# Moving into 2015 and Beyond — Prepare for Meaningful Use II Launch and Meaningful Use III Planning

POINT-OF-CARE PARTNERS

Health IT Management Consultants

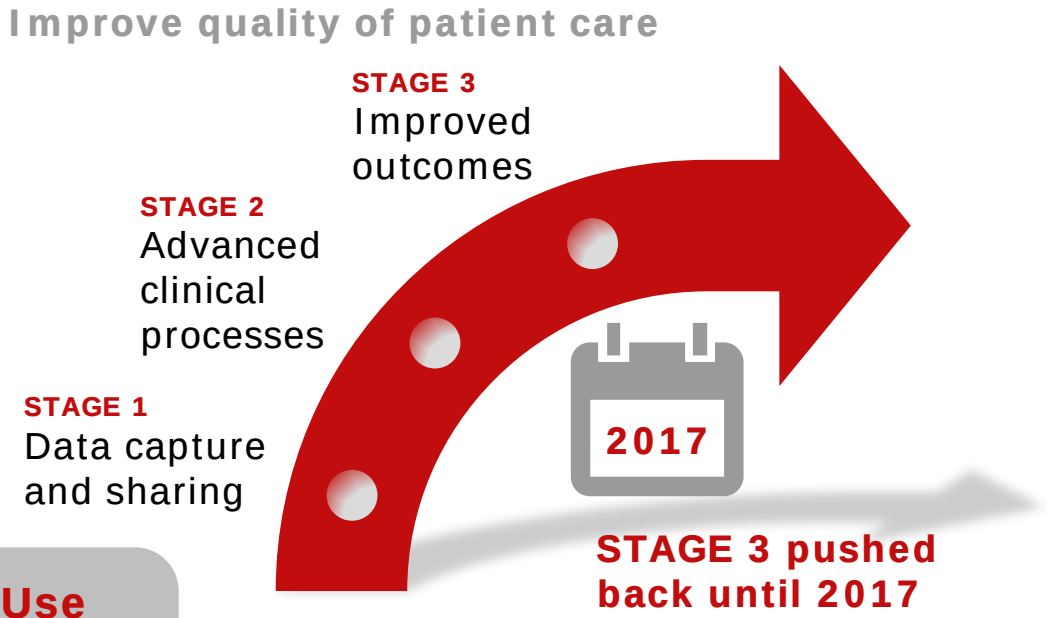
# Agenda

- Meaningful Use to Date
- Formulary Data in EHRs
- Electronic Prior Authorization
- Closing the Disease Management Loop
- Available Technologies: CDS
- Call to Action
- Future View

# Meaningful Use – to date

# Meaningful Use – Driving EHR Adoption

- Incents HCPs to adopt and "Meaningfully Use" EHRs
- Incentives replaced by penalties for non-participants




**Through July 2014, Meaningful Use has paid $24B to more than 4,600 hospitals and 392,000 HCPs**

# Meaningful Use Stage 2 – Slow Going So Far

| Attestations | Stage 1 | Stage 2 |
|---|---|---|
| Physicians | 264,921 | 3,152 |
| Hospitals | 4,071 | 143 |

**Fewer MU2 attestations:**

- delays in EHR availability
- uncertainty on future of program

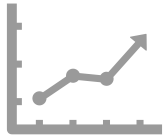
| Certifications | Stage 1 | Stage 2 |
|---|---|---|
| Ambulatory EHRs | 3,757 | 1,049 |
| Hospital EHRs | 1,210 | 746 |

**Fewer EHRS certified:**

- 30%+ EHR churn rate
- caused by immature products rushed to market

# MU Impact on Pharma Marketing and Sales

- Established a baseline functionality
  - Features
  - Clinical Decision Support
  - Quality Measures and Reporting
  - Patient Portal
- Features are available, even if HCP is not MU participant



**Our evidence suggests that practices activate CDS rules one diagnosis at a time.**

**POCP analysis of attestations shows that 18% of MU providers utilize reminders, and 55% use patient education materials.**

