

AHRQ National Resource Center for Health Care Information Technology
A National Web Conference on Electronic Prescribing (e-RX) and the Medicare
Modernization Act e-RX Pilot
August 13, 2007

Good afternoon or good morning, depending on where you are. My name is Jon White. I'm the director of Health IT at the Agency for Health Care Research and Quality. Thank you for joining us today for one in a series of teleconferences at the National Resource Center for Health IT held on a regular basis for the education and advancement of Health IT to improve the quality of health care in the country.

Today we are going to be starting a series of four conferences on electronic prescribing. The initiative of the agency is to improve quality of health care throughout the country, and in particular, our part of the agency focuses on using Health IT to do that. What we're kind of prescribing is what we use to advance quality through various improvements to make a difference in the delivery of health care. Although we have many activities around electronic prescribing at the agency, it has been our pleasure to be involved for the past two years with our partners at CMS and the Medicare Modernization Act -prescribing pilots.

These are projects that were authorized by the Medicare Modernization Act of 2003, and we're going to talk to you about those today and some of the standards that go along with them. Presenting to you today is a stellar group, my colleague Tony Trenkle, who is from the office of e-Health Standards and Services at CMS; Chelle Woolley from Woolley and Associates; Kevin Johnson from Vanderbilt University Medical Center, and each of them will introduce themselves.

I'd like to mention to everyone that in addition to the chat pools that are available to you through the WebEx, we will also have a question and answer session at the end of the teleconference. I'd also like to mention to everybody that the slides and a recording of this teleconference will be made available after the teleconference. All attendees will receive an e-mail to that effect that will notify you when those slides and recordings are available. So with that, I will turn the floor over to Tony Trenkle.

Thank you very much, Jon, and welcome to everyone. I'd like to spend a couple minutes this afternoon to give an overview of e-Prescribing and Part D: you know the drug plan that was mandated by the Medicare Modernization Act of 2003. As Jon said, my name is Tony Trenkle, and I'm the director of e-Health Standards and Services at CMS, and basically my office is responsible for the e-Prescribing standards and work that goes along with that. As such, we partnered very closely with AHRQ for the past several years on developing and then implementing the e-Prescribing pilots that we'll be discussing in my detail later on.

Let me spend a few moments giving you the background before we get into some further discussion. The one thing I do want to point out is that CMS and the Department of Health and Human Services are very much in support of e-Prescribing. We feel that it offers a lot of benefits from patient safety, from a number of aspects, and we're very pleased to be partnering very closely with AHRQ in promoting and moving this forward.

Now we'll turn to the slides, and I'll go through them very quickly to touch on a few highlights, and then we'll get into the other discussion. The Medicare Modernization Act of 2003 created an ambulatory e-Prescribing for Part D plans that creates a mandated e-Prescribing use of standards when e-Prescribing is done. It's voluntary for physicians, providers, and pharmacies; however, it is mandatory for Part D plans that choose to do e-Prescribing.

The standards that we first put into place were implemented on January 1st, 2006. We then pilot tested initial standards during the calendar year of 2006. This resulted in a report that came out to congress last April. We are also required by the MMA to promulgate final standards by April of 2008, with these standards to be effective no later than one year after the promulgation of them.

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Therefore, we're now in the process of doing additional rule making based on the report to Congress.

Briefly on the standards, the initial foundation standards were effective January 1st, which is also the implementation date for Part D. There were basically three standards, one for transactions between prescribers and dispensers; and then two, eligibility benefits and inquiry sponsors; one, prescribers and part D sponsors, and the other between dispensers and part D sponsors. So these were just basically very basic foundation standards.

In 2006, we tested a number of different standards, which is on the next slide. Six key standards that we did test on 2006 were the formulating of benefit information, exchange of medication history, fill status notification, structured patient instructions, clinical drug terminology, and prior authorization messaging. In addition, we also tested the foundation standards in this environment.

We had five pilots that we tested these in over the course of 2006, and we tested them in a variety of settings. On the next slide are some of the key participants: RAND Health; SureScripts; Achieve Health, which tested e-Prescribing in a long-term care environment; Brigham and Woman's Hospital in Boston; and the University Hospital Health System with the Ohio KePRO. Ohio KePRO is one of the quality improvement organizations that CMS contracts to promote quality improvements with the provider community.

The results of the pilots were based on a series of core evaluation questions, and you can see them in the next slide. I'm not going to go through all of these, but basically it looked at the six standards, as well as the foundation standards, in different environments and looked at the type of data being sent, usability and accuracy, what was the workflow; how could the standards be improved to address various workarounds, how long does it take to conduct these transactions and all the appropriate jobs and other therapies ordered via electronic prescribing. We tested these over a period of about six months last year. We didn't start them exactly on January 1st. We had an evaluation done after that, in which there will be more information given.

As a result, we issued a report to Congress in April of 2007, which is available both on our website and AHRQs. But just briefly, we found that of the six proposed standards, formulary, benefits and medication history were ready for Part D use and field status notification was ready from a technical standpoint, but from a marketplace standpoint there was not a pressing demand. Finally RxNorm, prior authorization, and Codified SIG still need work, probably additional pilot work before we can move forward with standards regulations tied to that.

In addition, long-term care has a lot of potential for e-Prescribing. However, we found that it still needs some additional workarounds and that it is not quite ready to list the current exemption that we have with Part D in long-term care and e-Prescribing.

Currently, we are in the process of rule making in order to reach the mandated dates that were set by Congress, on April 1st of 2008, which will be for the final rule, and a year later for the final standards to become effective.

We will continue to work with AHRQ and others on the standards that will not be part of the initial or final rule to continue to move forward in this process. At this point, I have finished my formal presentation, and I'll turn it back to Jon and whoever is next.

Thank you, Tony. I appreciate that. I think Chelle Woolley is up next.

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Good afternoon, everyone. I'm Chelle Woolley. I'm with Woolley and Associates and Independent Consulting. I have over 20 years experience working in the health-care arena, as well as information technology and was one of the evaluators of the five e-Prescribing pilots.

What I want to do today is talk about the basics, why is there a need for electronic prescribing? I'm going to start with what is a prescription? I'm going to define e-Prescribing and talk about what the problem is, who the players are, who are the stakeholders, who can solve this problem, and why do we need to be concerned about this today.

