



HIT Perspectives

Perspectives and Updates on Health Information Technology



February 17, 2011

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Healthcare Reform

PCAST Recommendations: A Game Changer for HIT?

By Tony Schueth, Editor-in-Chief

As if Washington weren't chock full of advisory groups, a new one has weighed in and its recommendations are sending shock waves through the health information technology (HIT) community. On December 8, 2010, the President's Council of Advisors on Science and Technology (PCAST) released a voluminous report entitled "Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward." In typical Washington fashion, it contained a bombshell tucked inside the 109 pages of verbiage.

The big news? PCAST's report calls for the use of a Web-friendly "virtual exchange language" using tagged data. This would allow the exchange of health records, regardless of format or source, using the universal language (PCAST recommends the Internet standard, XML). Each record would be tagged with metadata, which contain information to help identify patients, locate records and indicate privacy protections and access permissions. The aim of the recommendations is to help achieve interoperability across the numerous data sources involved in patient care, promote rapid interoperability and ultimately facilitate public health reporting.

Do the recommendations have legs?

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Electronic Health Records

The Last Mile: Boosting Physician Use of EHR Functionality

By David Green, Contributing Editor

The new year traditionally is a time to review where we've been over the past year. In 2010, physician adoption of electronic health records (EHRs) slowly increased, and the needle should tick higher in 2011. The challenge will be to get physicians to go that last mile and use their available EHR functionality to provide safer, higher-quality and more cost-effective care.

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Health Information Exchange

Health Insurers Start Calling the Shots for Major Health Information Exchange Vendors: What's Next?

By Michael Solomon, PhD, Contributing Editor

Two of the nation's largest insurers each recently bought a major vendor of health information exchange (HIE) technology. Clients want to know: Why this? Why now? What's ahead?

Many in the health information technology (HIT) industry are still wondering if and when the HIE sector will be a viable market worthy of significant investments. Yet Aetna and United Health Group have jumped in with their acquisitions of Medicity and Axolotl, respectively. Considering it will be a long time before these acquisitions generate positive cash flows for their parent companies, strategic reasons for these multimillion-dollar purchases became readily apparent, beyond the day-to-day business of supplying HIE technology.

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In our opinion, it's a longer-term opportunity. PCAST is an advisory group and its recommendations are, well, recommendations. There are no legislative or regulatory requirements attached to them at this point, so nobody has to do anything with them just yet. On the other hand, this is a very prestigious group comprised of a lot of heavy hitters in academia and representatives from Google, Microsoft, the National Academy of Sciences and the National Academy of Engineering. Their ideas carry quite a bit of weight, so much so, in fact, that the federal Office of the National Coordinator (ONC) will convene a multi-stakeholder work group to conduct an in-depth review of PCAST's report and make recommendations on implementation by April.

We at Point of Care Partners (POCP) – like some others in the industry – find PCAST's recommendations intriguing. And we –like some others – think this is where the industry is ultimately headed. But the devil is in the details and time lines can be problematic.

Payers, providers and vendors are struggling to implement HIPAA version 5010, ICD-10, and ePrescribing for controlled substances, much less being able to deal simultaneously with the evolving electronic health record (EHR) and meaningful use (MU) requirements of the recent reform legislation. As a result, implementing another set of far-reaching requirements cannot be accomplished anytime soon due to technical, budgetary and practical reasons. Doing so anytime soon would be an incredible burden that the industry would find almost impossible to meet. We also believe that if PCAST's recommendations end up being folded into the MU requirements, it probably won't be in Phase 2 as some have suggested. Perhaps, MU Phase 3 (or Phase 4?) and beyond would be a more likely scenario.

And what does this mean for the HIT industry? The recommendations certainly open the door to innovation by enabling entrepreneurs to create a whole new world of health care apps and modular software. This could be good for the entrepreneurs, but it could be a real shot across the bow for health information exchanges (HIEs) and monolithic EHR vendors. An example is software modularization, which the geeks define as "a segment of logical functionality" such as embedding ePrescribing in an EHR system. This kind of modularity is definitely a threat to these HIEs and big EMR vendors, as is the notion of easy sharing of data outside the walls of their infrastructures.

In addition, the health care industry operates in a much different environment than the software world. Things just don't happen overnight in health care. Change comes slowly. Health care is highly regulated and the rule-making process can be lengthy and convoluted, translating into lengthy implementation time lines, especially for a change as expansive as this one. For example, how long has it taken to get regulations on versioning and updating for HIPAA transactions? Will the innovation envisioned by PCAST be slowed or strangled by bureaucracy? It's also important to note that some other key issues will need to be addressed. For example, privacy and security fields may need to be augmented. Aggregation of longitudinal data is very complex. All this will take time, so it will be interesting to see if and how another government mandate will be laid across the shoulders of the health care industry.

In the meantime, POCP will monitor industry and government reaction to PCAST's recommendations and analyze ONC's implementation recommendations once they are issued. Let us know if we can do a custom analysis on PCAST's implications for your organization.