# Formulary Data in EHRs

# EHR Formulary Data – Impact on Drug Decisions

**Meaningful Use requires electronic formulary validation to be enabled and that the prescriber has access to at least one formulary. There is no requirement for the prescriber to look at or use the formulary data.**

- HCPs turn on formulary validation to "check the box" for MU but routinely ignore the data:
  - Incomplete
  - Inaccurate
  - Stale
- Several industry initiatives ongoing:
  - Require "PA" flag in existing NCPDP Script EDI standard
    - Exists today, optional field, not populated by all participants
  - Real time formulary validation
    - Likely 5+ year interval, development needed at PBM and EHR

**Despite availability of data at point of care, today formulary substitution is initiated mainly at the pharmacy.**

# Electronic Prior Authorization

# Electronic Prior Authorization (ePA)

**ePA enables faster patient access to treatment by reducing the administrative overhead of the prior approval process**

- Adoption slow but steady
  - Prescriber demand low because of lack of awareness
  - EHR integration key to success
- Industry norm is retrospective (pharmacy initiated based upon claim reject)
- Prospective EPA is better solution, moving decision to point of prescribing

**ePA was proposed for MU Stage 3, but deferred. Some states have passed ePA regulations, but mandated ePA is years away.**

# Closing the Disease Management Loop

# Using EHR to Close the Loop Between Disease Management & Outcomes

- MU 2 mandates Clinical Decision Support and Clinical Quality Measures
- Even if HCP isn't an MU participant, features are "in there"
- CQMs by themselves are reporting mechanisms. Add CDS to guide HCPs toward CQM standards with alerts and reminders to affect outcomes
  - Challenges:
    - Reimbursement
    - Change management
    - Infrastructure – people, technology

**Opportunity lies in leveraging the MU-related reporting to become actionable in the HER.**

# Leveraging MU EHR Clinical Quality Measures

## MU mandates reporting on 9 (of 64) CQMs and use of Clinical Decision Support

Patients whose HbA1c level is > 9%; plus patients who don't have an A1c test.

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Patients 18-75 years of age with diabetes who had a visit during the measurement period.

=

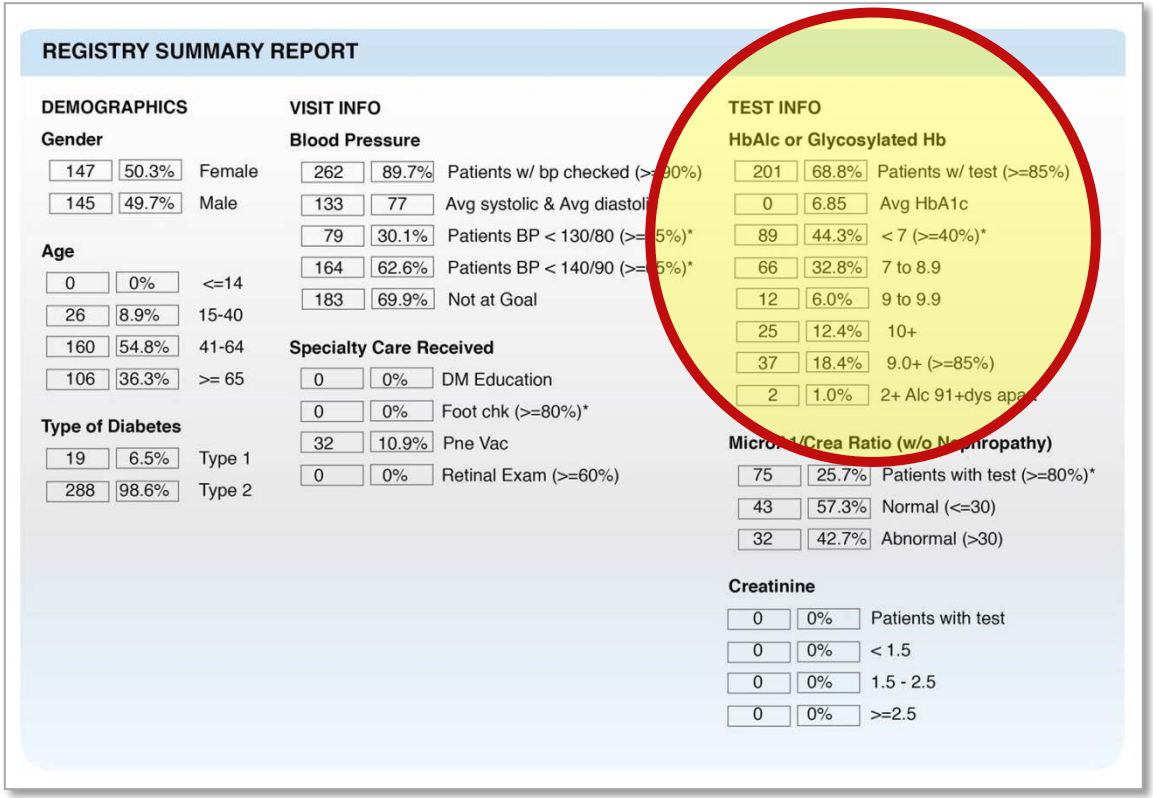
**Patients in need of testing & treatment evaluation**

