February 2014

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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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10 Health IT Trends for 2014

Part 1: Gazing Through the Snow Globe: 10 Health IT Trends for 2014

By Tony Schueth, Editor-in-Chief

As the Point-of-Care-Partners (POCP) Team hunkered down during the January 2014 snowstorm and lay behind what developments are likely for the year ahead, frigid air and bad weather could not dampen our enthusiasm for opportunities for health care growth and innovation in 2014, which will be enabled by advances in health information technology (health IT). Here are our top trends for 2014.

Value-based care picks up more steam. Although this is not a new trend, we’ll see continued acceleration in 2014 in the move away from fee-for-service to value-based payment that is enabled by health IT.

• One driver is the impact of accountable care organizations (ACOs), which numbered around 532 in 2013. For these ACOs to be sustainable, they must integrate their clinical and payment operations. This is a tall order and requires significant investment in health IT infrastructure.

• A second driver is Medicare payment policies, which continue to focus on use of health IT to create and report metrics for accountable pay-for-performance and value-based purchasing programs. Proposed changes to the Medicare payment formula for doctors include a major quality component, which again underscores the overall shift toward value-based care.

• One result is an increased focus on population health (for more detail, see the article in this issue of HIT Perspectives). At the same time, there are opportunities for care management applications to “pull” patients into the health care system and proactively manage high-risk patients through a range of health IT applications, including care registries, quality reporting, predictive analytics and patient self-management applications.

• Electronic health record (EHR) products currently don’t do any of these functions very well, so innovation will step in to fill the gaps with niche products. Creating value beyond meaningful use. Implementing meaningful use (MU) stage 2 requirements are critical for vendors and providers, and we’ll see providers demanding that their vendors commit to 2014 certification and show a tangible return on investment (ROI).

• The latter will be measured in terms of improved operational efficiencies and moving the needle on quality measures. If vendors can’t demonstrate ROI, providers will switch to those that can.

• Although providers will want to ensure they can continue to meet MU requirements, they will have an additional laser-focus on capabilities needed from their integrated revenue cycle management (RCM)/EHR system to survive in a value-based payment world.

This is especially true for independent physician organizations and community hospitals, which are seeing their future viability called into question.

Consolidation of the EHR vendor market. Consolidation in the vendor market is a given in 2014.

• It’s clear that the herd will start to be culled, given that there are as many as 550 systems in the market.

• Government mandates, innovation and physicians’ technology needs and expectations will influence who stays and who goes. The ability to meet MU stage 2 requirements is a must.

• Niche vendors — such as smaller players that can serve a specialty well, customize documentation and write interfaces to their equipment — will have staying power, as will vendors with integrated RCM/EHR systems.

• Roughly half of physician practices are expected to replace their EHRs in the near future. They will be looking for different functionalities this time around. The evolution toward value-based care and integrated delivery models is making new demands on the types of data needed for clinical care, quality improvement and payment and how those data must be exchanged and stored. Marketplace demands for lower total cost of ownership, cloud-delivered technology also will influence who stays and who goes.

Pharmacists: Adding value in collaborative care. Pharmacists are uniquely positioned in the health care system to help optimize appropriate medication use and reduce medication-related problems.

• As a result, pharmacists in 2014 will continue to take on more clinical roles through such collaborative efforts as participation in patient-centered medical membership on ACO care teams.

• They will use new technologies to deliver such personalized care as telepharmacy and mobile health and to monitor outcomes and adherence.

• Pharmacists also will continue their central roles in medication therapy management (MTM), which will be facilitated by health IT. Integrated systems of care, such as ACOs, already view MTM — the more complex of which is performed by pharmacists — as essential to care delivery and to meet ACO quality and cost targets.

Electronic prior authorization gets off the ground. 2014 will be a formative year for electronic prior authorization (ePA).

• Last year brought to fruition a new ePA framework that was rolled out by the National Council for Prescription Drug Programs (NCPDP).

• With that behind us, we will start to see uptake by payers and vendors. Payers will be adding basic systems that support text

Electronic Prescribing of Controlled Substances gains momentum. Off to a slow and somewhat rocky start since it became legal at the federal level in 2010, electronic prescribing for controlled substances has some more mainstream in 2014.

• Providers are ready and vendors are bringing compliant systems to market.

• Reimbursement typically is being extended to a wider range of providers and to cover use of these mobile technologies.

• Electronic Prescribing of Controlled Substances goes mainstream

Teledhealth goes mainstream. Once rarely used, telehealth is among the biggest trends in 2014, allowing remote diagnosis, treatment and monitoring of patients through such electronic means as smartphones, tablets, virtual consultations and wearable self-monitoring devices.

• Drivers include growth in the number of payers willing to cover telehealth services and the expanded scope of reimbursable procedures.

• Payors covering telehealth services include most Medicaid programs, the military, which is expanding coverage (especially to address post-traumatic stress), and such private payors as Aetna, WellPoint, Cigna and Highmark, which are covering member cohorts beyond those in rural areas.

