HIT Perspectives

Perspectives and Updates on Health Information Technology

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eMedication Management

SafeRx Awards Provide Touch Point to ePrescribing Progress

By Mihir Patel, PharmD

On September 21 at the SafeRx Awards, Surescripts announced that 200,000 physicians are now prescribing electronically. This is a 28% increase since December 31, 2009. We've been watching carefully and this is in line with recent trends, showing no signs of a slowdown. Surescripts puts out its *National Progress Report on ePrescribing* in the first quarter of each year. A year is a long time, so this is an important checkpoint.

Separately we also learned that Surescripts is expected to have 300 million ePrescriptions by the end of 2010. When you consider that this is just Surescripts data – not the entire universe of ePrescribing (not counting Emdeon and large, closed systems like Kaiser) – you may come to the conclusion that we're at the "tipping point."

What does that mean to industry stakeholders? In general, it's happening and this time it's not hype. If you don't have a strategy, we suggest it's past time. If you do, perhaps you should revisit it based on current trends…

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eMedication Management

Payers Can't Afford to Turn a Blind Eye to ePrescribing

By Tony Schueth, Editor-in-Chief

It seems the health care world is laser-focused on implementation of electronic health records, which has led to a disturbing trend: many payers assume that ePrescribing has been safely put to bed and they don't have to pay attention to it anymore. Nothing could be further from the truth. While ePrescribing has come a long way and overall implementation is proceeding, left to its own devices, it may not be progressing in a manner that is advantageous to payers…

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Healthcare Reform

Watch Out for the New Kid on the Block: Accountable Care Organizations to Arrive on Health Care Scene

By Kurt Andrews, PhD

American health care has had its twists and turns with integrated delivery systems, pay-for-performance and capitated payments over the past three decades. Now come Accountable Care Organizations (ACOs). While there are many unknowns at this point, one thing is clear: ACOs cannot succeed without robust health information technology (HIT).

So, what are ACOs? The basic concept sounds pretty familiar, with some new wrinkles. They're a form of capitation. This time, the primary capitation agreement is between the health plan and the ACO, with the ACO accepting a single capitation for both inpatient and outpatient services. Thus, hospitals and physician practices will be pushed together as a single contracting entity. In many ways, ACOs can be thought of as a health system that brings together providers who are jointly responsible for improving quality and reducing costs for a pre-defined patient population…

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If you're a physician who is not prescribing electronically, you may want to start getting comfortable with the idea. If you're a patient – as we all are – and your physician is not prescribing electronically, why not ask why not. If you're a payer, we hope you're not taking your eye off the ball (see next article in this issue). If you're a pharmaceutical company, the train has left the station, so it's past time to find out if there's a seat. If you're a technology company, it's worth asking if your current strategy is valid.

At the event, Surescripts also awarded states with the most ePrescribing activity and its evangelists. Not surprisingly, there were some familiar faces in the top 10 for 2009, but there also were some newbies.

Massachusetts, Michigan and Rhode Island were again at the top of the list, though the latter two switched places this year due to criteria changes. This year, Surescripts looked at the percentage of electronically routed prescriptions to a patient's choice of pharmacy, which in the past was the only criterion considered. In addition, Surescripts looked at two other critical areas of ePrescribing: receiving prescription benefit information prior to sending an ePrescription and electronically cross-referencing a patient's medication history with pharmacies and payers. Michigan was strongest in the prescription benefit information category, allowing it to leapfrog Rhode Island. Massachusetts was strong in all three categories.

Rhode Island, however, got its due. The ePrescribing evangelist award went to its US senators, Sheldon Whitehouse and Jack Reed. In ePrecribing circles, Sen. Whitehouse is best known for grilling the Drug Enforcement Agency (DEA) in a December 2007 hearing that pressured the DEA to permit electronic prescribing of controlled substances. The former prosecutor also had a great deal to do with securing federal stimulus money for health information technology and ensuring that ePrescribing is not forgotten.

Other states conducting a great deal of ePrescribing activity are Delaware, North Carolina, Connecticut, Pennsylvania, Hawaii, Indiana and Florida, with the latter three new to the Top 10. Strong payer-backed adoption programs in Connecticut, Pennsylvania and North Carolina accounted for their staying in the middle of the top 10 in both 2008 and 2009. Hawaii definitely rose to make a strong showing, having been at the bottom of the list for the first four years and placing ninth in 2009.

We applaud Surescripts for adjusting its criteria this year. Inclusion of these new transactions provides a more realistic snapshot of what is happening in the industry. For example, Minnesota would have jumped to the top three in prescription volume alone because of its new mandates; however, it slipped to 16th overall due to low numbers of requests for eligibility and medication history. We hope Minnesota payers are taking note!

We cannot help but highlight our role in all of this, starting with our project management of the Southeastern Michigan ePrescibing Initiative, a health information exchange initiative originally dedicated to ePrescribing. We also played a role in North Carolina's activity. Two states that we were helping in 2008 dropped their efforts after deciding to use local consultants instead of national experts, such as us.