**CQM evaluates:**
- **Gaps in Care**
- **Patients needing treatment intensification**

**Clinical Decision Support reminders alert HCP when patients HbA1C level is >9% and prompt to evaluate treatment**

# Leveraging MU EHR Clinical Quality Measures

**Let's take a closer look.**



REGISTRY SUMMARY REPORT

DEMOGRAPHICS

Gender

| | | |
|---|---|---|
| 147 | 50.3% | Female |
| 145 | 49.7% | Male |

Age

| | | |
|---|---|---|
| 0 | 0% | <=14 |
| 26 | 8.9% | 15-40 |
| 160 | 54.8% | 41-64 |
| 106 | 36.3% | >= 65 |

Type of Diabetes

| | | |
|---|---|---|
| 19 | 6.5% | Type 1 |
| 288 | 98.6% | Type 2 |

VISIT INFO

Blood Pressure

| | | |
|---|---|---|
| 262 | 89.7% | Patients w/ bp checked (>=90%) |
| 133 | 77 | Avg systolic & Avg diastoli |
| 79 | 30.1% | Patients BP < 130/80 (>=5%)* |
| 164 | 62.6% | Patients BP < 140/90 (>=5%)* |
| 183 | 69.9% | Not at Goal |

Specialty Care Received

| | | |
|---|---|---|
| 0 | 0% | DM Education |
| 0 | 0% | Foot chk (>=80%)* |
| 32 | 10.9% | Pne Vac |
| 0 | 0% | Retinal Exam (>=60%) |

TEST INFO

HbAlc or Glycosylated Hb

| | | |
|---|---|---|
| 201 | 68.8% | Patients w/ test (>=85%) |
| 0 | 6.85 | Avg HbA1c |
| 89 | 44.3% | < 7 (>=40%)* |
| 66 | 32.8% | 7 to 8.9 |
| 12 | 6.0% | 9 to 9.9 |
| 25 | 12.4% | 10+ |
| 37 | 18.4% | 9.0+ (>=85%) |
| 2 | 1.0% | 2+ Alc 91+dys apa |

