

Perspectives and Updates on  
Health Care Information Technology

# HIT Perspectives

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## About the Newsletter

*HIT Perspectives* is published by Point-of-Care Partners. Individuals at the leading management consulting firm assist healthcare organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. The team of accomplished healthcare consultants, core services and methodologies are focused on positioning organizations for success in the integrated, data-driven world of value-based care.

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# 1 Part 1: 10 Takeaways from HIMSS18



By **Tony Schueth**, Editor-in-Chief

Another annual meeting of the Healthcare and Information Management Systems Society (HIMSS) is in the books. While some people still think it's too big and overwhelming, we think it remains — without a doubt — the best place to catch up with clients and gain insights on market innovation. The Point-of-Care Partners (POCP) team used its time with face-to-face discussions, presentations of our own and attendance at others, discussions with exhibitors and investment of a lot of shoe leather.

There are plenty of reports on various aspects of HIMSS18. We'd like to offer a longer view and give our insights on the trends we observed in Las Vegas and how they might impact the health information technology (health IT) industry in the year ahead. Here are our top trends from HIMSS18:

## 1. Accessibility and control of patient data.

Accessibility and control of patient data have been on the radar for several years, but they took center stage at HIMSS18. There were many vendor offerings and a lot of buzz about **Apple's new Health application (app)**. The Health app enables patients to aggregate much of their personal health information from various providers and see it on their iPhones. This new kind of personal health record (PHR) is available anytime, anywhere. Is this a game changer? It may be too soon to tell as pilot testing is under way; however, it is an example of disruptive technologies we will see more of in 2018. **Click here for our take on Apple's Health app.**

Also of note was the rollout of three government-sponsored solutions to empower patients through new ways to access to their health data. Two were announced in a keynote by Seema Verma, who heads the Centers for Medicare and Medicaid Services (CMS). One is the government-wide initiative called **MyHealthEData**, which is spearheaded by the White House Office of American Innovation. It aims to “empower patients by giving them control of their health care data and allowing it to follow them through their health care journey.” MyHealthEData will enable patients to get an electronic copy of their entire health record, which can then be shared among providers, regardless of site and geographic location. The second new product is called Blue Button 2.0, which is a “developer-friendly, standards-based [application programming interface].” Administrator Verma touted it as a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format. There were high hopes for the original Blue Button, which was an early PHR that never seemed to gain much traction.

With much less fanfare, the Department of Veterans Affairs **unveiled the beta version** of its Lighthouse Lab initiative. This initiative enables health IT developers to leverage open application programming interfaces (APIs) and Health Level 7's (HL7) FHIR standard (see below) to expand veterans' health data access.

It remains to be seen how these three government solutions complement each other and if they will have legs.



*photo credit: Oscar & Associates for HIMSS*

**2. Artificial intelligence (AI).** Every HIMSS meeting seems to have a buzzword and AI is the one for 2018. Maybe it's because of the focus on AI to improve the data analytics needed for the transition to value-based care. Maybe it's because there were a ton of AI vendors in the exhibit hall, including IBM (which was demonstrating the many new advances from Watson Health). Maybe it's because AI is among the Trump administration's major health IT priorities, as enunciated in Jared Kushner's keynote. Maybe it's because of the big announcement that Epic is joining forces with Nuance AI to integrate the latter's AI-powered virtual assistants — which have conversational functionality — into the electronic health record (EHR). The goal is to enhance how physicians and care teams capture and retrieve patient information. All of the new tools will run on both iOS and Android mobile devices. This strikes us as the kind of innovation that we are sure to hear more about this year.

**3. Block chain.** Block chain — a kind of secure electronic ledger — debuted last year at HIMSS as one of

health care's shiniest new objects. Although some people think it is overhyped, many stakeholders jumped on the bandwagon nonetheless. We are seeing use cases emerge. Many were showcased at HIMSS 2018, especially in the areas of supply chain management, security and privacy. We expect block chain to be of particular interest to pharmaceutical manufacturers for patient safety, pharmacovigilance, precision medicine and clinical trial recruitment.

