Perspectives and Updates on
Health Care Information Technology

HIT Perspectives Biopharma Insights

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About the newsletter

HIT Perspectives Biopharma Insights is published by Point-of-Care Partners. Individuals at the leading management consulting firm assist healthcare organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. The team of accomplished healthcare consultants, core services and methodologies are focused on positioning organizations for success in the integrated, data-driven world of value-based care.

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1 Part 1: Guidelines and Best Practices: Ripe for an Assist from Managed Markets Teams

By Brian Bamberger, Life Sciences Practice Lead

It seems that quality is king these days when it comes to improving patient care and outcomes while reducing costs. Payers and providers are expected to view use of clinical quality guidelines and best practices as central to their quality and value-based reimbursement efforts.

This is easier said than done. Adoption continues to be low, despite the proliferation of guidelines and best practices and widespread dissemination of research on their positive impacts. This represents a huge opportunity for managed markets teams to help accounts wade through the noise and disseminate credible information to providers so they can make more informed decisions, standardize care and improve quality.

The need is there. According to the Agency for Healthcare Quality and Research (AHRQ), there is a disturbing gap in quality — namely, the difference between present treatment success rates and those thought to be achievable through the use of best practices and clinical guidelines. This gap has been documented for some time. For example, a 2003 Institute of Medicine report identifies 20 diseases and clinical conditions that may be significantly improved or effectively managed by using best practice treatment guidelines.

As a result, patients suffer needlessly — and sometimes even die — from medical conditions that could be treated successfully if guidelines and best practices were followed. Meanwhile, public and private payers (and taxpayers) are stuck with the unnecessary bills. In addition, providers such as accountable care organizations and integrated delivery networks are being judged on their quality metrics and outcomes, which figure heavily in their reimbursement.

While this is a frustrating situation, managed markets teams can help bridge the gap because their pharmaceutical companies are sitting on a wealth of data and expertise on guidelines, both of which can be brought to bear. They also are uniquely positioned to overcome provider-centered barriers to adoption of evidence-based care. For example:

- There is a trust factor. Research has shown that providers are skeptical of guidelines and often believe that implementing the recommended practices would not represent a change for the better, consequently serving as a barrier to adoption. By building on their relationships with their accounts, managed markets teams can bring their own credibility to the conversation when disseminating guidelines and information from their company.

- Providers and their staff often lack time to keep up with the latest guidelines and assimilate the ever-expanding deluge of clinical studies and emerging treatment advances. Convenience is surprisingly important to adoption — the preferred option should involve the least mental and physical effort and be available "just in time."

- Guidelines change all the time. Managed markets teams can be their accounts' eyes and ears by bringing relevant information to their attention and helping to interpret results and applicability. They then can translate the needed changes into a series of easy steps to the electronic health record (EHR).

- Not all settings are created equal. An advanced specialty office may be highly effective in researching a topic but unworkable in the primary care practices. Managed markets teams can help providers and payers determine if and when research can be translated to their particular practice setting.

In short, managed markets teams can be an invaluable resource in identifying best practices, best EHR operational usage and best standards of care. Let Point-of-Care Partners help you identify those opportunities for your accounts and translate them into action.

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2 Part 2: What's Next for Meaningful Use?

By Michael Solomon, eCare Management Practice Lead

Meaningful use (MU) is at an interesting place in its evolution — that funny space between the end of stage 2 and the beginning of stage 3. Speculation about its future was rampant at the 2014 annual meeting of the Healthcare Information Management and Systems Society (HIMSS). As nationally recognized experts on health information technology (health IT), Point-of-Care Partners (POCP) has some thoughts about the whys and next steps for MU.

The ultimate success of MU will be influenced by several factors moving forward, including stage 3 requirements and new legislation.

Stage 3 requirements. A key driver for the future of MU is the stage 3 requirements themselves. At its March 11 meeting, the Health IT Policy Committee (HITPC) accepted its MU workgroup's draft stage 3 recommendations. The recommendations are being sent to the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology. After digesting them, a notice of proposed rulemaking (NPRM) will be issued this fall by CMS. A final rule is on the radar for 2015.