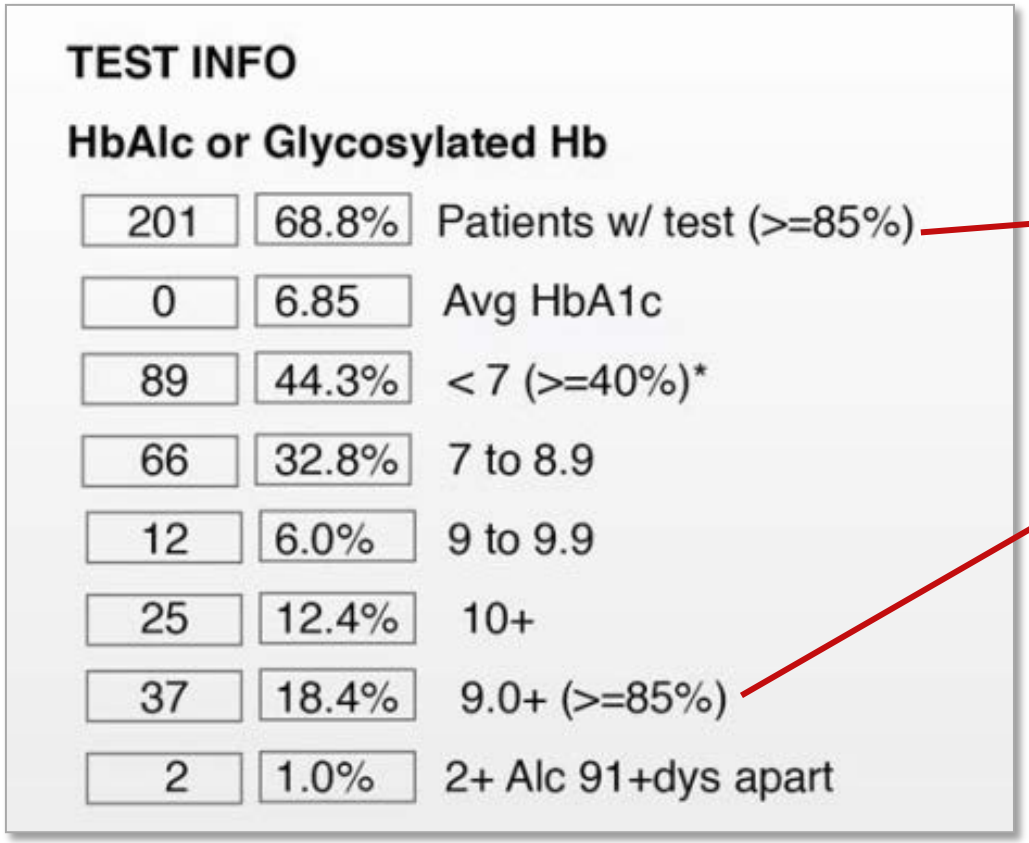
Micro /Crea Ratio (w/o N hropathy)

| | | |
|---|---|---|
| 75 | 25.7% | Patients with test (>=80%)* |
| 43 | 57.3% | Normal (<=30) |
| 32 | 42.7% | Abnormal (>30) |

Creatinine

| | | |
|---|---|---|
| 0 | 0% | Patients with test |
| 0 | 0% | < 1.5 |
| 0 | 0% | 1.5 - 2.5 |
| 0 | 0% | >=2.5 |

# Leveraging MU EHR Clinical Quality Measures



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68.8% of patients had an HbA1c test

18.4% of patients had an A1c value greater than 9.0

**Identifies:**

- **Gaps in Care**
- **Patients needing treatment intensification**

# Available Technologies: CDS

# Available technology to support MU 2 and beyond

To meet the demand created by the Meaningful Use incentives, many EHRs rushed immature products to market

- Weak design of EHRs necessitates duplicate data entry
  - Patient documentation
  - +
  - Tallies for MU reporting
- Well-intended CDS causes alert fatigue

