Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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POINT-OF-CARE PARTNERS
Health IT Management Consultants

1 Part 1: Gazing Through the Snow Globe: 10 Health IT Trends for 2014

By Tony Schueth, Editor-in-Chief

As the Point-of-Care-Partners (POCP) Team hunkered down during the January freeze, we looked at the year behind and what developments are likely for the year ahead. Frigid air and bad weather could not dampen our enthusiasm for opportunities for health care growth and innovation in 2014, which will be enabled by advances in health information technology (health IT). Here are our top trends for 2014.

Value-based care picks up more steam. Although this is not a new trend, we'll see continued acceleration in 2014 in the move away from fee-for-service to value-based payment that is enabled by health IT.

- One driver is the impact of accountable care organizations (ACOs), which numbered around 500 in 2013. For these ACOs to be sustainable, they must integrate their clinical and payment operations. This is a tall order and requires significant investment in health IT infrastructure.

- A second driver is Medicare payment policies, which continue to focus on use of health IT to create and report metrics for assorted pay-for-performance and value-based purchasing programs. Proposed changes to the Medicare payment formula for doctors include a major quality component, which again underscores the overall shift toward value-based care.

- One result is an increased focus on population health (for more detail, see the article in this issue of HIT Perspectives). At the same time, there are opportunities for care management applications to "pull" patients into the health care system and proactively manage high-risk patients through a range of health IT applications, including care registries, quality reporting, predictive analytics and patient self-management applications.

- Electronic health record (EHR) products currently don't do any of these functions very well, so innovators will step in to the fill the gaps with niche products.

Creating value beyond meaningful use. Implementing meaningful use (MU) stage 2 requirements is at the top of many lists in 2014. However, stakeholders are demanding value creation beyond what MU stage 2 requires.

- As the benefit/cost equation of MU stage 2 comes into clearer focus for providers and vendors, we'll see providers demanding that their vendors commit to 2014 certification and show a tangible return on investment (ROI).

- The latter will be measured in terms of improving operational efficiencies and moving the needle on quality measures. If vendors can't demonstrate ROI, providers will switch to those that can.

- Although providers will want to ensure they can continue to meet MU requirements, they will have an additional laser-like focus on capabilities needed from their integrated revenue cycle management (RCM)/EHR system to survive in a value-based payment world. This is especially true for independent physician organizations and community hospitals, which are seeing their future viability called into question.

Consolidation of the EHR vendor market. Consolidation in the vendor market is a given in 2014.

- It's clear that the herd will start to be culled, given that there are as many as 500 systems in the market.

- Government mandates, innovation and physicians' technology needs and expectations will influence who stays and who goes. The ability to meet MU stage 2 requirements is a must.

- Niche vendors — such as smaller players that can service a specialty really well, customize documentation and write interfaces to their equipment — will have staying power, as will vendors with integrated RCM/EHR systems.

- Roughly half of physician practices are expected to replace their EHRs in the near future. They will be looking for different functionalities this time around. The evolution toward value-based care and integrated delivery models is making new demands on the types of data needed for clinical care, quality improvement and payment and how those data must be exchanged and stored. Marketplace demands for lower total cost of ownership, interoperability and cloud-delivered technology also will influence who stays and who goes.

Pharmacists: Adding value in collaborative care. Pharmacists are uniquely positioned in the health care system to help optimize appropriate medication use and reduce medication-related problems.

- As a result, pharmacists in 2014 will continue to take on more clinical roles through such collaborative efforts as participation in patient-centered medical membership on ACO care teams.

- They will make use of new technologies to deliver such personalized care as telepharmacy and mobile health and to monitor outcomes and adherence.

- Pharmacists also will continue their central roles in medication therapy management (MTM), which will be facilitated by health IT. Integrated systems of care, such as ACOs, already view MTM — the more complex of which is performed by pharmacists — as essential to care delivery and to meet ACO quality and cost targets.

Electronic prior authorization gets off the ground. 2014 will be a formative year for electronic prior authorization (ePA).

