multispecialties.html.

\(^a\) Staff includes any employee, clinician, or administrator associated with the practice or program.

\(^b\) Includes only the proportion of costs devoted to collecting and reporting data specifically for the reporting program. Adapted with permission from “Cost to Primary Care Practices of Responding to Payer Requests for Quality and Performance Data.” Annals of Family Medicine, Vol. 7, No. 6, November/December 2009. Copyright 2006 American Academy of Family Physicians. All Rights Reserved.
### Figure 4. Actual Costs Incurred for Quality Program Participation

<table>
<thead>
<tr>
<th>Program and Practice</th>
<th>Physician Quality Reporting Initiative (PQRI)</th>
<th>Improving Performance in Practice (IPIP)</th>
<th>Bridges to Excellence: Diabetes (DPRP)</th>
<th>Bridges to Excellence: Physician Practice Connections (PPC)</th>
<th>Community Care of North Carolina (CCNC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implementation Costs, $</td>
<td>Maintenance (Annualized) Costs, $</td>
<td>Major Cost Sources, $</td>
<td>Major Cost Sources, $</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Per Clinician FTE</td>
<td>Incurred by Program</td>
<td>Total</td>
<td>Per Clinician FTE</td>
</tr>
<tr>
<td>A</td>
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<td>425</td>
<td>0</td>
<td>12,200</td>
<td>871</td>
</tr>
<tr>
<td>B</td>
<td>920</td>
<td>368</td>
<td>0</td>
<td>207</td>
<td>83</td>
</tr>
<tr>
<td>D</td>
<td>22,200</td>
<td>11,100</td>
<td>0</td>
<td>8,657</td>
<td>4,329</td>
</tr>
<tr>
<td>H</td>
<td>5,894</td>
<td>475</td>
<td>0</td>
<td>7,200</td>
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<tr>
<td></td>
<td>3,571</td>
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<td>1,000</td>
<td>4,229</td>
<td>4,229</td>
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<tr>
<td></td>
<td>18,210</td>
<td>3,035</td>
<td>1,673</td>
<td>11,563</td>
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<td></td>
<td>8,658</td>
<td>618</td>
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<tr>
<td></td>
<td>4,270</td>
<td>488</td>
<td>45</td>
<td>N/A</td>
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</tr>
<tr>
<td></td>
<td>11,294</td>
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<td>N/A</td>
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<td>1,865</td>
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<td>709</td>
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<tr>
<td></td>
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<td>563</td>
<td>261</td>
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<td>N/A</td>
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<td>N/A</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2,788</td>
<td>319</td>
</tr>
</tbody>
</table>

AM = annualized maintenance cost; CEO = chief executive officer; EHR = electronic health record; IT = information technology; N/A = not available; QI = quality improvement; S = start-up cost.  

a Includes only the estimated cost of program services delivered on-site in the primary care practice.  
b No maintenance participation costs available either because of nature of program (no maintenance phase of reporting) or insufficient time in program.  
c CCNC started in 1998; several practices did not have access to costs data from implementation. Adapted with permission from “Cost to Primary Care Practices of Responding to Payer Requests for Quality and Performance Data.” Annals of Family Medicine, Vol. 7, No. 6, November/December 2009. Copyright 2006 American Academy of Family Physicians. All Rights Reserved.
However, practices that capitalize sooner on quality programs, adjusting their workflows to take advantage of them, will be well-positioned once quality-based models become the norm—and before penalties go into effect for not adhering to those models.

Practices should begin to participate in P4P programs at their earliest opportunity. As providers master optimal EHR workflows to capture QM data and meet patients’ care needs, they not only close gaps in care but also make their participation in more P4P programs easier. This, in turn, makes it easier to achieve quality recognition and incentive dollars. Providers that get ahead of the quality management curve early will see a return on their EHR investment sooner and are more likely to increase ROI over time.

The Solution: An EHR Service that Enables Profitable Participation in Quality Programs

It’s a complex process to participate in quality programs. Your practice will need to find and enroll in the right programs. Then you’ll need to access quality guidelines and monitor your practice’s adherence to them. Finally, you’ll have to gather and submit data to verify that the practice has met program measures. It’s difficult for a practice, large or small, to go it alone without all of this becoming a burden. A full-service EHR solution delivered by a vendor that provides quality reporting services can make the difference between quality programs being a burden and their contributing to the practice’s clinical success and financial bottom line.

EHR capabilities and vendor services should include:

1. Notice of, and enrollment in, quality programs appropriate to your practice, as well as continuous tracking, monitoring, and incorporation of new programs and opportunities;

2. Tools that make it easier to deliver and monitor quality care as prescribed by those programs;

3. Population management tools that make it easy to close the care gap for patient populations targeted by quality programs; and

4. Electronic capabilities and support that remove the administrative burden of collecting and submitting quality data to the programs.

With these four capabilities in place, your practice can not only improve the quality of patient care, but also reap the financial benefits of delivering that high quality care. Let’s look at what each of these capabilities entails.