There are really four steps in creating a prescription, and the first starts with interaction between the physician and the patient. When a patient comes to visit a physician he/she talks about their symptoms and the purpose for the visit in addition to some medical history. Based on that information, the physician will write a prescription if it is required. The third step is the delivery of that prescription, which is typically a paper-based prescription to the patient's pharmacy of choice, and the fourth step is that the pharmacy will take that prescription and fill that prescription and produce the information that's needed for that patient to take that medication appropriately.

In today's prescribing process, as a predominantly paper-based process, what happens is that physicians will write close to four-billion prescriptions a year. Again, it starts with a patient visit to a physician talking about what the symptomology is. Based on the interaction with that patient, the physician will write a prescription that is typically from their top-of-mind drug list. These are the medications that physicians are most familiar with.

They have their favorites, and based on the symptoms and the patient's history, they will prescribe the medication that they're familiar with based on experience. That prescription is then handed to the patient. The patient will take that prescription to the pharmacy. The pharmacy will then look at that prescription and will have to determine whether that patient is eligible for their drug benefits. Typically that requires a call to the PBM, pharmacy benefit managers, or the payer organization to check eligibility, and to determine what benefit that patient has in terms of what drugs they are able to receive under their drug benefit.

If the physician has prescribed the appropriate drugs under the drug benefit, then the pharmacy typically checks for drug interactions, dosage, information, et cetera. If there's any need for clarification of this information, then the pharmacy is going to have to call the physician's office. Typically there are over 150-million calls every year to clarify a prescription, either based on its dosage, the correct drug, or administrative issues such as drug ineligibility, or drug formulary which was not followed accurately or it required step therapy or prior authorization. In the meantime, the patient is waiting at the pharmacy for their medication.

Just to automate parts of the prescribing process is not adequate. Therefore, if you just automated the transmission of the prescription from the physician's office to the pharmacy, you solve some of the problems. You may solve hand-writing issues, because typically a generated prescription will go via fax. It's typically generated off of a computer system and sent in a legible format. However, that prescription still has to be re-entered into the pharmacy's system, which introduces potential error points in transcription.

We still have problems with not being able to determine drug eligibility and drug coverage information, potential contraindications with other medications that that patient may be taking. Therefore if you just automated the connection between physicians and the pharmacy, you still have many of the problems left to solve.

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By just solving the problem from connectivity to physician to the payer site, you do resolve some of those issues in the terms of drug benefit coverage. You're able to see formulary-required medications. You also have the ability to look at the co-pay information and the medication history. However, the patient still has to deliver that prescription to the pharmacy.

What is really needed is a real time end-to-end solution, which starts with the patient visiting a physician and everything occurring from that point on being done electronically.

This is what e-Prescribing is. When we talk about e-Prescribing, we're talking about a process that goes beyond today's current writing of a prescription. We're talking about something that's more than just automating the prescription from the physician's office to the pharmacy. We're really talking about a physician being able to access real-time critical patient specific-information at the point of care, which means accessing information as to eligibility, formulary information, medication history, co-pay information, information regarding prior authorization, or step therapy, and taking that information into account in their decision making as to what is the most clinically and cost-effective medication for that patient, and then directly transmitting that prescription electronically to the pharmacy where the physician is basically writing an informed prescription, the pharmacy is receiving that informed prescription and providing the most efficient way for a prescription to be processed and fulfilled by the pharmacy.

Who are the stakeholders in the prescribing process today? They're the physicians who have the ability to prescribe medications; they're the pharmacies; the patients; the consumers; payers, pharmacy benefit managers, transaction networks such as our RxHub and SureScripts, technology vendors that develop applications for electronic prescribing, and the public policy and governments.

What is the value and benefit to each of these stakeholders in moving away from a current paper-based prescribing process and into an electronic prescribing format? For the physicians, it is access to the patient's medication history at the point of decision making. And when we talk about being able to access medication history, what we're saying here is that not only will the physician have the ability to look at medications that he or she has prescribed but now we'll be able to identify and look at medications that other providers who have seen that patient have prescribed. There is a whole view of the spectrum of medications that the patient has been taking that has been filled through their drug benefit. It's also the single act through the formulary information at the point of prescribing.

Physicians today are inundated with a number of different formularies, hundreds of formularies for all the patients that they see. For them to keep track of each patient's specific formulary requirement it's an untenable task, and having that information at the point of prescribing and not having to be bothered with rewriting the prescription because it didn't meet the formulary requirements after the patient has left their office, it's a huge time-saving and cost-saving investment for the physician.

A single access to eligibility in the pharmacy and benefit coverage at the point of prescribing, the ability to see co-pay information, can help in a dialogue between the patient and physician in making sure that the patient can afford that medication and will then pick up that medication from the pharmacy and be compliant with their drug regimen. With the ability to track compliance across with access to medication history, physicians would be able to look and see that the patients have actually picked up their prescriptions at the appropriate time; in addition to being

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able to identify potential abuse of doctor shopping, resulting in fewer call backs and administrative overhead for the office.

Of 150 million phone calls from the pharmacy back to the physician's office, typically each one of those calls requires a chart pull for the physician to be able to see what it was that they prescribed, what was the medication history, or medical history of that patient and being able to re-prescribe the appropriate medication.

There is a huge value and benefit for the pharmacies in e-Prescribing as well. They get better prescription information at the front end that will reduce potential medication errors. Prescriptions are now legible. Prescriptions are pre-checked for drug utilization review and contraindications. This is not going to take away the job that the pharmacy has in doing that, but that first step has been completed.

Prescriptions have been checked for eligibility and drug coverage requirements. We do see a number of phone calls that they have to make back to the payer and the PBM. Pharmacy professionals can now spend more time with customers, ensuring safer outcomes and less time on the administrative issues talking with the patient about the proper way to use the drug, and work environment that promotes employee retention.

The value and benefit for patients is that they feel comfortable in that they have received the safest prescription possible. They pay lower fees out of pocket because the prescription now utilizes their drug benefits, and they have more time to themselves because there are fewer hassles getting a prescription filled at the pharmacy.

