
EPRESCRIBING PERSPECTIVES

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1. NCVHS ePrescribing Testimony: Ten Things You Should Know
by Tony Schueth, Editor-in-Chief

From August 17 to 19, the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Standards and Security held the fourth round of testimony on electronic prescribing. The purpose was to contribute to a NCVHS letter to Health and Human Services (HHS) making recommendations on standards for electronic prescribing. At this point, it was looking for "low-hanging fruit;" that is, standards that either exist or have industry consensus that they should be developed.

As a reminder, NCVHS makes recommendations to HHS on various topics. The current charge is to evaluate and recommend electronic prescribing standards, as directed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

As a stakeholder, here are 10 things you should know about the subcommittee and letter:

- 1) The subcommittee consists of volunteers who advise HHS on a variety of issues, of which ePrescribing standards is just one. Supported by HHS staff, subcommittee members are health care information technology experts from a range of stakeholder organizations. Clearly committed to their assignments, these individuals cannot be compensated well enough for the number of hours they contribute or impact they have. To prepare for meetings, they read mounds of paper. During the most recent set of hearings, they worked late into the night. They must sort through the agendas of various organizations to try to understand the real issues. To be sure, we're lucky to have such a dedicated group!
- 2) As health care generalists, subcommittee members and HHS support staff are admittedly not electronic prescribing experts. Consequently, testimony has been one part education and one part sorting through standards recommendations and gaps. This is to your advantage, whether you're new to electronic prescribing or a veteran. Testimony from key stakeholders has resulted in a compendium of valuable information about this niche. Even if you've missed the testimony, you can access it via the NCVHS Web site (www.ncvhs.hhs.org). Click on the calendar URL and look up past meetings.
- 3) On Wednesday, August 18 and Thursday, August 19, the subcommittee worked on recommendations that would go in a letter to HHS. This document is still in draft form. It will be posted on the HHS Web site this week, with conference calls next Wednesday (August 25) and Friday (August 27). There's still a chance to have your say, should you so choose.
- 4) To be sure, the subcommittee is highly influential. However, if you haven't testified or submitted your

comments to it, you haven't lost your chance to contribute. Anyone can participate in the previously mentioned conference calls. The subcommittee is open to eMails. There will be additional testimony through next spring. Finally, recommendations become regulations that are posted for review and comment. HHS welcomes and encourages such feedback, understanding that only the industry knows what will and won't work. And, rest assured, it will listen. I've been told that all letters must be catalogued by substance and documented. The subcommittee WANTS your feedback.

5) The transaction standards development organization (SDO), the National Council on Prescription Drug Programs (NCPDP), appears to be a big winner. In the letter being drafted, the subcommittee will recommend that NCPDP Script's refill request/response and new Rx transactions be adopted without a pilot program because there are enough organizations using them in the marketplace. Furthermore, HL7, the SDO that tends to focus on transactions in the inpatient health care setting, deferred to Script for electronic prescribing, with a few caveats, such as communication between providers and pharmacies within the same integrated delivery network and a grandfather clause for existing installations. Finally, other standards such as formulary, prescription drug history and provider directory will be managed through NCPDP.

6) There will be a formulary standard. Now that CAQH and Rx Hub have partnered, there are basically two major formulary aggregators: Rx Hub & CAQH and MediMedia. Rx Hub created its format using the NCPDP Script standard; however, it did so outside the construct of the NCPDP process, which is accredited by the American National Standards Institute. Consequently, the subcommittee gave them a "wink" and suggested they work through NCPDP. (MediMedia's format was created when Script was being created.) Using Rx Hub's formulary formats, NCPDP has now formed a workgroup to create a standard in which MediMedia has agreed to participate.

7) The subcommittee will recommend X12's 270/271 v4010 Eligibility Inquiry and Response as part of the ePrescribing recommendations. This is what Rx Hub uses with its PBM and software trading partners.

8) There were also recommendations related to terminology, the biggest of which was to adopt Rx Norm for ePrescribing. Rx Norm is a semantic drug terminology developed and maintained by the National Library of Medicine. Through point-of-care software companies, it enables a physician to choose a drug by name. That name is associated with a code. Rx Norm is considered to be easier to work with than today's method of work-arounds using NDC numbers.

9) The subcommittee is struggling with identifiers for pharmacies and prescribers. The NPI was supposed to be the solution, but a number of issues are associated with it. For pharmacies, it is recommending the NPI for the long term but, in the interim, is OK with the continued use of the NCPDP Provider Identifier Number (formerly the NABP number). For physicians, it is recommending the NPI, but NCPDP's HCidea is being considered for inclusion, as well. For agents, the subcommittee recommends the NPI and that NCPDP Script allow for authorized agents.

10) Several "other related issues" are being considering. For example, it has been pointed out that inconsistent, vague state board of pharmacy rules and regulations are barriers to rollout. (For example, some states require "substitution permitted" and others "dispense as written." Furthermore, some state regs make it appear that ePrescribing is permitted, but after discussion with the board, point-of-care software companies learn that it is not.) The subcommittee is considering making a recommendation to address this issue by federal preemption of state board of pharmacy rules and regulations. Their challenge is that this is beyond to scope of its assignment.

The next round of testimony will be October 13-14. While the agenda has not been released, we believe one topic will be electronic signature.

What does all this mean?

Through the subcommittee, the feds have made a statement that they mean business. Their efforts have also served as a catalyst for positive change.

2. MMA and ePrescribing: What's Next?

On August 3, proposed regulations were published for Title One of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The rules include a 10-page section on electronic prescribing.

If you were unclear about the ePrescribing components of the MMA, you could review this document to clarify. The preamble is written in non-legalese. While we have seen other nontechnical descriptions of the law, this one comes from HHS directly.

