

Responses to Additional Web Conference Questions
A National Web Conference on E-Prescribing and Medication Management
Agency for Healthcare Research and Quality (AHRQ)
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Q: Dr. Bell, in the process modeling on an early slide - MONITOR was posted, but I noticed the pharmacist was not called out as a resource. Does this now need to be reconsidered?

A: Yes, pharmacists should be included. This isn't a step we've modeled quantitatively but we'll include pharmacists when we do.

Q: In terms of process changes for practices; how are you dealing with the local pharmacies in adopting to eRx? We find them unwilling or untrained in being able to accept a changed process, such as practices recommending that patient contact the pharmacy for refills so that the refill request could be sent electronically, rather than via phone call to practice, thus saving some office staff time.

A: This has indeed been a big problem. Some of the problem is in their training all of the different staff on at different times. Most of the chains are also in the process of rolling out new systems, which absorbs their attention. Also, I believe there's a transaction fee and the transaction doesn't really save them time if it's not integrated. One thing to consider would be banding together with other e-prescribers in your area to get the pharmacy's attention.

Q: The CMS pilots revealed that surrogates (staff) often input new prescriptions into eRx applications on behalf of the actual prescribers. When this happens, it appears to avoid the increase in physician time that your modeling suggests and transfers this to staff time. Have you tried to model surrogate-based new prescription workflows? Also, have you incorporated self-review of audit logs into your modeling, as required in some states - like Ohio - and which may be required all over by emerging DEA requirements?

A: Good idea – that's worth simulating.

Q: This is a comment more than a question that I'd like to hear the panelists' opinion on: I feel that one of the key factors in improving medication reconciliation is by pooling the physician, pharmacist, nurses and patient reconciliation data at critical POC decision points (such as review prior to writing a new RX). Technology, I believe, can greatly facilitate this if we identify a few key points in the clinical workflows as

a starting point then expanding and experimenting with these workflows over time. What are your opinions about this position?

A: I totally agree. It is why we provide medication history via ePrescribing applications at the Point of Care. It allows for the most medically appropriate prescription to be written the first time.

Q: Just adding to my prior statement, suggesting key workflow points. I think these points should be at transitions of care from different settings and transition to new providers or specialists (oncologist, cardiologist, endocrinologist, etc...)?

A: I also agree. We at Surescripts are involved in a project of sending a CCR from in store pharmacy clinics to primary care providers. For those who have ePrescribing applications, we can do it electronically. This will hopefully serve as a template to share information at transitions of care.

Q: Regarding the volume of data that a clinician has to review in med history: It can be rather large and difficult to review without adding a layer of presentation filtering to make it easier for a clinician to process. What are your thoughts about providing additional "interpretation" of historic raw data? Benefits versus risks?

A: This really relates to application functionality. I agree that throwing a list of medications in front of a physician may not always make the most sense. Creating focused functionality with the data may make more sense. There is currently a project being developed with the Markle Foundation, the American College of Cardiology, several ePrescribing applications, specifically Axolotl and DrFirst, as well as Surescripts to look at just this type of functionality for patients with cardiac disease.

Q: Six hours prescribing time per 1000 prescriptions pales in comparison to dispensing/monitoring time. How are e-prescribing systems impacting these domains?

A: I think to be competitive in the future, ePrescribing applications are going to have to offer enhanced functionality to handle the issues you raise. Smarter use of data and innovative functionality will be necessary to handle all the data that will eventually be available to clinicians at the point of care.

Q: Can you please discuss the evidence base for improved patient outcomes related to e-prescribing, improved adherence, and/or improved med reconciliation?

A: I would point you to the work done at Henry Ford in the South East Michigan ePrescribing Initiative. The use of ePrescribing technology led to multiple changes in prescribing due to Drug Utilization alerts related to allergies and drug interactions.

Walgreens and Surescripts announced the results of a collaboration that showed that prescriptions sent electronically were picked up by patients at an 11% higher rate than prescriptions that were sent to pharmacies by other means.

Please refer to our ePrescribing resource center at www.surescripts.com

Q: With increasing use of EMR's such as GE Centricity and E-Clinical Works, is the E-Rx component included in these type of EMR's or does it have to be purchased separately?

A: You will need to check with individual applications vendors as to what their business model is.

Q: The medication history will get longer and longer. Who is minding the store? Does each prescriber have to download and reconcile the med list? I pull down lists with meds from February 2008 for example.

A: This is an application functionality issue. First of all, what do you want to see versus what do you want to store and have access to? Issues like this need to be addressed as we get additional experience with digital systems. You can basically say the same thing for laboratory and imaging eventually.

Q: Are bonuses paid for E-prescribing at the time of discharge from the hospital? Who gets the bonus - the hospital or discharging prescriber?