- Last year brought to fruition a new ePA framework that was rolled into the SCRIPT standard from the National Council for Prescription Drug Programs (NCPDP).

- With that behind us, we will start to see uptake by payers and vendors. Payers will be adding basic systems that support text

questions. Vendors will need to determine how to integrate ePA into work flows and information exchange. We are already seeing some traction, with three large EHRs going into production with a PA capability.

- That said, we expect that transaction volume will be light, at best, as things get off the ground.

Improving formulary data. More also needs to be done to make formulary and benefit information more accurate and useful. Currently, what is presented to prescribers is representative and normalized. It also contains gaps and inaccuracies, which serve as barriers to use. Payers will be working in 2014 to increase the quality of formulary data as problems come to light.

o The spotlight on insufficient formulary data lacking PA and tiers will drive improvements and more granular benefit information now that data volume is no longer an excuse to dumb down data.

o The lack of PA indicators in formulary data will cause frustration as ePA capabilities come online.

o The requirement to upgrade to NCPDP Formulary and Benefit 3.0 will also require changes to payer formulary data.

Patient engagement takes off. Patient engagement—spurred by demand, innovation and MU requirements — is expected to gain traction in 2014.

- Patient engagement is part of MU and should continue accelerating growth in this area. Patients will increasingly want to be engaged in their own health care in a bigger way and make decisions with their doctor. According to a recent study, 90% of people want to have a say in important decisions regarding their health care. A third would like to make a shared decision with their doctor, 43% want to make the final decision with some professional input, and 16% prefer to be completely in charge of their medical decisions.

- There will be a proliferation of applications (apps) for smartphones and tablets, increasing patient demand for them as well as the willingness of providers and payers to make use of these mobile technologies.

- Patient portals — connecting patients with payers and providers — will still be in play. These will become increasingly important as hospitals, health care professionals and their EHR vendors incorporate features to support the engagement of patients and their families, which is required by MU stage 2 and anticipated under MU stage 3.

- Government-sponsored initiatives also will spur patient engagement. The Office of the National Coordinator for Health Information Technology recently announced a new initiative — Person@Center — that aims to empower patients to take a more active role in their health through health IT. Blue Button — another government-sponsored innovation — is gaining interest as it provides an easy-to-use way for consumers to electronically access their health information.

o Blue Button already is being used by members of the military, Medicare beneficiaries, other federal agencies and many companies in the private sector, such as United HealthCare and Aetna.

o Blue Button + Direct, a technology standard, will be available in all MU-certified technology starting next winter. This means Blue Button will continue to spread among payers, providers and their Health IT vendors.

- While many of these innovations will work well for younger patients, there is still a digital divide that affects the elderly and many minorities. As a result, greater innovation is needed to help health IT reach these vulnerable and often underserved populations, which are costly to treat. Folding caregivers into the equation will be imperative.

Telehealth goes mainstream. Once rarely used, telehealth is among the biggest trends in 2014, allowing remote diagnosis, treatment and monitoring of patients through such electronic means as smartphones, tablets, video consultations and wearable self-monitoring devices.

- Drivers include growth in the number of payers willing to cover telehealth services and the expanded scope of reimbursable procedures.

- Payers covering telehealth services include most Medicaid programs; the military, which is expanding coverage (especially to address post-traumatic stress); and such private payers as Aetna, WellPoint, Cigna and Highmark, which are covering member cohorts beyond those in rural areas.

- Reimbursement typically is being extended to a wider range of specialties and services, including behavioral health services, cardiology, dermatology, infectious diseases, neurosurgery, pain management and orthopedic surgery.

- Despite the growing popularity of telehealth, harmonization across various jurisdictions is needed to address variations in licensure, data transmission requirements, the kinds of services that may be provided and in what venues. This could require legislation and agreement among such stakeholders as state boards of licensing, pharmacy, nursing and medicine as well as state insurance commissioners. It could happen sooner than later with impetus from the federal government. Defense health care providers are allowed to practice across state lines and a House bill proposes that Medicare providers be allowed to do likewise.