The recommendations have caused quite a bit of consternation for HITPC members, according to media reports. Some are concerned that the recommendations were scaled back by 30%, with significant setbacks to the strategic goal of improving quality of care and safety, in particular. One troubling choice was the decision to remove a requirement related to medication adherence. (Click here for a deeper dive into this issue.) Excision of such criteria could be attributed, in part, to confusion on the part of stakeholders involved in implementing those objectives (e.g., access of images) or industry resistance to standards (e.g., pharmacy use of fill status to track adherence). Other HITPC participants called for even more pruning, claiming that providers and vendors are already overburdened.

We believe the narrower set of criteria in the stage 3 recommendations is the right approach, especially if the result is more robust certified EHRs to support clinical decision support (CDS) and patient engagement. The HITPC is linking CDS quality measures to the National Quality Forum's national priorities. This gives forward-thinking health care leaders the opportunity to focus on CDS that advances their organizations' patient-centered care model and improved care coordination efforts — critical to success in an accountable care organization. Medication management has a central role in the CDS interventions, with advanced medication-related decision support and more complete medication lists highlighted.

Anyone hoping for relief on the patient engagement front will likely be disappointed. Stage 3 objectives and criteria raise the bar, requiring providers to demonstrate receipt of provider-requested and patient-generated data. This requirement could finally push the envelope on the development of workable models for storing patient-generated data in EHRs.

Our take is that the stage 3 revision process is far from complete; some self-examination and realignment will be necessary. More changes will occur in response to the NPRM. It will be interesting to see how this core set of requirements changes due to stakeholders' concerns, and whether some are dropped and others are added in response to the comments received.

New legislation. The latest example of how new legislation would impact MU was the first round of legislation (H.R. 4015/S. 2000), which would have repealed Medicare's sustainable growth rate (SGR) requirements. As per usual with much legislation, a number of health IT provisions were tucked inside: a mandate that all EHRs achieve interoperability by 2017, a prohibition for vendors from deliberately blocking information sharing with other EHR vendor products, and creating a reimbursement process for clinical imaging based on appropriate use criteria (click here to read more about the latter in HIT Perspectives).

In addition, the legislation would have rolled MU into a gigantic new program called the Merit-Based Incentive Payment System (MIPS) in 2017, along with the Physician Quality Reporting System (PQRS) and the Value-Based Modifier (VBM). This would have put most of the federal government's quality-based pay-for-performance requirements in one place, with MIPS being the only Medicare quality reporting program.

Had it materialized, the MIPS implementation would have

depended on a strong health IT backbone. Beginning in 2018, MIPS would have provided bonuses ranging from 4% to 9% for physicians who scored well along the dimensions of quality, resource use, MU, and clinical practice improvement activities. Quality reporting was anticipated through EHRs or qualified clinical data registries. Participation in a qualified clinical data registry would also have counted as a clinical practice improvement activity.

All of these activities are very far reaching, but will not happen. The proposed bills were supplanted by the Protecting Access to Medicare Act of 2014, which stripped out those health IT provisions. However, given the legislative process, they are likely to reappear in one form or another in subsequent bills. After all, Congress must take another shot at "fixing" the SGR formula issue next year because this year's legislation only staves off SGR-based payment cuts for Medicare physicians until March 2015. (It should be pointed out that this year's temporary SGR "fix" was the 17th such patch that Congress enacted since the SGR formula became law in 1997.) Of course, there will be plenty of legislation throughout the rest of the year that could be vehicles for health IT-related provisions.