Bridges to Excellence Quality Program

Bridges to Excellence (BTE) is a private non-profit organization that works with outside organizations, including insurance companies, EHR vendors, and clinical data repositories, to facilitate quality improvement and incentives through pay-for-performance programs.

To be eligible for recognition through BTE, a physician must achieve minimum thresholds for quality care assessed through both process and outcome measures. The organization has relationships with some payers who provide incentives for BTE-Recognized Physicians treating their patients. BTE-Recognized Physicians have opportunities to demonstrate to the public and to professional peers that the standards of care assessed by the program have been met, such as issuing a press release and having achievements posted on BTE’s consumer portal, HealthGrades (www.healthgrades.com). Where applicable, clinicians can establish eligibility for pay-for-performance bonuses, differential reimbursement, or other incentives from payers and health plans.

For more information on BTE, go to http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=18c or write to info@hci3.org.

The University of North Carolina study concludes that, “Despite the enthusiasm for quality improvement, reporting activities have occurred with relatively little regard to the challenges...practices face in collecting and reporting requested data. These challenges include inadequate data collection and reporting systems, multiplicity and inconsistency of measures required by different quality improvement organizations, the need to converge or reorganize multiple paper and electronic data sources, and insufficient financial resources to maintain office systems and educate office personnel.”

It’s no wonder that practices are skeptical about the value of participating in these programs. Even after all this clinical and administrative work is done, practices still might not succeed in satisfying quality program requirements. In 2008, for example, PQRI only had a 55% success rate among participating providers.14
1. Notice of, and enrollment in, quality programs

As noted above, quality programs originate from many places and have many purposes, and new programs are being developed continuously. What practice has the time and staff to keep abreast of new programs as they arise, investigate their suitability, enroll in them, and incorporate their guidelines and measures into the workflow? This is where your EHR vendor should come in.

Your vendor shouldn’t just sell you software and disappear; it should be an organization that has its finger on the pulse of the health care industry and of your practice. Your EHR workflow should always reflect the latest clinical best practices. In addition, your vendor should be knowledgeable about existing and developing quality programs and incentives of all kinds that can benefit your practice. In fact, your vendor should know your practice well enough that it notifies you of any new programs/incentives that would be financially beneficial for your practice, and then make it as easy as possible for you to enroll—in some cases even handling enrollment for you.

2. Tools that make it easier to deliver and monitor quality care

Physicians might ask themselves: What good is an EHR if it doesn’t make it easier to both consistently deliver the highest quality care and reap any financial rewards available for delivering that care—without increasing the administrative burden? This is the kind of promise that led to the development of electronic medical records in the first place. Your EHR vendor should be able to deliver on that promise.

In practical terms, this means that quality guidelines should be integrated into your EHR workflow, enabling physicians to see and act upon them at the point of care. Neither the physician nor practice staff should bear the burden of making those guidelines available as they are developed and as the practice enrolls in new programs. Your EHR system should take on the burden of this work for you. Each day, when you go online, the latest appropriate rules and procedures should be available on each patient’s record. Figure 5 shows a system where quality guidelines appear directly on the patient record. Using the quality guideline example mentioned earlier, if a physician is treating a diabetic, the patient’s record should show the guideline about diabetics receiving at least two A1C tests per year. The record should, of course, make it possible for the physician to order the A1C test electronically, but it should also record the test being ordered for quality-tracking purposes.

An EHR vendor that understands how quality program compliance is being achieved by practices nationwide can make it easier for your practice to achieve compliance. Beyond integrating quality guidelines into the workflow, your vendor should also be able to help you analyze your workflow and week-to-week performance for missing procedures or gaps in care.

Figure 5. Quality Guidelines in the Patient Record – at the Point of Care
3. Population management tools that make it easy to close the care gap for patient populations targeted by quality programs

Patient outreach, also known as population management, is essential for successful participation in quality programs. Practices must reach out to their patients in order to get them to schedule the checkups, tests, and procedures required for meeting quality measures. Your EHR system should be capable of zeroing in on a specific patient population and rolling up population data for convenient reporting. It should be capable of uncovering a new targeted population within your patient database and enabling you to manage that population efficiently and effectively.

Your EHR should also allow you to easily and continually communicate with any patient population through targeted e-mails and voice-mails. It should enable you to build a practice website where patients can get information and schedule their own appointments, once notified of the need for a checkup, test, or procedure. Figure 6 provides an example of an EHR system that enables practices to track communications with specific patient populations.

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**Humana-athenahealth Medical Home Rewards Program**

Some payers are innovating with their own programs to financially reward physicians for improving the quality, efficiency, and coordination of care. In 2010, Humana and athenahealth launched the Medical Home Rewards Program. Humana will subsidize the implementation cost of athenahealth’s EHR service for physicians who are eligible for participation. In addition, Humana is so confident that athenahealth’s clinical platform will deliver quality results that it is waiving the extensive NCQA Medical Home Recognition requirements for eligible users—while enabling them to earn up to 20% above their current fee-for-service collections paid by Humana.

