Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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Part 1
Deciphering the Mystery of Popula-
tion Health Management

Part 1: Deciphering the Mystery of Population Health Management (continued)

1 Part 1: Deciphering the Mystery of Population Health Management

By Tony Schueth, Editor-in-Chief

Meaningful use (MU) introduced us to population health in a big way. Improving population health is one of its overarching goals and there are many related objectives for managing it in stages 1 and 2. More, undoubtedly, will be added in stage 3, whenever it is finalized. Understanding this concept will be critically important to any health care stakeholder moving forward.

Point-of-Care Partners (POCP) advises as broad a base of such stakeholders as any firm its size. Our clients represent a veritable "who's who" of payers: employers, health plans, pharmacy benefit managers, managed care organizations, drug knowledge-based companies, biopharma, federal and state government agencies, electronic health record (EHR) and tech companies, physician groups, accountable care organizations (ACOs), pharmacies and connectivity companies. For some, the simple explanation that population health is just "actionable lists" is enough. For most, that's a nice start.

As a health information technology (health IT) strategy and management consulting firm, we help our clients manage the health of a population first by determining which technology is needed to support the various elements of population health management (PHM). We next consider appropriate context and means of managing necessary change.

To be sure, however, making PHM actionable is critically important. In our engagements, we start with the four pillars of PHM: communications, management, analytics and reporting. The health IT that is needed for each breaks down like this:

- **Health Communications.** Health IT infrastructure is needed to "pull" consumers into active management of their health and connect the patient with his/her care team. Health IT facilitates notifications to patients and providers, as well as messaging among them.

- **Health Management.** This combines most of the functions we think of with an EHR system, coupled with (1) disease registries that serve as "work lists" of patients having gaps in care, health risks etc., and (2) a patient portal connecting patients with their EHRs and having tools to help self-manage care.

- **Health Analytics.** These are the "engines" driving health management and health communications because they will help us manage care as well as risk. The core includes clinical decision support rules engines that are enhanced to take into account the patient's medical history, comorbidities, and health risk. Plus, new algorithms are emerging to predict risk in individual patients and subsets of the population needing various kinds of care, coupled with care recommendations that are based on that risk assessment.

- **Health Reporting.** This simply is concurrent and retrospective quality scorecards, utilization and cost trends, etc. We have been doing this for some time, to a limited extent, but more will be required.

It's easy to see that all of this quickly leads in a variety of new directions. So, where do we go next?

To be sure, current technology needs to evolve. More than 60% of physicians have attested to adopting EHRs, but the MU stage 1-certified EHRs of today only have pieces of the puzzle. As shown on the Office of the National Coordinator for Health Information Technology (ONC) Dashboard Quick-Stat #9, at the end of last year, key capabilities were missing in over 50% of EHRs.

On the positive side, today's EHRs are pretty good at creating a problem list, assisting with care planning and providing clinical documentation and test results. In the communications arena, they can provide reminders, facilitate patient-provider messaging and present rules-based alerts and recommendations. They can also generate some quality-based reports required by Medicare, private payers and emerging ACOs. While this is a good start, more is obviously needed – both in terms of the technologies themselves as well as the broader environmental context. That is why savvy health care systems are pulling away from being EHR-centric and looking at the broader environment to address their technology and data requirements for PHM.

What's needed is more complete and interoperable data, and the infrastructure to facilitate its exchange and use. In order to communicate, manage the patient's condition(s), predict risk, support care processes and report on quality and outcomes, a complete record of data is needed. In the past quarter century, this has meant the merger of medical and pharmacy claims data. However, the end results do not present a complete picture of a patient's health, clinical experience, costs and outcomes. As a result, a variety of data sources are needed. Health enterprise data are becoming more widely available, beyond what come from EHRs. This includes data that are self-reported by patients, patient portals and member panels. While such data may help provide pieces of the puzzle, they tend to be unstructured and not interoperable. Accuracy, reliability, privacy and security also can be problematic. Such issues must be addressed so the benefits of PHM may become a reality.

Finally, we need to manage all the transformation related to managing the health of populations. An important component is refocusing physicians' mind-sets because PHM is uncharted territory. Physician training typically concentrates on dealing with the health of an individual patient, not managing the health of specific populations. Care is currently not organized around the concept of practicing in teams. Physicians' roles are evolving within systems of care. As a result, they may end up working in areas in which they are no longer the expert or "guru" in charge. This does not need to be a bitter pill; however, change management will be crucial.

Vendors also will have to evolve to successfully address population health. POCP is tracking 40+ vendors supporting various areas of the health IT environment for PHM. Several support more than one area. For example, Wellcentive helps health care organizations manage populations with disease registries, gaps in care notifications, and a patient portal. Other EHR vendors are also moving quickly to support PHM. For example, Cerner has its Cerner Wellness solution, Allscripts has the FollowMyHealth product suite and Epic has MyChart and client integration with Health Catalyst.