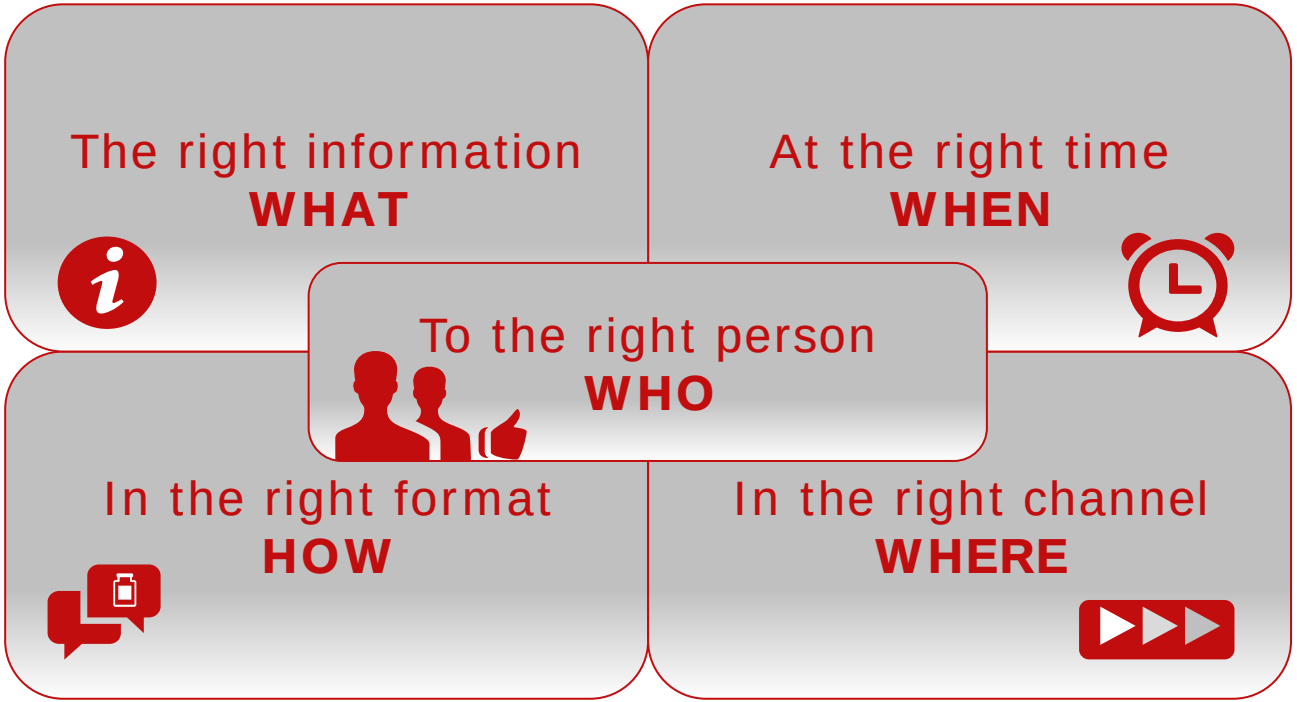
**HCPs are conservative with CDS, activating one diagnosis at a time**

Computer Assisted Flying as CDS


SOURCE: Advancing Electronic Measurement: What kind of learning network will be most effective in supporting those working to develop and implement e-Measures; 2013 NQF National Conference

# 5 R's of Clinical Decision Support

Effective Clinical Decision Support is deployed using these 5 principles



# Decision makers for EHR Workflow Changes

- The process of review, approval and implementation of workflow change such as Clinical Decision Support is multi-tiered

| | |
|---|---|
| EHR Development & Operations Committee | • Provides executive leadership for the program |
| CDS Oversight Committee | • Interdisciplinary, enterprise-wide leadership team responsible for providing oversight on CDS development<br>• Determine issues to be addressed with CDS interventions |
| CDS Workgroup | • Responsible for developing, deploying & monitoring CDS interventions |
| Content Expert Teams | • Ad-hoc, temporary teams with reps from medicine, nursing, pharmacy, allied health, diagnostic & therapeutic services, billing & compliance, & CDS Workgroup members<br>• Members work in focus groups to develop & review CDS requests approved by the Oversight Committee |