Through this first-ever (outside of integrated delivery systems) clinical integration of a health plan, its physician network, and a PMIS/EHR, athenahealth will ultimately integrate payer-derived clinical data into its network to drive care gap closure and other payer and physician goals. Since Medicare will eventually require that PCPs meet Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, practices can get a head start toward meeting these measures and win incentives for doing so.

Physicians or practices interested in participating in this program can e-mail humanarewards@athenahealth.com.

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**Figure 6. Patient Outreach/Population Management Screen in an EHR System**

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Population</th>
<th>Not Satisfied</th>
<th>Satisfied</th>
<th>Excluded</th>
<th>Report Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C Screening in Diabetes (Practice Report)</td>
<td>11</td>
<td>3 (23%)</td>
<td>8 (77%)</td>
<td>0 (0%)</td>
<td>Print/Export to CSV</td>
</tr>
<tr>
<td>LDL-C Control in Diabetes (Practice Report)</td>
<td>11</td>
<td>3 (27%)</td>
<td>8 (73%)</td>
<td>0 (0%)</td>
<td>Print/Export to CSV</td>
</tr>
<tr>
<td>LDL-C Control in Diabetes (&lt;100mg) (Practice Report)</td>
<td>50</td>
<td>6 (12%)</td>
<td>44 (88%)</td>
<td>0 (0%)</td>
<td>Print/Export to CSV</td>
</tr>
<tr>
<td>LQC 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LDL-C Control in Diabetes (<100mg) (Practice Report)

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOS</th>
<th>Age</th>
<th>Sex</th>
<th>Phone</th>
<th>Result Status</th>
<th>Best Appointment</th>
<th>Recent Result</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
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<td>56</td>
<td>M</td>
<td>761-858-3012</td>
<td>Satisfied</td>
<td>09/02/2016 89</td>
<td>LDL DIRECT, 05/17/2010</td>
<td></td>
</tr>
<tr>
<td>RICK STEVENS</td>
<td>07101999</td>
<td>56</td>
<td>M</td>
<td>761-858-3012</td>
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<td>LDL DIRECT, 05/17/2010</td>
<td></td>
</tr>
</tbody>
</table>

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**Figure 6. Patient Outreach/Population Management Screen in an EHR System**
4. **Electronic capabilities and support that remove the administrative burden**

Your EHR system should be capable of automatically capturing the administration of checkups, tests, and procedures that fulfill quality measures for specific quality programs. The captured data should then be available when the practice does program reporting—for example, rolling up the data on all diabetics who received A1C test during the prescribed reporting period. Producing such reports manually is a grueling, time-consuming process—one of those processes that discourage practices from participating in quality programs. But with the right EHR system and vendor, the process can be relatively painless and inexpensive. Figure 7 provides an example of quality management reports available through an EHR system.

Once the data has been accumulated, practices must submit the data they collect. Methods for submitting data vary from program to program. Some accept electronic data, others require submission of an Excel spreadsheet, and still others require inputting the data on a website. Again, this can be a frustrating and time-consuming process. Your EHR system should be able to automatically submit electronic data to any program that accepts it. It should also produce reports in the form of Excel spreadsheets, which can either be submitted to programs that accept spreadsheets or used to speed the input of data on a program website.

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**Figure 7. Quality Management Reports Available in an EHR System**

![Quality Management Reports Example](image-url)
There is a Better Way

Participating in quality programs can be good for a practice, clinically and financially, but it can also create an administrative and financial burden that significantly diminishes, or even cancels out, the financial value of such programs. With the right EHR system and vendor assisting you, however, the financial rewards for doing what you do best every day—providing quality care for your patients—can help boost your income and prepare you for additional changes to health care reimbursement in the future.

athenahealth: More money and more control over quality care

athenaClinicals is a low-investment, high-return, cloud-based EHR designed to address the limitations of traditional EHRs and make participation in quality programs as easy and rewarding as possible.

athenaClinicals enables you to:

• Stay on top of and enrolled in HITECH Act, P4P, and other incentive programs by continuously tracking, monitoring, and incorporating new programs and opportunities for your practice behind the scenes;

• Achieve compliance with “Meaningful Use” requirements and get Federal HITECH Act incentives because compliance is built into the software and continuously updated to keep up with new requirements;

• Use built-in software tools to deliver and monitor quality care as required by quality programs;

• Use built-in population management tools to easily close the care gap for targeted patient populations;

• Offload paperwork, improve care, and meet quality requirements through closed-loop order management;

and

• Achieve all this and much more without the cost and hassle of buying servers, paying up-front licensing fees, and installing expensive and disruptive software upgrades.

At no additional charge, athenahealth’s back-office services electronically sort and route to charts all faxed and electronic clinical information—we even build and maintain electronic connections with labs, pharmacies, hospitals, and HIEs.

To learn more about how athenaClinicals can help your practice, visit athenahealth.com or call 800.981.5084.
Endnotes


5. Ibid.


9. Ibid, pg. 495.

10. Ibid, pg. 499.

11. Ibid, pg. 500.


Notes
we connect care™
A leading provider of cloud-based services and mobile tools for medical
groups and health systems. Our mission is to be the most trusted service
to health care providers, helping them do well by doing the right thing.