All in all, population health management is adding a new dimension to the world of health IT. Let POCP help you understand the PHM environment, the vendor landscape and what PHM means for your organization. The earlier PHM is on your radar, the more competitive you'll be in today's rapidly evolving marketplace.

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Part 2
Meaningful Use Learnings for Pharma-
ceutical Companies

Part 2: Meaningful Use Learnings for Pharmaceutical Companies (continued)

2 Meaningful Use Learnings for Pharmaceutical Companies

By Michael Burger, Senior Consultant,
and Brian Bamberger, Life Sciences Practice Lead

Meaningful Use (MU) is coming under more scrutiny these days. Partly because the program soon will be heading into its third and final phase, everyone is interested in MU's progress and its impacts. Despite MU's success in creating a tipping point in the adoption of electronic health records (EHRs), usage attestations suggest that providers are not sticking with the program as vendors have been slow to certify their products for the stage 2 requirements. While a slowdown in meaningful use uptake is not the optimal outcome as far as the government is concerned, MU does create opportunities for pharmaceutical companies to improve quality and outcomes.

Today's MU landscape. Meaningful use is a federal incentive program created to foster adoption and use of health information technology (healthIT) such as EHRs, including those with electronic prescribing functionality. Use of EHRs is expected to improve quality and outcomes while at the same time reducing costs of care.

According to the government, MU exceeded its goal of half of physician offices and 80 percent of eligible hospitals having EHRs by the end of 2013. Despite this early success, participation seems to be dropping off as we are entering stage 2 of the program. One indicator is physician attestations. MU attestation is a process that documents whether an organization or individual is "meaningfully using" certified EHRs by successfully fulfilling government-mandated requirements. The scope of the requirements has ramped up from MU stage 1 to MU stage 2, which will run through 2016. Successful attesters are eligible for incentive payments. Unsuccessful attesters and non-participants will have their Medicare payments reduced because of noncompliance, beginning in 2015.

So far, the vast majority of attestations have been for stage 1 of the MU program. For stage 1, there has been a substantial drop off in 2nd year attestations. In other words, physicians attested for the first year and then, for various reasons, opted not to continue to attest in subsequent years. A common theme for 2nd year dropouts has been that the real cost of EHR adoption far exceeds the cost of

the software acquisition covered by the MU incentives, both in terms of lost productivity and required workflow reengineering.

MU Stage 2 has now begun. A large number of EHR vendors who certified their systems for stage 1 have not yet done so for stage 2. We can only speculate as to know why this is the case or what these vendors' intentions are relative to certifying for MU stage 2. While the hundreds of such vendors don't represent the majority, their products are in the offices of more than 40% of physician EHR adopters. This significant core of physicians then face a tough choice – do they continue using their chosen EHR and drop out of MU or do they switch systems?

MU clearly is facing some bumps in the road, which many find to be quite troubling. MU has been a major investment: the federal government has paid out more than $33 billion in incentives to 383,000 healthcare providers – both individuals and groups – between May 2011 and April 2014 to help them adopt certified health IT. Now that investment is being called into question. In a story reported by Politico, Rep. Michael Burgess (R-Texas), a former obstetrician/gynecologist, was quoted as saying, "As we get to the end of those dollars and they've been expended, have we gotten what we've asked for?" "Probably not exactly," he continued. "Some of that responsibility lies in the United States Congress for sure."

Opportunities for pharmaceutical companies. Despite the issues involved with keeping MU up and running, the program unquestionably has fulfilled its intended purpose of furthering adoption of EHRs. Whether physicians participate in MU or not, virtually all of the EHRs they have purchased contain MU-mandated features. The drops in physician attestation rates suggest that such features may not be used at all or to their fullest extent. This creates opportunities for pharmaceutical manufacturers to advantage those features to improve outcomes.

There are several examples of these opportunities. One of the MU measures evaluates the use of the EHR to send reminders to patients for preventative or follow-up care. A Point-of-Care Partners (POCP)

analysis of attestation data reveals that only 18% of respondents are using their EHR to send reminders. Encouraging practices to leverage their EHR investment to remind patients of appropriate care, and assisting practices to ensure the use of appropriate care guidelines, is a ready-made role for pharmaceutical manufacturers.

Similarly, 55% of attesters reported providing patient education materials to patients. Supporting practices with current and appropriate patient education materials encourages patient engagement, and promotes medication adherence.

An interesting finding revealed by POCP's analysis is that 84% of respondents attested positively to the "drug formulary check" measure. It calls for a physician to have "enabled the (formulary validation) functionality and have access to at least one drug formulary." This means that as long as the EHR has formulary validation "turned on," the physician can attest that she or he has met the requirement. There is no obligation to look at the formulary data, or to use the data to make clinical decisions. While this is checking the MU box, more can be done.