The value and benefit for the payers and PBMs, one reason why we have pharmacy benefit managers is that they are really the agents of the insurance company to provide a managed drug benefit, enhancing the patient's safety and reducing its cost related to medication errors. There's a significant adherence from compliance to formulary and there's a measurably reduced plan administration cost.

The current status shouldn't be your status quo. With all these benefits and values to each of the stakeholders in the prescribing process, why is it that only 10 to 15 percent of physicians today are using electronic prescribing? I will say that that number is ramping, but it's ramping very slowly. 45 percent of the physicians who are using e-Prescribing say that it has improved compliance with formularies, 50 percent of the physicians said that e-Prescribing improved efficiency, reduced the number of call backs, clarification, administrative issues, and 33 percent of the physicians said that it had a major impact on the quality of care.

The impact of staying with our status quo and not adapting to an electronic process is that preventable errors in hospitals kill 44,000 to 98,000 people each year. You've seen this report from the Institute of Medicine.

Also the Center for Information Technology and Leadership produced a study that looked at more than 8.8 million of the adverse drug events that occur annually in ambulatory care, which over 3 million are preventable. 57,000 Americans die needlessly each year because they don't receive the appropriate care. 7,000 deaths each year due to the manual process of prescribing errors, and non-compliance with medication regimes causes more than 125,000 deaths annually. These are all problems that can be solved with electronic prescribing.

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What are some of the workflow accelerators? Better management of patients. Physicians say that the ability to have information at the point of care is an immediate value-add in driving efficiency, as well as reducing potential errors. There needs to be a leadership commitment, a physician champion who will help raise the awareness and drive adoption within a physician's practice or specialty environment. New technology is being developed that's more conducive to physicians' practice. We're seeing that the applications are now much more user friendly. They follow physicians' workflow. They enhance the patients' interaction. By having information at the point of care that the physician is able to share with the patient, this opens us up a new avenue for dialogue, saves time on the patient encounters, improves patient outcomes, and reduces, again, the administrative re-work.

So what are some of the potential drivers to adoption? The biggest issue is alignment of incentives. There also needs to be a sustainable business case and return on investment. Initially physicians don't see what that return on investment is. They figure it takes longer to write a prescription initially, but what it does do is reduces the number of administrative issues on the back-end of the prescribing process.

One huge potential driver to adoption is the MMA, the Medicare Prescription Drug and Improvement and Modernization Act in its defining of what an e-Prescribing program is and how it should be entered into. Public sector grants, federal legislation, Health IT and patient safety. Some of the pay for performance programs are helping to accelerate adoption, and some of these regional and statewide health information organizations and the health information exchanges are helping to promote and drive electronic health information exchange and adoption, including e-Prescribing.

Let's talk a little bit about the Modernization Act. Basically what that bill did was define an e-Prescribing program. It stipulated that there must be uniform standards that must be adhered to. It provided safe harbor, grants, and preemption. And these are all areas that we will talk about further in the next series.

The MMA required that all health plans and pharmacies that were participating in the new Medicare prescription drug benefit for Part D would support an e-Prescribing program; that the secretary of health and human services would establish federal standards; and that all e-Prescribers that were Part D eligible; that the standards would be published specifications that establish a common language, contain technical specifications, and provide other specific criteria that would be designed to be used consistently as rules or definitions.

As Tony mentioned and described, six initial standards were to be pilot tested and to investigate their interoperability with foundation standards, as well as the clinical and economic outcomes associated with e-Prescribing.

In summary, the e-Prescribing markets, the infrastructure is in place. The Medicare Modernization Act is promoting e-Prescribing. The states are removing roadblocks to e-Prescribing. Over 48 states are good to go for true electronic prescribing. The pharmacies are ready. Over 85, probably closer to 90 of the nation's pharmacies are certified to connect to pharmacy networks through SureScripts. PBMs and payers are ready. The PBM and payer representing over 165 million lives are able to share plan information and medication history, eligibility checks to RX Hub's National Patient Health Information Network. The incentives we've seen are helping to drive adoption. Software, hardware, education, training, paper performance models are evolving, and some are showing early successes in physician adoption. The technology vendors are responding to industry demands. Thousands of physicians today are

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connected, and vendors representing tens of thousands of physicians are establishing connectivity.

The future impact will be that the patient's safety, saving lives, affordable health care, saving costs, and the convenience and effectiveness of e-Prescribing and health information exchange will save time.

This is Brian at the AHRQ National Resource Center. We're going to pause in two places today for questions. We will have a second Q and A period at the end of our session today and can share specific questions about Kevin's presentation, which is coming next, or any of the other presenters in more of a generic Q and A.

If you have specific questions now, you can type them into the chat feature and just make sure the drop-down box says all panelists. You can also raise your hand, whether it's an icon that looks like a hand on the right-hand side. It should be underneath where your name is displayed, so either of those methods will allow you to ask a question. And we'll pause here if there are questions, otherwise we'll continue.

Let's start with, where will prescription monitoring programs fit into this scheme? How will the risk of duplicate system functionality of pharmacies be mitigated?

I'm not sure where the state prescription monitoring programs will fit in. In terms of the risk of duplicate system functionality of the pharmacies, I think that one of the roles of SureScripts is to be able to connect to the retail pharmacies and that we move from a system where today the majority of the prescriptions are sent electronically via fax, which actually results in an additional workflow in that somebody has to take that fax and reenter that information into the pharmacy system. Through total electronic prescribing that information will automatically feed into your pharmacy's computer system, and they populate the screen that allows the pharmacy to fill the prescription as well as to accept that information for adjudication purposes. Therefore there should be no duplication of pharmacy systems.

What is the expected rate of growth of scripts from the current base of four billion scripts per year? And what information is that based on?

That's information that was received through the NACDS which annually conducts research on the number of prescriptions and that number is projected to rise to five billion by 2008. So that number is increasing exponentially.

There's a question that I'm going to save for the end, which is, please address the issue of the inability to send controlled substance medications, which is a great question. But I think I'd rather save that for after Kevin's presentation. So next we'll go to the question that says from whom is the marketplace demand for fill status notification to be expected? And I guess either Tony or Chelle can address that. So who's going to be asking for fill status?

Can you repeat the question again, Jon?

Yeah. The way it's reverting that, as Mr. Trenkle said there is no marketplace demand for fill status notification. From whom is this demand expected? So I think the question is who in the marketplace is going to be demanding fill status?

