



Payers are Driving E-Prescribing

Health plans have the most to gain financially from e-prescribing, but benefits also await others.

By Bill Briggs, Senior Editor

(May 2006) Drug prescribing is one of the health care industry's traditional sore spots. Until recently, the watchwords have been "clumsy" and "dangerous" as the process relied on often illegible handwritten notes and multiple follow-up telephone calls to clarify a doctor's order or approve a refill.

Problems associated with prescription errors range from patient inconvenience—such as a return trip to the pharmacy to get the right medicine—to harmful or fatal reactions from ingesting the wrong medicine or dosage.

Payer organizations believe e-prescribing can have a dramatic impact on such problems. CareFirst BlueCross BlueShield, for one, estimates that each adverse drug event affecting one of its 3.3 million members costs the organization about \$200.

In 2005, the first full year of CareFirst's electronic prescribing program, Pete Stoessel calculates the Owings Mills, Md.-based payer organization avoided about \$1.3 million in costs, mostly associated with prescribing errors. Stoessel, the director of medical affairs and networks management, minces no words when it comes to describing who is reaping the most benefits from e-prescribing technology. "It does streamline some processes for providers, but frankly, this helps us and helps members."

The potential for cutting costs associated with medication errors is one reason that payers increasingly are pushing physicians to adopt electronic prescribing technology. Other reasons include substituting generic drugs for high-cost branded alternatives and keeping doctors attuned to drug formularies. Both can save millions of dollars for payers, and ultimately bring down the cost of health care.

Benefits also accrue to providers, pharmacists and patients, because, at the most fundamental level, all stand to gain precious time that in the past was devoured by telephone calls to clarify or refill prescriptions.

When electronic prescribing software is combined with drug reference information and interfaced with decision support and electronic medical records systems, the benefits expand. Among them: reduced duplicate prescriptions, better records of all medications a patient is taking and detailed patient records, including drug allergies.

Just a few years ago, electronic prescribing began and ended with the PDA or personal computer where the prescription was entered. Technological limits were quickly reached as physicians sent the prescription to a printer and either handed it to the patient or faxed it to the patient's pharmacy.

Now many electronic prescriptions are flowing from computer to computer via direct Internet connection between physician and pharmacy or through clearinghouses such as SureScripts, Alexandria, Va., and RxHub LLC, St. Paul, Minn. SureScripts manages the electronic flow of prescriptions among physicians and pharmacies, while RxHub links physicians to patient medication histories and prescription benefits information.

"Now prescriptions can flow electronically to the pharmacy," says Tony Schueth, managing partner at Point-of-Care Partners LLC, a Coral Springs, Fla.-based consulting firm specializing in e-prescribing. "It's also possible to get claims histories from many payers loaded into an e-prescribing system so the prescriber is aware of other medications a patient is taking."

Cost avoidance

Since the Institute of Medicine study in 1999 lit the beacon for patient safety, health care organizations have been trying to assign value-in the form of avoided costs-to preventing bad things from happening to patients. Payer organizations in particular have been calculating the savings derived from various initiatives to hold down health care costs and improve patient safety.

The business case for electronic prescribing is easiest to make for payers, Schueth says. "There is value from switching a patient from a brand-name drug to a generic, and in reduced hospitalizations from fewer medication errors."

Payers are driving the movement, Schueth says, led by Medicare, which is funding a \$1.85 million pilot program to study standards for e-prescribing. "And private payers are succeeding with some rollouts, particularly in the Massachusetts area," Schueth adds. Even though there is little statistically significant data on the use of e-prescribing technology, small-scale studies are increasingly identifying cost savings.

As a result, many payer organizations around the country are attempting to advance the e-prescribing cause. Some are offering providers software and hand-held computers for free or at a discount, or cash incentives to entice them to try and then to use the technology.

For example, in Massachusetts Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Neighborhood Health Plan started the E-Prescribing Collaborative in early 2004.

The initiative dovetailed with a push by providers to increase the use of electronic medical records systems. Blue Cross Blue Shield of Massachusetts has invested about \$5.3 million to develop the e-prescribing initiative, says Jessica Fefferman, program manager of e-health innovation at the Boston-based payer organization, which covers 2.9 million lives. The investment includes licenses for software from Dallas-based Zix Corp. and DrFirst Inc., Rockville, Md., and hardware from Dell Inc., Round Rock, Texas.

