Perspectives and Updates on
Health Care Information Technology

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September 2013

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Part 1
Stakeholders Shine Spotlight on
Improving the Quality of ePrescribing and
ePrescriptions

1 **Part 1:** Stakeholders Shine Spotlight on Improving the Quality of ePrescribing and ePrescriptions

By Brian Bamberger, Life Sciences Practice Leader

Now that the majority of prescriptions are being "written" electronically, attention is focusing toward improving the electronic prescribing process (ePrescribing) and the quality of electronic prescriptions (ePrescriptions). By highlighting related problems, we can begin to improve the entire process.

That said, we are hearing more and more about problems related to accuracy of ePrescriptions. Public comments at the two most recent workgroup meetings for the National Council for Prescription Drug Programs (NCPDP) highlighted the mounting problem of electronic prescription quality.

We also learn about these issues through the ePrescribing help desks Point-of-Care Partners (POCP) has run for a half-dozen pharmaceutical companies this year. The help desks address issues received by sales representatives from prescribers with whom they interact. The main issues they see relate to products that are not in tablet form, including those that are injected or inhaled, creams, ointments, sprays and liquids. Some issues are fairly benign and concern the quantity of the prescription, for example. Others include strength and dosing, which have a more dramatic impact on patient safety. All of these issues result in pharmacy callbacks to physician practices for clarification.

NCPDP has been addressing these issues at recent meetings using two task groups. The first examines best practices related to the prescribing of acetaminophen, especially for children. The second focuses on milliliter (mL) dosing, such as how to accurately make metric conversions and incorporate this process into the work flow. More work is needed as these are only two high-profile issues that have surfaced.

These ongoing efforts also are getting a boost with additional stakeholder input. This fall, NCPDP and the Pharmaceutical Research and Manufacturers of America (PhRMA) will convene a prescription quality stakeholder action group to address a broader survey of issues impacting prescription quality. The meeting will include a cross section of the industry: pharmacy, electronic health record vendors, ePrescribing vendors, payers, physicians, drug compendia and pharmaceutical companies. At the conclusion of the meeting, we expect to have more information regarding issues that need to be addressed, their high-level causes and the start of action plans that will create tangible results. Follow-up items will most likely be championed in existing NCPDP workgroups and task groups.

Regardless of the source, we are sure to hear more about quality issues from stakeholders as more prescriptions arrive at pharmacies electronically. It may take years to eliminate all sources of errors. We expect the dialogue to increase and a process to emerge that will address issues as they are identified by stakeholders.

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Part 2
Why Meaningful Use Attestation Is
Dropping and What Can Be Done About
It

Part 2: Why Meaningful Use Attestation Is Dropping and What Can Be Done About It (continued)

2 **Part 2:** Why Meaningful Use Attestation Is Dropping and What Can Be Done About It

By Michael Burger, Senior Consultant

Despite millions of dollars of meaningful use (MU) incentive payouts by the federal government, provider attestation rates continue to drop. It's counterintuitive to the policy makers' playbook, in which incentive payments are supposed to spur adoption and sustained use.

According to recent data from the Centers for Medicare and Medicaid Services (CMS), 4,100 physicians attested in May this year, compared to 5,400 in May 2012, and only 3,300 attested in June, down from 5,300 in June 2012. This downward spiral is not entirely unexpected, given that we are approaching the end of the stage 1 attestation period. However, it's noteworthy that if the current rate of attestation continues, less than 60% of eligible physicians will qualify for stage 1 at the end of the reporting period (February 2014). Another interesting trend is the drop-off of year 2 attesters. Analysis is showing growing numbers of stage 1 attesters who did not attest for year 2 of stage 1. By extension, we assume this means they will not attest for stage 2.

