Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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Part 1
How To Gain Traction For
ePrescribing For Specialty
Medications

Part 1: How to Gain Traction for ePrescribing for Specialty Medications (continued)

1 **Part 1:** How to Gain Traction for ePrescribing for Specialty Medications

By Brian Bamberger, Life Sciences Practice Leader

The use of specialty medications is on the rise — especially for the growing number of patients who are chronically ill with such complex diseases as cancer, multiple sclerosis and rheumatoid arthritis. However, these drugs are expensive and complicated to prescribe and dispense. Now that electronic prescribing (ePrescribing) is the norm for most other medications, it increasingly is being viewed as a solution to reduce the costs and administrative burdens associated with specialty prescribing.

Increased spending and utilization are major reasons why stakeholders are looking to ePrescribing as a mechanism to help contain the costs of specialty medications. Growth in spending for specialty drugs is far outpacing that for traditional drugs, and many new ones are in the pipeline. According to a 2013 analysis by Express Scripts, domestic spending on specialty prescription drugs is projected to increase 67% by the end of 2015. By then, cancer, multiple sclerosis and such inflammatory conditions as rheumatoid arthritis — all specialty conditions — will account for higher drug spending than any other therapeutic class except diabetes. A separate analysis by Prime Therapeutics predicts that, based on recent average yearly increases, specialty drug costs will rise 15% annually while non-specialty drug costs will remain flat. At this rate, specialty medications are expected to account for 50% of overall drug costs by 2018 for commercially insured individuals.

These huge outlays are directly related to the micro-level costs and use of specialty medications, which payers and pharmacy benefit managers (PBMs) are struggling to manage. Specialty medications often cost more than $2,000 per month per patient. Many cost much more, with the most expensive specialty drugs running upward of $100,000 to as much as $750,000 annually. This represents an obvious economic challenge for payers, while copays can be budget busters for many patients.

Specialty prescribing stakeholders also are looking to improve work flow and savings on administrative overhead through ePrescribing. Specialty prescribing has been mired in paper and yesterday's phone-fax processes, and should be brought into the digital age. ePrescribing can help facilitate the prior authorizations (PAs) that are needed for many specialty medications, reducing extensive outlays by pharmaceutical companies for administrative assistance for prescribers and patients and getting PAs approved much more quickly. The result: improved sales and less abandoned prescriptions. ePrescribing also can assist with risk evaluation mitigation strategies. For example, ePrescribing could streamline the coordination and communication of the "authorization identification," which is necessary for medication ordering and patient reporting.

While ePrescribing holds much promise for addressing costs and workflow issues associated with prescriptions for specialty medications, they are outside today's ePrescribing process. Stakeholders have been working on solutions and progress has been made. As nationally known experts in health information technology (health IT) and ePrescribing, Point-of-Care Partners (POCP) has four ideas on how to gain additional traction for ePrescribing of specialty medications.

- **Continue forward motion on a standard**. The National Council for Prescription Drug Programs (NCPDP) has made changes to the formulary and benefit standard to incorporate information about which pharmacies are included in specialty distribution for specific products and payers. If the modification is withdrawn in the Formulary and Benefit Taskgroup at the November NCPDP Workgroup meeting, it would create a setback for ePrescribing of specialty medications.

- **Increase use of PA flags.** To enhance ePrescribing of specialty medications, it's also critical that the drug includes a PA indicator in the Formulary and Benefit data supplied to electronic health records if a prior authorization is needed. However, few PBMs identify all PA drugs in their formulary data. Increased use of PA indicators could lead to identifying the need for a PA in the physician's office, rather than at the pharmacy after the prescription has been written. Faster turnaround of PAs and more streamlined processes are needed by both providers and specialty pharmacies.

- **Add needed patient and clinical data.** Safe and appropriate prescribing of specialty medications depends on a wide range of data, such as a patient's weight, diagnosis and laboratory values. These are especially important for correct dosing, for example. While these are outside of today's ePrescribing processes, stakeholders continue to work on related standards and software. Including these data elements in the ePrescription will enhance the timeliness and quality of the specialty prescribing process, as well as improve patient safety and specialty pharmacy efficiency.

- **Step up manufacturer involvement.** For pharmaceutical manufacturers, ePrescribing of specialty medications represents an opportunity to identify appropriate patients for a designated drug while reducing approval obstacles for physicians. As more complicated medications come to market, physicians and plans increasingly must identify appropriate patients. That's why manufacturer involvement in supporting ePrescribing of specialty medications is important and will benefit all stakeholders.

POCP is working closely with stakeholders to move ePrescribing of specialty medications forward and monitor progress. Let us know if we can give you an in-depth picture of the opportunities and challenges.

