Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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: At Last! A Compelling Business Case for Interoperability

By Tony Schueth, Editor-in-Chief

Interoperability clearly is the word of the day as we begin 2015. Until now, it has been one of the "warm and fuzzy" words bantered about in our industry and often associated with health care reform or used as a reason for being critical of electronic health record (EHR) vendors that are not supporting interoperable health care (see our related HISTalk article). So, what makes 2015 much more compelling for interoperability? We finally have a robust business case as a true interoperability driver.

To be sure, newly announced initiatives by the Office of the National Coordinator for Health Information (ONC) are aiming to drive interoperability through harmonized standards itemized in its Advisory and the 10-year vision outlined in its Roadmap. They undoubtedly will move the ball up the field. However, the real game changer is the rapid movement toward value-based care, which creates the compelling business case we've been missing to date.

That business case is embodied in newly announced payment reforms by public- and private-sector payers. They feature reimbursement methods tied inextricably to health information technology (healthIT) and interoperability. Providers must seriously start to consider and act on these new payment models if they want to remain profitable, and even solvent, past next year. Medicare is planning to move away from fee-for-service (FFS) medicine within four years, with half of all Medicare dollars paid by the end of 2018 through such "alternative" reimbursement models as bundled payments, patient-centered medical homes and accountable care organizations. At the same time, 85% of all remaining Medicare FFS payments are expected to be tied to quality or value by 2016 and 90% by 2018. The result will be a renewed emphasis on pay for performance by linking reimbursement to quality measures and patient outcomes. Similar goals were enunciated by a coalition of private payers.

This rapidly moving train of payment reform will drive true interoperability. In order for providers to survive and thrive in this new reimbursement environment, sharing of high-quality data will be a necessity. Providers will have a business case for interoperable systems to meet quality and outcomes goals on which reimbursements will depend. Vendors, in turn, will meet that demand — which will be driven by specific buyer needs predicated on defined and required interoperability. This demand will incentivize vendors to develop innovative products and meet short timeframes envisioned by Medicare, private payers and the ONC. While the Roadmap and Advisory represent valuable future guidance, the emergence of a robust business case is the strong motivator that will yield active interoperability among providers and vendor systems.

As experts in healthIT, we would be happy to put our expertise to work and help you understand and capitalize on the new world of interoperability and value-based care. Point-of-Care Partners can help you understand ONC's draft Roadmap and Advisory, as well as help draft comments to guide ONC finalization of the documents. Stakeholder comments regarding the Roadmap are due April 3, with commentary due May 1 for the Advisory.

2 Part 2: Exciting Changes Ahead in 2015 for HealthIT

By Tony Schueth, Editor-in-Chief

Change is the hallmark of health care and health information technology (healthIT). This year promises to be another with tectonic shifts. On one hand, healthIT will continue to respond to evolving changes in the health care ecosystem by building on what has been in the pipeline. On the other, several new entrants into that ecosystem will significantly affect health care and healthIT going forward.

With that in mind, here are the top 10 trends we see ahead in 2015 for healthIT.

EHRs: Will only the strong survive as this market consolidates? In 2015, we could see increased consolidation in the electronic health record (EHR) market, mostly involving integrated delivery networks (IDNs). The emergence of value-based reimbursement and other market forces have fostered a migration of physicians and small groups into large group practices. The gamut of individual EHR systems represented by acquired practices will be abandoned or gradually swapped out as these merged entities focus on an enterprise solution. Not surprisingly, enterprise systems favor large, well-established vendors.

Nonetheless, opportunities do exist for small- and medium-sized firms. Those focused on meeting specialists' unmet needs will have an advantage. EHRs offering cloud-based platforms will continue to increase market share.

Population health: Why we'll finally see it pop. Payers, policy makers and IDNs will have population health on their minds in 2015 more than ever before. Why? Because it makes sense from a business perspective and promises a fairly quick return on investment (ROI). Part of meaningful use (MU) and the federal strategic plan for healthIT for 2015 to 2020, population health represents a tectonic shift away from treating episodes of care for individual patients to managing the health of specific populations, such as the chronically ill or members of IDNs.