So, why is this happening and how can things get turned around? As a leading expert in health information technology (health IT), Point-of-Care Partners (POCP) points to five reasons why MU provider attestation is declining:

- The ride is not worth the fare. There are two groups of providers that aren't attesting because they don't think the carrots and sticks associated with MU are worth the effort. The first group has dug in its heels and simply won't adopt electronic health records (EHRs) that meet the government's requirements or on the government's timeline. Some will retire before the penalties for nonadoption kick in. Others have done the math and determined they are willing to accept reduced Medicare and Medicaid payments rather than incur the cost and effort of implementing an EHR. The second group bought their EHRs and attested for stage 1. The cost and effort of implementing and "meaningfully using" an EHR for stage 1 has given them a glimpse of the future, and they don't like what they see on the horizon for stage 2. Their early experience has convinced them that it won't be worth the expense for the upgrades, the time needed for the necessary work-flow modifications, and what it will take to meet stage 2 requirements simply to gain an installment of MU incentive dollars.

- "Wait and see" may be worth the wait. Some providers believe that sitting on the sidelines is a calculated gamble that may worth the effort. Since penalties won't kick in until next year, a small subset of providers is taking a bye and deliberately foregoing this year's MU incentive payments. They are stepping back to see how things shake out and will consider taking action next year. Another subset of providers is betting that stage 3 will be the end of the MU era, so they can afford to wait it out. This may be a valid assumption in some sense because Congress is unlikely to extend the program as it stands today. On the other hand, dodging the bullet may be difficult. The government, private insurers and integrated delivery systems are likely to require adoption of a certified EHR as a condition of provider participation during the transition from fee-for-service to quality-based reimbursement.

- Misleading numbers. Attestation numbers may be misrepresentative due to marketplace consolidation and churning as practices are being gobbled up by hospitals or merging to form accountable care organizations (ACOs). As a result, many of those providers may be concentrating on the details of a merger or acquisition, not MU, driving down attestation rates. It also means that fewer providers will be attesting, which drops overall attestation rates and skews monthly and year-to-date comparisons.

- Vendor readiness. Not all vendors are yet ready for stage 2, which will negatively affect the ability of some providers to successfully attest. Some, especially smaller vendors, may opt not to seek stage 2 certification because of the cost and complexity. This challenge should only get worse in 2014, when attestation requirements become more stringent and far reaching. Some vendors may deliberately not keep up-to-date on MU attestation requirements because they are concentrating on making their products more user-friendly in response to rising customer complaints. This could come back to bite them in the end because they will be too far behind to catch up quickly and profitably in a volatile market.

- Provider confusion. As evidenced by widely reported user dissatisfaction, it's a simple fact that many providers don't understand how to use their EHRs and report usage, which also affects attestation along certain measures. For example, some providers may find the MU dashboards to be confusing or difficult to use, so their reporting is inaccurate and corrective actions may be unclear. Other providers don't realize that all the information they've painstakingly entered in a text field in their EHR probably won't count because the reporting software cannot capture it or aggregate it.

Regardless of the reasons for declining attestation, it is clear that action should be taken to ensure that meaningful use achieves its goal. What can be done? One possibility is delaying stage 2 or extending the reporting period so vendors and providers can catch up. A number of industry organizations have proposed a variety of plans and timetables to ease the timeline for MU stage 2. The list is long and includes the Medical Group Management Association (MGMA), American Academy of Family Physicians (AAFP), American Medical Association (AMA), American Hospital Association (AHA), the Healthcare Information and Management Systems Society (HIMSS) and the College of Healthcare Information Management Executives (CHIME). Another possibility is reimagining the regional extension centers (RECs) so they place more emphasis on successfully using EHRs rather than focusing on attestation. To keep providers in the program, more education and outreach is needed so they understand their return on investment—beyond the incentive payments— once they have an EHR. Additional help with work-flow integration—from vendors and RECs—is necessary going forward,

Attestation is one of many significant pieces of the MU puzzle, but it is important because it is a key metric on which the success of the program will be judged. POCP advises policy makers, providers and vendors about all phases of meaningful use. Let us assess your attestation needs and help you develop successful strategies and tactics.