• Despite the growing popularity of telehealth, harmonization is slow to address variations in licensure, data transmission requirements, the kinds of services that may be provided and in what venues. This could require legislation and agreement among such stakeholders as state boards of licensing, pharmacy, nursing and medicine as well as state insurance commissioners, which could happen sooner than later with input from the federal government. Defense health care providers are allowed to practice across state lines and a House bill proposes that Medicare providers be allowed to do likewise.

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• Reimbursement typically is being extended to a wider range of providers and to cover use of these mobile technologies. Patients will increasingly want to be engaged in their health care in a big way and make decisions with their doctor. According to a recent study, 90% of people want to have a say in important decisions regarding their health care. A third would like to make a shared decision with their doctor, 43% want to make the final decision with some professional input, and 16% prefer to be completely in charge of their medical decisions.

• There will be a proliferation of applications (apps) for smartphones and tablets, increasing patient demand for them as well as the willingness of providers and payers to make use of these mobile technologies.

• Electronic prior authorization — now being extended to a wider range of providers as well as to address variations in licensure, data transmission requirements, the kinds of services that may be provided and in what venues. This could require legislation and agreement among such stakeholders as state boards of license, pharmacy, nursing and medicine as well as state insurance commissioners, which could happen sooner than later with input from the federal government. Defense health care providers are allowed to practice across state lines and a House bill proposes that Medicare providers be allowed to do likewise.

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The move from volume- to value-based payment is accelerating as payers require that providers meet population health-based quality payment and delivery policies (including ACOs, PCMHs, and Medicare Shared Savings Program). This allows the care team — physicians, patients, and caregivers — to electronically prescribe medications, which is informed by electronic claims data. This data is collected by health IT tools and is integrated into the hands of clinicians at the point of care. A technology platform that enables normalization of claims and EHR data.

Growth in Accountable Care Organizations (ACOs) and population health-based programs conducted by the Centers for Medicare & Medicaid Services (CMS) are related to an expanded focus on population health. For example, most hospitals must conduct a Community Health Needs Assessment once every three years that includes a prioritization of health needs in their community along with measures and resource strategies to address them.

What is causing the growing momentum toward population health management in response to value-based payment? Working with our clients, we see the same set of drivers as 12 to 24 months ago. However, they are looming larger, with rapid advances in health information technology (health IT) acting as the catalyst for change.

Drivers. Pressures are mounting to proactively manage populations rather than episodes of care. Driving change more than ever are:

• Growth in Accountable Care Organizations (ACOs) and their nucleus of Patient-Centered Medical Homes (PCMHs). At the core of improving quality and reducing costs is the ability to proactively identify patients needing care and then effective coordination across the continuum of care. ACOs — which numbered about 200 in 2010 — is part of meaningful use (MU) stage 2 and expanded requirements are expected in MU stage 3. Several provisions of the Affordable Care Act are related to an expanded focus on population health. For example, most hospitals must conduct a Community Health Needs Assessment once every three years that includes a prioritization of health needs in their community along with measures and resource strategies to address them.

• Federal stimulus. Improving population health through the use of health IT is a goal of the strategic plan of the Office of the National Coordinator for Health Information Technology (ONC). This ensures that resources and requirements will be brought to bear in this area. The federal government also will continue to intensify its numerous population-health-based programs for managing chronic conditions, mental health, and substance abuse — the latter of which is becoming a growing problem among the elderly. These will be above and beyond the population-health-based programs conducted by the Centers for Disease Control and Prevention.

• New ONC leadership. Dr. Karen DeSalvo recently was named head of the ONC. To be sure, Dr. DeSalvo brings much relevant health IT experience to the table. But you also view the world from where you sit. Dr. DeSalvo also holds a master’s degree in public health from Tulane University and a master’s degree in clinical epidemiology from the Harvard School of Public Health, both of which taught her to look at many health care issues through the lens of population health. This intensive training, plus her clinical work with diabetic patients, is likely to bring more attention on how population health issues can be addressed by health IT. In fact, she has publicly stated that ONC’s “next phase” will include emphasizing how health IT may be moving forward through health IT. The accelerated migration towards population health will be enabled by a range of health IT tools, including electronic health records (EHRs), health information exchange (HIE), data analytics, patient engagement and care management processes. For example:

- It has the potential of harvesting data in the EHRs by 50% — soon-to-be-90% — of health care professionals in America.
- It can be used by payers to create patient predictors and begin to recommend interventions to prevent emergency room visits and hospitalizations.
- The advancement of technology and standards in this area enables normalization of claims and EHR data.
- It can create more actionable, higher quality data for pharma to make product marketing decisions and offer more meaningful care recommendations at the point of care.
- It can improve risk management and help maximize revenue.