Part of this is driven by a renewed focus on value-based reimbursement, with the recent announcement that Medicare will move away from fee-for-service medicine and transition toward payment through such "alternative" reimbursement models as bundled payments, patient-centered medical homes (PCMHs) and accountable care organizations (ACOs). This new way of doing business — based on value-based reimbursement — will require changes to healthIT infrastructures and EHRs to capture clinical, administrative, cost and outcomes data. EHRs and health information exchanges (HIEs) will be needed to gather and report data, both internally and externally, to payers such as Medicare.

Another driver is the business case for population health, represented by ROI. According to a survey by KPMG, half of health care organizations could recoup their population health investment within a short four-year window, many within the first 1 to 2 years.

Clinical decision support: Docs will learn to love it. This year will mark a turning point in the provider community, which will come to perceive clinical decision support (CDS) as a value-add and must-have rather than simply an annoyance. MU stage 2 includes several CDS requirements, but some providers consider these to be too much and too heavy handed. Others — especially early adopters — will be rethinking it. Savvy physicians have become comfortable with basic CDS and are now looking to expand beyond the basics to more advanced features.

These physicians, along with IDNs and ACOs, have realized that effective use of CDS means patients receiving the correct tests and preventive services, appropriate medications, and proper treatment, particularly for chronic conditions. This translates to better outcomes, which lead to successful value-based reimbursement. As a result, clinician demand for more and improved CDS will stimulate EHR vendors to respond. They will be adding such CDS tools as documentation templates,

diagnostic support, condition-specific order sets, focused patient data reports and summaries and evidence-based guidelines — all of which may be deployed on a variety of platforms (e.g., mobile, cloud based or locally installed). Look also for CDS tools to enhance clinicians' quality of patient care in PCMHs and ACOs, as well as remote patient monitoring.

Patient engagement: It will lead to innovative market marriages. Engaging patients in their care has been disappointingly slow despite its being part of MU, significant noise coming out of Washington and increased demand by some patients and IDNs. This could be the year patient engagement begins to take off. Under pressure to reduce costs and improve outcomes — both within value-based reimbursement systems and outside — payers and providers will be looking for patient engagement solutions, particularly those that are technology-based, to drive action and get results.

Moreover, the need for better patient engagement is an opportunity that investors and entrepreneurs will jump on in 2015. This should not be surprising given low interest rates, increased availability of venture capital and growing awareness throughout the business community of the need to cut health care costs while promoting wellness. That should translate into a wider range of wearables, mobile devices and applications to monitor patients and help them meet clinical and lifestyle targets customized to their age, health status, conditions and insurance coverage. Expect to see greater innovation in electronic patient/provider messaging that provides targeted actionable information across various patient populations as well as meaningful feedback.

Data sharing is another area that is ripe for opportunity, particularly regarding ways patients can contribute information to their EHRs and how caregivers can be included. Both entrepreneurs and institutions are looking to leverage technology to educate patients about their care and conditions. Innovative healthIT solutions are needed to reach the elderly and many minorities, who tend to be underserved and have multiple chronic illnesses that are costly to treat.

Electronic health records: Will they be easier to use? Washington is abuzz these days with the perceived need for better healthIT interoperability. We heartily support ongoing work by the industry and federal government for improvements in this area. Take, for example, suggestions in the new draft Roadmap recently issued by the Office of the National Coordinator for Health Information Technology (ONC) and its 2015 Interoperability Standards Advisory (the Advisory). To be sure, these initiatives will drive interoperability, but newly announced payment reforms will be the game changer. (Learn more in our related article in this issue of HIT Perspectives.)

While ONC's interoperability recommendations are being finalized, the industry in 2015 will be building on MU requirements and processes that have already left a core of basic interoperability supported across many EHR vendors. MU's cookie-cutter approach has created usability gaps that vendors will be working to address. Physicians want systems that are straightforward to use, more easily and securely integrated into their work flows, and customized to the unique needs of their specialties. Many will be replacing hastily purchased EHRs because they desire enhanced functionalities, such as specialty-specific work flows. That lesson is underscored in a recent survey by the American Academy of Family Practice, which found that 59% of family physicians who switched EHRs got better functionality — the top reason for the change in the first place. Other physicians will be implementing new EHRs because they will be joining IDNs that require use of a particular system. IDNs, ACOs and even large group practices will need expanded data capture, analytics and reporting capabilities.

