

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.

Contact Information

Tony Schueth
CEO & Managing Partner
tonys@pocp.com
info@pocp.com

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1 Part 1: Eight Takeaways from HIMSS 2017

By **Tony Schueth**, Chief Executive Officer

It's a wrap for this year's annual meeting of the Healthcare Information and Management Systems Society (HIMSS). While some think it's getting too big and overwhelming, we believe it's still — without a doubt — the best place to catch up with vendors and clients and on doing by various stakeholders in the area of health information technology (health IT). The Point-of-Care Partners team used its time productively through face-to-face discussions with stakeholders, attendance at presentations, discussions with exhibitors and investment of a lot of shoe leather.

We will leave it to others to report the specifics of HIMSS17. That said, here are some of the highlights of what went on in Orlando and a look at what the health IT industry might see in the year ahead.

1. No news from the government. In previous years, HIMSS has been the launching pad for new government initiatives or the fleshing out of regulatory guidance. Not so in 2017. That's not surprising since the key federal players in health IT were still in transition at the time of the meeting. Secretary of Health and Human Services (HHS) Tom Price had just been confirmed and barely moved into the Humphrey Building. Seema Varma — the Trump administration's pick to head the Centers for Medicare and Medicaid Services — was in the middle of the confirmation process (she has since been confirmed). It is unknown who will be tapped to run the Office of the National Coordinator for Health IT (ONC) or its fate. [Since the meeting, we have learned that former Rep. John Fleming, R-LA, has been named deputy assistant secretary for health technology at HHS, a newly created position that could suggest an ONC reorganization is in the offing.] In terms of buzz about govern-

ment programs, there was some talk about readiness for implementing the Medicare and CHIP Reauthorization Act and its Merit-based Incentive Payment System. Meaningful use popped up occasionally. There was a lot of speculation about the future of health insurance, what with changes to the Affordable Care Act in the offing. However, there was not the usual fever pitch associated with government programs at HIMSS17. It's relatively quiet on the government front and things may not resolve for quite a while.

2. Adding artificial intelligence to make personalized medicine more, well, personal. IBM's Watson Health was a big presence. It began with the opening keynote address by IBM's Ginni Rometty, who, not surprisingly, spoke very positively about Watson Health. This is one of IBM's big initiatives, which uses a cloud-based approach to store vast quantities of medical data and analyze them leveraging artificial intelligence. This approach will allow Watson Health to provide specific insights to hospitals, physicians, insurers, researchers and, potentially, even individual patients. IBM touts this as creating personalized health care on a very big scale. The IBM booth was packed as HIMSS17 attendees were trying to figure out how Watson Health works and what it could do for their organizations. Some wondered if it was overhyped and whether it would gain traction — especially in light of **the news that broke just before the meeting** indicating that the partnership between Watson Health and the prestigious MD Anderson Cancer Center seems to have gone south. We'll have a better picture of Watson's status as the year progresses.



With Greg Dorn (right), CEO of Hearst Health

3. The Interoperability Showcase shifts gears. Interoperability continues to be another key concept in health IT. It was translated into reality by numerous vendors who strutted their stuff in the HIMSS17 Interoperability Showcase. Last year's showcase seemed to focus on innovations by smaller companies and start-ups. The 2017 showcase emphasized practical ways to address work flow and functionality in electronic health records (EHRs). Epic seemed to be everywhere, although there was participation by some other major EHR vendors. They were almost saying, "Stop it already with this 'information blocking' baloney!"

4. Population health is a concept whose name shall not be spoken. Population health has been a buzzword at the last several HIMSS meetings. Many think the term is misunderstood — nobody seems to know exactly what it means — and overused. Maybe that's why it didn't seem to be on anyone's lips at HIMSS17. That said, there was a major emphasis on practical solutions that would address issues related to population health with existing systems. Examples include improved and targeted clinical decision support and applications that could intercede with patients when gaps in care are identified.

5. Salesforce.com emerges in health care. Salesforce.com made a big splash at HIMSS17. Even though its platform is most widely used outside of health care, it

claims to help companies engage physicians and patients. It remains to be seen if Salesforce.com can successfully penetrate the already crowded health IT world, but it's gaining traction. More than a better mousetrap may be needed to take on the big guns like Epic and Cerner.

6. The forecast is not entirely sunny for the cloud.

Everyone seemed to be talking about cloud-based applications at HIMSS17. In reality, evolution to the cloud has been slow in health care. The technology is stronger, smarter and less expensive than ever, but reliability and especially security remain big concerns in the conservative world of health IT. These may well be limiting factors for Salesforce.com.

7. Blockchain is the newest buzzword. Every HIMSS

meeting seems to have a buzzword. Blockchain was it for 2017. Blockchain is a data structure that can be time stamped and signed using a private key to prevent tampering. Some may know it as the technology underlying the online currency Bitcoin. Those in health IT may recognize it from ONC-funded work on its use in health care. **Last year's Challenge program**, for example, resulted in 15 white papers on the subject. Some people are still trying to get past the hype and figure out if the technology and its security features truly have legs in health IT.