**4. Fast Healthcare Interoperability Resources (FHIR).** FHIR is one of the latest in the HL7 family of standards. It rapidly is underpinning the accelerating movement toward open, standards-based APIs. Increased adoption of FHIR-based APIs is expected this year as EHR vendors and pharmaceutical companies consider how to use innovative APIs to enable communication with patients and partners. FHIR also is becoming key to Internet-based information exchange networks and is being considered for the transport of data for specialty pharmacy enrollment, which is part of efforts

“...interoperability is key to the future of patient-centered health care and the time is now to make that happen.”

to automate specialty pharmacy. It is in the background of Apple's new patient data on the iPhone initiative, described above. It also underpins the Da Vinci project, which is described below. In short, FHIR rapidly is becoming a standard of choice for health IT applications.

**5. Government alphabet soup.** Every year, stakeholders gather at HIMSS to ponder how to address various healthIT initiatives from government agencies, which usually are referred to by their acronyms. Two seemed to be on everyone's lips at HIMSS 2018. The first is the meaningful use's (MU) EHR Incentive Program, which CMS promises to revamp in a major way. In her keynote, CMS Administrator Varma said this will be a “complete overhaul” of the MU program for hospitals and the Advancing Care Information performance category of the Quality Payment Program. This got the thumbs up from such stakeholders as HIMSS and the American Hospital Association, which were cautiously optimistic about the possibility of meaningful changes to the MU program.

The second is the **Trusted Exchange Framework and Common Agreement (TEFCA)**, which is an outgrowth of 21st Century Cures Act requirements. TEFCA is taking an expansive look at interoperability and improving data exchange by health information networks (HINs). Implementation and high-level oversight are being done by the Office of the National Coordinator for Health Information Technology (ONC). The agency issued **draft implementation guidance** in January containing policies, procedures and technical standards the government views as an onramp to interoperability. This is expected to bridge the gap between providers' and patients' information systems

and enable interoperability across disparate HINs. The feeling among stakeholders is that TEFCA tries to do too much, too soon. Stay tuned to see how this unfolds. ([Click here for our analysis of TEFCA](#)).

**6. Improving prescription decision making and price transparency.** One HIMSS takeaway is a new emphasis on standards use cases to solve specific problems. While FHIR was everywhere as a problem-solver, electronic prior authorization (ePA) and the real-time benefit check (RTBC) were showcased as ways of addressing two long-standing prescribing problems, respectively: improving the prescription decision-making process for medications needing preapprovals and providing better price transparency at the point of prescribing. Both Surescripts and CoverMyMeds exhibited their new solutions for ePA and RTBC. Surescripts noted that its RTBC solution was the result of a collaboration with Epic, Allscripts, Cerner, GE Healthcare, Practice Fusion and Aprima, whose EHRs represent 53% of the US physician base. In pilot tests, participants — which included CVS and Express Scripts — generated 3.75 million transactions in one year and provided patient-specific prescription benefit price data to prescribers in real time. Surescripts' RTBC solution is being **integrated by Cerner into its EHR** — a development announced just before HIMSS.

**7. Interoperability.** Interoperability is another concept that was put front and center at HIMSS18, especially from the government side. Interoperability will be top priority for the Trump administration, according to keynote speeches by Jared Kushner and Seema Varma. Kushner noted that interoperability is key to the future of patient-centered

health care and the time is now to make that happen. Efforts to address interoperability also were underscored by Donald Rucker, head of the ONC, who said ONC will focus on interoperability and related provisions of the 21st Century Cures Act, including information blocking, increased use of APIs and TEFCA (described above). ONC is still relevant, especially in the area of interoperability. It dodged a bullet in the newly passed **Omnibus budget bill** and will maintain its current funding level at least through September. This should give the agency some breathing room to keep fully focused on its various interoperability initiatives. That said, HIMSS 2018 also demonstrated that there is private-sector demand to build to interoperability. There are more and larger data sets and a burgeoning array of tools, such as FHIR and block chain, to connect them. Interoperability still is very fragmented, but we are making progress.

**8. Multistakeholder efforts.** HIMSS 2018 was teeming with multistakeholder groups, all of which aim to facilitate data exchange in one way or another. There were data exchange networks, including the Commonwealth Alliance and Sequoia Project. There was the Argonaut Project, a private-sector initiative to expand information sharing among EHRs and other health IT using FHIR. On the consumer side, there was the multisector collaborative, the CARIN Alliance, which is working to advance consumer-directed exchange of health information. Despite their differing makeup and foci, the groups had one thing in common: convening and problem solving on their own, as opposed to letting the government initiate and oversee the initiative. We learned the benefits of doing that years ago, with the creation of the Southeastern Michigan ePrescribing Initiative (SEMI). SEMI helped save stakeholders \$119 million in drug costs and \$11 million in prevented health care costs. **(Click here for our white paper on the project.)** It's a workable concept that can produce quick — and real — results. But who you pick to run it is critical. As managers of SEMI, we're happy to share other lessons learned and best practices.