Biosimilars: They will be blinding us with science. One of the newest trends is the entrance of biosimilar pharmaceuticals into the US market. The Food and Drug Administration is poised to begin approving these drugs, which are similar to, but not identical copies of, the originator biologic and are not generic alternatives. (For a more detailed primer on biosimilars, see our article in the December 2014 issue of HIT Perspectives.) We expect that the trickle of approved biosimilars soon will turn into a flood, creating numerous challenges and opportunities for healthIT in terms of standards and changes to EHRs and dispensing systems. Many of these will be driven by the need to add the manufacturer name and lot number to the drug ecosystem in response to provisions of the Drug Quality and Security Act of 2013. These changes will be needed to "track and trace" adverse drug events potentially associated with biosimilars and other medications. That is easier said than done as normal industry practices, and the standards used for electronic communication between prescribers and pharmacists, don't typically contain lot number or manufacturer information.

Specialty medications: ePrescribing will be the prescription for success. Specialty medications will continue to be of intense interest by payers and providers as their costs and share of the nation's drug spend continue to rise. The rise in biosimilars also will contribute to the focus on specialty meds. As a result, emphasis will be placed on using electronic prescribing (ePrescribing) and prior authorization (PA) to improve management of the prescribing and distribution processes of these medications and reduce the significant overhead costs associated with today's paper/phone/fax processes.

In fact, ePrescribing of specialty medications is already in use

today on a limited basis. One barrier to wider use of ePrescribing for specialty medications is that the data transmitted do not contain vital information — such as height, weight and PA approvals — needed by the specialty pharmacy. This means the pharmacy must request additional information from the prescriber and revert back to paper- and fax-based processes. The industry is aware of these gaps and will continue to work on filling them. Examples include the wider integration of electronic prior authorization (ePA) into EHRs and modification of the prescription transaction standard to accommodate this information. We will also see more robust integration of pharmacy and medical benefits, thus allowing plans to better track the usage of specialty drugs across beneficiaries. This will necessitate major changes in ePrescribing, standards and payer and pharmacy systems.

EPCS: Adoption will be getting a shot in the arm. Electronic prescribing of controlled substances (EPCS) will continue to gain traction in 2015. Part of this is because EPCS is the final frontier of ePrescribing and it is natural that market forces will try to fill the void. Pharmacies are ready for EPCS. So are EHR vendors, which are increasingly bringing EPCS-compliant products to market now that demand has been demonstrated. In addition, the process for accrediting EPCS-compliant products will be streamlined now that the Electronic Healthcare Network Accreditation Commission (EHNAC) is exclusively handling certification. This should result in more EPCS-compliant products hitting the market sooner and will stimulate adoption by providers. The move toward interoperability and value-based care by public and private payers also should stimulate EPCS adoption in 2015. (Read more in this issue of HIT Perspectives.)

Another major driver for EPCS is the war against substance abuse being led by the federal and state governments. One example is the I-STOP Program in New York, which requires ePrescribing of all medications in March 2015 and the consultation by most prescribers of the state's Prescription Drug Monitoring Program (PDMP) Registry when writing prescriptions for Schedule II, III, and IV controlled substances. The PDMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. This information will allow practitioners to better evaluate their patients' treatment with controlled substances and determine whether there may be abuse or nonmedical use. Many states are considering following New York's lead, which would not be that difficult since all states have a monitoring program that is authorized or already up and running. A challenge to more widespread adoption, however, is that while providers are adopting EPCS-compliant ePrescribing systems, PDMP data are not yet integrated into the EHR. This represents an opportunity for EHR vendors to fill a market gap with a feature that will yield significant patient safety benefits.

Electronic prior authorization: Health care will just say yes. Vendors in 2015 will increase their implementations of ePA. Despite availability of the standard, its integration into EHRs has been slow. That should change as demand for ePA continues to grow. Some will be due to the entry of biosimilars entering the market, coupled with the increasing demand for specialty medications spurred by the continued rise of chronic diseases. All of these will require PA, eventually creating a tipping point for ePA away from the traditional paper/phone/fax PA methods.