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This is Drew Morgan out of Private Pilot. What we found with the fill status was that the pharmacies weren't really using it and that also the doctors didn't really perceive it as a value to them. They just didn't want to be inundated with all those messages coming back and forth. So at this time we felt since it wasn't being widely used in the marketplace, that we would hold off on it to see if there there's a demand for it.

The next question says, Tony alluded to limitations of RxNorm and will there be additional specifics regarding these limitations during this session? And I think the answer to that is not during this session but in some of our future e-Prescribing teleconferences, we're going to take a look in detail at what the standards that were addressed and what the positives were as well as some of the issues that were raised.

Are additional long-term care pilots planned, or is it just to acknowledge that more study is needed? Is there a plan currently?

This is Denise Benning at OESS. We did do the one pilot based on industry input that asked us to test the standards in a long-term care setting because of the unique workflow situation. At this point in time, we would certainly like to see more long-term care pilots of e-Prescribing, but nothing is in the works at this point.

What issues kept most physicians from reaping the benefits of e-Prescribing as a positive?

Well, I think Kevin's going to address those barriers in the next 15 minutes or so.

What are the five states that are not set up for e-Prescribing, and actually I think, Chelle, said 48 states, is that correct Chelle?

Yes. It is a moving target, and I believe that a lot of work with each of the states has been done and has access to that information on the website. You can look to see what the status is of each of the states.

Could you give details about the politics of RxNorm, and I think that was addressed previously.

The next question is when does the Medicare Modernization Act go into effect? I may turn that to my friends over at CMS.

I'm not sure exactly what that question is alluding to. That already went into effect January 1st.

Maybe we should address the sections relating to e-Prescribing along with some of the other major components of the MMA.

Well, in terms of the prescription drug program, obviously that went into effect in the beginning of 2006; e-Prescribing we prior tested 2006. The report to congress came out in April of 2007. Then we had to issue an NPRM and a final rule by April of 2008. And I believe it will be one year after the issuance of that final rule that the e-Prescribing standards will take effect.

Here's a question I think I can answer for you all. Can you speak to final CMS rules on fax script so all pharmacies are connected? And the answer is, no, you can't speak to that. Would that be correct?

Yes, that is correct.

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What are your thoughts on external drug databases in relation to e-Prescribing, how they can help and what are the benefits associated with them?

I assume that means things like First Databank or Multem.

Those are actually very usable in terms of providing information on decision support. Again, the best drug database that can be received for an individual patient is obviously the drug database that that particular patient has. So being able to access medication history based on that individual physician and all physicians who treat a patient is probably the most accurate complete drug database you would want and to be able to use that specific information against queries for drug contraindications for drug interactions is the truest database.

This is Kevin. The answer is that most of the e-Prescribing tools available nationally do rely on some external database. I think all of the outcome studies that we'll describe in the later call to some of the strengths from the standpoint of integration within the workflow of those databases; decision support is one of them. Simple things like drug monographs and other components of drug databases are also really important in helping with adoption and helping people to feel that they're prescribing the right medication. I think some of the studies looking at Hippocrates point to how important that kind of knowledge is in helping prescribers at the point of decision making.

The Santa Barbara Project told us that unless the technology solution increases revenue for providers, the technology solution would not be successful. None of the benefits listed touched on increasing provider revenue. Given this lesson learned, why should e-Prescribing be successful? And a related question is "Is the constructive nature of e-Prescribing for MDs offset by the time savings seen after long-term use?"

I think that in most physicians' experiences moving from a paper-based system, which they've been using for centuries, to an electronic version, there is an initial time element to be comfortable with the application, and there's a learning curve. I will tell you that in my experience in talking with physicians who have successfully adopted electronic health information technologies within their practice didn't go back to the paper base. Once that learning curve has been overcome, they do find that it is much faster, more efficient, and more accurate to use electronic tools. There's a clean documentation and auto trail of every transaction and there is an increase in quality of care in patient safety issues.

This is Kevin again. I think it's an interesting question. I think it's an issue whether what we learn from the Santa Barbara Project and some other projects really translates into sort of predicting the success or failure of e-Prescribing, because they have fundamentally different purposes. I would say that most outpatient primary care providers identify saving patient lives, saving practices money, and improving their overall practice satisfaction as the key drivers to adoption. And typically they say if you can get me at least one of those three, I'll move forward. And so it's a question of whether what we're doing, is stuff that people perceive in any of those lights.

We also do have a verbal question to be asked. We had two hands raised. One is up right now.

PM: I was actually just typing my question in right now. Thanks for letting me asking it orally. Do you have information or guidance for state and medical licensure boards and pharmacy boards that have a duty to regulate e-Prescribing? In other words, do you have any resources or information available that would guide a state medical licensure board or pharmacy board in adopting regulations to regulate e-Prescribing in their state?

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We believe that the National Association of States Boards of Pharmacy might be of assistance to you.

And as far as state and medical licensure boards, do you have any other resources other than the federation of state and medical licensure boards?

Nothing's coming to mind right now, but we can do some more research, and if we come up with something, we can get back to you.

Could you please provide the source for the statistic, over 7,000 deaths occur each year due to manually processed prescribing errors?

Yes. If I can get the name of the person who asked that, I'll get back to them.

Follow-up question on federal requirements: CMS seems to require simple compliance with standards by a payers plans, PBMs do not seem to do anything to accelerate physician adoption. Is this true? If so, do you see anything stronger coming from the Federal Government to push or require physician adoption?

We only have authority over Part D plans. We don't have any authority over providers or pharmacies or anything else. So that's why our mandate is for those plans, where they have to support e-Prescribing in the Part D environment. It's very specific.

The satisfaction of current adopters does not seem to be that high. What is the reason for this? I have some thoughts, but I'll let our panelists comment if they want to, first.

This is Kevin. I'll start. I'd really like to challenge this, only because I don't know that there's great data one way or another about the actual individual providers in an ambulatory environment satisfaction. There are some data that we're going to share from the report, but I think let's just assume that the satisfaction could be higher, and the reasons why it could be higher include aspects of the system's current functionality for sure. I think that to a certain extent, as you'll see in one of the slides I'm going to show, it really does relate a little bit to the expectations of the prescriber versus the expectations of the patient and the pharmacist. And I'll save the rest of this for a few more minutes. But I think there are some reasons that might be out there.