Electronic Prescribing of Controlled Substances gains momentum. Off to a slow and somewhat rocky start since it became legal at the federal level in 2010, electronic prescribing for controlled substances (EPCS) will become more mainstream in 2014.

- Pharmacies are ready and vendors are bringing compliant systems to market.

- Providers are getting over the shock of meeting the EPCS criteria set by the Drug Enforcement Administration and are beginning to come on board.

- EPCS uptake in 2014 will be significantly spurred by its perceived potential to curb fraud, diversion and abuse (such as overprescribing). To that end, New York is mandating electronic prescribing (ePrescribing) for all prescriptions, including controlled substances, effective March 27, 2015.

- Stakeholders, including CVS Caremark, are also calling for mandatory EPCS.

- Policy makers are taking up the EPCS cause. There is also congressional interest in making ePrescribing a requirement for coverage of controlled substances under Medicare Part D, which is a provision of H.R. 3392 — Medicare Part D Patient Safety and Drug Abuse Prevention Act of 2013. (Read more about EPCS in this issue of HIT Perspectives).

Big data is here. "Big data" is one of the big buzz words for 2014. Big data sets in health care aren't new. What's new is the increased appetite and ability to use health IT to analyze these data sets employing predictive analytics, and to share data and results through the health IT infrastructure.

- Health analytics offers something for everyone

Part 1: Gazing Through the Snow Globe: 10 Health IT Trends for 2014 (continued next page)

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2 Making the Leap: Going from Managing Episodes of Care to Populations

By Michael Solomon,
eCare Management Practice Lead

The move from volume- to value-based payment is accelerating as public and private payers change the rules to shift more financial risk to health care providers and consumers. Winners in this seismic transferal of how care is paid for are already in the midst of redesigning their organizations to proactively manage acute episodes of care as well as the health of defined populations. This entails changes to every aspect of care management, including patient outreach, clinical integration across the continuum of care, quality improvement and financial performance. Underlying all these reengineered functions is a robust, patient-centric information technology infrastructure to support care across the continuum — from the physician's office to the patient's home and every point of the continuum in between.

What is causing the growing momentum toward population health management in response to value-based payment? Working with our clients, we see the same set of drivers as 12 to 24 months ago. However, they are looming larger, with rapid advances in health information technology (health IT) acting as the catalyst for change.

Drivers. Pressures are mounting to proactively manage populations rather than episodes of care. Driving change more than ever are:

- **Growth in Accountable Care Organizations (ACOs) and their nucleus of Patient-Centered Medical Homes (PMCHs).** At the core of improving quality and reducing costs is the ability to proactively identify patients needing care and then effective coordination across the continuum of care. ACOs — which numbered about 500 in 2013 — will be focusing on improving the health of attributed populations to improve outcomes, manage risk and cut costs. Many of them will be elderly and chronically ill, so successfully managing the care of these high-cost populations will be integral to ACOs' meeting cost and quality targets.

- **Payment policy levers.** Reimbursement is one of the most powerful means available to effect change. Medicare and Medicaid payment and delivery policies (including ACOs, PCMHs, and bundled payments) promote prevention and wellness, which are cornerstones of population health. They also incentivize providers to take responsibility for population health outcomes. The same is true for many private payers. In addition, both public and private payers require that providers meet population health-based quality measures and report on them using health IT.

- **Statutory requirements.** Proactively identifying patients needing preventive and follow-up care — a key function of population health management — is part of meaningful use (MU) stage 2 and expanded requirements are expected in MU stage 3. Several provisions of the Affordable Care Act are related to an expanded focus on population health. For example, most hospitals must conduct a Community Health Needs Assessment once every three years that includes a prioritization of health needs in their community along with measures and resource strategies to address them.

- **Federal stimulus.** Improving population health through the use of health IT is a goal of the strategic plan of the Office of the National Coordinator for Health Information Technology (ONC). This ensures that resources and requirements will be brought to bear in this area. The federal government also will continue to intensify its numerous population health-based programs for managing chronic diseases, aging, mental health and substance abuse — the latter of which is becoming a growing problem among the elderly. These will be above and beyond the population health-based programs conducted by the Centers for Disease Control and Prevention.

