
EPRESCRIBING PERSPECTIVES

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1. Bradley Leaves RxHub; McLean New CEO

by Tony Schueth, Editor-in-Chief

After successfully advancing RxHub as the nation's leader in the electronic exchange of prescription information connecting prescribers, pharmacies, pharmacy benefit managers and payers, Jim Bradley will be handing over leadership responsibilities to Dave McLean. A seasoned veteran in growing companies to the next stage of evolution, Mr. McLean was named RxHub's Chief Operating Officer on January 7, 2003.

With 25 years of health care and HMO experience, he is uniquely positioned to take the organization's reigns. At the time of Mr. McLean's appointment, Mr. Bradley said, "'David has worked in all facets of the pharmacy industry from clinical pharmacist through CEO, which gives him a unique insight into the intricacies of today's complex prescribing environment. He understands the importance of having an informed prescription and the inherent value of the efficiency RxHub is bringing to the prescribing process. With his wealth of pharmacy industry experience, David will strengthen our executive management team and help RxHub realize its vision."

Prior to joining RxHub, he was Chief Executive Officer of United Resource Networks (URN) for UnitedHealth Group Company. At URN, he was responsible for the growth and development of the company that provides services in the areas of organ and tissue transplantation to over 40 million lives. David also held the position of Vice President of Business Development, Specialty Division at UnitedHealth Group where he was responsible for business development activities that included new business ventures, product development, and strategic planning.

Mr. McLean was also President, COO of Clinical Pharmaceuticals, Inc; Principal of Jensen, McLean & Associates and Senior Vice President at American MedCenters/Partners National Health Plans. He received his Ph.D. Pharmacy Administration from the University of Minnesota and his B.S in Pharmacy from Ohio State University, and currently serves on the board of the National Kidney Foundation and President of the Board of Directors for the Ronald McDonald House Charities Upper Midwest.

Mr. Bradley is a visionary, entrepreneur and industry leader in health care technology. In the three years he was at the helm of RxHub, he accomplished what he set out to do: (1) develop an electronic exchange for the prescribing industry that increases efficiency, reduces costs and improves patient medication safety; (2) create a national awareness of the need to accelerate adoption of technology to improve the health and lives of all Americans and (3) educate the industry on the need for open standards to promote interoperability among all players with the purpose of sharing patient information to reduce medication errors and adverse

drug events

Despite Mr. Bradley's departure, RxHub's mission will not be changing, RxHub officials stressed. Governance remains the same. The organization's structure remains largely in tact. RxHub is now at a stage that will require operationalizing its products with a focus on sales and implementation. Mr. Bradley brought Mr. McLean into RxHub for precisely this reason. Mr. McLean will continue to lead RxHub into the future with the same vision and enthusiasm — at this most exciting time in the e-prescribing industry.

RxHub was founded on February 22, 2001 by the three largest PBMs at the time – AdvancePCS, Express Scripts and Medco Health Solutions. Earlier this year, CareMark purchased AdvancePCS, inheriting its seat on the RxHub board.

2. Postscript on NCVHS ePrescribing Testimony

In the June 7, 2004 issue of ePrescribing Perspectives, we wrote that on May 25 and 26 ePrescribing stakeholders testified to the National Committee on Vital Health Statistics (NCVHS) subcommittee on standards and security, and promised to make you aware as to when the testimonies would be on the NCVHS Web site. Well, they're there, and you can access them at <http://www.ncvhs.hhs.gov/040525ag.htm>. Just scroll down to the "Transcript" URL above the agenda for each day.

We'll warn you, however, that the transcripts for both days are more than 200 pages. That's 80 pages more than the eHealth Initiative report that is either sitting on your veranda, in your briefcase or in a file. And there are no pictures!

If you're on this distribution list, we'd recommend that you take the time to skim them, time-consuming though they may be. As you're working on that, here are some insights and observations that might help you put them in perspective:

- There seems to be consensus on just one point – the National Council on Prescription Drug Programs (NCPDP) Script standard works for every stakeholder that presented. Health and Human Services (HHS) Secretary Tommy Thomson has said that he wants recommendations faster than the schedule the Medicare Modernization and Drug Improvement Act of 2003 (MMA) lays out. To accommodate that request, the committee was clearly looking for "low-hanging" fruit, and it appears to have found it in NCPDP Script. (Note: If you need any help, let us know. For two years, our managing partner, Tony Schueth, was co-chair of NCPDP's Workgroup 11, which is responsible for the Script standard. In addition, many POCP affiliates have been active in Workgroup 11 over the years, and we have all implemented Script for our respective employers.)
- There was no consensus that there should be additional standards. That's right, ZixCorp said it has worked around not having standards and they really aren't needed, thank you very much. At least that was the way the presenter, Dan Nutkis, Vice President, Strategy, came across in the transcript and to just about everyone who heard him speak. What we really think he meant, though, was that standards are good, but the priority should be financial incentives. On that, we agree. The biggest current challenge is utilization, not adoption.
- The new drug classification schema, RxNorm, received a lot of love, but there was no consensus on that, either. Not to get too technical, but in the electronic data interchange (EDI) world, computers speak to each other by bits and bytes (numbers, if you will). Drugs have always been classified by what's called an NDC number. The problem with NDC numbers is that they are far too detailed for the electronic prescribing world. For example, a physician wants to prescribe 200 mg of Ibuprophen, not 200 mg of Ibuprophen capsules manufactured by X pharmaceutical company. RxNorm is less detailed and presented in a way that prescribers