Somebody indicated that the IOM report is the source for the 7,000 deaths due to manual prescribing process. We'll see if we can track that down a little bit more carefully. There are many questions that are coming up. But given that its 1:50, I think I might go ahead and have Kevin present, if that's okay, and then try to track back to some of these questions. And again, a lot of these things are coming up may be addressed by Kevin's presentation.

What I really wanted to do was to make sure that the sort of framework for barriers was put out on the table. As I kind of alluded to, there aren't a lot of data at all for e-Prescribing systems, however, there are some frameworks and there are some things we can learn. I'm kind of the baby of the group, having only been doing this for about 17 years. I have a Masters in Medical informatics from Stanford, and at that point went to Hopkins to practice pediatrics and to work with clinical information systems. I came to Vanderbilt in 2002. I've been the project director here for our e-Prescribing work and have received a few grants from AHRQ to evaluate e-Prescribing functionality.

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Most recently, I have been working with the evaluation team on the CMS pilot, and so I'll talk about this to a certain extent from that perspective. So the barriers to adoption can really be viewed in four categories; situational, which include economic and external factors; cognitive or physical things, which include basically skills and abilities, so you can imagine typing as one of the potential problems one might have with certain types of e-Prescribing tools; legal, which is obviously a big subject of what we've talked about thus far, regulated versus unregulated practices; and then attitudinal, primarily behaviors and opinions which may or may not be correct.

Some of the situational barriers that have been found so far include costs of hardware, software, training, and maintenance, especially in smaller group practices. Most of the data come from CITL's report on ACPOE; disruption or change to the office practice and lost revenue. And as, we were talking earlier about revenue enhancement being one of the adoption incentives and obviously lost revenue, which I think there is only literature to suggest, in the electronic health record world is the reason why people perceive that it may not be good adoption.

I think poorly developed software is certainly an issue. As a pediatrician milligram/kilogram dosing, understanding rounding, many of the compounding rules are not typically integrated, which makes the software very difficult for us to adopt. We'll talk more about this later, but there are similar problems even in some of the pilots with regards to adding new functionality and integrating it into existing e-Prescribing workflow.

Another situational barrier includes the faxing to pharmacies piece. I'm sure our CMS colleagues have a lot to say about this, but at the very least, the pharmacist's workflow has not typically been thought about in the process of e-Prescribing. For example, faxing to pharmacies often occurs on a machine that's in the back room with a potential for paper to run out. There are all sorts of things that make that process unreliable. And of course since faxing is a one direction interface, is it possible to know whether the fax has been received appropriately. That makes a big challenge to some practices that are thinking that they can push a fax button and then stop paying attention.

In terms of cognitive barriers, there are challenges in choosing the best software. We hope that some of the work that's being done by the certification commission will help there. I think that's a big concern, also lack of comfort with the technology. There were a lot of people who had an interest in mobile computing a few years ago. Early studies in that area did not show as much promise as the hype might have made us think it would.

Under legal barriers that include the liability concerns, state and local rules, which have already been touched on by one question, but in particular and something that we face here regarding the nurse's roll in e-Prescribing. The rules that limit e-Prescribing of controlled substances, again brought up by the panelist and the attendees. In terms of attitudinal barriers, we have the fact that many of these are not as supportive of practice workflow as we'd need them to be; that there's clearly apprehension about change, both in terms of what it will mean to the practice, what it will mean to the patients. Not being comfortable with e-Prescribing, interfaces with their ability to fill a prescription; for example, future prescriptions.

And then finally, misinformation about the personal quality of care, the fact that there may be some perceptions about the way in which you view e-Prescribing and electronic health records impacts the physician/patient dialogue. This graphic is from a paper that came out in the "Journal for the American Medical Informatics Association" in 2006. And the good news is this graphic is meant to depict the complexity of the workflow. There are actually specific activity diagrams for the way in which prescription writing occurs in ambulatory practice during a visit versus before or

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after a clinic visit. It says about 70 percent of some prescriptions in some practices occur outside of the clinic visit, refills and renewals. Now obviously that complexity turns out to be an extremely important part of what must be implemented in e-Prescribing tools.

I would also argue that what we learned in the in-patient ordering environment is a barrier. And this gets to another one of the questions and what we call the “tip of the orderable.” It’s very likely that a small practice of a very well-trained nursing staff will simply say, “Call in 40 of Pravachol daily.” And they expect that everything that happens below that is going to happen; however, in a typical e-Prescribing environment, all of these steps are typically added to the work of a person who would have normally said “Call in 40 of Pravachol,” and that ensures that it’s 40 milligrams not grams, making sure that if it’s generic version, Prevastatin, is what they should be selecting; making sure that the sig line itself is appropriate, which may include that dose being before bedtime and sufficient refills covering, that fact that it may need a mail order prescription to allow a year’s supply, and finding out the number or the location of the patient’s favorite pharmacy, so lots and lots of steps.

None of the projects that has looked at CPOE systems, which is a paper that came out in “JAMA” a couple of years ago and got a lot of attention, noted that one of the other major attitudinal barriers is a belief that these pools are, in fact, capable of facilitating, as well as mitigating errors. I won’t go into details here, but it’s important to recognize that that has, in fact, been shown in the literature in a number of settings, primarily in-patient, but it is very clear that these systems do have their own framework for potential errors they can cause. The early studies looking at PDA-based ordering did disclose, for example, that simple medication selection errors may occur because of the distance, the fidelity that was required to accurately select the right medication formulation from a relatively small screen.

And then finally I bring up this slide that looks like at first it may not fit, which is some work that was done by Redelmeier, looking at the cognitive psychology of missed diagnoses. And I would submit that many of the issues that cause very, very good physicians, very, very good clinicians to make inaccurate diagnoses are exactly the same types of cognitive psychology errors or behaviors that can contribute to a lack of acceptance of e-Prescribing. Many physicians feel that they already know the right medication or the right dose. Therefore, they have a context error.