- **New ONC leadership.** Dr. Karen DeSalvo recently was named head of the ONC. To be sure, Dr. DeSalvo brings much relevant health IT experience to the table. But you also view the world from where you sit. Dr. DeSalvo also holds a master's degree in public health from Tulane University and a master's degree in clinical epidemiology from the Harvard School of Public Health, both of which taught her to look at many health care issues through the lens of population health. This intensive training, plus her clinical work with disadvantaged populations, suggests that Dr. DeSalvo is likely to bring more attention on how population health issues can be addressed by health IT. In fact, she has publicly stated that ONC's "next phase" will include emphasizing how health IT may be harnessed to improve population health.

Moving forward through health IT. The accelerated migration toward population health will be enabled by a range of health IT tools, including electronic health records (EHRs), health information exchange (HIE), data analytics, patient engagement and care management processes. For example:

o It has the potential of harvesting data in the EHRs used by 50% — soon-to-be 90% — of health care organizations in America.

o It can be used by payers to create patient predictors and begin to recommend interventions to prevent emergency room visits and hospitalizations.

o The advancement of technology and standards in this area enables normalization of claims and EHR data.

o It can create more actionable, higher quality data for pharma to make product marketing decisions and offer more meaningful care recommendations at the point of care.

o It can improve risk management and help maximize revenue.

- However, just because everyone is talking about big data doesn't mean that everyone can or will use it.

o Predictive analytics in health care lag behind those in banking and retailing, for example, so there is a lot of catching up to be done.

o Standards and better interoperability are needed to ensure the accuracy, security and privacy of the large data sets.

o Innovations in health information exchange will be needed to share such data successfully among users.

POCP is looking forward to helping our clients — old and new — analyze these trends and develop strategic and tactical options to maximize opportunities and revenues. Let our nationally recognized team of experts make 2014 a memorable — and profitable —year for your organization.

- **Health data analytics.** Innovations in data aggregation and online analytics are bringing powerful tools to the market that can be used by managers and clinicians at organizations large and small. The challenge will be to determine which particular types of analyses on what data will be most beneficial to an organization that must manage risk for a defined population. Identifying the 20% of patients driving 80% of a cohort's health care costs is a good place to start. From these data, patients who are most likely to experience a high-cost intervention can be identified with predictive analytics and targeted proactively with appropriate care interventions.

- **Proactive care management.** Population health management innovators recognize that the only way to move the needle on patient outcomes is to put the results of data analytics into the hands of clinicians at the point of care. A technology platform that integrates an EHR with a patient registry — both connected to an HIE with access to other EHRs and claims data — will provide the basis for new work flows. These will facilitate coordination of care and "pull" the patient into the system before conditions worsen or become even more costly, or before potentially adverse events occur, such as an emergency room visit or hospital readmission. Innovative communications will be employed, based on identification of high-risk patients, to interact with the care team, patients and caregivers. Innovations in health IT will also enable care coordination in community practice settings, where the integrated care management platform is very important to assist the care coordinator with essential activities.

- **eMedication Management.** A major aspect of care management is the management of a patient's medications across the continuum. Because of the substantial role of medication therapy in caring for patients with chronic conditions, this is a fault line for financial viability and quality of care. Health IT will enable the electronic management of medications (eMedication management) to reduce costs and improve quality, safety and adherence. eMedication management, for example, relies on EHRs to electronically prescribe medications, which is informed by clinical decision support, and share the information among the care team and other stakeholders, such as prescription benefit managers and payers. This allows the care team — physicians, patients, pharmacists, nurses and care managers — to collaboratively develop and effectively manage medication therapy for the patient regardless of his or her health status and location on the continuum of care. Health IT is central to medication reconciliation. Point-of-Care Partners (POCP) has developed a new model describing the need for and use of eMedication management. Click here to learn more.

