

HIT Policy Committee

Information Exchange Workgroup

January 25, 2010

9:00 a.m. – 1:00 p.m. (Eastern)

HHS Humphrey Building, Room 505A

200 Independence Ave, SW

Washington, DC 20201

Written Comments:

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I want to thank the HIT Policy Committee- Information Exchange Workgroup for the opportunity to comment on e-prescribing. I have three perspectives. First as a practicing medical home physician focused on leveraging the medical home movement as a point of not only care coordination but patient-centered quality management. Second, as a point of defining e-RX as a component of a general telemedicine problem that needs addressing in clinical practice. Third, in the context of the role of a Regional Extension Center as a component of the overall effort in Texas to assist patients and practitioners to join the information age.

I would like to open my comments with an overview of what I believe are fundamental issues.

1. First I think we need to define a framework for achieving meaningful care through meaningful communication with technology that can enable that work. As a practicing physician who leads a rapid implementation of a medical home model (meet NCQA Level 1 in a day with a one hour training program for Physicians and staff), I believe e-RX has a role but it must be viewed in the context of the overall need for communication across all silos of care for a patient's "network of networks" with the competing demands for all components of information management by the staff and practitioners both in an office and for highly mobile populations. Many practitioners choose to not use an e-Prescribing tool in practice for many of the reasons cited in the literature and policy and trade reports. These include principally cost, workflow impact, usability, and lack of meeting all needs for order entry / patient management. There are several issues that I feel are essential in order to help medical home practitioners to use an eRX system. First, as with my other prescribing colleagues, I don't want to be a data entry clerk. I want to dictate / delegate order entry, verify, and

manage via preferably verbal orders only. I am willing to do data entry if it takes less time than what I currently do for RX/documentation etc. Second, even though some tools allow review of data from other providers that are prescribed, it does not do enough for full care plan reconciliation and not just medication reconciliation, manage the cross call situation optimally for small practices or the “courtesy prescriptions” common in practice. Third, there needs to be a full teleaccess approach to communication among the e-RX group (doctor, pharmacist in particular). Fourth, there needs to be a surveillance approach of DEA prescriptions to get us over the hump of prescribing controlled substances. Separate processes are difficult to do and a major barrier. If these could be accomplished, it would be very significant for moving eRX forward either for stand alone or those integrated into EMRs (but with increased hurdles). Fifth, correcting errors in existing systems can be a challenge not only for pharmacists but for practices in general.

In Houston, we are in the midst of an NIH funded field trial to test a new method for doing care reconciliation with the medical home as not only a point of care collaboration but a point for outcomes collection and feedback to practitioners for ambulatory quality and as a point of quality management across the spectrum of care. We are including eRX with final selection to be announced after the in lab testing is complete in February. We want to integrate e-RX solutions as a component but it must decrease overall time of the physician and staff, cost little to use if it is a standalone product is used, and allow most rapid care reconciliation across all practitioners in a patient’s care system for their entire distributed care plan to assure that they and their personal delivery network are “on the same page”, and embed a pharmacist for “curbside consultation” on questions / suggestions and secure messaging.

2. As a faculty of a School of Health Information Sciences which is leading one of four proposed Regional Extension Center for the Texas Regional Extension Consortium, we are establishing a consolidated RFP proposal process that will include eRX / other order entry / HIE interoperability standards as part of the RFP process for EMR and other tools that help the practitioner to use automation to provide meaningful care. The School has leading experts on usability that are driving the heuristic evaluation as part of that RFP process. We welcome specific input from this hearing on how to best position the eRX component in that process. It is not a check box certification, it is a process that establishes a heuristic evaluation from everything from initiation, training, workflow and change management, technical support, user group management. We believe this will serve our REC participants (priority primary care providers) well in not only the eRX area but in the EMR arena as well and more importantly the quality outcome movement.

Now to specific areas requested of the committee.

General Themes

How would you describe the current state of electronic prescribing?

Low adoption. See Surescripts Tx2008 and TMA Survey for more detail.

What are the technological challenges surrounding electronic prescribing?

