



# HIT Perspectives

Perspectives and Updates on Health Information Technology

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## ePrescribing

### Gazing into the Crystal Ball: Trends and Issues for 2009

*by Tony Schueth, Editor-in-Chief*

Each new year begins with optimism, and 2009 is no exception. Despite the country's ongoing economic challenges, ePrescribing is alive and well. Funding and new initiatives are expected to be available. Adoption promises to accelerate beyond the early adopter phase. And ePrescribing will continue to lead the way toward EHR adoption, which appears to be a major continued policy goal this year and something that is high on the new Administration's radar screen.

POCP follows ePrescribing and its relationship to other trends and initiatives in the marketplace. Here's what we're seeing so far for 2009. As always, give us a call or drop us an e-mail for more information or technical assistance.

**Health Information Technologies (HIT) initiatives.** The media continues to cover President Obama's commitment to HIT. Things are happening quickly here. On January 28, the US House of Representatives passed an economic stimulus bill that had \$20 billion set aside for HIT. The Senate is working on its own bill. Business groups continue to push for HIT, both at the White House and on Capitol Hill.... Sens. Debbie Stabenow and Olympia Snowe introduced a bill that would provide \$4 billion in health IT grants to qualified health care providers who treat low-income patients or those covered by Medicare, Medicaid or the State Children's Health Insurance Program. We are watching these developments closely and will keep you updated on funding levels and potential spending vehicles.... In the meantime, the Agency for Health Care Quality (AHRQ) has published an RFP, "Using HIT to Improve Healthcare Quality" (for details, go to <http://grants.nih.gov/grants/guide/pa-files/PAR-08-270.html>). Awards will be made for demonstration projects that evaluate factors associated with successful implementation and utilization of health IT in order to improve the quality, safety, effectiveness and efficiency of health care in ambulatory settings and in the transitions between care settings. The scope includes projects that use HIT to improve the quality and safety of medication management via the integration and utilization of medication management systems and technologies; that use HIT to support patient-centered care, the coordination of care across transitions in care settings, and the use of electronic exchange of health information to improve quality of care; and, that use HIT to improve health care decision making through the use of integrated data and knowledge management. ePrescribing and HIT continue to be a significant part of AHRQ's research portfolio, and we believe that a wide range of ePrescribing activities fit well within the scope of this RFP. POCP will be developing opportunities and partnerships to take advantage of these funding opportunities. Let us know if you are interested.

**Incentives.** 2009 will be the year of incentivizing ePrescribing adoption and use. This trend gained significant traction in the last year by private payers and culminated with the Medicare Improvements for Patient and Providers Act

of 2008 (MIPPA) incentive bonus program announced in the fall (see the October 27, 2008, issue of *HIT Perspectives* [www.pocp.com/erxarchives](http://www.pocp.com/erxarchives)). The bonuses will begin this year. Based on self-reported ambulatory patient visits, the proportion of self-reported ambulatory patient visits that result in an ePrescription or use one of a handful of specified reasons for not ePrescribing during the visit. A "qualified" system must be used for at least 50% of ambulatory visits per eligible prescriber for the year, and not all the ePrescribing offerings in the marketplace will measure up. Providers who have a qualified ePrescribing system in place, or will be installing one soon, will have the best chance of maxing out on the bonus. Those who don't have a system in place in the near future will be unlikely to reach the minimum visit threshold, since it is calculated on an annual basis. Reporting to CMS will be complex and entirely new for most providers. CMS likely will change the bonus calculation denominator from Part B claims volume to Part D claims volume in the near future. POCP is monitoring these activities closely and is here to explain current and future Medicare requirements and assist providers with implementation.