- **Patient engagement.** Patient engagement is a key part of population health management. Health IT tools to integrate patients into care team activities and help a patient self-manage his or her health are critical to the "last mile" of population health management — working with individual patients who are at the greatest risk of adverse outcomes. As patients move through the continuum of care, health IT tools will be essential for enabling them and caregivers to access health information and share in decisions about the patient's care plan; assessing patient adherence and satisfaction; and managing care transitions across multiple provider organizations. This will involve use of applications (apps) for smartphones and tablets, mobile technologies, and "wearable" devices for patient self-monitoring. Remote patient visits and monitoring will improve care for the elderly and chronically ill, as well as allow them to stay within the community instead of being institutionalized.

- **Infrastructure.** According to the American Medical Association, the current health care infrastructure was designed to treat acute episodes and must evolve to also more effectively promote preventive care and treat chronic conditions. That transformation is happening today through an increasingly robust health IT infrastructure. For example, disease prevention, early detection, and condition management for various populations are being enabled through the exchange of clinical and administrative data within and across sites of care. Population managers are using health IT to exchange data across the entire continuum of care. HIEs are on the rise and are the nexus for exchanging population health data among stakeholders and permitting large-scale data analytic efforts.

POCP is advising several clients on strategies and programs to position their organization and its customers to manage populations in the new era of value-based care. Our consultants are recognized throughout the industry for their expertise in eMedication management, data analytics, and patient engagement. Let us put our knowledge and experience to use for your organization in the management of this transformational shift in health care.

3 Part 3: Accelerating ePrescribing for Controlled Substances

By Michael Burger, Senior Consultant

Electronic prescribing (ePrescribing) now is the norm for most prescriptions, except those for controlled substances. In fact, electronic prescribing for controlled substances (EPCS) has gotten off to a slow and somewhat rocky start. Some consider EPCS to be the "last mile" in getting the nation wired to send and receive prescriptions electronically. But things are changing — and fast.

Recent metrics show significant progress in physician and pharmacy adoption of EPCS. Although the actual number of physicians using EPCS is relatively low (<4,000), the rate of uptake is rapidly accelerating. A DrFirst industry briefing notes a 428% increase in physician adoption of EPCS just in the latter half of 2012. Pharmacy enablement to accept EPCS appears to have grown to a point where some 14,000 pharmacies are now able to accept electronic prescriptions for controlled substances. (Surescripts lists 14 pharmacy systems that have completed certification for EPCS, including Walgreens, CVS and Rite-Aid). In Arizona, where Point-of-Care Partners (POCP) helped Arizona Health e-Connection (AzHeC) flood the state with "EPCS is legal" messaging, EPCS transactions increased more than 7-fold from less than 200 to more than 15,000 in only seven months (May to December 2013). We saw these kinds of numbers in the early days of ePrescribing, right when adoption really began to skyrocket.

In short: the momentum for EPCS adoption is growing. Why is EPCS adoption picking up steam? How can that trend be accelerated?

Adoption of EPCS should continue on its rapid trajectory due to several drivers. Some reveal market readiness while others reflect broader stakeholder needs.

- **Vendors are ready.** EPCS has finally bubbled to the top of vendors' to-do list, which was dominated for the past couple of years by development for meaningful use (MU) compliance and certification and the changeover to the International Classification of Diseases, 10th edition (ICD-10). Vendors also suffered from uncertainty. If they built EPCS-compliant products, would anybody buy them? Those issues are resolving and vendors are now bringing EPCS-compliant products to market. Currently, Surescripts reports 14 vendors with EPCS-certified products. Wider availability of certified products will help drive volume as well as enable physicians meet the higher ePrescribing threshold for MU stage 2.

- **Pharmacies are ready.** Pharmacy willingness to become wired and ready to receive ePrescriptions for controlled substances was a real barrier to EPCS adoption. That changed as big pharmacy chains began to go live with EPCS. In Arizona, for example, Walgreens turned on all of its 250 stores for EPCS in August 2012. CVS turned on all of its pharmacies and trained its pharmacists in August 2013. Frys and Safeway were expected to be onboard at the end of 2013. So, the top 4 chains in Arizona — 704 stores or 80% of the chain drugstores in the state — were expected to be live for EPCS at the end of last year.

