

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: Trends to Watch in 2018



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

By all accounts, 2017 was a busy year for health care organizations, health information technology vendors and others. We expect that hard work will continue — if not accelerate — in 2018 to address the myriad business and legislative requirements facing the health care system. With that in mind, here are a baker's dozen trends to watch in 2018.

1. Biosimilars. The federal government and states will continue their efforts to establish the needed infrastructure for approval and adoption of biologics and biosimilars, which are gradually being approved for use in the United States. **The Food and Drug Administration (FDA) issued guidance on new naming conventions.** The new change-over in names applies to both newly licensed biologics and biosimilars, and will also be applied retrospectively to biologics already on the market. Understandably, stakeholders are concerned about associated costs and burden of implementation and are raising their concerns to the FDA, which might tweak its guidance in response. There also is a need to capture patient information and outcomes in electronic health records (EHRs) for pharmacovigilance purposes as biologics come on stream.

2. Blockchain. Blockchain is health care's latest bright, shiny object, meaning it will continue to attract attention in 2018. A data structure that can be time stamped and signed using a private key to prevent tampering, some people may know blockchain as the technology underlying the online currency Bitcoin. Payers are jumping in with both feet to implement blockchain, **according to a survey by Black Book:**

- 76% of payers in the survey said they're either considering deploying or currently in the process of implementing blockchain solutions.
- 98% of payer respondents with plans of more than 500,000 members are currently considering deploying it, while 14% are involved in trial deployments right now.
- 70% of payer respondents of all sizes anticipate integrating blockchain into their systems by the first quarter of 2019.

Despite the apparent — and possibly premature — enthusiasm by payers, many questions surround the use of blockchain in health care. For example, it is too new to be well understood; infrastructure and interoperability requirements are unknown; and rules of the road will be needed for its implementation. Use cases must be developed.

3. EPCS. Electronic prescribing of controlled substances (EPCS) will experience an accelerated uptick in adoption in 2018, along with the rapid increase in controlled substance prescription volume seen over the past couple years. Providers are finally beginning to invest in and use EPCS infrastructure because it's time and it will help them meet required quality reporting targets for Medicare and other payers. Vendors are ready, so technology is no longer problematic.

Also, several states are requiring — or are poised to require — that all such prescriptions be sent electronically as a tool to fight the opioid epidemic. Along similar lines, a House bill (HR 3528) was introduced for mandatory EPCS in Medicare Part D. Such legislation at the federal level will



jumpstart EPCS adoption because Medicare is a huge driver and nearly everyone else follows suit. That said, vendors will have to be nimble to adapt to such rapidly changing state requirements as controlled substance prescribing limits and new data elements like adding diagnosis onto prescriptions. In addition, there is no consistency in implementing these requirements across states, making implementation even more challenging for vendors. EHRs will need new forms of decision support to meet evolving state and federal requirements.

4. Electronic prior authorization (ePA). An increasing number of drugs — especially specialty medications needed for the rising number of chronic illnesses — require prior authorization (PA). The manual process has been a pain point for prescribers, pharmacies and patients alike. The industry responded with an ePA standard, which is being implemented. We believe that ePA is poised to take off in 2018. Why? Consider that we're already seeing implementation involving the ability of many EHRs and pharmacy benefit managers to accept and exchange basic information for PAs. As another example, CoverMyMeds, a

large ePA platform that uses the National Council for Prescription Drug Programs (NCPDP) ePA standard to help automate and accelerate PA requests and approvals, was recently bought for \$1.4B by McKesson. This shows market recognition of the value and opportunities inherent in ePA. Pharmacists already have information to process PAs in that environment. As pharmacy moves to become instrumental in the care process in 2018, new use cases will arise, such as pharmacists becoming involved in ePA for long-term care patients.