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Those numbers are expected to continue to rise in 2011, owing to the meaningful use (MU) incentives. The survey also found that about 41% of office-based physicians are currently planning to acquire EHRs and apply for the incentives. Of those, four-fifths (or about a third of all office-based physicians) are expected to enroll during Stage 1. Interestingly, some 14% of physicians said they are not planning to apply for the MU incentives.

What the figures don't show is the traditional gap between functionality and usability. While basic EHRs are a starting point for getting physician offices to go electronic, the government maintains that most will need to upgrade their systems in order to qualify for the MU incentives. What's more, adoption does not mean that all of the available functionality will actually be used. As recent history has taught us with ePrescribing, we certainly can't assume physicians will use a technology simply because it is available to them. Undoubtedly, we will see that same phenomenon with EHRs: implementation \neq utilization.

The issue, of course, is beyond qualifying for the incentive payments. The value proposition for EHRs lies in having the functionality and using it. So, what needs to happen? Outreach and education, especially by regional extension centers (RECs), will be key. There needs to be a significant level of effort beyond the initial system installation to transition work flows and train physicians and their office staff on how to use EHRs fully and effectively. Dedicated office time for adequate training and education must be ensured.

The government is betting heavily the RECs will help. As of the end of 2010, RECs had enrolled more than 28,000 providers. Some RECs, such as Mississippi and Maine, have enrolled over 60% of their overall primary care provider target. Others, including Colorado, the California Health Information Partnership Service Organization, Massachusetts, North Carolina, New York City, and Washington/Idaho RECs, have enrolled more than 1,000 providers in the past few weeks. The RECs will likely have mixed success in ultimately getting physicians to implement an EHR system and then use it according to the government's MU requirements, while creating a sustainable business model for themselves.

At the same time, vendors and payers must step up. Vendors need to collaborate and promote best practices. Payers, including employer-based plans, can align their pay-for-performance initiatives with the MU requirements. Money certainly talks when it comes to spurring physician adoption and use of technology.

When it comes to EHRs deployment and implementation, consider Point-of-Care Partners' (POCP) EHR strategy development service. It is designed to give you an action plan for optimizing opportunities presented by EHR technology, as well as identifying and solving its challenges in your environment. The result will be a step-by-step plan for attaining your objectives, including achieving MU and developing outreach and educational strategies for EHRs. POCP also can provide whatever level of support is necessary for execution. Write us or give us a call.

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The electronic exchange of health information among stakeholders in patient care can be considered a quality improvement expense for purposes of calculating a health insurer's medical loss ratio (MLR) under the new health reform MLR provisions. Having a HIE technology infrastructure in a health insurer's portfolio can certainly help the company meet the MLR thresholds and avoid rebating premiums to beneficiaries. You can read more about this in detail in [my article](#) which is available on the [Point-of-Care Partners \(POCP\) Web site](#).

More important is the advantage of having a HIE technology infrastructure that can be deployed across an accountable care organization (ACO). As ACO development strategies and models emerge, an infrastructure enabling the electronic exchange of health information among providers in the network is increasingly recognized as an essential element. We are starting to see electronic medical record systems (EMRs) that are HIE enabled. This is+ becoming a criterion that a provider organization must meet in order to participate in ACOs sponsored by commercial health insurers. Without a HIE, effectively managing a population's health, proactively coordinating care, and accurately measuring change in quality would be incredibly costly and difficult, if not impossible.

Returning to the health insurer's role as owner of an HIE vendor, Aetna, with its Activehealth and new Medicity subsidiaries, has the potential to blaze new trails for care management using HIT, or what POCP has termed "eCare Management." ActiveHealth's "CareEngine" clinical decision support system will now have access to patient care data sourced from EMRs to augment its claims information. Giving physicians actual test results (not just what was ordered) and a prescriber's original prescription (not just what was filled) are two nuggets in a gold mine of information available via a CareEngine supported by Medicity that could have a significant and measurable impact on detecting gaps in care and coordination of services. The result could be clinical decision support at the point of care that is truly meaningful to clinicians and accessed directly from their EMR.

This changes the value model for HIEs. Until recently, the HIE market was something of a puzzle. Getting stakeholders to pay for the basic service of sending and receiving clinical transactions has been an insurmountable challenge for most HIE initiatives. The market has difficulty attracting adequate and reliable sources of capital because of valid questions about the business model and sustainability. For example, what revenue streams will replace federal financial incentives for HIT adoption when they run out? The answer, depending on the directions that Aetna and UHG take their new companies, could be value-added HIE services. They could, for example, gather health risk assessments across a defined population, alert patients and their physicians to follow-up care that is due, and produce quality scorecards to help providers stay on top of patients falling short of target outcomes. These services could yield significant savings in medical expenses for payers and ACOs.

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There is more to the story, and you can find it on the POCP blog at www.pocp.com. This is a new feature in which POCP's team of HIT strategy and marketing experts provide new insights and analyses of marketplace developments. Log on and post your comments. You'll be glad you did.

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