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Part 3
Using Health IT to Move Care
Coordination Forward

Part 3: Using Health IT to Move Care Coordination Forward (continued)

3 Part 3: Using Health IT to Move Care Coordination Forward

By Ed Daniels, Senior Consultant

As health care consultants, we are often asked to help a relative or friend navigate the health care system to obtain appropriate and effective care. Without this assistance, too frequently patients are lost to follow-up, tests are duplicated, care plans are not followed, referrals don't lead to timely specialist care and medications are not taken on time or in the correct dosages. All of these failures lead to poor outcomes, excessive costs and a bad experience for both patients and providers. Multiplying these suboptimal experiences across the health care system, it's easy to see that the time is right for care coordination enabled by health information technology (healthIT).

Care coordination is a formal way to address these issues by assigning a specific individual to the job of helping guide patients through the maze of diagnostic, care and treatment activities required to execute their individual plan of care. A care coordinator may perform this task as only one part of his or her job, or care coordination can be a full-time assignment. Care coordination can be performed in an individual physician practice or it can be a service provided by a health plan or other agency. The Veterans Health Administration actively coordinates care across various care settings using dedicated care coordinators who are usually nurses or social workers. Typically, an individual care coordinator manages a panel of between 100 and 150 general medical patients.

In a recent article, Marjie Harbrecht, MD, CEO of Colorado-based HealthTeamWorks, describes care coordination and also highlights the role of health IT. She defines care coordination as "… [focusing] on tactical issues: using patient registries to ensure that individuals and specific patient populations (e.g., diabetics) get needed services, tracking lab tests/referrals and naming a point person to manage information flow in and out

of the practice…[A] key tenet…is to coordinate care across the medical neighborhood of providers, which includes referrals to specialists, imaging centers, physical or occupational therapists, mental health providers or community resources."

Technology enables care coordination in community practice settings, where a computerized registry and electronic health record (EHR) are very important tools to assist the care coordinator with essential activities. These include ensuring that all necessary results and reports are available for the care team, reviewing the assessment and treatment plan, and completing evidence-based guideline recommendations.

The Veterans Health Administration has taken the use of computerized tools to a much higher level, and provides a model that other practices can use once the necessary payment mechanisms are in place. The agency uses health IT extensively to support coordination across the continuum of care, ranging from the hospital to the home. Their health IT program includes not just an EHR and registry, but also real-time telemonitoring technology.

Care is actively managed by full-time care coordinators. Every patient is formally assessed by his/her care coordinator upon enrollment in the program. Once a patient is enrolled, the care coordinator selects the appropriate home telehealth technology, gives the required training to the patient and caregiver, and communicates with the patient's physician. The patient's underlying chronic condition is used to determine which technology is needed. Possible technologies include videophones, messaging devices, biometric devices, digital cameras, and telemonitoring devices. Messaging devices present disease management protocols, including text-based questions for patients to answer. Responses help assess a

patient's health status. Biometric devices record and monitor the patient's condition, including pulse, temperature, blood pressure, oxygen saturation, weight and blood glucose levels. Videophones and video telemonitors support audio-video consultations in the home, which replicate face-to-face examinations.

This data is accessible on the care coordinator's desktop computer for follow-up. Each individual patient is risk stratified daily through color-coded alerts that indicate significant changes in any patient's symptoms. Once patients are identified as "at risk," care coordinators get involved to prevent hospital admissions and emergency department visits.

The cost of the Veterans Health Administration care coordination program, including home telehealth monitoring, is modest: $1,600 per year per patient, which is substantially less than other programs. Moreover, the program is effective. Quality and performance data from a cohort of 17,025 patients showed a 25% reduction in numbers of bed days of care, a 19% reduction in numbers of hospital admissions and a mean satisfaction score rating of 86%.

Care coordination is a necessary addition to the arsenal of tools used to advance the country's goals of improved outcomes, reduced health care costs and a better experience for patients and providers. Automation starting with registries and EHRs, but advancing to the most modern biometric monitoring and patient engagement tools, can contribute substantially to the effectiveness of these interventions.

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