5. Fast Healthcare Interoperability Resources (FHIR). FHIR is one of the latest in the Health Level 7 (HL7) family of standards. It underpins the accelerating movement toward open, standardized application programming interfaces (APIs), which are getting a further boost under the 21st Century Cures Act. Providers and pharmaceutical companies are considering how to use innovative APIs to communicate with patients and partners. Increased adoption of FHIR-based APIs is expected in 2018. FHIR also is becoming key to Internet-based information exchange networks. Its accelerating momen-

Health care organizations will continue to collaborate on strategies and tools to help patients adhere to their medication regimens.

tum continues with public backing. For example, Anthem joins Independence Blue Cross in using the FHIR standard to build out value-based data exchange work flows with providers. FHIR is also being considered for the transport of data for specialty pharmacy enrollment, which is part of efforts to automate specialty pharmacy (see below).

6. Information blocking. The 21st Century Cures Act requires the government to address perceived information blocking by EHRs. In addition to prohibiting the practice, the act bars certification of offending systems and permits such actions as decertification of noncompliant ones. This puts the ball squarely in the lap of the Office of the National Coordinator for Health Information Technology (ONC) and aligns with other ONC activities. To that end, ONC is expected to issue a regulation this spring defining information blocking, which is the first step in any enforcement process. The act allows financial penalties for noncompliance, and you can't enforce something that isn't spelled out in detail.

7. Interoperability. Interoperability is no longer a buzzword but a concept that is being put in place. Drivers for 2018 include requirements of ONC programs, the Medicare and CHIP Reauthorization Act and a downstream impetus from the 21st Century Cures Act. Health care stakeholders also are embracing the need for interoperability. **According to a recent survey**, interoperability projects for health care organizations include connecting to external databases, such as health information exchanges (65%), connecting applications within the organization (58%), and adding connections from medical devices to existing systems (37%). Emphasis also will be placed on greater integration of EHRs and provider work flows.

8. Medication adherence. Poor medication adherence is partially responsible for avoidable hospital admissions, and 33% to 69% of all medication-related hospital admissions at a cost of about \$100 billion per year. To be sure, medication noncompliance is a long-standing issue. Now we have reached an inflection point where technology, value-based care and concerns about the costs of chronic illness are converging to meaningfully address the problem. Medication adherence is becoming an outcomes measure in accountable care and performance-based contracting, including the Medicare Star Rating System. This will require the ability to mine EHR data to identify noncompliant patients and provide information about costs, gaps in care and outcomes. Health care organizations will continue to collaborate on strategies and tools to help patients adhere to their medication regimens. An example is the eHealth Initiative's Electronic Medication Adherence Collaborative.

9. Patient identifier. Stakeholders will continue to focus on the need for a national patient identifier, which is a key to true interoperability. Because various technical and legislative constraints exist around the topic, stakeholders will continue to undertake various patient data and complicated algorithms to identify patients and try to link them correctly with their records. EHR vendors are aware that patient matching is an issue for their customers but a business case is needed. Even if a national patient identifier is created (which currently is prohibited by law), it is likely that individual stakeholders will request additional and varying data elements and formats. Such customization is expensive and time consuming. Moreover, EHR vendors are reluctant to make any changes without user demand, which traditionally has been driven by legislation. Meanwhile, **ONC issued a framework to help health organizations** correctly match patient data with the proper source. We expect to hear more about the patient matching issue from the Government Accountability Office, which was tasked to delve into the topic by the 21st Century Cures Act.

10. Prescription drug monitoring programs (PDMPs). Sadly, the opioid epidemic will show few

signs of abating in 2018. In response, states will continue to enact legislation mandating that prescribers and pharmacists consult PDMPs before controlled substance prescriptions are written and the drugs dispensed. PDMPs are independent, state-run databases of controlled substance prescriptions that now exist in all states and the District of Columbia. In addition, states will increasingly demand that PDMPs become more interoperable due to the differences in states' ability to exchange data. Efforts will accelerate to integrate PDMP data into EHRs, which also is a growing legislative requirement by states.