**9. Population health.** Population health continues to be a goal in need of solutions and wider user acceptance.

Maybe 2018 is the year. The Trump administration clearly is advocating population health, so its efforts could help move the needle in terms of technology and use. Many HIMSS presenters linked new interoperability efforts with population health, such as MyHealthEData. A number of exhibitors showcased practical solutions that would address related issues with existing systems. An example is a presentation by UMass Memorial Healthcare. It centered on UMass development of improvement efforts in the hospital and primary care practices through the creation of practice improvement facilitators, who work with practice staff to implement population health across the 32 EHRs in use in the affiliated practices. They support practice efforts to educate and implement programs to identify patients and have appropriate interventions, especially among patients who are “rising risk” on their way to being the future sickest patients.

**10. Value-based care.** Health care's transition to value-based care was another major theme of HIMSS 2018. It was clear from presentations and new vendor offerings and strategic partnerships that value-based care is beginning to gain more momentum. That is because data sets are more easily accessible and the tools to facilitate their availability and analysis are becoming more sophisticated.

Along those lines, HIMSS 2018 featured presentations on the Da Vinci project. This new private-sector initiative is developing a rapid multistakeholder process using HL7's FHIR standard for addressing value-based care use cases between payers and providers. The project will: 1) identify specific value-based care use cases that are amenable to national solutions using FHIR-based APIs; 2) rapidly develop implementation guides and reference implementations; and 3) field test those materials to validate readiness and efficacy. Co-led by POCP's Jocelyn Keegan, **the Da Vinci project** is being overseen by a multistakeholder group consisting of HL7, payers, providers, health IT vendors, and key government agencies.

See you next year in Orlando! •



## 2 Part 2: The Da Vinci Project: Helping Payers and Providers Get the Most From Value-Based Care



By **Jocelyn Keegan**, Senior Consultant

As the health care system transitions to value-based care, stakeholders need new tools to share and analyze data, improve population health and clinical outcomes and cut administrative burdens. Enter the Da Vinci Project, a private-sector initiative that kicked off in late January.

Da Vinci is developing a multistakeholder process to promote and accelerate the use of Health Level 7's (HL7) Fast Healthcare Interoperability Resources (FHIR) standard for the data exchange needed for value-based care delivery. Project participants believe FHIR is uniquely positioned to bridge interoperability gaps across the many disparate systems used today to exchange clinical and administrative data between payers and providers and providers and providers.

As shown in the infographic below, Da Vinci's governance model comprises payers, providers, health information technology vendors, HL7 and key government agencies. The group is focusing on specific value-based care use cases to create reference implementations that may be amenable to national solutions using

FHIR-based application program interfaces. The goal is to enable improved patient care outcomes as well as empower better clinical decision making by shifting key information into provider teams' work flow and sharing that information across organizational boundaries to ensure best care and outcomes for patients.

Initial use cases under consideration involve medication reconciliation, coverage requirements discovery, and documentation templates/coverage rules. Other likely use cases include quality measures reporting, laboratory results, value-based care member identification, ADT notifications concerning transitions in care, and electronic health records exchange to support Healthcare Effectiveness Data and Information Set and Medicare Stars ratings.

10 Payers

4 HIT Vendors



1/2 Dozen Providers

Discovery is under way for the initial use cases. Outputs from the project are intentionally public and will be available for implementers, including implementation guides and reference implementations. These will be pilot tested to validate readiness and efficacy. Implementation guides that merit broad-based standardization will be brought into the HL7 standards development process for coordination, co-development and balloting. •