Part 2: Making the Leap: Going from Managing Episodes of Care to Populations (continued)

- Health data analytics. Innovations in data aggregation and online analytics are bringing powerful tools to the market that can be used by managers and clinicians at organizations large and small. The challenge will be to determine which particular types of analyses on what data will be most beneficial to an organization that must manage risk for a defined population. Identifying the 20% of patients driving 80% of a hospital’s health care costs is a good place to start. From these data, patients who are most likely to experience a high-cost intervention can be identified with predictive analytics and targeted proactively with appropriate care interventions.

- Proactive care management. Population health management innovators recognize that the only way to move the needle on patient outcomes and satisfaction, and managing care teams results of multiple years of experience at the hands of clinicians at the point of care. A technology platform that integrates an EHR with a patient registry — both connected to an HIE with access to other EHRs and claims data — will provide the foundation for a new generation of health IT that will facilitate coordination of care and “pull” the patient into the system before conditions worsen or become even more costly, or before potentially avoidable events such as an emergency room visit or hospital readmission. Innovative communications will be employed, based on identification of high-risk patients, to interact with the care team, patients and caregivers. Innovations in health IT will also enable care coordination in community practice settings, where the integrated care management platform is very important to achieve the cost and quality. Additionally, health IT will enable care management in community practice settings, where the integrated care management platform is very important to achieve the cost and quality.

- Electronic data exchange. According to the American Medical Association, the current care infrastructure we’ve designed to treat acute episodes and must evolve to also effectively promote preventive care and treat chronic conditions. That transformation is happening today through an increasingly robust health IT infrastructure. For example, disease prevention, early detection, and condition management for various populations is being enabled through the exchange of clinical and administrative data within and across sites of care. Population managers are using health IT to exchange data across the entire continuum of care. Health IT will also enable care management in community practice settings, where the integrated care management platform is very important to achieve the cost and quality.

Infrastructure. According to the American Medical Association, the current care infrastructure we’ve designed to treat acute episodes and must evolve to also effectively promote preventive care and treat chronic conditions. That transformation is happening today through an increasingly robust health IT infrastructure. For example, disease prevention, early detection, and condition management for various populations is being enabled through the exchange of clinical and administrative data within and across sites of care. Population managers are using health IT to exchange data across the entire continuum of care. Health IT will also enable care management in community practice settings, where the integrated care management platform is very important to achieve the cost and quality.

Part 3: Accelerating ePrescribing for Contingent Subscribers

- However, just because everyone is talking about big data doesn’t mean that everyone can or will use it.
- Predictive analytics in health care lag behind those in banking and retailing, for example, so there is a lot of catching up to be done.
- Standards and better interoperability are needed to ensure the accuracy, security and privacy of the large data sets.
- Innovations in health information exchange will be needed to share data successfully among numerous stakeholders.

PCCP is looking forward to helping our clients — old and new — analyze these trends and develop strategic and tactical options to maximize opportunities and revenues. Let our nationally recognized team of experts make 2014 a memorable — and profitable — year for your organization.
Part 3: Accelerating ePrescribing for Controlled Substances

By Michael Burger, Senior Consultant

Electronic prescribing (ePrescribing) now is the norm for most prescriptions, except those for controlled substances. In fact, electronic prescribing for controlled substances (EPCS) has gotten off to a slow and somewhat rocky start. Some consider EPCS to be the "last mile" in getting the nation wired to send and receive prescriptions electronically. But things are changing — and fast.

Recent metrics show significant progress in physician and pharmacy adoption of EPCS. Although the actual number of physicians using EPCS is relatively low (<4,000), the rate of uptake is rapidly accelerating. A DrFirst industry briefing notes a 428% increase in physician adoption of EPCS just in the latter half of 2012. Pharmacy enabling to accept EPCS appears to have grown to a point where some 14,000 pharmacies are now able to accept electronic prescriptions for controlled substances. (Surescripts lists 14 pharmacy systems that have completed certification for EPCS, including Walgreens, CVS and Rite-Aid.) In Arizona, where Point-of-Care Partners (POCP) helped Arizona Health e-Connection (AzHeC) flood the state with “EPCS is legal” messaging, EPCS transactions increased more than 7-fold from less than 200 to more than 15,000 in only seven months (May to December 2013). We saw these kinds of numbers in the early days of ePrescribing, right when adoption really began to skyrocket.

In short: the momentum for EPCS adoption is rapidly accelerating. A DrFirst industry briefing notes a 428% increase in physician adoption of EPCS just in the latter half of 2012. Pharmacy enabling to accept EPCS appears to have grown to a point where some 14,000 pharmacies are now able to accept electronic prescriptions for controlled substances. (Surescripts lists 14 pharmacy systems that have completed certification for EPCS, including Walgreens, CVS and Rite-Aid.) In Arizona, where Point-of-Care Partners (POCP) helped Arizona Health e-Connection (AzHeC) flood the state with “EPCS is legal” messaging, EPCS transactions increased more than 7-fold from less than 200 to more than 15,000 in only seven months (May to December 2013). We saw these kinds of numbers in the early days of ePrescribing, right when adoption really began to skyrocket.

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