Oftentimes there may be specific dosing regimen, a specific set of indications or other information that they lock into, which is what we often call an “availability error.” Also, premature closure can be a big part of what happens when modifications to the way things are typically done aren’t considered; for example, a patient’s creatinine clearance or other data that might be important, or for example the BRS criteria for geriatric prescribing. And so many of the challenges of people who think about the importance of e-Prescribing and who look at the slides that Chelle so nicely presented, none of the immediate challenges are related to the fact that most of the people who we like to adopt frankly don’t realize that they are as unsafe as they may be.

In addition to having questions on the chat, if folks would like to raise their hand and ask their question verbally, you might be able to express it better than I can. So I’d certainly invite you to raise your hand too, and your line will be unmuted if you want to ask questions directly.

So here’s a good question, which is, at the ground level the difficulties in getting locals and pharmacies to become e-Prescribing is slowing adoption in the community. What resources are available to help providers assist their local pharmacy partners to become functional with e-Prescribing?

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I don't think there is anything from SureScripts on the quality, because I think the answer to this is that there may be some resources available through other groups whose incentives are to help other pharmacies becoming e-Prescribing able. I don't recall that most of the e-Prescribing vendors with whom I've communicated have taken on that challenge.

Kevin, this is Brian. I know that there are a number of folks on the line from those vendors, so maybe one of them could raise their hand or identify themselves. We've got MK with a raised hand. It might be a good time for Mr. K to chime in.

Hi, this is M at RxHub, and that was a great question. And Kevin is right. SureScripts would be the entity that would help those independent pharmacies to connect. The issue isn't, however, the independent pharmacies, it's the technology vendors who support those independent pharmacies and their ability to connect. I should also say that there are other pharmacy networks out there that can help them with e-Prescribing including e-Rx Networks and McKesson. Those are all entities that can help the technology vendors and independent pharmacies get connected to electronic prescribing.

We have one of the e-Prescribing pilots K, if he is unmuted.

I guess I would just follow up on that previous comment from K that, indeed, we do have resources available for independent funding if people are interested in getting involved in electronic prescribing. Most all of the vendors that service that part of the marketplace are now certified on SureScript, so what we find is that an awful lot of the pharmacists just aren't aware that their vendor has been certified. So it's certainly something that if they have a question about, they can call SureScript and we can help them through their issue.

A question that I had saved for right here but has come up a couple times, the issue of prescribing of controlled substances that there's a divergence between the ability to prescribe most things and the ability to prescribe controlled substances. I don't know if my colleagues at CMS want to comment on that. But if they don't, Chelle and Kevin, if you might consider commenting on that as well.

This is CMS. As I think most everybody knows, there was a public forum held in the Washington, D.C. area last July. It was co-sponsored by DEA with assistance from CMS and some other entities that really explored the problems and the issues concerning the e-Prescribing of controlled substances. Of course DEA is coming at us from a fraud and prevention perspective, compared to CMS and some of the more health-care oriented entities that were looking at it from a convenience standpoint and also patient safety. I can tell you that as a result of that July meeting last year, we are continuing dialogue with DEA and continuing to work closely with them to explore their needs, as well as the needs of the health-care community regarding e-Prescribing of controlled substances. And, again, that dialogue is continuing.

A question here from one of the attendees. Is Medicare planning to mandate e-Prescribing by April 2009, based on Chelle's timeline?

Well, I responded to that one, and I said that there is really no mandate in the CMS provision. Basically what it says is that if physicians or prescribers are going to prescribe electronically, then they must adhere to the standards that are promulgated by the MMA. But there is no mandate for physicians to prescribe electronically.

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This is Denise. That is correct, there is no mandate that forces anyone to e-prescribe. The recommendation is that, again, if you're e-Prescribing that you use the standards they have adopted for that particular transaction. The only thing that the MMA really says is that e-Prescribing is voluntary and that if you are Part D plan you must support those standards that's in use for Part D prescribing. But again, no one is forced to e-prescribe.

A question from much earlier is do you see the consolidation for datasets for drugs and sig/direction coming soon? And I don't know if some of the folks at CMS involved in the sig standard may want to comment on that.

This is Drew Morgan. The NCPDP work group worked on the sig standard- we went back to them and showed them the results of the pilot and what the sig standard is. Currently there is a workgroup going on, and they're trying to complete it and make some of the changes, and once that is submitted, it will get voted on by NCPDP. I don't really have a timeframe of when the next round of that is going to happen. But what will happen is if they come out with a new standard, it will be pilot tested.

I just wanted to follow up on Drew's comment. We just wrapped up the NCPDP work groups in San Francisco last Friday, and the sig standard was adopted by the two work groups, so it will now be passed onto the board of directors and start through the balloting process.

Within the four barriers to adoption enumerated by Kevin Johnson, inoperability was not listed. Has the inoperability hurdle been cleared?

First, one of the things we hope to address when we talk about the standards is the extent to which those standards actually help us there. But the answer really kind of begs another question, which is which component is inoperability? If by inoperability we mean defining a particular medication unambiguously across systems, then that gets a little bit to the RxNorm analysis, as well as potentially to the use of external databases and whether there is kind of a market leader. And I don't actually have a good answer for that, except it appears right now that RxNorm would not necessarily be that resource yet. But it's certainly moving quickly, and we'd love to see some more work being done there, and I know about some work that's been going on that looks very promising.

If in the terms of interoperability, we're talking about getting a particular e-Prescribing vendor system to work with other outpatient or inpatient systems, the answer to that is that as of right now that moves along at a relatively slower pace, many of the EHRs that you'd like to have interoperable now have their own e-Prescribing solution. It's not a terribly complicated interface set until you start getting at what is called by e-fives, sort of the level five e-Prescribing tools, where there's very sophisticated interoperability needed under things like lab data, patients gender, things that you use to actually make decision support really work well. So I'm not exactly sure which level of interoperability this question is referring to. Now perhaps that person will repost more specific information so we can answer it.

Please expand on the role of nurses as delegated prescribers in the prescribing process? How is this a barrier to adoption of e-Prescribing?

It has been the single largest barrier that I have had here at Vanderbilt, and it absolutely came out in all of the e-Prescribing pilots that were in outpatient settings. So much so that some of the pilots that had built tools to assess outcomes and were specifically working with physicians found that the physicians weren't the ones doing a lot of prescribing in those practices.