8. The value of HIMSS is still there. This year's meeting was not the largest, but the 42,000+ attendance for HIMSS17 certainly puts it near the top. As mentioned previously, some think HIMSS is too big and is losing its utility. If you've been around a long time, you'll remember that's why HIMSS split off its own meeting from the American Hospital Association's annual meeting. We don't think HIMSS has reached the tipping point yet. Despite its size, HIMSS is still useful and relevant. One measure is change in attendance cohorts. HIMSS used to be for hospital CIOs and their staff. Attendance continues to expand, with an increasing number of biopharmaceutical and payer types attending this year. There were also policy makers, start-ups and a host of others, as well. The face-to-face interactions are invaluable. In short, HIMSS offers a lot of bang for the business-to-business corporate travel buck.

See you next year at HIMSS18 in Las Vegas. ●

2 Part 2: FHIR Sets the Stage for Targeted Applications for Payers and Providers

By **Jocelyn Keegan**, Senior Consultant

Interoperability — or the ability of unrelated clinical and administrative systems to “talk” to one another — is one of the biggest health care challenges today. Fast health interoperability resources (FHIR) is an emerging transaction standard that many view as a key tool to make interoperability a reality. As FHIR takes the world of interoperability by storm, many stakeholders are committing resources as they discover useful applications for it and creating targeted applications for payers and physicians.

The FHIR standard was developed by HL7, which is one of the nation’s major standards development organizations and particularly applicable to electronic health records (EHRs) and clinical systems. FHIR’s appeal lies in its flexibility, permitting the selection and exchange of specific pieces of patient information instead of having to import entire documents, which has been the norm. This makes it easier for developers to create targeted applications because they can use FHIR to select only those data fields the individual user needs. It creates a nimble way to exchange specific or supplemental (“side car”) data among users. Examples include patient demographics or specific disease states. This approach also spares users from having to plow through many pages to hone in on the specific information they require.

In addition, many — including the Office of the National Coordinator for Health Information Technology (ONC) — view FHIR as a way to create application program interfaces (APIs) to help unrelated software programs “talk” to each other. Unrelated clinical and administrative systems, including EHRs, can now exchange data, allowing consumers and

providers to get useful health information when and where they need it most. FHIR-based APIs also will enable payers and providers to incorporate this information directly into physicians’ work flow, improving their quality and ease of patient care.

Moreover, FHIR lowers the barrier to entry. One-off customization isn’t needed.

Because of its flexibility, FHIR applications are gaining traction between business partners, even though it is still in a draft standard state. Using FHIR, specific data can easily be imported into customized dashboards or alerts that are tailored to the needs of providers and payers. This provides a solution to exchange the data needed, for example, on patients in risk panels for discrete, value-based care contracts. Big insurers, EHR vendors and provider organizations are actively standing up FHIR-based servers.

While specific use cases are emerging, payers and developers see opportunities for FHIR-enabled systems and APIs for population health management, patient engagement and precision medicine. They also see use cases for FHIR-enabled interoperable health records, as well as mobile health and wearables.

Want to join the conversation? Meet Point-of-Care Partners in Chicago on April 11 and 12 at a newly added HL7 **value-based care Connectathon**. There will be activities for those who want to learn more about FHIR and teams that are ready to roll up their sleeves and try it out.

To be clear, despite the usefulness of emerging FHIR-based applications, partners will still need to grapple with foundational level issues related to security and patient matching. In the meantime, FHIR provides a modern standard to enable the exchange of critical information to all aspects in the care life cycle. ●

3 Part 3: Stakeholder Impacts of the AMA's Prior Authorization Reform Proposal

By **Tony Schueth**, Chief Executive Officer



Prior authorization (PA) for medications and therapies is viewed as a valuable utilization management tool by payers but a long-standing pain point for providers and pharmacists and a barrier to access for pharmaceutical manufacturers. Led by the American Medical Association (AMA), a 17-member coalition — including the American Hospital Association and groups representing providers and pharmacists — recently drafted a framework for PA reform based on *21 Principles*.

Over time, we believe the *21 Principles* have a good chance of being implemented. The timing is right, coinciding with

advances in the health information technology (health IT) marketplace. An example is the adoption of the new electronic prior authorization (ePA) standard from the National Council on Prescription Drug Programs (NCPDP). Moreover, the AMA-led coalition includes many powerful members whose influence carries a lot of weight in Washington and the industry. Many (or all) of the *21 Principles* could end up being carried out via government regulation — unless, of course, the industry adopts them first.

Here is a quick overview of the *21 Principles* and how they impact vendors, payers and pharmaceutical companies.

What the Principles Require. Most of the *21 Principles* seem aimed at payers, addressing specific coverage and process issues. Reducing burden as well as improving accuracy and transparency are themes that run throughout. However, several *principles* have direct implications for health IT:

- **Principle #9** proposes that utilization review (UR) entities provide and vendors display accurate, patient-specific and up-to-date formularies that include PA and step therapy requirements in electronic health record (EHR) systems for purposes that include electronic prescribing (ePrescribing).
- **Principle #12** proposes that a UR entity requiring health care providers to adhere to PA protocols should accept and respond to PA and step therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits.
- **Principle #18** encourages UR entities to standardize criteria across the industry to promote uniformity and reduce administrative burdens.