A relatively high (84%) instance of formulary data availability creates an opportunity for pharmaceutical manufacturers to push for more comprehensive and higher quality formulary data. This will have two effects. First, the formulary data will be used for more than "checking a box" for meaningful use. Secondly – and more importantly – it will help drive formulary compliance. Formularies are a cost of doing business for pharmaceutical manufacturers, so a higher level of formulary compliance provides a return on that investment.

Review of the meaningful use attestation data reinforces the anecdotal evidence that we've been seeing in our physician practice and EHR vendor engagements. Practices are slow to adopt new features, even those which are required for meaningful use. As a result, treatment protocols which are in place update very slowly, despite the introduction of new decision support algorithms based upon clinical findings which affect suggested treatment protocols.

We at Point-of-Care Partners believe that an effective way for pharmaceutical manufacturers to harness the power of EHRs is to create programs which prioritize and promote clinical guidelines that impact strategic therapeutic areas. Simplifying the EHR implementation of these guidelines strengthens the partnership with physicians, and yields better outcomes for patients.

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Part 3
Surescripts Stats Show ePrescribing
Rounds Third Base

Part 3: Surescripts Stats Show ePrescribing Rounds Third Base (continued)

③ Part 3: Surescripts Stats Show ePrescribing Rounds Third Base

by Tony Schueth, Editor in Chief

After years in the minor leagues, it looks like electronic prescribing (ePrescribing) has finally arrived. The story is told in large part via Surescripts' newly issued National Progress Report 2013 and Safe-Rx Rankings. It indicates the company routed more than 1 billion electronic prescriptions in 2013, representing a majority (58%) of all eligible prescriptions in the United States, sent by 73% of all office-based physicians. The report also shows mail-order ePrescription volume increasing and nearly all community pharmacies are good to go. Outside sources estimate an additional 21 million prescriptions are flowing through other networks.

All in all, it's safe to say that ePrescribing is rounding third base. However, it's too soon to say the game is over, as some stakeholders keep saying. Despite its strong showing in major-league health care, we at Point-of-Care Partners (POCP) don't believe ePrescribing will be sliding into home anytime soon. We still need to increase adoption, utilization and volume from the remaining types of prescribers, prescriptions and transactions.

Increasing transaction volume. Nobody can fully quantify who and how much still is missing from the ePrescribing lineup. The Surescripts report provides some clues, beginning with ePrescribing for controlled substances (EPCS). While gaining traction, EPCS is still a low-volume proposition – so much so that these prescriptions are not yet included in Surescripts' denominator. Although the Drug Enforcement Administration (DEA) predicted it would take some 15 years for EPCS to become mainstream, others are more optimistic. David Yakimischak, Surescripts' Executive Vice President and General Manager for Medication Network Services, estimates 5 to 10 years. He notes the major progress that's been made even though we are only just a few years removed from issuance of the DEA interim final rule in 2010, which set forth its criteria for EPCS. Physicians are increasingly perceiving EPCS as important and are becoming certified. There are other drivers that will spur EPCS, including legislation (such

as New York's I-Stop) that will make EPCS mandatory to help curb controlled substance diversion and abuse. Yakimischak expects the shorter horizon if mandates become more commonplace.

Although renewal requests will always be a small percentage of the total, increasing their use and volume will enhance overall ePrescribing numbers and complete the picture. The report noted a 29% increase in renewal requests in 2013, but they only accounted for roughly10% of the Surescripts network volume within the past couple of years.

Next up is medication history, which registered 19% growth to reach nearly 700 million Surescripts transactions in 2013. While we'd like to see more, this growth is encouraging because this transaction can fuel medication reconciliation at the transitions of care as well as adherence messaging and improved drug-to-drug alerts. Again, more can be done. "We are seeing situations where certain markets are much more interested in working to create a collaborative environment providing timely, filtered information in addition to understanding what happens to the Rx around things like adherence," said Kevin Mahoney, Executive Vice President for Pharmacy Services, Emdeon, a collaborator with and competitor of Surescripts. "More and more, we're seeing our clients wanting to know if an Rx was filled and, if not, why not."

Finally, there are the "benefits" transactions, which surprisingly were not covered in this year's report. These have traditionally been the eligibility requests and responses that fed the formulary information provided to electronic health records (EHRs) in batch transactions, but may take on new meaning as the National Council for Prescription Drug Plans (NCPDP) works on a solution for a preadjudication transaction that will give prescribers likely benefit information at the patient level.