11. Real-time benefit check (RTBC). Intense interest will continue in 2018 around the RTBC. In contrast to current formulary and benefit information provided to electronic prescribers, the RTBC provides real-time information at the patient level, which is pulled directly from the payer. It allows the prescriber to see patient-specific condition management programs (such as PA and step therapy), true out-of-pocket costs for a medication (specific copay/coinsurance amount) and specific deductible information. This will prevent dispensing delays caused by inadvertent prescribing of a drug that is not covered by the patient's insurance. RTBC can help the prescriber find affordable drugs for individual patients' conditions. This, in turn, will increase medication adherence because patients will not take drugs they can't afford. As evidence that RTBC is poised to take off in 2018, solutions already are in the market, including **CVS** (for patients supported by the company), **DrFirst** (which uses a modified NCPDP Telecommunications D.0 standard) and **Surescripts** (which uses a modified NCPDP SCRIPT standard). Meanwhile, an NCPDP task group will continue its work on use cases and standards development, including whether a new, hybrid standard is needed.

12. Specialty pharmacy automation. The industry will continue working on automating specialty prescribing in 2018, with focus on the specialty enrollment process. These efforts build on standards and implementations for electronic prescribing as well as complement the work under way to automate other aspects of specialty pharmacy. Stakeholders are coming together to identify additional

or enhanced standards to support enrollment and other aspects of specialty pharmacy automation. HL7's FHIR is likely to become the standard of choice to extract relevant patient administrative and clinical data from EHRs. NCPDP's Specialty Electronic Prescribing Task Group is looking at how new data elements that are useful for the enrollment process can be incorporated into the SCRIPT standard. These include, for example, additional patient contact and demographic information, diagnosis, lab values, height and weight.

13. Virtual visits. Stakeholders will continue to jump on the virtual visit (aka telehealth) bandwagon in 2018. Myriad efforts are under way to implement and pay for such services by the Department of Veterans Affairs, Medicare, Medicaid and private payers. In fact, a majority of the nation's health systems plan to expand virtual visit offerings or patient access based on early experience with the technology, **according to a study from KLAS Research and CHIME**. Pharmacies will ramp up use of virtual visits as part of a strategic move to offer more direct patient care. For example, New York-Presbyterian (NYP) and Walgreens are teaming up to provide remote access to NYP physicians on Walgreens' website and kiosks at certain Duane Reade drugstores in New York City. **CVS similarly is exploring opportunities** for direct-to-consumer care through telehealth availability in its clinics and pharmacies. Despite the enthusiasm for virtual visits, critics (including the **Medicare Payment Advisory Commission**) wonder if potential cost savings and consumer acceptance and satisfaction will actually materialize at expected levels. [Read more about virtual visits in this issue of *HIT Perspectives*.] •

Interested in what else is in store for 2018? I'd be happy to share my thoughts. Reach out to me at tonys@pocp.com.



2 Part 2: Fighting a Root Cause of the Opioid Epidemic: New POCP Report Examines State Responses to Opioid Prescribing



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

Legal opioid prescriptions often lead to abuse, fraud, diversion and addiction. Sadly, they are a root cause of the nation's opioid epidemic. That is why states are using a variety of legislative and regulatory measures to address the opioid epidemic at the prescription level. A detailed look at these actions is in a new, first-of-its-kind report from Point-of-Care Partners (POCP). *Fighting the Opioid Epidemic at the State and Rx Levels* explains overarching trends across the states on opioid prescribing and provides the latest details on a state-by-state basis.

Unlike other reports in the marketplace, our new analysis is based on the most up-to-date information (as of January 2018) and focuses strictly on the range of state responses to opioid prescribing. These include changes in prescriptions and prescribing behaviors through laws and regulations, required use of electronic prescribing for controlled substances (EPCS), mandatory consultation of state prescription drug monitoring programs (PDMPs) and education for providers and patients.

However, the whos, whats, whys and hows of these key strategies vary across the country. In response, this new report was designed to help stakeholders understand the details and complexities of how states are handling opioid prescriptions. To be sure, electronic health records (EHRs) and health information technology (HIT) stakeholders can play a valuable role in facilitating prescriber compliance with mandated behavioral changes that will ultimately limit the number of future addicts. This is the subject of POCP's next report, which will come out in this spring.

What the report contains. The 33-page report includes details of state responses to opioid prescribing organized around

three main trends: prescribing, curbing fraud and abuse, and preventing and treating addiction. These analyses are supplemented with 12 figures, including state maps indicating required consultation of PDMPs by prescribers and dispensers. Specific details are summarized in two appendices. The first provides a state-by-state overview of controlled substance rules and limits, a portion of which is reproduced below. The second highlights controlled substance midlevel prescribing authorities.