- **EPCS is a tool to fight drug abuse and diversion.** Drug abuse and diversion are at epidemic proportions, especially for Schedule II medications. To aid in the fight, stakeholders are increasingly calling for the end of paper prescriptions for controlled substances and demanding a move to EPCS. New York is leading the way, mandating ePrescribing for all prescriptions, including controlled substances, effective March 27, 2015. Stakeholders, including CVS Caremark, are also calling for mandatory EPCS. There is also congressional interest in making ePrescribing a requirement for coverage of controlled substances under Medicare Part D, which is a provision of H.R. 3392 — Medicare Part D Patient Safety and Drug Abuse Prevention Act of 2013.

- **The rise of value-based care.** America's health care system is gradually transforming to value-based systems of care and reimbursement. In a value- based model, participants will want EPCS to ensure a complete picture of patients' medications in order to better understand and control costs, manage risk, conduct medication reconciliation and improve care coordination. Although controlled substances account for less than 20% of all prescriptions, they largely represent treatments for the chronically ill —high-cost patients who are growing in number for all payers but will be a core group for accountable care organizations and other value-based systems. A more accurate accounting of the costs and use of controlled substances for the chronically ill will be a critical success factor.

With so many opportunities in place, it is clear why EPCS is gaining attention. However, there are still opportunities for improvement that can help move the dial even further in 2014.

- **More education is needed.** Despite the educational efforts of vendors and others, providers still have many misconceptions about EPCS. We realized this recently in Arizona, where POCP was engaged by the AzHeC to promote EPCS adoption (read about it in a recent blog). One eye-opening finding was that many physicians and pharmacists weren't aware that it was legal, even though that had been the case for more than a year. Through this engagement and others, we learned that providers are still mystified and overwhelmed about how to begin the EPCS process. Resolution of such problems and perceptions will ultimately drive adoption.

In the face of these challenges, there are many opportunities for stakeholders to step up educational efforts. For example, we've produced some webinars with leading ePrescribing vendors for prescribers (EPCS for webinar for prescribers) and pharmacists (EPCS webinar for pharmacists) that were well received by these audiences, who don't have the time or resources to attend conferences and off-worksite training. ePrescribing vendors should view EPCS as an opportunity to assist their users with the identity-proofing process. Prescribers and their practice staff will also need training to become efficient with EPCS. More of these concerted efforts are needed to move the dial.

- **Complete pharmacy connectivity.** Although many chain pharmacies have EPCS-certified systems, there are many others that are not yet certified. It's one thing to have a certified system; it's another to actually accept electronic prescriptions for controlled substances and integrate them into the pharmacy work flow. EPCS will be more of a struggle for independent pharmacies. Specialty pharmacies still need to get wired and are unable to accommodate regular ePrescribing, much less EPCS.

- **Reconcile discrepancies in state prescribing laws.** Variations in state EPCS laws are problematic. Some states allow EPCS and some don't; some allow only certain schedules while others allow all schedules; some change the schedule of individual drugs from that defined by the Drug Enforcement Administration. Resolving differences in state laws would remove a great barrier to EPCS adoption and improve prescribers' work flow. Consistency of rules across all states will reassure prescribers that EPCS is allowed wherever they practice.

- **Keep current with the laws and regulations.** One barrier to EPCS adoption is the ever-shifting legal and regulatory landscapes at the federal and state levels. Electronic health record and ePrescribing system vendors need to stay ahead of new legal, regulatory and board of pharmacy developments. This is necessary now more than ever to ensure the accuracy of their products and prevent going into panic mode to address some new wrinkle of which they were unaware. Associations and other groups representing providers, medical specialties and pharmacies need to keep current so they can get the word out to their constituent groups and help prevent them from getting caught up in an enforcement action. (For additional information regarding state prescribing laws, see the article in the December 2013 issue of HIT Perspectives about POCP's ePrescribing law compendium, which is a major resource concerning ePrescribing and EPCS).

POCP has been involved with EPCS since ePrescribing was barely a notion in the minds of federal regulators. Let us put our long-term experience and up-to-date expertise to work for you.

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