- Non-standard software. Some software has a notes field allowing a physician to send notes or comments about the patient or the prescription to the pharmacist. Some pharmacy does not have the notes field, so it is dropped and pharmacist never sees physician instructions; physician has no idea instructions are not conveyed.
- Internet connectivity particularly for rural areas
- Full adoption by community pharmacies though improved remains problematic.
- For users insistent on handheld devices, screen size and input method hamper effectiveness.

What are the business case impediments to electronic prescribing?

The greatest beneficiaries of eRX are health plans and employers (and PATIENTS), but payors are generally unwilling to pay for physicians to adopt the technology. The meaningful use incentives could change this.

What are the operational impediments to electronic prescribing?

- 10 % or higher in some practices require DEA substances. Multiple workflows are difficult. Even though DEA controlled substances cannot be e-prescribed, pharmacies will send refill requests for controlled substances electronically. Physician must deny prescription electronically, and turnaround and fax prescription.
- Dispense as written or brand medically necessary. For Medicaid patients, if a physician wants to prescribe a brand name drug, then he/she must follow-up with a hard copy within 30 days with a wet signature. If pharmacy does not receive, refill will default to generic.

What are the regulatory impediments to electronic prescribing?

DEA and state variation in practice which is particularly difficult if have patients that travel a lot.

What's a priority to facilitate easier/broader adoption and use of electronic prescribing systems even if not immediately actionable?

ePrescribing of controlled drugs
Medicaid and VA-military formulary/benefits/medication history availability
Payor incentives (not just CMS or state Medicaid), need broad adoption.

What best practices would you recommend in this area?

Please see Surescripts Best Practices for Implementing ePrescribing for standalone systems. Issues of systems inside EHRs is a different story.

Specific Themes:

Where can e-prescribing help with medication reconciliation and adverse drug interaction detection? What works today, and how can this be improved going forward?

As stated above, I think care plan reconciliation broadly is a key element with the medical home model and eRX is a component.

Where are the main barriers to greater adoption likely to be found?

See opening comments.

With the workflow and ePrescribing software applications that physicians use? Workflow flexibility is difficult.

In the network connecting physicians to pharmacies? No interactive communications. We are currently testing a model for this in a pilot.

In the workflow and pharmacy software applications that pharmacists use? No interactive communication.

Is affordability of an electronic prescribing system a barrier to adoption?

Probably not stand alone but full EMRs absolutely. I think the DEA and other issues described above are bigger for stand alone.

How can a Drug Enforcement Administration (DEA) proposed rule on electronic prescribing of controlled substances help in the widespread adoption and use of e-prescribing? Another way to phrase might be: in What actions should DEA take to promote the electronic prescribing of controlled substances while also meeting their law enforcement needs?

There will always be potential for abuses. I think if there was a good surveillance program, it would answer many of the DEA concerns.

What are the biggest successes and challenges in the implementation and use of e-prescribing systems?

Described earlier in opening comments.

Please describe your (or your organization's) experience adopting and using e-prescribing systems. Was the adoption experience user friendly? How could it have been made better?

We are focusing on a care reconciliation plan and then add e-RX as a component.

Please describe your experience with the following eRX transactions

- Prescribing: Large variability in products.
- Retrieving and using formulary information User interface issues and the opportunity for using data to define such things as Medication Possession Ratio as a model for patient compliance.
- c-d. Retrieving and using medication history from claims
- Patients who have more than one doctor using systems if have different patient interactions, e.g. one has them call pharmacist, one their office staff can be confusing.

How does electronic prescribing help fill status notification?

Defer to others.

How can electronic prescribing help with prior authorizations?

Payers need to agree.

What are your views surrounding stand alone vs. integrated EHR solutions?

The current emphasis on EHR could make eRX worse as it provides too many changes in a physicians workflow.

What are your views surrounding the creation, adoption, and widespread use of a standard interface for drug formulation?

All for standardization as it decreases barriers not only for eRX but for HIE.

How do you see the future of e-prescribing and enhanced or secondary uses of prescription data?

I think we are at an early point in adoption. I remain very optimistic that there is a great deal of inertia that is being generated and that data that is currently in electronic format should be rapidly deployed in ways that are meaningful to prescribers to help them. Doing this could enhance adoption.

Thank you for the opportunity to contribute to this important national priority. On behalf of the School of Health Information Sciences at the University of Texas Health Science Center we look forward to establishing a rigorous research agenda in collaboration with key stakeholders.