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Part 2
New Toolkit Helps Payers Realize the
Value of Health Information Exchange

Part 2: New Toolkit Helps Payers Realize the Value of Health Information Exchange (continued)

2 **Part 2:** New Toolkit Helps Payers Realize the Value of Health Information Exchange

By Michael Solomon, eCare Management Practice Lead, and Bill Hein, Payer/Provider/ACO Executive Lead

Providers are generally quick to understand and embrace the value propositions for participating in local, regional and state health information exchanges (HIEs). The same is not necessarily true for payers, who often have been dragging their collective feet in joining these up-and-coming opportunities for a variety of reasons, including an incomplete understanding of what's in it for them. However, payer attitudes may change quickly when they learn that HIE participation can significantly and positively impact administrative and clinical costs, efficiency, outcomes and quality and can translate into meaningful return on investment.

Educating payers about HIE value propositions and engaging them in how to make it work within the payer ecosystem are the twin goals of a new payer toolkit that has been developed by Point-of-Care Partners (POCP) with funding from the Office of the National Coordinator for Health Information Technology (ONC). The toolkit is coming soon to the ONC website (www.healthit.gov) once it has been formally presented to its HIE grantee leadership.

The toolkit is divided into four sections. The first clearly lays out the value proposition for payer participation in four areas: costs, efficiency, outcomes and quality. HIE participation may prevent avoidable inpatient admissions and reduce service utilization and costs associated with emergency department visits. At the same time, HIE participation may permit payers to simplify and streamline

medical and drug authorizations. It may also help them develop streamlined flows and presentation of longitudinal data from electronic health records, which will help reduce time spent interpreting data from disparate sources. As a result, payers will be moving forward with HIE participation because they have a stake in most tangible benefits of engaging with HIEs. Successful HIEs that have effectively engaged payers in their ecosphere are projecting that 30% to 66% of revenues will ultimately be generated from them.

The second section represents case studies from four state/regional HIEs: Indiana, Nebraska, Wisconsin, and Rochester, NY. They demonstrate how payers have successfully engaged in HIE to reduce costs and risk or improve quality and health outcomes. Their lessons learned can stimulate thought for HIE leaders in other regions and provide real-life success stories to be shared with their local payer communities.

The third section expands on the value propositions for costs and efficiency, and outcomes and quality. For each value proposition, charts provide an at-a-glance overview of technological considerations for implementing HIE services in such areas as analytics, clinical document architecture support, consumer connectivity, data repository, decision support, event notification, provider directory and workflow applications.

The third section also contains measures for each area,

which drive home the benefits for payers. For example, mounting quantitative evidence of the importance of HIE to "big cost levers" indicates that it's not a question of whether payers should participate in an HIE, but one of magnitude. Payer investment in HIE services to improve quality and outcomes may qualify as "quality improvement expenses," thus improving the medical loss ratios of affiliated health plans.

Finally, the fourth section details implementation strategies that HIEs can use with payers to connect the dots for their leadership and get their organizations effectively engaged. For example, it is imperative to get health plan chief medical officers on board. Active participation in statewide quality initiatives also will help payers successfully integrate with HIEs in their areas.

POCP was selected by ONC to develop the Payer Toolkit because of our deep expertise in the ecospheres of health information exchange, health plans and other payers, and their supporting technology and service vendors. Let us know if we can help you leverage your health IT strategy or solutions to traverse the complex post-health reform era.

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Part 3
Moving Health IT Forward in Long-Term
and Post-Acute Care

Part 3: Moving HIT Forward in Long-Term and Post-Acute Care (continued)

3 Part 3: Moving Health IT Forward in Long-Term and Post-Acute Care

By Maria Friedman, Senior Consultant

Most of the world seems to be laser-focused on watching how health information technology (health IT) is being adopted in ambulatory and inpatient settings. However, they might be overlooking the major health IT strides being made in long-term care and post-acute care, collectively known as LTPAC.

Drivers. To be sure, health IT development and adoption in the LTPAC environment lag behind those in ambulatory and inpatient settings. However, the need for—and use of—health IT in LTPAC have increased in recent years due to an expanded set of drivers:

• LTPAC has rebranded and now goes far beyond the traditional long-term care (LTC) focus. It now encompasses many types of care: home and community-based services, nursing homes, assisted living, long-term acute care hospitals, rehabilitation and post-acute care facilities, Program of All-inclusive Care for the Elderly (PACE), hospice, chronic disease and comorbidity management, medication therapy management and wellness providers.