In addition, look for payers' renewed interest in medical electronic preauthorization. This shift in payer mind-set is fairly easy to understand. Payers are beginning to see the success in ePA for medications now that the standard has become more widely adopted. Paper/phone/fax PA processes for medical procedures, lab tests and devices have been a long-standing and expensive pain point for both payers and providers, and the success in ePA may point to relief for that.

Real-world evidence: Data and methods will be making it real. Wider use of real-world evidence (RWE) will be a major transformational trend in 2015. Expect to see payers, regulators, pharmaceutical companies and others increasingly look at RWE as a new way to assess patient outcomes and create value. Analyses of large sets of anonymized patient-level data, or real-world data (RWD), can yield an assessment of the true effectiveness, risks, safety and cost benefits of a drug, procedure or device. As a result, RWE provides an unprecedented window into how a particular product is used — by whom, under what circumstances and yielding what outcomes. Drug manufacturers are now using large data sets and sophisticated analytics to see how their existing drugs actually perform in the real world. This increases their understanding of how drugs actually perform — on top of the knowledge gained from the narrow confines and small populations of the gold standard of randomized, controlled clinical trials.

RWE will also become increasingly important to payers, providers and regulators. Using RWE, they can have an accurate and advance assessment of the risks and benefits of treatments and actual health outcomes in large patient populations. RWE further can be translated into action-oriented messaging for patients and health care providers at the point of care. Additionally, RWE creates opportunities for healthIT infrastructure vendors to provide the RWD needed for the analyses. Vendors can create value for payers and regulators by collecting and aggregating clinical data from EHRs, as well as by linking claims and registry data.

3 Part 3: Interoperability, Value-Based Care and the War on Painkillers to Drive E-Prescribing for Controlled Substances

By Tony Schueth, Editor in Chief

E-prescribing for controlled substances (EPCS) has been slow to take off but will gain renewed traction due to policy and legislative changes at the federal and state levels that have created new drivers expected to hasten the adoption of EPCS beginning in 2015.

Controlled substances account for roughly 13% of all prescriptions each year. EPCS has long been approved by the Drug Enforcement Administration (DEA), providing certain requirements are met. It is legal in 49 states, whose requirements must meet or exceed those put in place by the DEA. According to Surescripts, nearly all physicians who electronically prescribe (ePrescribe) also prescribe controlled substances. However, the vast majority of controlled substance prescriptions are still handled via traditional phone/paper/fax methods. It is estimated that only 1% of controlled substance prescriptions are transmitted electronically.

This percentage is expected to rise quickly because the federal government, in particular, has added policy levers in terms of increased interoperability of health information technology (healthIT). Movement by Medicare and private payers toward value-based care also will require greater EPCS adoption. Finally, states are looking to enact legislation requiring EPCS as a tool to combat the war against abuse of prescription painkillers.

Improved interoperability. EPCS is included in a federal interoperability initiative to improve care through increased, interoperable exchange of clinical and prescription data. Created by the Office of the National Coordinator for Heath Information Technology (ONC), the draft Shared Nationwide Interoperability Roadmap has an overall goal to achieve basic electronic health data interoperability by 2017. EPCS, with concurrent availability of data from state prescription drug monitoring programs (PDMPs), is featured among the Roadmap's 2015 to 2017 calls to action — specifically, for providers to routinely leverage standards-based healthIT to support priorities and work flows. The combination of the ONC throwing its considerable clout behind this recommendation and its two-year implementation horizon are sure to be short-term drivers for increased EPCS adoption.

PDMPs are secure, state-administered electronic databases that track the prescribing and dispensing of controlled substances and other prescription drugs of concern. Both the federal and state governments recognize PDMPs as effective tools toward reducing prescription fraud and abuse of controlled substances. Currently, 49 states and Guam have an operational PDMP, which collects data from dispensers and reports information from its database to authorized users. (Click here for an in-depth overview of PDMP programs.)

Despite the promise of PDMPs, more work needs to be done to enable the exchange of EPCS data and their integration into EHRs and the ePrescribing work flow. The ability of PDMPs to exchange data across state lines is presently suboptimal. As of November 2014, 29 state PDMPs can share data with other state databases.

