HIT Perspectives
Perspectives and Updates on Health Information Technology

Health Reform

Health Reform and HIT: Will the Baby be Thrown out with the Bath Water?
By Tony Schueth, Editor-in-Chief

Health information technology (HIT) seems to be everywhere these days, with provisions included in the contentious health care reform bill, also known as the Patient Protection and Affordable Care Act (PPACA). While it looks like the fate of PPACA will be decided by the Supreme Court in the next couple of years, the question is whether the HIT provisions will be tossed out with the entire law, or whether the Court will strike down only the contentious provisions relating to insurance mandates.

In the near term, we may see some legislative action as the new Congress flexes its muscles. What actually will be done is open to debate. Some are calling for repeal of all or parts of the package. In our opinion, that is unlikely. Even if both the House and Senate were to pass legislation repealing the law or dismantling it piecemeal, President Obama is sure to veto whatever is put on his desk…

Read more…

Health Reform

Is Reporting a Higher MLR and Better Bottom Line an Oxymoron?
By Michael Solomon, Contributing Editor

Certainly one of the most contentious provisions of the health reform legislation — at least for health plans — is that they allocate a minimum percentage of premiums toward reimbursement for clinical services or activities that improve health care quality. The latter broadly covers improvements in patient outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, and stimulating wellness and health promotion. The minimum percentage is known as the medical loss ratio (MLR), which is derived from a complicated formula. The legislation limits large group plans to an MLR of 85% of premiums and small group/individual plans to 80% of premiums.

Read more…

eMedication Management

Where's Waldo (i.e. Lipitor, Nexium)? The Search for Branded Drug Products
By Mihir Patel, Contributing Editor

We've all heard about it: frustrated prescribers can't find a branded product in their electronic health record (EHR) or ePrescribing system. Or, if that isn't bad enough, prescribers – upon finding the branded drug they want – discover the formulary status is incorrect…

Read more…

POCP Company News

Congratulations to POCP's Michael Solomon Upon Earning his PhD
By Tony Schueth, Editor-in-Chief

Michael Solomon recently earned a Ph.D. in Health Services from Walden University. Michael's dissertation, "Web-based Self-management in Chronic Care: A Study of Change in Patient Activation" draws on research he has conducted as the lead of Point-of-Care Partner's eCare Management practice. Results from the controlled trial reported in Michael's dissertation will be presented at HIMSS11.

Subscribe   Contact Us   Unsubscribe

Health Reform	**Health Reform and HIT: Will the Baby be Thrown out with the Bath Water?**

By Tony Schueth, Editor-in-Chief

(continued from p. 1)

Don't forget that the Congressional Budget Office (CBO) scored the reform package as creating major savings over a multiyear period. In government-speak, this means that sweeping repeal attempts could be linked with enormous costs. This is likely to be unpalatable to many on both sides of the aisle. According to Beltway insiders, the more likely scenario will involve Congress starving health care reform to death by refusing to authorize funding or appropriating next to nothing.

Despite the drama surrounding whatever happens to the PPACA, many experts, including Point-of-Care Partners (POCP), believe that PPACA's HIT provisions will survive and do so with funding. Modernizing health care--and making it safer, more efficient and less costly—will depend on HIT, and both sides of the aisle seem to agree. Don't forget that many — if not most —health care innovations will be enabled by HIT. Also keep in mind that many HIT solutions are being mandated and funded through a separate piece of legislation, the American Recovery and Reinvestment Act of 2009 or ARRA. You remember that one: the law created meaningful use and major adoption incentives and requirements for electronic health records (EHRs).

So, let's look at some of the HIT-enabled provisions in the PPACA.

New payment and delivery models. PPACA created several new payment and delivery models. At the top of the list is the accountable care organization (ACO). As we reported in *HIT Perspectives* last September, ACOs will be accepting a single capitated payment for both inpatient and outpatient services for Medicare beneficiaries in a way that unites hospitals and physician practices as a single contracting entity. ACOs that reduce Medicare spending can keep some of resulting savings, providing they reach certain quality and cost-control targets that will need to be reported electronically. Then there is a new Medicaid option, in which states could allow recipients with a defined set of chronic physical conditions or persistent mental conditions to designate a provider, a team of health professionals, or a health team as their "health home" from which to receive care. Health homes and patient-centered medical homes are "kissing cousins" of ACOs. For more information, please see the September issue of *HIT Perspectives.*

Let's also not forget about grants and demonstration projects. The Community Health Teams to Support the Medical Home Act will create grants or contracts in which specially created multidisciplinary teams can support primary care practices within specific hospital service areas. The Independence at Home demonstration program will test a payment incentive and service delivery model in which home-based primary care teams provide care for Medicare beneficiaries. The hope is that it will reduce costs and improve patient outcomes.

Wired for Success. HIT is the key to the success of all these models. All must have a solid HIT infrastructure to capture and transfer various data within and across sites of care, as

Health Reform

well as report that information to payers. Payments and incentives will depend on how well participants meet performance goals, with quality and outcome metrics measured and reported electronically.

Interestingly, the use of HIT is specifically called out in a number of cases and not just limited to traditional EHRs or computerized physician order entry. Other modes include mobile health, handheld computers and electronic monitoring systems. For example, patient-centered medical homes are defined as a "mode of care that includes…safe and high-quality care through evidence-informed medicine, appropriate use of health information technology and continuous quality improvements." Practices qualifying for the Independence at Home demonstration must use "electronic health information systems, remote monitoring and mobile diagnostic technology." States adopting the new Medicaid option must include in their revised plan amendment "a proposal for use of health information technology in providing home health services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their providers)."