think. The ePrescribing companies are okay with this new schema, even though it will cost them quite a bit to switch over their systems. The dissenter was SureScripts, which represents retail pharmacy. It may be more impactful on pharmacy management systems.

- Prior authorization received a lot of attention. There was consensus that there was a need to standardize the prior authorization process, but there was no agreement as to how. Truth is, this was the wrong time to discuss this topic. In August, pharmacists and pharmacy benefit managers (PBMs) will testify. In September, health plans will get their chance. Prior authorization is sure to be discussed at both sessions.

- There was agreement that there needs to be a standard for formulary, both one that is interactive and one that is transmitted in batch mode. However, when software vendors were pressed on how high a priority this should be, they seemed to waffle. Formulary standards will probably end up being developed and maintained by NCPDP.

- There was a little drama on day 1. After the scheduled testimony, the microphone was opened for comments from those observing the session. Pfizer's Ross Martin, MD made the point that full financial information needs to be disclosed to the prescriber and patient at the time the prescribing decision is being made. While PBM representatives in attendance agreed that some financial information such as relative cost could be (and is being) presented, they argued that full financial disclosure would be almost impossible to present at the point of care because so many factors go into determining those calculations. Dr. Martin urged the subcommittee not to "look at relative hardship for any individual player" when creating standards.

We hope these insights put things into some perspective. Happy reading!

3. Don't Fall into the "Free Is Not Good Enough" Trap – Leverage the Opportunity

In their NCVHS ePrescribing testimony, both Jill Helm from Allscripts and Rohit Nayak from MedPlus made the point that "free wasn't good enough" for physicians using ePrescribing applications. What alarms us is the implication that physicians not only need to be given the device, but also paid for using it. We doubt that the seasoned Ms. Helm or Mr. Nayak believe this; however, we're concerned that others might interpret this statement incorrectly.

One of the positive implications of this is pay-for-performance (P4P) programs. In their NCVHS testimony, Robert Mandel, MD, BCBS Massachusetts, described a P4P program in which BCBSMA is paying \$1 PMPM to providers prescribing electronically, and ZixCorp's Dan Nutkis said Zix is involved in several other such programs. Furthermore, HHS Secretary Thomson recently said he would consider paying physicians for electronic prescribing. We applaud initiatives that positively incent physicians to prescribe electronically (and can help put them together, by the way).

One danger can be gleaned from the American Academy of Family Physicians' written NCVHS testimony. In it, David Kibbe, MD, made the point that because of the ROIs to plans and society, physicians shouldn't have to pay anything for electronic prescribing. We respectfully disagree with Dr. Kibbe, who recently served on a panel with our managing partner, Tony Schueth, and for whom we have the utmost esteem. Several studies have shown that there is a real ROI for physicians. A study conducted by Mr. Schueth in 2000 with a 14-physician group in Kokomo, Indiana came to this conclusion, as did one we cite in this issue. We firmly believe that for electronic prescribing to be viable, every stakeholder that receives value must pay its fair share – health plans, PBMs, pharmacies and physicians.

For years, companies have given hardware to physicians, paid the software licensing fees and provided every incentive imaginable, except the direct payment that is now being tried. The result is 5%-18% adoption. Will

\$1 PMPM be enough? In two years will we be saying, "free + \$1PMPM just isn't enough?"

As we have stated before, physicians, like all human beings, do not value something they receive for free. They're busy. As Dr. Mandel noted in his NCVHS testimony, when a prescriber encounters one obstacle, he or she will set down the ePrescribing device. This is particularly true if it's free! On the other hand, if the physician had chosen to pay something for it, he or she would mentally give it another try or two so that the dollar amount he or she paid wouldn't be water down the drain. This is not a criticism of physicians. It's human behavior 101.

To be sure, there will be glitches. This is technology, for goodness sake! If you don't have those expectations, then you've forgotten the last piece of technology you purchased. Think back. Did you have a learning curve with your cell phone? Absolutely. Every time you purchase new technology, you have to read the directions, play with it and work through glitches. But you stick with it because you made the decision to make that purchase – because you believe it will bring you value. If it was given to you, you'd simply toss it aside at the first sign of frustration and forget about it. It's human behavior 101.

ePrescribing applications are much more complex than a cell phone. There is no company in the world that can put out a software application that has connections to insurance companies, pharmacies, practice management systems, etc., and won't have a glitch, especially in the early days of implementation when the situation is most precarious.