To address those concerns, ONC has sponsored a stakeholder-driven Standards and Interoperability (S&I) Workgroup. It is looking at harmonizing standards for PDMP data exchange, facilitating pilots and creating an implementation guide. (Click here to learn more about this S&I initiative.)

More standards interoperability. Another piece of ONC's impetus for interoperability is its 2015 Interoperability Standards Advisory (Advisory). This represents a framework

and process going forward by which ONC will coordinate functionality-specific standards recommendations with stakeholder input. The result, according to ONC, will be the identification, assessment, and determination of the best available interoperability standards and implementation specifications for industry use toward specific health care purposes. The 2015 Advisory is basically a set of lists of best practices for standards in four broad categories: vocabulary/code sets/terminologies, content/structure, transport and services. These are broken down to indicate which standards are appropriate for specific uses. Recommended standards for ePrescribing (and EPCS by extension) include SCRIPT v.10.6 and Formulary and Benefits v3.0, both created and maintained by the National Council for Prescription Drug Programs (NCPDP). ONC's clout behind this standards-focused project will raise all boats, including EPCS.

Rise in value-based care. Public and private payers are renewing efforts to move toward value-based care, which, among other requirements, will rely on more EPCS to provide better medication and cost data. Medicare recently announced a plan to move away from fee-for-service (FFS) medicine within four years toward reimbursement through such "alternative" models as bundled payments, patient-centered medical homes and accountable care organizations. At the same time, nearly all remaining Medicare FFS payments are expected to be tied to quality or value by 2018. The result will be a renewed emphasis on pay for performance by linking reimbursement to quality measures and patient outcomes. This will require better data and better, interoperable data exchange.

Similar goals have been enunciated by a coalition of private insurers and health systems that have partnered to accelerate the transition to value-based care. Members of the Health Care Transformation Task Force intend to move 75% of their business to value-based contracts that prioritize quality and cost effectiveness by 2020. Stakeholders include Aetna, Health Care Service Corp. and major employer groups, including the Pacific Business Group on Health.

With those goals in mind, increased EPCS will be a necessary requirement in this new environment. Currently, lack of EPCS creates major data holes in a patient's electronic medical record, medication history and treatment plans. The resulting gaps in treatment and difficulties in medication therapy management and medication reconciliation represent major quality concerns. Lack of EPCS also contributes to costly and dangerous adverse drug events because drug-drug and drug-allergy interactions with controlled substances are unknown at the point of prescribing. In addition, the lack of EPCS data results in an incomplete cost profile — both for the patient and particular drugs on a payer's formulary. A complete picture of a patient's medications and their costs will be necessary in alternative reimbursement models and value-based payment. For those reasons, the transition of payers to value-based care on a short-term horizon will spur increased EPCS adoption.

State legislation. States are considering using policy levers to further EPCS adoption as a tool against prescription drug abuse. New York is leading the way with enactment of the Internet System for Tracking Over-Prescribing Act in 2013, also known as the I-STOP bill. I-STOP has two parts. The first was creation of the Prescription Monitoring Program (PMP) Registry, which is essentially a PDMP as described above. Prescribers in New York must consult with the PMP before creating a prescription for Schedule II-IV controlled substances. The second part of the bill requires ePrescribing of all medications (both controlled substances and non-controlled substances) beginning March 27, 2015 (although that date may slip in response to concerns about stakeholder readiness).

The federal government, states and stakeholders (such as physician groups) are watching I-STOP with interest. Several states (including California, Illinois, Oklahoma, Texas and Utah) are considering passing similar legislation.

We expect EPCS will come out of the shadows in 2015 and emerge as a major source of quality and cost data for public and private payers, as well as a tool to fight prescription drug abuse. Point-of-Care Partners (POCP) has long been active in ePrescribing and EPCS. Let us put our expertise to work and help keep you up-to-date with the transition to EPCS. Our ePrescribing State Law Review is the most succinct yet comprehensive analysis of federal and state rules, regulations and statutes governing electronic prescriptions, including EPCS. We are closely monitoring the progress of the I-STOP Program in New York and interest in similar programs by other states, which we would be happy to share with you. Finally, POCP can help draft stakeholder comments regarding ONC's draft Roadmap, which are due April 3, and its 2015 Advisory, due May 1.