The analyses are based on original research and data collection by **POCP's Regulatory Research Center**, led by Connie Sinclair, RPh, who is also the report's lead author. The report's content also was informed by POCP's nationally recognized expertise in electronic prescribing, health information technology and eMedication management.

Findings. The POCP report has new and detailed data on state responses to opioid prescribing. Among the high-level findings:

- In total, as described throughout this report, 11 different mandates are being used across the states to combat the opioid crisis.
- The states with the highest observed drug overdose death rates have implemented and proposed the most measures. Those states and their efforts are highlighted.
- A majority of states have enacted — or are considering — legislation requiring prescribers to consult PDMPs before prescribing. The report contains a table summarizing which states are doing what.

APPENDIX A: Controlled Substance Rules and Limits

As of January 15, 2018¹

State	EPCS	Schedule II Opioid Quantity Limits	Counseling, Consent or Documentation Required	Frequency of Dispenser PDMP Reporting	PDMP Integration with EHR/HIE
AL	Allowed	None	-	Daily	-
AK	Allowed	Opioids: Adults 7DS for initial, Minors 7DS for all opioids	Non-Opioid Directive Form	Daily	-
AZ	Allowed	Opioids Medicaid: Adults 7DS for initial, Minors 7DS for all opioid	Risk counseling and informed consent	weekly, Friday for previous Sunday to Sunday	PDMP to be integrated with HIE, if integrated with EHR, prescriber may view that. EHR integration is promoted
AR	Allowed	None	-	Weekly	-
CA	Allowed	6-month duration	Pain assessment documentation	within 7 days	HIT firm must have MOU with CA PDMP in order to provide access via EHR
CO	Allowed	None	-	next business day	-
CT	Mandatory, 1/1/2018	Opioids, Adults 7DS, Minors 5DS	-	Next business day; eff 7/1/2016	-

- Several states have mandates in place requiring prescribers to submit controlled substance prescriptions via EPCS, while others have proposed EPCS mandates in the past few weeks. The components of these mandates are highlighted in the report.
- An increasing number of states are limiting fill quantities and restricting those who can prescribe opioids and Schedule II narcotics, in addition to requiring such additional data as diagnosis. The report provides details on a state-by-state basis.
- In another key trend, states are mandating that providers counsel and provide more education to patients regarding opioid use. •

Want to learn more about the specifics? [Click here to purchase a copy of the report](#). POCP's Regulatory Resource Center also can do a deep dive on this and other state prescribing-related issues. For more information, contact Connie Sinclair at connie.sinclair@pocp.com.

3 Virtual Visits: Now Coming to Your Home, Doctor and Pharmacy



By **Jocelyn Keegan**, Senior Consultant

Many payers, providers and pharmacies are banking on virtual visits in which patients receive remote diagnosis and treatment to improve quality care, reduce costs and increase patient access to medical care. These can be done through a variety of arrangements, including kiosks at pharmacies connected to some of the nation's finest medical centers or video visits at home from specialists through use of computers or mobile phones.

Sometimes known as telehealth visits, virtual visits are not new. Whatever you call them, their use is accelerating beyond connecting to a limited number of patients in rural areas. Major payers, including Anthem, Aetna and UnitedHealth Group, pay for virtual visits for traditional medical care. **Early adopters of virtual medicine, like Kaiser Permanente**, are now seeing more patients remotely than in brick-and-mortar offices. In the public sector, the Department of Veterans Affairs (VA) is leading the way with one of the nation's largest virtual visit programs, which served 700,000 veterans in 2016. **Through VA Telehealth**, veterans can virtually access some 50 clinical specialties, from dermatology to intensive care. Both public and private payers are looking to virtual visits to increase access to mental health services.

Drivers for virtual visits. There are many reasons why virtual visits have become so popular. They include:

- **Costs of care.** The **average virtual visit costs** around \$40, in contrast to \$125 for an in-person office visit. In addition, virtual visits are expected to reduce costs of care, hospitalizations and emergency room (ER) visits for chronic illnesses, especially diabetes. Diabetes is one of the most common chronic illnesses, with treatment costs significantly higher than other diseases. Moreover, **government statistics show**

that complications from diabetes result in 7.1 million hospitalizations and 14.2 million emergency department visits each year. The vast majority are considered preventable.