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Here we are struggling to understand how our state regulations will allow nurses to do the things that we listed in the workflow documents that we have described above or in my slides. So it is a big challenge and it is something that we're going to address at a national level, because it's very clear that within the scope of practice of many outpatient nurses, at least the renewal process is included. Sometimes other processes have been the same scope of the practice like managing Coumadin or other things. I'd love to hear from anybody else who has a comment about that actually.

Assuming there is e-Rx adoption generally, is there a critical mass of participants needed for a national system to be self-sustaining? So I guess the question is to the extent that most that are currently e-Prescribing are self-sustaining, there are some that go backwards but there are a lot that continue to do it. Do you feel like there's some sort of critical mass of prescribers that need to adopt in order to really push us as a health-care system over to electronic prescribing?

Jon, let me just tell you that one of the things that's difficult to measure is the number, when you talk about what the critical mass in terms of absolute numbers. We're looking for the top prescribers when we're talking about e-Prescribing. So for those, what's the percentage of physicians that prescribe 80 percent of the medications today; that would be the critical mass that we're looking for. Following the 80/20 rule.

There are a couple more chat questions, but let me jump to TD, who has his hand raised.

I just had a question as far as the adoption piece, to me, one of the big adoption things is the fact that a lot of the benefits that physicians get from e-Prescribing are related to better formulary use and increased use of generics, and that a lot of those benefits are described to the insurers and not to the physicians. So is there any discussion on ways to help funnel some of those savings to support the costs of equipment, software, and etc.?

This is Kevin. I would love to share more from CMS about pay for performance and ways that we might be able to incentivize adoption using that mechanism. I have not heard any other discussion. Larger institutions, for example Blue Cross, have worked with specific academics or other organizations to engage in sort of challenges to improve generic prescribing. But again, getting the incentive all the way down to the prescriber is clearly a challenge. That gets to the revenue question; if you know that generic prescribing increases your bottom line, then you have an incentive that we don't otherwise have.

Here in Michigan, Blue Cross has worked with some of the big auto companies and others to help incentivize the physicians for adopting e-Prescribing with some monetary incentives. But they've been limited one year or shorter timeframe, not an ongoing support.

That's correct. I guess they're hoping that once the nursing staff gets turned on to it, that it will be self-sustaining. But I don't know.

So let me go down to our next question. What percentage of adverse drug events overall are related to controlled substances, and if it's substantial, will the promised benefits of e-Prescribing remain essentially unmet?

That's a really good question. It's so difficult, especially in an ambulatory setting, to get a good handle on ADEs, because, again, they're pretty much self-reported. And this is something we struggle with. With that being said, just being able to get that based on information and in terms

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of controlled substances I haven't seen anything on it. Jerry have you seen anything? I would say at this point if anybody's got any information on that, we'd love to hear it.

This is Kevin Johnson. There have been some studies in the inpatient world looking at units that primarily prescribe controlled substances, and pain medications.

Right. The inpatient information is a lot easier to find.

Correct. And I think the implication of the question is that at least the initial data that has been out certainly suggest that there is a higher rate of medication errors, not all of which translate to adverse drug events in controlled substances. There have been a couple of studies that I've seen that talked about this. Numbers as high as 50 percent of the orders have some kind of mistake in them.

You'll find in the most recent Institute of Medicine report, "Preventing Medication Errors," a section that describes that particular problem in the outpatient environment, and it's speculated that that's one of the areas where there is likely to be a high level of potential adverse drug events, whether they're really not is another issue. There's also a very high rate of duplicate therapy. In some states, like the one I'm from, that's a major concern; that there are many people who are on multiple controlled substances and probably that relates more to their ability to work around the system.

So I do believe that there are promised benefits of e-Prescribing in that area. I think we do need good data to show how those benefits may be offset by potential risks. And you kind of get the critical mass question, in the that I think to get regulatory work, regulatory information lined up with what the incentives should be for adoption, we will need enough of a mass to move states and the Federal Government in terms of their opinion with regard to controlled substances and faxing.

I'm going to put out that there's 15 minute on the call, and we've got a couple questions so we'll try to get to them as quickly as we can. Here's a good one potentially for Chelle. I think she might be able to answer this well. An intended list for pharmacies is that pharmacy professionals would be able to spend more time with customers ensuring safer outcomes and less time on administrative third-party issues. What is the basis for this assumption?

That concerns some of the literature review and interviews and surveys with pharmacies directly that there is a national shortage of pharmacists today in the United States and that a lot of their time is spend on these administrative issues in dealing with calls back to PBM, calls back to physicians, and if we can minimize the administrative burden, they will be able to spend more time with the patient in terms of patient education and counseling.

And when we talk about administrative third-party issues, are we talking about prior authorization?

We're talking about clarifying drug coverage issues, formulary and non-formulary. It's the biggest bulk of the administrative issues. There are some routine issues in terms of clarification of the drug itself and dosage. But when I'm talking about the administrative issues, it's basically eligibility and drug coverage.

Let me jump to the next question. Can you clarify what "must support" standards means for plan D sponsored medication. I assume that's Medicare Part D. This appears to involve transactions

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between the prescriber and the pharmacy, do plan sponsors need to support only eligibility, formulary, and medication history standards?

I think what we mean by must support it, it's the eligibility and the medication history. It obviously wouldn't be the claims payment piece, which would be the script standard. But at times I guess plans do utilize that standard if they have their own in-house pharmacy, which in very rare cases some of the plans do have that. I guess what we're saying is that they must be able to support it because it's within their contracts that if they have one physician or one pharmacy in a network that's going to be prescribing, they have to be able to support these standards.

In essence what they mean is that if they are a Part D plan sponsor, then they must have the ability to send and receive prescribing messages in the standards that you use to adopt business regulation; is that correct?

That's correct.

Another quick question. Is an ER scenario a barrier to e-Prescribing considering the large inflow of patients? Kevin, what do you think about that? Is a large flow of patients like emergency room that sees 50,000, 60,000, 70,000 patients a year, a barrier to electronic prescribing?