**Implementation support.** Speaking of implementation, moving ePrescribing forward is not just about incentive payments. Implementation support above and beyond what a handful of vendors already are providing will be key, and we will be seeing more of that in 2009. The Health Alliance Plan's Matt Walsh has a rule of thumb for successful ePrescribing programs. He says that for every \$5 spent on incentives, program sponsors should consider spending \$1 on education, training, advocacy and trouble-shooting for the physician practice. More and more entities have started hands-on or on-line assistance programs. The hands-on programs could be managed by an independent third-party such as a program sponsor, consulting company or Quality Improvement Organization (QIO), or by the vendors themselves. There are pros/cons to each approach. In 2008, POCP had experience with each one of these approaches, and can help you sort through which one might work best for your situation.

**Regulatory actions.** Heading the list of expected regulatory action in 2009 for ePrescribers is a final rule that is expected from the Drug Enforcement Administration to allow ePrescribing for controlled substances. There was some expectation that the rule would have been published by the end of 2008, but the federal government (CMS, HHS, DOJ, OMB and DEA) were busily thrashing out details at both the executive and staff levels in response to the numerous comments received in response to the proposed rule, which was published in July 2008. Agreement has not yet been reached on some of the major provisions, sources tell POCP, but there is hope that we might see something by late Spring.

In January, CMS issued final rules requiring the use of ICD-10 code set, version D.0 of the NCPDP Telecommunications standard, version 3.0 of the NCPDP Medicaid subrogation standard and the 5010 version of HIPAA transactions. Under the transaction standards final rule, covered entities must comply with Version 5010 (for some healthcare transactions) and version D.0 (pharmacy transactions) on January 1, 2012. The Medicaid pharmacy subrogation transaction (version 3.0) must be used beginning on January 1, 2012, except by small health plans, which have an additional year to come into compliance. The ICD-10 compliance date is October 1, 2013. Both rules are posted on the following web sites: <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf> and <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>. POCP has done

significant work on these standards and code sets and can assist in implementation.

**Privacy and Security.** Protecting the privacy and security of healthcare information continue to top concerns of patients, providers, payers, vendors and regulators. We expect to see these issues addressed in legislation at the federal and state levels in 2009, although movement may be slow because of the complexity and contentiousness of the issue. A framework for implementation for privacy issues and a related toolkit were unveiled by outgoing HHS Secretary Mike Leavitt at the recent National Health Information Network Forum in Washington (for more information, go to [www.hhs.gov/healthit](http://www.hhs.gov/healthit)). According to the HHS press release of December 15, 2008, the principles are as follows:

- **Individual Access** – Consumers should be provided with a simple and timely means to access and obtain their personal health information in a readable form and format.
- **Correction** – Consumers should be provided with a timely means to dispute the accuracy or integrity of their personal identifiable health information, and to have erroneous information corrected or to have a dispute documented if their requests are denied. Consumers also should be able to add to and amend personal health information in products controlled by them such as personal health records (PHRs).
- **Openness and Transparency** -- Consumers should have information about the policies and practices related to the collection, use and disclosure of their personal information. This can be accomplished through an easy-to-read, standard notice about how their personal health information is protected. This notice should indicate with whom their information can or cannot be shared, under what conditions and how they can exercise choice over such collections, uses and disclosures. In addition, consumers should have reasonable opportunities to review who has accessed their personal identifiable health information and to whom it has been disclosed.
- **Individual Choice** -- Consumers should be empowered to make decisions about with whom, when, and how their personal health information is shared (or not shared).
- **Collection, Use, and Disclosure Limitation** – It is important to limit the collection, use and disclosure of personal health information to the extent necessary to accomplish a specified purpose. The ability to collect and analyze health care data as part of a public good serves the American people and it should be encouraged. But every precaution must be taken to ensure that this personal health information is secured, deidentified when appropriate, limited in scope and protected wherever possible.
- **Data Integrity** – Those who hold records must take reasonable steps to ensure that information is accurate and up-to-date and has not been altered or destroyed in an unauthorized manner.

This principle is tightly linked to the correction principle. A process must exist in which, if consumers perceive a part of their record is inaccurate, they can notify their provider. Of course the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers that right, but this principle should be applied even where the information is not covered by the Rule.