That's what we are – experts in health information exchange, ePrescribing, health information technology and project management. Please let us know if we can give you a hand with your efforts and help you win national recognition.

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This situation basically results from the rush toward meeting the federal government's meaningful use (MU) requirements so eligible providers can receive hefty incentive payments [see the August issue of *HIT Perspectives* for additional details on MU implementation]. These incentives are designed to encourage adoption of electronic health records (EHRs), of which ePrescribing is a component. Surescripts estimates that ePrescriptions will jump from 190 million in 2009 to 300 million in 2010, in part due to the government's MU incentives.

While the electronic transmission of a prescription to the pharmacy is an integral part of MU, the transactions that add most value and return on investment for payers are not front and center among the MU requirements. Specifically, formulary and benefit checks have moved to the menu set or optional requirements, and eligibility checking has been bumped off the list entirely. While formulary and benefit checking will reportedly be mandatory in Stage 2, it is not known publicly why eligibility drew the short straw or if it will reemerge in future stages.

Now, we acknowledge that an eligibility request must be completed before a medication history request and that this transaction can feed medication reconciliation, which is also in the MU menu set. In addition to it being optional in Stage 1, we also point out that there are other ways to complete medication reconciliation, the MU metrics don't require a transaction and all eligible providers are doing is "attesting" that they're performing medication reconciliation.

What's happening is that an increasing number of providers using electronic health records (EHRs) are turning off the formulary and eligibility checking functions. One reason is because formulary is elective and eligibility is not a requisite. Another harkens back to the EHR architecture, which can be clumsy when it comes to linking a formulary and doing eligibility requests. The source is both technical and philosophical. On the technical side, many EHRs are still client-server models, which mean there are servers in the group practice that, in turn, link to a main server. Getting the response from an eligibility request can take longer than the physician desires as it bounces from point to point. If formulary is linked to the patient by a means other than eligibility, there are challenges, as well, often involving a manual process. On the philosophical side, EHRs evolved from electronic medical records, which were designed to be the electronic version of paper records, meaning that they weren't meant to be interoperable.

For payers, formulary matters because it affects the value proposition, which is derived initially and significantly from encouraging prescribing of lower-cost alternatives. It's also the easiest component of the EHR to measure. Eligibility matters because of the complexities associated with pharmacy benefit design. It's kind of complex but, in summary, benefits for companies such as GM, Ford and Chrysler or the UAW—who carve out the pharmacy benefit—may often be misidentified in the EHR if eligibility is not involved. In managing the Southeastern Michigan ePrescribing Initiative (SEMI), we found an average savings of $4.78 per prescription. When that analysis was completed, all prescribing decisions were made from an eligibility-informed formulary.

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To our knowledge, no one has controlled for the difference between eligibility-informed formulary and that which is not, or that which is not informed by formulary at all. Nearly all studies conducted on ePrescribing have found savings in the $2.50 to $7/e-Rx range. The exception was a study published in 2005 in the *Journal of Managed Care Pharmacy* in which the authors, S. Michael Ross, MD, MHA, et al, were unable to find improvements in formulary compliance between ePrescribers and a control group. This was in the early days of ePrescribing (2001-2002), before the eligibility transaction and when plan-level formulary was being linked manually to benefits information derived from the practice management system. We would submit that this kludge method had a great deal to do with the findings.

In managing SEMI, we saw a shift from free-standing, robust, interoperable ePrescribing solutions to EHRs that were becoming increasingly interoperable but, in some cases, regressing to 2001-02. We're there to remind the providers why they don't want to turn off formulary, work with the vendors to address their architecture issues and promote formulary linking, in general. If we weren't there, what would the results have been?

The reality is that the value of eligibility-informed formulary doesn't just accrue to the payer. It reduces downstream noise and inefficiencies for providers and hassle for the patients. In addition, it helps providers meet Stage 1 of MU, and can help them qualify for pay-for-performance programs. Sometimes, however, the provider isn't aware of all of this or how the complex system works and either gets frustrated or chooses the path of least resistance.

In Michigan, we're there to ensure the value proposition. In your market and with your providers, who's doing the same?

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Accountable Care

To be sure, it's too soon to know how ACO networks will be configured, which patient populations will be included, how financial risk will be shared, how savings will be measured and how compensation will be determined. It's too soon to know whether ACOs can actually become a model that can provide quality, lower-cost care for uninsureds down the line, a basic rationale in the legislation. And it's way too soon to know if ACOs will cause a redistribution of capital within the health care delivery system or what legal changes will be needed, such as those to antitrust laws and Medicare rules concerning relationships between hospitals and physicians.

Point of Care Partners is monitoring the emerging ACO movement and how it is being translated into practice, along with its close relative, the patient-centered medical home (PCMH). In fact, the PCMH is a core requisite of the ACO, although not all PCMHs will be part of an ACO. We can help payers, providers and delivery systems understand what PCMHs and ACOs are all about and make sense of the new ACO regulations once they are issued. More importantly, our expertise in HIT can help payers, providers and delivery systems to hit the ground running with value-driven HIT strategies and purchasing decisions. Call us or drop us a line.