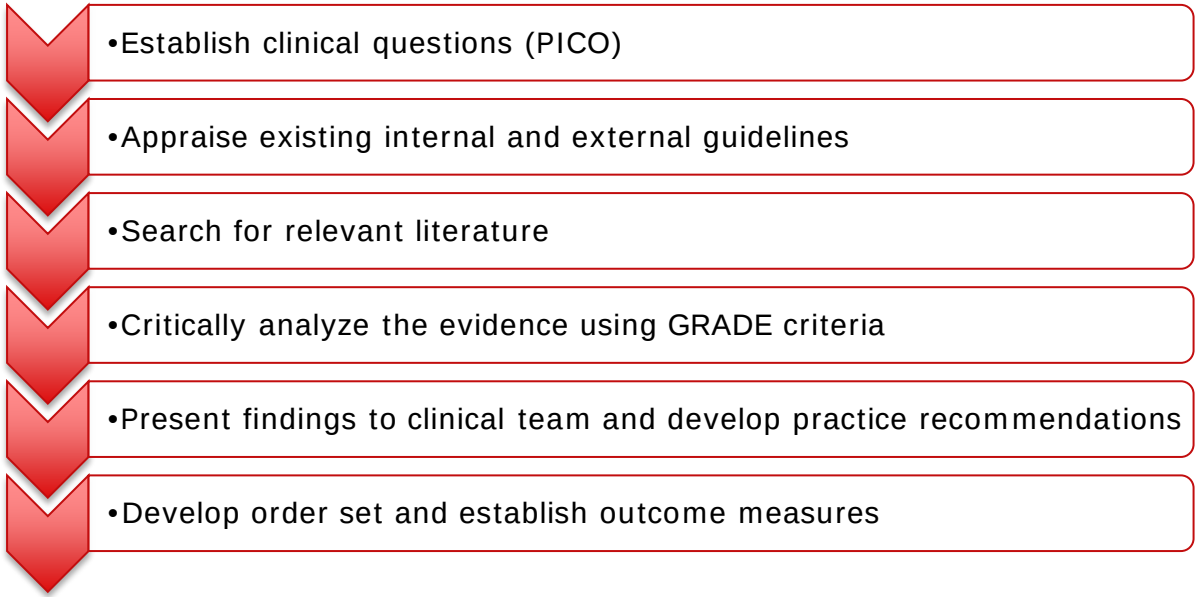
**Identifying the key influencers enables effective client support for pharma**

Osheroff, O.A., Pifer, E.A., Teich, J.M., Sittig, D.F., & Jenders, R.A. (2005). Improving Outcomes with Clinical Decision Support: An implementer's guide. Chicago, IL: HIMSS

# Process for EHR Workflow Changes

- Use of EHR standardizes and sets a more formal process for workflow changes

MUSC's Evidence Review Process for Order Sets




SOURCE: ???????

**Understanding the process enables effective client support for pharma**

Barnes, Itara, Crabtree, Ellizabeth, MPH. PhD., (2014). Coordinated Clinical Decision Support: Improving care and clinical quality measurement, HIMSS 2014 Annual Conference, Orlando FL

# Call to Action

# It Takes 17 Years For a Published Guideline To Be Adopted Into CDS

**MU-certified EHRs can hasten the use of guidelines by leveraging Clinical Quality Measures Reporting and Clinical Decision Support.**

CQMS CAN BE LEVERAGED TO IDENTIFY:

- Gaps in Care
- Opportunities for treatment intensification
- Workflow improvements to improve care quality

**Pharma can assist by assessing the quality measures available in EHRs to identify ways to assist practices to implement quality improvement programs and track progress.**

# CQMs to manage Population Health

**Features which already exist in EHRs can be leveraged for clinical quality improvement across patient populations.**

EHR REGISTRY REPORTS SUMMARIZE PRACTICE PERFORMANCE TO CQM GOALS

- Set achievable short and long term goals
- Regular review cadence

**TREAT REPORTS AS ACTIONABLE POPULATION HEALTH TOOLS:**

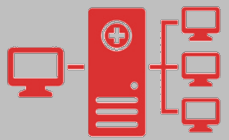
- **Patient outreach**
- **Workflow change to address outliers**

# Future View

# What Does the Future Hold?

The future of Meaningful Use is far from certain. Pressure continues to mount from industry and now legislature to relax timelines.

- Timeline for MU3 pushed back to 2017
- Participants question the ROI for 2nd and 3rd installment relative to penalties
- Will there be penalties?
- Legislative questions about ROI
- Changing Federal administration
- Will there be an MU4?



**Regardless of future, program a success because it has caused more than 50% of doctors and virtually all hospitals to install EHR technology with a baseline of functionality. This has happened much more quickly as a result of incentives than it would have in a unsubsidized market.**

# Thank you!

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