It's only just begun. We believe this is just the beginning of a push to a new era, fueled first by ePrescribing and then by "meaningful use" of HIT. The outline is there, whether it's from PPACA or ARRA. A lot of funding is already available and the technology stream is coming on hard and fast. It's up to us to connect the dots.

Health Reform

Is Reporting a Higher MLR and Better Bottom Line an Oxymoron?
By Michael Solomon, Contributing Editor

(continued from p. 1)

Needless to say, there has been a lot of pushback and gnashing of teeth. Health insurers generally view the MLR provision as too strict. There are concerns that it will force payers to withdraw from certain markets or discontinue product offerings, as well as drive smaller plans out of business. Conversely, patient advocates are worried that if it doesn't go far enough, health plans won't reduce administrative costs or premiums.

The list of issues goes on and on, but there is a silver lining: health information technology (HIT) is the backbone for quality improvement activities and its use can help plan executives take the sting out of the MLR equation. Further, the MLR provision strengthens the business case for health insurer investments in health information exchange (HIE) infrastructure for care management. How does that compute? It's not as much of a stretch as you might think.

It's very obvious that none of the allowable quality improvement categories in the MLR model can be accomplished — in part or in toto – without HIT. That's why certain HIT expenditures are allowable expenses against the MLR. There is a whole laundry list of such activities, most of which have a familiar ring and already may be on organizations' capital budget radar. Aside from EHRs and patient portals, they include using HIT for patient monitoring, measuring or reporting clinical effectiveness, and avoiding and reporting harmful drug interactions or medical care.

Moreover, payers can strengthen their medical management programs and quality initiatives with HIT/HIE investments that improve the MLR. All areas of medical costs for qualifying quality improvements can benefit from an HIE that supports clinical and consumer applications. These investments can help clinicians make more informed decisions. They are also the foundation for scalable member self-care programs and facilitate proactive, evidence-based care interventions. At the back end, these kinds of HIE investments translate into cost savings and better quality of care for payers and patients, alike.

At the same time, investments in HIT and HIE infrastructure to improve quality add value to a health insurer's physician network, enhancing its readiness to implement the patient-centered medical home model, develop accountable care organizations, achieve pay-for-performance targets, and report on a variety of patient and performance data. In contrast with tactics that simply reallocate funds which would otherwise be lost, HIE-based quality improvement strategies in response to the MLR provision will accelerate the transformation in the ways health insurers interact with their providers and members.

In the end, meeting the MLR objectives need not be scary or pie in the sky. The objectives of the MLR provision sync nicely with requirements of other mandates, such as provider qualifications for EHR meaningful use incentive payments. Let Point-of-Care Partners help your organization by identifying where synergies in mandates and HIT/HIE investments can help your bottom line.

Pharma & HIT

Where's Waldo (i.e. Lipitor, Nexium)? The Search for Branded Drug Products
By Mihir Patel, Contributing Editor

(continued from p. 1)

This is a bad scene for prescribers, patients, payers and the pharmaceutical (Pharma) industry. It makes providers reluctant, dissatisfied and angry ePrescribers, giving the technology a bad name and denying them the safety and treatment information they need. Patients lose the benefit of receiving the right drug at the right price, which also is problematic for their insurers.

The fallout is particularly acute for Pharma. When their brands are MIA in ePrescribing systems and EHRs, brand managers find that prescriptions are being written for competitive brands. Post-launch, the sales force may not be able to find their branded drugs on systems for some time, undermining their credibility and that of their products among providers. Both scenarios negatively affect sales volume and market share and are likely to have a possible chilling effect on the next product launch.

To be sure, these problems have always existed but have only now begun to appear on Pharma's radar. And, until recently, it was possible to dismiss the impact of ePrescribing. This is no longer an option. According to Surescripts, use of ePrescribing functionality grew at a rate of 181% from 2008 to 2009, and sharp increases in ePrescribing adoption are universally predicted to continue. More than 1 million ePrescriptions are being transmitted daily, and the numbers continue to jump exponentially.

The problems resulting from missing drug data or inaccurate formularies have not been lost on the drug database companies. Point-of-Care Partners (POCP) works regularly with several, and they are working diligently to issue more frequent new drug updates to clients and reconcile their databases in light of the complexities of differing release schedules and constantly changing formularies.

Unfortunately, Pharma has been much slower to react. In general, the industry still has not fully embraced ePrescribing, and constant restructuring creates a lack of continuity on the problems between one generation of managers and sales reps to the next. When these situations are brought to light, management inevitably asks why a brand's drug compendia and formulary distribution weren't considered during launch, relaunch or marketing plans. Uncomfortable discussions can ensue about dipping sales and loss of market share.

POCP helps Pharma ensure that newly launched products are properly represented in electronic formularies, EHRs and ePrescribing systems. We work directly with vendors and clearinghouses before a product is launched to ensure that it is represented accurately. Post-launch, we respond to errors and omissions identified by the field team, identifying and following up directly with the responsible organization. This program helps build a positive brand impression, increase prescription volume and protect your product investment. We also offer an innovative, prospective program that maximizes the availability of branded medications, as well as the availability and accuracy of formulary information in EHR and ePrescribing software systems. Give us a call or drop us a line. We're here to help.