• Momentum is building through a high-level stakeholder collaborative, the Long-Term and Post-Acute Care Health IT Collaborative (LTPAC Health IT).

• LTPAC is on the federal policy radar. For example, the federal Office of the National Coordinator for Health Information Technology (ONC) recently awarded challenge grants to four states to promote LTPAC health information exchange initiatives for transitions of care. Besides participating in LTPAC Health IT's annual meeting and disseminating a summary of its results, ONC published an issue brief about health IT in the LTPAC environment. The Assistant Secretary for Planning and Evaluation and the Centers for Medicare and Medicaid Services also are ramping up support for health IT in LTPAC.

• New care delivery and reimbursement mechanisms — including pay-for-performance programs and such new integrated delivery models as accountable care organizations —create a growing need for LTPAC entities to cut costs as well as electronically track quality measures and report on them.

• Nursing homes are turning to health IT to help control increasing costs because hospitals are discharging patients sooner. This, in turn, forces these facilities to care for higher acuity, clinically complex residents, which results in higher medication and labor costs.

• Significant increases in the elderly and chronically ill populations make health IT adoption a business imperative for LTPAC to improve quality, reduce costs and better align with reimbursement criteria by public- and private-sector payers.

• LTPAC technology solutions may be certified. Certification plays an important role in driving adoption and utilization of electronic health records (EHRs). Now EHRs for use in LTPAC may be certified through the Certification Commission for Health Information Technology (CCHIT). However, this certification is optional and not related to meaningful use certification, which does not include LTPAC solutions.

Barriers. Despite the considerable progress that has been made, there are many barriers to adoption. Main ones include:

• Meaningful use (MU). While many providers are getting incentives from MU programs, LTPAC providers as a group are not directly eligible for them. This funding barrier has held back facility EHR adoption. Further, MU requirements do not directly address LTPAC. This has kept vendors from building to LTPAC needs and facilities from adopting health IT.

• Technical and workflow issues. Although some LTPAC solutions are getting certified, there is a lack of necessary functionality and work-flow integration that must be overcome. For example, LTC facilities may have the opportunity to adopt a nearby hospital's EHR system; however, that system may not meet the facility's specific complex and diverse needs, thus resulting in partial use and limited value. Moreover, few residential care facilities support electronic HIE with other providers.

• Electronic prescribing for controlled substances (EPCS). The EPCS requirements issued by the Drug Enforcement Administration (DEA) create two pain points for LTPAC entities. The first is that the DEA does not recognize nurses as agents for Schedule II prescriptions, which does not accurately reflect procedures in the LTPAC environment. In addition, the EPCS requirements are so onerous that most LTPAC entities drop back to the traditional paper-phone-fax methods for prescriptions for controlled substances. There also are state regulatory barriers to EPCS in the LTPAC environment that must be resolved.

Moving forward. Considerable progress has been made by the LTPAC community regarding health IT, and many lessons have been learned that can help spur health IT adoption going forward. For example:

• As an integral part of the health care system, LTPAC must be considered when developing MU stage 3 and other federal health IT programs. This may change going forward. We see glimmerings of motion in that direction in MU stage 2. This may be a baby step in supporting the needs of persons who receive LTPAC services by requiring eligible providers to send care summaries during transitions of care that may include LTPAC providers. More needs to be done. Opportunities to fold LTPAC into MU stage 3 requirements include person-centric longitudinal care plans, transitions of care and federally required patient assessments. LTPAC technologies must be made part of the MU certification process. This may encourage health IT vendors to build to LTPAC needs and for their LTPAC providers to get in the health IT mainstream.

• Health IT facilitates transparency in how the facility is operating, which can lead to more accurate medical records and documentation. Such improvements can make preparing for a state survey easier and more likely to end in a better result. Improved transparency and documentation also improve billing accuracy and thus enhance reimbursements.   Having laboratory values and radiology results available online ultimately contributes to the value proposition.

• Training and coaching help ensure that clinical best practices are followed; they also complement use of technology to drive standards and decision support at the point of care. Without them, staff can remain resistant to change and do not learn the basics correctly. As a result, they may introduce errors or omit critical information, which can be problematic for basic patient care and preparation for state nursing home surveys.

• Strong institutional leadership — including a committed director of nursing — also are crucial to make a successful organizational transformation away from paper. Leadership can help staff understand the benefits of health IT, which will motivate them to become expert health IT system users.

• EPCS issues need to be resolved.

Needless to say, there is a lot on the collective LTPAC plate regarding health IT policies and adoption. Point-of-Care Partners (POCP) continues to monitor progress in this key health care sector and can provide strategic guidance to providers, payers and vendors.

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