3  
EHRs

9  
Use  
Cases

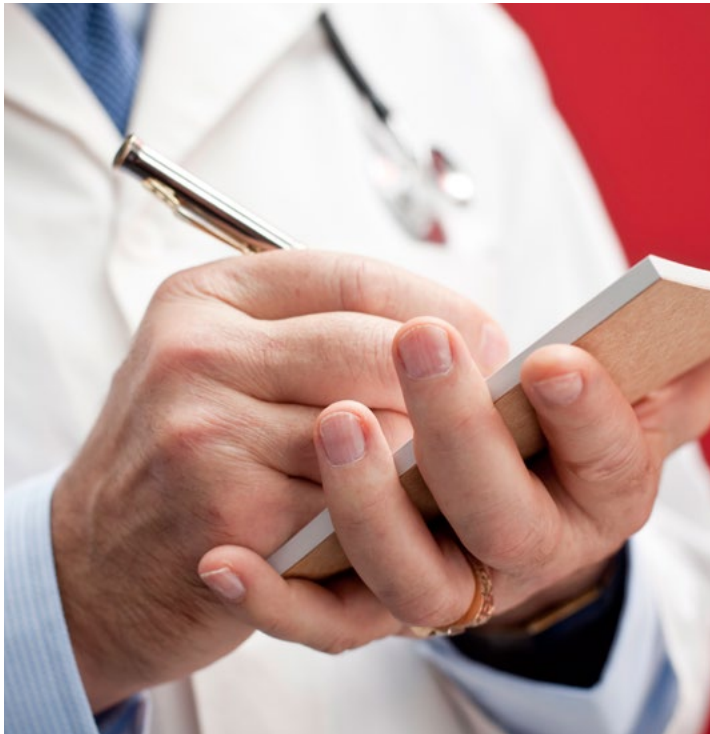
*Want to learn more? Please reach out to me, as Da Vinci Project Manager, at [jocelyn.keegan@pocp.com](mailto:jocelyn.keegan@pocp.com). You can also follow the Da Vinci page on HL7's website ([click here](#)).*



# 3 The Impact of Cost on EPCS Adoption



By **Michael Burger**, Practice Lead, EHRs and EDI



Here are three things to know concerning the costs of EPCS and other factors that may affect adoption. The analysis is based in part on research by Point-of-Care Partners.

**1. Costs associated with basic ePrescribing.** Both basic ePrescribing and EPCS typically are features within electronic health record (EHR) software. Virtually all EHRs include basic ePrescribing. EPCS is often an add-on that prescribers can request. For many EHRs, basic ePrescribing is included in the price of the software. As shown in Table 1 (below), others charge annual fees ranging from \$180 per provider to as much as \$1,200 per provider, with the majority falling somewhere in the middle.

**Table 1. Costs for basic ePrescribing in the most widely used EHRs.** Source: Point-of-Care Partners.

EHR	Annual Cost of ePrescribing
Allscripts Professional	\$0.00 (included w/EHR)
Allscripts Touchworks	\$0.00 (included w/EHR)
Amazing Charts	\$0.00 (included w/EHR)
Athena	\$0.00 (included w/EHR)
Cerner	Varies based upon # of providers
DrFirst	\$948 per provider
eClinicalWorks	\$0.00 (included w/EHR)
e-MDs	\$0.00 (included w/EHR)
Epic	Varies based upon # of providers
GE Centricity	\$0.00 (included w/EHR)
Greenway Intergy	\$372 per provider
Greenway PrimeSuite	\$180 per provider
NewCrop	\$948 per provider
NextGen	\$0.00 (included w/EHR)
Practice Fusion	\$1,188 per provider

*Correction: The “Costs associated with EPCS” table (Table 2) misstated the costs for DrFirst. The actual cost is \$90 one-time setup fee, \$75 annual ongoing cost, token included in the setup fee.*

Healthcare is rapidly going digital. However, electronic prescribing for controlled substances (EPCS) is lagging way behind this trend. Surescripts data show that only 14 percent of prescribers are utilizing EPCS, as compared with 64 percent who prescribe “basic” prescriptions electronically (ePrescribing), or ePrescribing for noncontrolled substances.

These statistics show that EPCS has a long way to go to reach the tipping point. Why is EPCS adoption so low, even though it has been legal since June 1, 2010? The most frequently cited reason is cost. Yet there could be other factors affecting uptake.