- **Safeguards** – Personal identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.
- **Accountability** – Compliance with these principles is strongly encouraged so that Americans can realize the benefit of electronic health information exchange. Those who break rules and put consumers' personal health information at risk must not be tolerated. Consumers need to be confident that violators will be held accountable.

In addition, Secretary Leavitt announced several tools to help consumers and health information exchanges advance toward privacy protection and consumer access to their information. For example, the "Leavitt Label," modeled after the nutritional labels on food packaging, would allow consumers to quickly compare personal health record products. Despite the change in administration, POCP expects we'll be seeing more of these principles, or something like them, as requirements by the federal government in research and demonstration projects, contracts and grants. We can also expect some of these themes in legislation....

**Odds & Ends: Zix Corp. and United Healthcare** joined forces in December 2008 to provide **ePrescribing technology and implementation support to 200 primary physicians in Texas**. The rollout of this program follows similar pilots in Ohio and Florida, according to corporate press releases. ... A study published in the December 2008 in the *Archives of Internal Medicine* found that **physicians who adopted ePrescribing with access to formulary data increased their prescribing of generics and other lower-cost options, which resulted in a very conservative estimate of savings for consumers and insurers of \$845,000 per 100,000 patients per year**. Data came from the eRx Collaborative program in Massachusetts and Zix Corp. ... **SureScripts-RxHub's Center for Improving Medication Management** on December 15, 2008, **launched [www.LearnAboutRxSafety.org](http://www.LearnAboutRxSafety.org)**, a new Web site where consumers can learn how to use medications safely. Developed in conjunction with the National Council on Patient Information and Education (NCPPIE), the site is primarily intended as a resource for families and all individuals seeking information on medication safety. The Center will collaborate with consumer organizations, provider and payer organizations and other groups interested in promoting medication safety and adherence for consumers....**CMS' actuaries** reported that **national health spending growth in 2007 slowed to its lowest rate since 1998, due in large part to increased use of generics** and loss of patent exclusivity for several block-bluster medications. Nonetheless, health spending in 2007 increased 6.1% to \$2.2 trillion, or \$7,421 per person, and accounted for 16.2% of GDP, up from 16% the previous year. The study was

published in the January/February 2009 issue of *Health Affairs*. ... **The successor to the AHIC just announced its new name: the National eHealth Collaborative.** John Tooker, M.D., M.B.A., Executive Vice President and Chief Executive Officer of the American College of Physicians, was elected to serve as Chair of the 2009 Board of Directors. Kevin Hutchison, President and CEO of Prematics, Inc., was elected Vice Chair, and Thomas Fritz, M.A., M.P.A., CEO of Inland Northwest Health Services, will serve as Treasurer. Laura Miller, M.P.A., FACHE, National eHealth Collaborative Interim Executive Director, will act as Secretary. The group also elected several committee chairs, whose role will be to drive efforts and progress in various areas specific to achieving its shared mission. [The complete Board list, with committee chairs, can be found on the website, www.NationaleHealth.org](http://www.nationalehealth.org)

**POCP Staff Highlights:** David Green was the lead author of an ePrescribing Feasibility & Planning Study that the state of Vermont contracted with Point-of-Care Partners to research and write. Other contributors included Kurt Andrews, PhD, and Tony Schueth, MS. Here's a link to the study: <http://www.vitl.net/uploads/1232716151.pdf>

## Chronic Care Management

### HIE is Key to the Patient-Centered Medical Home

*by Michael Solomon, Executive Editor*

The patient-centered medical home (PCMH) model continues to gain traction – now in a variety of demonstration sites sponsored by public and private payers. With the support of several large payers, including IBM, CIGNA, and United Health, there are more than 20 PCMH pilots underway in the private sector, not counting a handful of Medicaid and Medicare demonstrations in the planning stages through the Patient-centered Primary Care Collaborative.