Impact on stakeholders. Overall, the *21 Principles* have implications for affecting the accuracy and timelines of how medications are prescribed. Their adoption will have a profound and sustained impact on the use of EHRs, utilization management, PA and related provider work flows. It also will improve the accuracy and transparency of formulary and PA decision criteria. Ultimately, implementation of the *21 Principles* will spur use of the NCPDP ePA standard.

There also are impacts on specific stakeholders, as described below.

Vendors. EHR and ePrescribing vendors can use the *21 Principles* as a guide to improve their products. For example, they can:

- Hasten integration of ePA functionality in EHRs and ePrescribing. They have been moving conservatively to embrace ePA because of uncertainty of utilization by providers, despite the fact that there are state mandates requiring ePA. As utilization management entities that support ePA begin to reach critical mass, provider demand will be sufficient so that software vendors

Overall, the *21 Principles* have implications for affecting the accuracy and timelines of how medications are prescribed.

feel confident in building ePA functionality into their products.

- Keep an eye on pilots, which are providing patient-specific, real-time formulary and benefit information at the point of care ([see more information here](#)). As utilization management entities elect to leverage this emerging technology, EHRs should actively consider incorporating it into their solutions.
- Take advantage of standardized criteria. Having better, standardized and more specific requests for information means they can be built into the ePA process, with answers that could be extracted automatically from the EHR.
- Should ensure that payers include complete coverage restriction data in the formulary files they provide. Although EHRs have been programmed and certified to show proper formulary data, many payers are not providing robust information. Of course, this only works on pharmacy benefit medications because medical benefit medications are left out of the ePA process.

- Should develop their products to accurately display coverage restrictions, which many today feel are missing or inaccurate.

Impact on payers. There are several steps health plans and pharmacy benefit managers (PBMs) can take to address adoption of the *21 Principles*. For example, they can:

- Continue critical upgrades to their health IT systems to automate PA. This will ensure their systems accept transactions using the NCPDP ePA standard. The industry has made significant progress and investment over the past several years to implement the first generation of ePA processing. Continued adoption of ePA-based transactions on the provider side will drive more payers and PBMs to make richer returns on these investments.
- Address the accuracy and completeness of formulary data head on. Payers and supporting vendors must make it a priority to ensure that complete coverage of restriction data are included in formulary files provided to EHR vendors.
- Consider making sure that their coverage restrictions and supporting documentation requirements are both transparent and consistent. They can work with EHR vendors to ensure that coverage restrictions are displayed – and displayed accurately —and documentation requirements are clearly stated in EHR offerings. Updates also should be made available to vendors and incorporated on a timely basis in EHRs.
- Support the migration of specialty work flows for prescribing and dispensing to NCPDP standards. Specialty medications generally are expensive and almost always require PA. Yet, specialty pharmacies are still mired in the antiquated paper-phone-fax processes for PA. Known limitations to work flows required for the ASC X12 278 are holding automation work back for all but drugs covered under the pharmacy benefit.

Impact on pharmaceutical companies. While the *21 Principles* themselves do not directly affect pharmaceutical companies, their adoption ultimately will reduce barriers for selecting medications with PA for appropriate patients.

For example:

- Standardized PA questions would lower provider barriers in addressing PA requirements while increasing the precision of responses pulled directly from medical records.
- Making the criteria and supporting documentation used by payers more publicly visible could create new pressure from medical societies and patients for timely updates as new criteria arrive. Such transparency might also create a better understanding by providers of the criteria underlying a payer's decisions to use a medication, appeal it or deny its use.
- Adoption of the *21 Principles* will affect payer portals. Today, most PA is done via payer portals, which provide an electronic door to paper-based processes. In addition to the hassles and inefficiencies of paper, finding and accessing portals for various payers are not integrated into the EHR work flow. Adoption of the *21 Principles* will move everyone toward established transactions in the NCPDP Script standard for pharmacy benefit products and ASC X12 278 for medical benefit products and away from independent portals, either payer specific or multipayer. For the pharmaceutical industry, automation of the provider work flow facilitates use of drugs with PA requirements. Portals, as seen with reimbursement hubs, create barriers to high use because they are outside providers' work flow.

Going forward. Point-of-Care Partners (POCP) applauds the work of the AMA and coalition for restarting the conversation on ways to balance patients' need for quick access to appropriate therapies and the needs of payers and PBMs to control costs and utilization. We also acknowledge the work and foresight of the NCPDP and others supporting the infrastructure needed to make PA a totally electronic process.

POCP also understands the work flows and pain points involved in switching to ePA — both as national experts on the issue as well as conveners of the NCPDP task group on ePA. Let us know how we can put our expertise to work for you. ●