A: I am not aware of bonuses, but there will be incentives from the American Reinvestment and Recovery Act (ARRA) for adoption to an EMR with ePrescribing with "meaningful use". Hospitals can also receive money from ARRA for utilizing electronic records. Additionally MIPPA incentivizes physicians to ePrescribe for Part D patients.

Q: What incentives are available for pharmacists as recipients of e prescriptions?

A: Some state ePrescribing initiatives incentivize pharmacies to participate. BCBS North Carolina had an ePrescribing initiative last year that included pharmacy initiatives. Several other states are considering similar initiatives. I would encourage you to get involved in local and regional ePrescribing initiatives and rally them to include incentives for pharmacy.

Q: You mention all states are approved for e-prescribing; can you discuss the status of approval for controlled substances and Schedule 2 drugs? Thank you.

A: The DEA has not yet come out with a ruling on ePrescribing Controlled substances. We anticipate something soon.

Q: Can you give more specifics about the proven ROI for E-prescribing?

A: Michael Fisher from Harvard published a paper in Archives of Internal Medicine last December documenting savings for health plans because of formulary compliance using ePrescribing applications.

Michael Rupp documented pharmacy savings in an article he published.

Please see the ePrescribing resource center at www.surescripts.com

Q: Is SureScripts working with connected pharmacies to address issues of E-prescribing not yet being adopted into standard work processes, in order to reduce exceptions?

A: We do work with pharmacies in standardizing use of the ePrescribing SCRIPT transaction standard. We try to help with workflow issues when we hear of problems.

Q: SureScripts is making money on each transaction. Why do the physicians only receive incentives for 2-3 years and are then penalized?

A: Surescripts was founded by payers and the retail pharmacy community with a \$100+ million dollar investment. We operate as a low cost utility with payers and pharmacies paying for ePrescribing transactions. Physicians and physician applications receive and send data at no cost.

The original MIPPA incentives are for 4 years and the new ARRA incentives go through 2015. I am not sure what will follow. I am sure that CMS and others would be interested in hearing your ideas for future physician incentives and I would encourage you to follow through in sharing them.

Q: After last year's comment period, I never heard if there would be a change in FDA rules regarding E-prescription of Scheduled drugs?

A: The DEA is still reviewing comments and we hope to have additional information soon.

Q: Can E-prescribing be combined with the new pill kiosks (there is an ongoing trial using Pharma Trust Med Centre kiosk in a local hospital in our area)?

A: There is that potential. We have not as of yet worked with kiosk companies as we have focused on ambulatory ePrescribing.

Q: Who is responsible for upgrading (e.g. when a new medication comes onto the market)?

A: Our technology vendors must use a commercial database. As new drugs come to market, these databases are updated. Payers update their formularies on a continuous basis. Technology vendors get new formulary files on a daily basis.

When new versions of standards occur, we recertify all stakeholders over an agreed period of time and then eventually sunset the standard.

Upgrading is a constant process and one of the key functions we undertake as an infrastructure company.

Q: Are you aware of any eRx systems that can screen for drug-drug interactions among herbals and/or OTCs in addition to prescription meds?

A: I am not personally aware and would encourage you to check with the individual companies concerning the functionality they offer in their products.

Q: How often are there MPI problems with E-prescribing (i.e. how often are patients not found so no information can be sent back to the office)?

A: As of now we have about 220 million members in our MPI. On a daily basis we find 75 to 80% of the people whom information is requested.

Q: Our experience with eRx and fulfillment data is that even though it is requested 72 hours in advance the information arrives back to our EHR about 96 to 120 hours after the request.

A: Our turnaround time for a Medication History transaction is 3 to 5 seconds. We send out 150,000+ medication histories a day. I would be interested in talking to you about your issue.

Q: Is patient PBM formulary supposed to be pushed out to the prescriber automatically?

A; Yes, within the functionality of the application.

Q: When will E-prescribing of scheduled meds be permitted? There are costs associated with secure Rx paper. This is especially challenging for Pain Management Centers.

A: Hopefully the DEA will have additional rules to comment on soon.

Q: What about eRx for controlled substances? What's the current status?

A: See above.

Q: When sending eprescriptions, which are electronically signed, we often get calls back from the mail order pharmacies in Texas. They say state law does not allow them to accept an electronic signature. Also we have problems with electronic signatures for controlled substance prescriptions due to federal laws. What is happening to fix these issues?

A: see above on DEA. Without knowing whose mail order pharmacy you are talking about, it's difficult for me to answer this question.

Q: What is the progress being done by DEA to allow for the electronic prescribing of controlled substances?

A: See above

Q: Are there ways in E-prescribing to capture OTC meds, or is one planned?

A: If an OTC drug is prescribed, than it can be captured in Pharmacy fill data. Non-prescribed OTC's would be very difficult to capture.