This is also a way to be heard. Comments are encouraged. According to HHS staff members, CMS will document and review all submissions, so you can rest assured that your perspective will be considered. Comments can be transmitted electronically, mailed or hand delivered and must be received by October 4, 2004.

One area of emphasis is on incentives, which is something that we see as very positive. As we've written in the past, it is critical that we find ways to encourage physicians to prescribe electronically.

Another encouraging aspect of this document is the section showing that HHS is beginning to understand the challenges of ePrescribing. For example, it indicates that approximately 10% of physicians are prescribing electronically, and that the adoption rate is weaker in solo or small practices, where the majority of physicians practice. It's important to understand the situation if we're going to move forward.

To review the document, you can go to the CMS Web site: (<http://www.cms.hhs.gov/medicarerereform/>). There's a press release and fact sheet, as well as the rules themselves. If you need any help interpreting them or getting an issue considered, let us know.

3. NCPDP's Educational Session on ePrescribing Attracts 200 by Grady Clouse, Wellinx

On August 10, more than 200 people gathered near San Francisco Airport for an NCPDP educational session entitled "ePrescribing – The Wave of the Future." A large number of attendees were systems vendors focused on the pharmacy sector, and the PBM community was also broadly represented.

The day-long session focused on standards, adoption and incentives, and the policy issues surrounding ePrescribing. Pfizer's Ross Martin, MD, facilitated and served up the first of a few humorous lines when he described being selected because he was the "most neutral member of the planning group," then asking the audience to "imagine a situation in which the pharmaceutical manufacturer is the most neutral party at the table."

While many of the presentations were predictable, a few stood out.

Dr. Helga Rippen, who works for David Brailer at ONCHIT ("onkit") and Dr. Simon Cohn of NCVHS described the respective roles of their organizations in the development of the National Health Information

Infrastructure (NHII). Rippen asked the group to ponder such questions as how electronic prescribing fits in the context of increased EMR adoption. Part of the ensuing Q&A revolved around decision support and how NCVHS and ONCHIT were responding to this portion of their mandate.

Dr. Doug Bell of RAND reported on an expert panel review of desirable features of electronic prescribing applications designed for use by developers and policymakers, alike. Sixty features were ranked across four metrics (safety, patient cost, privacy, and physician acceptance). Results are available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.305v1>, and the detailed appendix is available at <http://content.healthaffairs.org/cgi/data/hlthaff.w4.305v1/DC2/1>.

During a panel on “Challenges to Adoption,” Mike Simko of Walgreens delivered a nuts-and-bolts analysis of adoption issues from the pharmacy point of view, stressing “change management” challenges and the role of the physician office staff in adoption. On the same panel, Michael Weinberger of Johnson & Johnson stressed his position that ePrescribing shouldn’t “tilt the playing field” by unduly influencing physician decision making. This elicited some chuckles from the audience, which recognized pharmaceutical manufacturers’ concerns that their own DTC and detailing efforts could be diluted behind the closed doors of the exam room.

Dr. Bob Elson of Rx Hub delivered, by far, the most humorous and one of the most insightful presentations on “The Top 10 Myths About e-Prescribing.” He pointed out that most ePrescribing happens in the context of EMR use and mostly in large groups. Thus, given the increasing adoption of EMRs, concern over ePrescribing adoption may be misplaced. However, he did acknowledge a role for incentives in getting smaller groups up the adoption curve.

Dr. Marc Overhage of the Regenstrief Institute provided some welcome drama by arriving just in time for the final presentation after being delayed enroute. The Regenstrief Institute in Indianapolis has made major contributions to health care informatics through the development of LOINC and sponsorship of a local EMR system and community health information network. One of Marc’s notable comments on ePrescribing and safety was the assertion that the most severe and most numerous outpatient medication errors involve monitoring of patient status (lab values, etc.). As a result, only prescribing systems incorporating these data provide protection against roughly 65% of outpatient drug errors.

As inspiring as the Regenstrief example is, even HCIT diehards should take note of the story of Clement McDonald, MD, a pioneer of Regenstrief’s 30-year EMR effort. Apparently, Dr. McDonald has been overhead for years saying, “A few more years on this EMR system, then we can move on to the really exciting stuff. . .”

Updated slides from the day’s presentations will be available on NCPDP Web site within a few weeks.

4. Odds & Ends: DrFirst lands CareFirst, CapGemini Launches CafeRx, Florida Expands with Gold Standard Multimedia

- On August 10, DrFirst announced that CareFirst BlueCross BlueShield will provide its ePrescribing product, Rcopia, to 500 physicians. CareFirst is Maryland’s largest insurer and represents DrFirst’s second announced managed care relationship in two months. In July, DrFirst and Kaiser Permanente announced an expansion to 10 new Kaiser facilities in northern Virginia, and that Kaiser will purchase 30 licenses for physicians outside its owned facilities.

- On August 10, CapGemini announced the formation of a coalition on electronic prescribing called CafeRx (www.cafex.com). The nine initial members include the National Council on Prescription Drug Programs, Allscripts, SureScripts, Microsoft, Cisco, Hewlett Packard, NDC and Rx Hub. It will initially provide

education and best practice models, and plans to start a program to educate physicians. Its Web site also indicates it will testify and lobby for electronic prescribing.

· Florida's Medicaid program has awarded Gold Standard Multimedia nearly \$6 million in contracts to provide personal digital assistants (PDAs) to physicians who see a large number of Medicaid patients, according to the Tampa Tribune. The contract expands on a 1,000-physician pilot in which the providers could access drug histories. What's interesting is that Gold Standard has traditionally been a reference source, but appears to have written an ePrescribing application that includes formulary. It also indicated that it would be offering a similar program to another state.

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