There was a project that I actually did, funded by AHRQ that was with one of the commercially available prescribing tools, and that was a barrier in that project, where the thought was that it was taking on average five minutes to complete a new prescription, where e-Prescribing tools tend to have a lot of their benefits in renewals and refills, and in general, that's not the work of the ED. So I think that it is fair to say that I haven't seen any tools that take into account the work flow of an ED and the way in which a new prescription is sort of thought about in an ED that would suggest a low barrier of entry for most of the commercial tools I've seen.

And I can personally tell you that it's most effective in an ER scenario when it's integrated as part of the documentation and care delivery system. So there is electronic medical records, electronic health records, some specifically designed for that. When they've got electronic prescribing specifically fit into their workflow, it makes the ED physicians and nurses and everybody very happy to have it there because it's all documented, it's all part of the record. If it's a separate tool, I think you're going to run into the issues that you just described, Kevin.

Can you please clarify what nursing staff are allowed to do as far as e-Prescribing? We talked about the issues of nurses and e-Prescribing before. What are the nursing staff allowed to do as far as e-Prescribing goes?

This is Kevin, again. I'd like to hear from some of our other colleagues on this. In our state, nurses are allowed to act as agents of the physician in certain capacities but not in all capacities. Nurses are never allowed to sign or call in a Schedule 2C controlled substance prescription, but this is advanced practice nurses but LPN, RNs, do call in prescriptions as an agent of their provider, thinking that's a part of scope of practice of the nurse. Specifically, however, nurses are not allowed to write a prescription as a verbal order as an agent of the same provider that they could have called it in for.

So what that has meant for us in the e-Prescribing world, is that we've recently run into lots of challenges with call backs because nurses who have written a prescription for a particular doctor are no longer allowed to do so. So that's the answer, they're mostly allowed to generate the

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prescription but not sign it. They're allowed to often conduct a renewal over the phone, as well as a new prescription, as long as they're doing so as an agent of an authorized prescriber.

That answers the question most immediately so thank you for doing that. We have just about eight minutes left. I'm going to ask you a few questions. There's one that I'm going to throw out. I don't necessarily want everybody to answer because I think it's worth a whole teleconference in itself. The question is, can we more fully discuss the legal liabilities?

Here in California we're struggling with how to give prescriptions to teens, not their parents, in particular relationship to reproductive rights. This goes a little bit beyond just prescribing. You're starting to get really into the whole privacy security confidentiality around the use of Health IT, and information technology to exchange health care information. So that's a great question. If anybody thinks that they can make some brief comments on the panel, you're welcome to. My guess is that that would probably be more fully addressed at a later time.

Jon, this is Denise at CMS. I want to remind everyone that when we talk about e-Prescribing from a CMS perspective, we're talking about Part D. We're talking about people who are eligible to receive Part D covered drugs under Part D sponsored plans. So in a sense that question becomes moot. But I agree that it's a broader question out there that can be addressed in a variety of different ways, but probably not for our purposes here.

Okay. So we'll do one more quick question. The e-Prescribing process also worked well with interface to dispensing solutions like Pixis, which is a type of dispensing solution. Given that we're talking about the ambulatory setting, certainly it does in the in-patient setting. For the outpatient setting, are there dispensing solutions that I'm not aware of in the outpatient setting that you all want to talk about?

I'm not familiar enough with what's happening in the pharmacies to know whether any of the robots or other tools are used there for the fill component.

Jon, this is Drew. I had an idea on that. If the pharmacies are truly doing true electronic prescribing where they're sending it electronic data interchange with the pharmacy software, and if they're using robots, that pharmacy software is probably hooked up to that robot. And if they're doing true prescribing, then, yeah, I would think that some of these pharmacies that have automation, it's a one-stop type of deal. I would think that the mail orders are doing it that way. However, that's my opinion.

So I went through a number of questions. At this point we have about five minutes left. I'd like to turn it over to phone questions. Somebody may have asked a question on the chat that I haven't gotten to. I guess we'll go to the first question of SS.

Good afternoon. Actually I have a response back to that last question. State Board to pharmacy, especially at the NABP level, have submitted model language on what we call "remote dispensing." So there are instances where remote dispensing can occur in the ambulatory setting, whether it's in the clinic or especially in rural areas. So to answer that question, State Board of Pharmacy has addressed dispensing where automation can be used. So it is coming and having an e-Prescribing solution will also assist in that.

This is Kevin Johnson. Thank you, Chelle. May I ask a question? Since you've talked about the NABP, can you comment at all about the rules for nursing and how those may be modified for nursing staff and e-Prescribing?

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Those are E only. My specialty is really long-term care pharmacy. And in long-term care pharmacy from an NABP standpoint, we have addressed the state boards of pharmacy. Actually there was a joint paper written between NABP and the American Society of Consultant Pharmacists concerning the nurse as the agent of the prescriber, and the use of chart orders.

So the state boards of pharmacy are aware of the nurse as the agent of the prescriber model and are looking at what we've addressed in the long-term care side, how that will be affected between the prescriber's responsibility and the nurse's responsibility on a facility level. Now will that expand to an ambulatory level? I think that state boards are interested in it. Maybe they'll look at the model that we've put together for long-term care, although it's more of an institutionalized setting, but some of those regulations may apply to ambulatory, especially ambulatory clinic settings. I don't know if I answered your question.

Before we get anymore questions, I would like to turn to Brian Dixon for a brief announcement.

Thanks, Jon. Before folks log off today, I'm going to post events poll up for folks to fill out. If you could give us some feedback, it's really, really important to AHRQ and the National Resource Center that we get your feedback so that we can continually improve these events and your comments and have input into future events. So please do fill that out before you log off, and I'll start that in a couple minutes. Thanks.

There are no more questions coming in, so I'd really like to thank our presenters today, Tony Trenkle, Drew Morgan, and Denise Benning from CMS; Chelle Woolley from Woolley and Associates; Kevin Johnson from Vanderbilt University Medical Center, and thanks to all of you who attended today. Some fantastic questions, some fantastic interactions and great answers back, frankly, from the audience members.

This is the first in a series of teleconferences on electronic prescribing, and I can already see that the rest of them will be quite interesting. Please do fill out the post teleconference poll for us so that we can help improve what we do. And I thank you for your time, and this has been helpful to you.

Thanks, Jon. I will remind folks that the next event is scheduled for November 17th. From 1:00 to 2:30 p.m. Eastern. And e-mails for that will go out in the coming week or so.