Why are these pilots and other PCMH projects taking off? The answer is two-fold: the business case and the growing availability of the viable HIE infrastructure.

From the RHIO/HIE company's perspective, the PCMH model is an opportunity to deliver essential services that can also be the foundation to a sustainable business model. Through the combination of cost savings and incremental reimbursement to PCMH providers, there is real potential for money flowing to the HIE.

Critical to the success of these demos—and all PCMH projects, for that matter—is a health information exchange infrastructure. For example, participating physicians will need access to an electronic health record, which presents a longitudinal view of key information about the chronically ill patients, such as their medication history, recent tests and results, and encounters. Without this information, PCMH doctors will be unable to achieve the quality and safety performance measures. Pure and simple. And HIE is essential to three of the seven components of the PCMH model:

- Coordinated/integrated care requires shared medication histories populated by electronic prescribing, patient disease registries, and a continuity of care record that spans providers.
- Integral to the Quality and Safety component are clinical decision support and e-health tools enabling patients to self-manage their disease.

- Improved Access requires efficient means of communication between patients and their providers (translation: e-visits, self-service, and collaborative care applications).

The synergies between the patient-centered home infrastructure and health information exchanges should be top of mind of every strategist and policy-maker promoting the adoption of both of these fledgling innovations.

In addition to the disease registries described previously in this column (see the July 8, 2008, issue of HIT Perspectives in our archives), two HIE services stand out as “low hanging fruit” with significant potential. The first is the secure, clinical data repositories supporting provider access via the Web to core patient data contained in a continuity of care record (CCR), which are being developed by eHealth Connecticut and the South Carolina HIE among others. These make medication lists, recent lab tests, and patient medical history available at the point of care. The second is Web-based electronic prescribing, a key component of the Illinois Health Network and Foothills HIN service offerings. This is a “lightweight” approach to getting electronic health records into the hands of doctors who may otherwise hold back until a comprehensive EMR is a viable option. Let's not forget that even when EMRs are in place in every medical practice, the services we've described for the PCMH would still not be available. Unless you believe the NHIN is around the corner...

**Odds and ends:** The first comprehensive study on the **value of personal health records** was recently published by **CITL**. Interesting findings include the conclusion that most of the health care savings accrue to payers, ROI models are highly dependent on a reimbursable e-visit component, and the value of provider-tethered PHRs is diminished by their costs and lack of economies of scale. A disappointing aspect of this study was the lack of attention devoted to self-management tools, which is the principal source of value for chronically ill patients... **ActiveHealth Management** published research showing that when patients receive care recommendations along with their providers, compliance with evidence-based care guidelines is significantly better. Stanford University Medical Center is realizing savings on malpractice premiums in the range of 15% -- 40% as a result of implementing Web-based patient education system (Modern Healthcare, 12/15/08)... **CCHIT is in the midst of soliciting comments regarding PHR Certification**. Our work on a number of committees responding suggests the volume of comments is quite high, with security and interoperability being hot issues. Stay tuned....The **University of Missouri Family & Community Medicine Department** reports that **46 doctors are managing chronically ill patients using the patient-centered medical home**. Software from Cerner Corporation is providing the IT infrastructure to support the practice model....The January/February 2009 issue of Health Affairs is devoted to **“The Crisis in Chronic Disease.”** A number of research papers and perspectives offer insights into spending, prevention, management, and other topics, including several focusing on diabetes and cancer. The table of contents may be viewed at [www.healthaffairs.org](http://www.healthaffairs.org), and papers are available on pay-per-view.

**POCP Staff Highlights:** Michael Solomon was interviewed for the December 8<sup>th</sup> issue by Health Plan Week regarding PHRs being offered by payers. He is also the author of the recently published article “Information Technology to Support Self-Management in Chronic Care”, appearing in the December issues of *Disease Management & Health Outcomes*.

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