The Protecting Access to Medicare Act also delayed International Classification of Diseases, 10th edition, (ICD-10) implementation for a year. While this temporarily relieves hospitals and physician organizations of the stress of implementing ICD-10 and MU stage 2 requirements in tandem, the delay in ICD-10 implementation signals how things can play out due to delays or abrupt changes in program direction. First, this delay will be expensive. Many organizations have spent considerable time and money to get with the program. Code mapping and crosswalks have been under way for several years. The result: an additional $1 billion to $6.6 billion on top of what has already been incurred due to the previous implementation delays, according to the American Health Information Management Association. There also will be consternation among trading partners — those that have implemented and those that have not. While voluntary trading partner agreements are likely to be the way things play out, it is not beyond the realm of possibility that the government will step in and issue some kind of regulatory guidance, as was the case with the Health Insurance Portability and Accountability Act. Finally, delaying ICD-10 adds to the uncertainty and complexity of implementing the health IT infrastructure needed to support population health management and value-based reimbursement, which is not a good thing in our opinion.

POCP is closely monitoring developments with MU and on the legislative front. We are working with our clients as they: 1) align their MU compliance strategies with the broader strategic priorities of population health management, clinical integration and quality-based performance monitoring; 2) transform their organizations to succeed in a value-based payment environment. We would be happy to help your organization interpret the MU landscape and its impacts, as well as assist with the development of comment letters when the NPRM is issued in the fall.

3 Part 3: Improving Adoption of Clinical Decision Support

By Brian Bamberger, Life Sciences Practice Lead

Use of effective clinical decision support (CDS) has been shown to improve health care quality — especially when enabled by electronic health records (EHRs) and integrated into ambulatory and acute care work flows. As such, increasing adoption of CDS was a focus of discussion at this year's annual meeting of the Healthcare Information Management and Systems Society (HIMSS). (Click here for additional takeaways from HIMSS 2014 in HIT Perspectives.)

CDS includes a variety of techniques and data designed to facilitate and guide doctors' decision making toward evidence-based practice. Adherence to CDS can improve quality of care, reduce costs and figure heavily in quality-based reimbursement and incentive programs.

HIMSS 2014 featured presentations by many health systems regarding their experiences in developing and using CDS, as well as barriers to its adoption. Most of the presentations for both inpatient and ambulatory systems included discussion of how entities were developing their own guidelines via literature searches and/or discussions with key physician leaders. One, in particular, showed the process used by one major health system to evaluate multiple studies —including those from competing organizations. It concluded that although CDS is based upon clinical evidence, often the algorithms used will be one-offs that are unique and specific to a hospital or practice.

While research suggests that CDS can be effective, its use is currently limited, as it is enabled disease by disease over a long period of time. According to the Agency for Healthcare Quality and Research (AHRQ), new and more effective health care treatment practices are not adopted quickly. Recent studies indicate an average of 17 years elapses before new knowledge generated through research becomes disseminated and is adopted into widespread clinical practice.

Successful development and implementation of CDS programs can be delayed for a number of reasons, including:

- Getting physician buy-in and participation in CDS development.
- Ensuring development isn't executed solely by a technical team.
- Getting order sets that are set up specific to a particular pathway.
- Overwhelming physicians who are new to EHR technology.
- Developing triggers to identify the correct order set. With all the talk and documentation of alert fatigue, it's easy to assume a new message will be overlooked.
- Measuring results and exceptions can be challenging.

The slow adoption of CDS development can be related to the current state and use of EHRs. This was exemplified in a presentation by a major health system who is dissatisfied with its current EHR. Tempted to "rip and replace," this large integrated delivery network eventually decided to redouble efforts to configure its existing system with new documentation templates, order sets and triggers. Naturally, training also played a big part in this endeavor.

That health system is not alone. According to another survey, dissatisfaction with EHRs is widespread; one in four medical practices using EHRs is thinking about replacing its system. Usability issues, lack of capabilities to support value-based care and limited interoperability are fueling this dissatisfaction. Inadequate training, content, and availability also are problematic issues.

This atmosphere of dissatisfaction is not lost on government researchers and policy makers who are anxious for EHR (and CDS) adoption to continue increasing. For example, AHRQ recently funded its Clinical Decision Support Consortium to determine ways to improve CDS adoption and use. Details are available on the AHRQ web site.

Point-of-Care Partners (POCP) is helping its pharma and biotechnology clients understand what CDS is all about and where opportunities might lie in assisting health plans, accountable care organizations, and integrated delivery networks in developing CDS that is meaningful to their providers and quality goals.

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