All these transactions represent the sweet spot in the lineup because they can significantly improve quality and safety, though they will admittedly take some work on the parts of payers, pharmacies, vendors

and providers. Payers need to improve the timeliness, availability and accuracy of information provided in formulary and benefit files, particularly the prior authorization flag. Pharmacies must increase their accuracy and availability of medication history information — issues that have served as barriers for physician usage of ePrescribing. Vendors will need to improve representation on ePrescribing systems. Providers must better understand the value of this information and do a better job of integrate it into their work flows, once they are assured of its veracity.

Specialty prescribing was also missing in the report, but could become a heavy hitter in years to come. Although such prescriptions also are low in volume (1% today) in the overall scheme of things, they represent a huge growth area with big price tags. Specialty medications run at least $2,000 per month per patient; those at the high end cost upward of $100,000 to $750,000 per year. The high price tags of specialty drugs are a major reason why expected outlays for them are projected to reach some $402 billion annually. A recent study estimates that nearly half of all prescription drug sales will be for specialty medications by 2021 due to their use by the growing elderly and chronically ill populations. These factors undoubtedly will bring specialty prescribing onto payers' radar; they soon will recognize this as an area for cost containment and will be looking for ways to wring savings from the process. Moreover, these prescriptions are ripe for automation.

People tend to consider specialty prescribing to be a single transaction; in fact, it is a series of transactions that are done mostly by paper, phone and fax. Enter ePrescribing of specialty medications, which is used today but on a limited basis. Standards and ePrescribing infrastructure already are available to handle the basic prescription process. Other necessary elements, such as electronic prior authorization (ePA), are emerging that will facilitate automation of other specialty prescribing processes. Given the complexity of specialty prescribing, arriving at meaningful metrics will be challenging. Prescription volume alone is not enough.

Gaps in the provider roster. Mahoney points to several provider types that are missing from the ePrescribing lineup. Rural providers and long-term care facilities need to get connected and up to speed. In addition, many other providers are connected but have a low transaction volume due to churning in the EHR market. Significant numbers of physicians are changing EHR systems because they are fed up with their current system or they are joining value-based systems and need to have the "corporate" model. They then need to learn the new EHR system and integrate it into their daily work flow. As a result, it will take time for their transaction volume to meaningfully increase and significantly affect the ePrescribing denominator.

Bringing up the bottom of the roster are those providers who are doing the minimum or plan to do nothing at all. Some simply have bought an ePrescribing system to garner various incentives and use it

at a threshold level to avoid statutory payment penalties. The result: their utilization will never do much to increase the ePrescribing numerator. Sadly, there will always be a small percentage of providers who will never ePrescribe despite the best efforts of the government and industry and the benefits to multiple stakeholders.

State rankings. Surescripts also released its SafeRx rankings for 2013. The top rankings didn't change all that much, although North Dakota and Connecticut moved up into the top 10. There was churning in the middle, and some states, like California, stayed near the bottom. How this all works is somewhat mysterious. According to Surescripts, "… the rankings recognize the full utilization of [ePrescribing] based on volume of use of Surescripts' Prescription Benefit, Medication History and Prescription Routing Services." Despite all of this, we do know a couple of things. A few blips can really change the rankings of states with small populations and/or small geographic areas, which accounts for the Dakotas being in the top 10 for 2013. We also know that payer nonparticipation with Surescripts can skew these ratings. We are aware of one state in which the major commercial payer is not a Surescripts contributor, serving to knock it down 10 to 15 spots. This means that their transactions for medication history and benefits transactions, for example, are not included in Surescripts' totals. We wonder how widespread this situation might be and how much it could affect outcomes overall. On the other hand, it's probably safe to say that the SafeRx rankings don't have the impact they once had. In the early days, these rankings really did a lot to spur competition among states and boost the cause of ePrescribing. We wonder if the orientation should shift to EPCS and get some competition going among states to champion this important piece of the ePrescribing puzzle.

Looking to next year. Surescripts' report provides a partial annual snapshot of an industry that has rapidly moved beyond its humble beginnings, which focused on transaction volume. As we hit the midpoint of 2014, POCP finds that vendors, infrastructure providers and standards development organizations are concentrating on adding value and innovation to the ePrescribing process. For some, that means working to create a collaborative environment that provides timely, filtered information. Plans are afoot in many quarters to add various kinds of clinical and administrative data to ePrescriptions, such as diagnosis, height and weight, and insurance policy number, to determine whether coverage will fall under a patient's medical or pharmacy benefit. This will increase accuracy and usefulness of ePrescriptions for tracking costs, quality and outcomes, as well as reduce administrative overhead. Mobile applications are rapidly coming onstream. Payers and providers are becoming interested in understanding what happens to a prescription with regard to such considerations as adherence. Work is beginning on more advanced functionalities for ePA that will enhance its usability for specialty prescribing. The list is long and growing every day. Let Point-of-Care Partners help you understand how ePrescribing is a becoming a whole new ballgame and how the new value-adds can be home runs for your organization.