- **Scarcity of physicians.** The doctor shortage is real. **The United States could lack between 46,000 and 90,000 physicians by 2025.** The biggest gap is for primary care doctors. There also is an inequitable geographic distribution of physicians (particularly specialists), with rural areas hit the hardest.
- **Strategic adoption by pharmacies.** Pharmacies are ramping up use of virtual visits as part of a strategic move to offer more direct patient care in clinics and pharmacies. For example, New York-Presbyterian (NYP) and Walgreens are teaming up to provide remote access to NYP physicians on Walgreens' website and kiosks at certain Duane Reade drugstores in New York City. **CVS similarly is exploring** direct-to-consumer virtual visit opportunities. Virtual visits are perceived as a way to create competitive advantage as well as bring patients into stores.
- **Physician payment penalties.** Because many hospitalizations and ER visits are preventable, payers — particularly Medicare — are reducing reimbursement for readmissions. This is driving providers to adopt virtual visits to prevent readmissions and related payment penalties. In addition, the move toward value-based care also can negatively affect reimbursement if providers do not meet outcomes and other quality targets. Providers are responding, **with over half investing in virtual visits** to improve patient outcomes.
- **Expanded access to care.** The explosion in electronic technologies has created a wide availability of options for virtual visits. Now virtual visits can be done just about anywhere

and anytime through kiosks, tablets, mobile devices and other applications. Virtual visits also can add expert capacity across health care systems and individual providers.

Moving forward with virtual visits. Despite the enthusiasm for virtual visits, a number of considerations must be addressed to ensure a smooth transition. For example:

- **Payers.** Payers must consider which services will be covered, where and under what circumstances, as well as what individual states allow. Will coverage include just basic diagnostic visits for limited needs, such as dermatology, or run the gamut, including follow-up care, maternity and mental health? Will coverage extend beyond physician visits to those provided by such other practitioners as physician assistants and registered dietitians? Payment structures will have to be revisited and often depend on individual states. Will special copays be instituted? The proposed bipartisan **Medicare Telehealth Parity Act** would significantly expand Medicare payment for virtual visits. If enacted, the bill would modernize how Medicare pays for telehealth care, which could affect how private payers provide benefits and reimbursement for virtual visits.
- **Patients.** The jury is out whether patients will understand virtual visits and use them. Certainly payers, providers and pharmacies are making substantial bets that they will. However, critics, including the **Medicare Payment Advisory Commission**, wonder if consumer enthusiasm will materialize at sustainable levels.
- **Providers.** Practices and integrated delivery networks will need to take stock of how to fully integrate virtual visits into their existing support services. What technology model will work best for their organization? Is integration with the electronic health record possible? Which patients, services and appointment types will work best, given locale and patient mix? Will current staff be used or will they be augmented with external resources? Issues such as reimbursement, cost, and clinical resistance also need resolution to increase provider adoption.
- **Legal issues.** There are still many legal barriers that must be resolved by the states, which regulate insurance and various aspects of medical practice. A very basic issue is what



constitutes telehealth or virtual visits. The definition varies across states and will need to be updated to address changes in technology and medical practice. Another issue is malpractice coverage across state lines, which not all states and insurers allow. Then there are varying credentialing and privilege laws and regulations across the states. These are gradually changing in favor of licensure compacts, which allow licensure portability or reciprocity across state lines. **About half the states** have enacted or proposed such legislation for physicians and a handful have done so for nurses. **A new proposed rule from the VA** could help things along, given the size and scope of its system. This rule would allow doctors anywhere in the VA system to see patients regardless of location as well as remove licensing barriers. The Federation of State Medical Boards, representing the 70 state and territorial medical and osteopathic boards, is behind compact arrangements and **has developed model language.** •

It is clear that virtual visits are rapidly becoming part of the new health care landscape. Point-of-Care Partners has done a deep dive on what that looks like, as well as opportunities and gaps. Let me know if you want to learn more. You can reach me at jocelyn.keegan@pocp.com.