**Table 2. Costs associated with EPCS in the most widely used EHRs.** *Source: Point-of-Care Partners.*

EHR	EPCS Setup (One-time fee)	Annual Ongoing Cost	Token for EPCS
Allscripts Professional	\$340 per provider	\$150 per provider	Included in ongoing cost
Allscripts Touchworks	\$6,000 per practice	\$150 per provider	Negotiated directly
Amazing Charts	\$0	\$250 per provider	Included in ongoing cost
Athena	\$0	\$0 per provider	Included in ongoing cost
Cerner	Varies based upon # of providers		
DrFirst	\$90 per provider	\$75 per provider	Included in the setup fee
eClinicalWorks	\$250 per provider	\$0 per provider	\$250 per year per provider
e-MDs	\$225 per provider	\$120 per provider	Included in ongoing cost
Epic	Varies based upon # of providers		
GE Centricity	\$0	\$5,988 per provider	Included in ongoing cost
Greenway Intergy	\$150 per provider	\$90 per provider	Included in ongoing cost
Greenway PrimeSuite	\$150 per provider	\$90 per provider	Included in ongoing cost
NewCrop	\$150 per provider	\$150 per provider	Included in ongoing cost
NextGen	\$0	included in ePrescribing	Negotiated directly
Practice Fusion	\$0	included in ePrescribing	Included in ongoing cost

**2. Costs associated with EPCS.** EPCS systems must meet stringent Drug Enforcement Administration (DEA) requirements for credentialing, software certification and dual factor authentication. To cover those costs many EHR vendors have imposed fees, which vary widely by product and vendor. Often, basic ePrescribing is included in the EHR without a specific itemized fee. EPCS sometimes follows the same model, although a surcharge is common. In some cases, the authentication token needed for EPCS is included in the surcharge; in others, it is priced separately. The following is a summary of costs associated with EPCS in the most widely used EHRs, estimated to represent about two-thirds of ambulatory EHR market share.

**3. Going beyond costs.** Costs are a major decision factor in adopting health IT. However, there are potentially offsetting factors to be considered, such as the following:

- **Return on investment (ROI).** Positive early ROI analyses are emerging. An example is ROI results presented at the March 2018 meeting of the Healthcare and Information Management Systems Society by Geisinger Health, which is a large integrated delivery

system (IDS) in Pennsylvania. Geisinger demonstrated calculated savings of \$1 million in the first year as a result of implementation of EPCS across 126 clinics and 1,661 physicians. These savings were achieved through reductions in call center and diversion control human resources, as well as prescribing efficiency for physicians and nurses. Using EPCS, prescribers reduced the amount of time spent per controlled substance prescription from 3-5 minutes to 30 seconds. In addition to improving provider satisfaction, EPCS enhanced patient safety and care quality through better pain management and a significant reduction in opioid prescriptions. These are important measures — not only in and of themselves, but also as factors upon which providers will be measured and reimbursed as healthcare transitions to value-based care.

- **Mandates.** In an effort to fight the opioid epidemic, several states have followed New York's lead and are mandating — or are soon to mandate — EPCS. According to data from POCP's **Regulatory Resource Center**, four are mandating EPCS and another five have passed legislation requiring electronic prescribing for opioids. Other states are considering jumping on



the bandwagon. Legislation is pending in Congress to mandate EPCS for Medicare Part D, in part as a way to address the opioid crisis. Regardless of cost concerns, mandates will drive adoption of EPCS.

**Conclusion.** For a provider who writes few controlled substance prescriptions, the costs and fees for EPCS, as outlined above, may not be viewed as cost effective. However, that may be different for the typical provider, for whom controlled substance prescriptions account for 15% to 20% of prescription volume. For such providers, the cost of adding EPCS is not exorbitant on a per-prescription basis.

Thinking in terms of addressing a national public health crisis, the cost of EPCS is small in comparison to those of treating opioid addiction, unnecessary emergency department visits and hospitalizations for overdoses, and lost productivity due to death and disability. These are **estimated to cost the US economy** more than \$500 billion annually.

Ultimately, cost may not be the only factor affecting EPCS adoption. As healthcare transitions to value-based reimbursement, the costs of EPCS must be viewed in a broader context. This includes costs versus benefits for patient care and quality, reimbursement based on metrics related to EPCS and the requirements of value-based care organizations and IDs for implementing EPCS using specific EHRs.

Finally, the costs of EPCS adoption may be a moot point if EPCS is mandated at the state and federal levels. However, increased uptake due to mandates may drive down implementation costs, but this will be on a longer-term horizon. •

*Need to keep up with state EPCS mandates? Our **Regulatory Resource Center** team members can help you quickly uncover answers to your most pressing regulatory questions. All clients in our premium portfolios receive complimentary access to our regulatory team members who are fully committed to providing the utmost quality in tracking and defining regulatory issues. Drop an email to Keith Fisher ([keith.fisher@pocp.com](mailto:keith.fisher@pocp.com)) and we can show you how our expertise and data can meet your needs.*