There's another related issue that has come to light recently. In the June 2004 issue of Healthcare IT News, it was reported that an issue with the WellPoint initiative is that physicians get a form 1099 with the computer or device, and they don't like it because it's not really free. Free isn't good enough!

If you're investing in ePrescribing technology for your physicians, we implore you to target a large enough population, set appropriate expectations, educate your senior management, submit to them reachable goals and objectives, market the technology to physicians, sign up those who choose to give it a try and then incent them to use it.

One way you can ensure success is by bringing in POCP. Having developed and executed ePrescribing strategies, we can help you manage expectations. Depending on who you are, we can help you credibly educate you or your client's senior management. We can help you market your technology to physicians. We can help create P4P programs. Don't waste time and resources making mistakes that have been made in the past. Don't put your reputation on the line. Call us, and we'll help you create a winning program.

4. Six Sigma Study Shows Sustained Impact of ePrescribing

A study published in the March 2004 issue of Group Practice Journal shows that a practice that uses ePrescribing technology sustained its efficiency gains over a one-year period.

The study was conducted at Cardiovascular Associates (CVA), a 22-physician cardiovascular group in Louisville, Kentucky that was using ProxyMed's Prescribe system. Working with the large pharmacy benefit management (PBM) company Medco Health Solutions, Inc., the practice used Six Sigma techniques to assess the problem, identify and implement the solution and measure that solution's impact. Six Sigma is a data-driven quality improvement methodology that is used by large manufacturing and service sector companies to improve the capability of their business processes.

In the initial study, the clinic found that inbound calls from pharmacies decreased from 36% to 18.5% and outbound calls by more than 50%, from 70.2% to 35.2%. Time savings equaled \$3,000 per physician

annually.

In the study conducted one year later, the percentage of prescriptions resulting in inbound calls was 18.6%, statistically equivalent to the reductions seen in the first study. In addition, continued improvement was seen in the management of renewals and refill calls: 31.7%. And there is even greater opportunity. Today, only three of the more than 12 pharmacies at which CVA patients fill prescriptions are electronically connected to the clinic; however, they represent nearly 60% of the pharmacy marketplace in Louisville.

If all retail and home-delivery pharmacies were connected to CVA, it was estimated that the clinic would realize \$12,000 in annual savings.

5. Krohn Affiliates with Point-of-Care Partners, LLC

Rick Krohn has elected to affiliate with Point-of-Care Partners, LLC. A seasoned health care consultant, Mr. Krohn is president of HealthSense, a health care business development, eHealth technology and management consulting firm located in Guyton, Georgia.

“I couldn’t be more excited to have Rick affiliate with us,” said Tony Schueth, managing partner, POCP. “He fits the profile of having practical experience in developing and executing eHealth strategies, and his experience really complements the rest of the POCP team.”

Mr. Krohn has 15 years experience in health care consulting. During that time, he has guided physicians, health care systems, HMOs and entrepreneurs in devising and executing market-driven business strategies. He is also an accomplished writer, having authored more than 50 articles on a wide range of health care subjects for such publications as the Journal of Health Information Management, Healthcare Informatics, Group Practice Journal, MGMA Journal, and Healthcare Financial Management. In addition, he has written a book, entitled Physician Networks: Strategy, Startup, and Operations, published by the American College of Healthcare Executives, and is currently writing another on the topic of eHealthcare technologies which will be published by HIMSS.

HealthSense specializes in health care services integration, innovation and the wise application of technology solutions. HealthSense has helped clients strategize and implement new business ventures, new products and new technologies whose benefits radiate throughout an organization. The firm operates according to the guiding principles of inclusive strategic and operational planning, thought leadership and client mentoring to guide project execution, implementation of business process and technology solutions that create competitive advantage, product excellence, organizational efficiency, customer satisfaction and economic rationality of all initiatives.

6. ZixCorp and PDR join forces

On June 22, ZixCorp announced an agreement with Thomson Healthcare’s PDR, a leader in providing information sources to health care professionals. The plan is to integrate PDR with ZixCorp’s PocketScript.

We see this as a positive move for Zix. PDR has been the drug information standard for nearly 60 years and reaches almost 500,000 practicing physicians in the US on a complimentary basis each year. A prescriber may have a need to access additional information before making a prescribing decision, and he or she will now have the ability to do this through PocketScript.

We’re not aware that PDR has licensed with any other ePrescribing company; however, such competitors as

DrFirst have announced that they have partnered with PDR competitor ePocrates. We see this as all good news for the industry.

ABOUT US

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