The program started slowly, but in 2005 the initiative reached its goal of 3,500 providers, including physicians and nurse practitioners, sending prescriptions electronically to pharmacies.

"We sent 2.6 million prescriptions through the collaborative in 2005 alone," Fefferman says, with a total of 3 million including 2004. The effort took off late in 2005 with a 135% increase in electronic prescriptions among the three payers from January to December.

Results such as those recorded by the Massachusetts payer organizations are helping to identify potential cost reductions in the prescription process. Patient safety has been a fundamental-and elusive-measurement sought by many payers and providers in recent years.

Until last year, Blue Cross Blue Shield of Massachusetts was unable to track such things as potential errors eliminated by e-prescribing, lost prescriptions, patient compliance and reducing transcription errors in the pharmacy, Fefferman says.

"Safety alerts now fire when a doctor or nurse practitioner prescribes medication so they can see not only what they prescribed but what others have prescribed, and they can measure drug interactions," she explains. "We are now seeing more than 5,500 prescriptions canceled each month due to the alerts."

Changing behavior

The Blues plan still is studying the implications, Fefferman says, "but we have changed providers' behavior."

The dispensed drug history from other health plans comes from the those involved in the initiative, so it doesn't cover all of a physician's patients, she notes. Still, "physicians are getting more information than ever."

One of the most important data elements payers want to put in front of physicians is a drug formulary. When doctors adhere to payer organizations' lists of approved medications, the savings can be significant.

Getting formulary information to physicians at the point of care is where real cost savings can occur, Fefferman says. "If they prescribe a high-cost, Tier 3 drug they might get a message that there is something more affordable and just as beneficial from a clinical standpoint."

Following a formulary has bottom-line effect on the cost of health care in general and makes medication more affordable for patients, she adds.

Blue Cross Blue Shield of Massachusetts members can save an average of \$20 to \$25 per prescription if a doctor switches a prescription to a lower tier alternative, Fefferman estimates. The health plan saves as well. It has logged savings of 1.5% on drug expenditures when physicians use e-prescribing almost exclusively, compared with those who don't use the technology at all.

The 370 physicians in CareFirst Blue Cross Blue Shield's e-prescribing pilot were 2% to 3% better at sticking with formulary drugs than those who did not prescribe electronically, says Stoessel, the director of medical affairs and networks manager.

Last October, CareFirst extended for another year its assistance program to physicians who wrote 50 or more e-prescriptions per month. In August 2004 the payer organization made Treo 650 hand-held computers from Sunnyvale, Calif.-based Palm Inc., available gratis to 500 primary care physicians.

Physicians meeting the e-prescribing requirement also received free licenses for software from DrFirst.

The software enables physicians to send prescriptions and refill orders electronically to most pharmacies in the Washington, D.C., area either directly or via the SureScripts network.

After a slow rollout in late 2004, the program gained steam through 2005, Stoessel says, and by year's end participating doctors were transmitting about 50,000 e-prescriptions per month.

The software also provides alerts to drug/drug and drug/allergy interactions. In 2005, the system registered some 9,400 warnings and a little more than 2,000 were drug/allergy related, he adds.

CareFirst does not limit physicians to writing e-prescriptions to its members, Stoessel says. But he estimates the Blues plan is saving about \$18 per e-prescription filled by members.

In addition to savings gained from physician compliance with formulary requirements, payer organizations are seeing cost reductions by substituting generic drugs for brand name products.

At Southwest Medical Associates in Las Vegas, use of generic drugs by its 235-physician group practice was at 65% as of early 2003, a rate described as "excellent" by Craig Morrow, M.D., medical director. Yet the numbers would improve as more physicians embraced technology.

Southwest Medical Associates is part of Sierra Health Services, a health care organization that includes health benefits services, care delivery and a health plan with 580,000 covered lives.

The group practice began using e-prescribing software from Allscripts Inc., Chicago, in February 2003. PDAs were used to send prescriptions to printers, and the drug orders then were handed to patients or faxed to a pharmacy.

In September 2003, the e-prescribing application became a component of an electronic medical records system developed by Allscripts. Since that time all of the group's prescriptions have been computer generated. From February 2003 until December 2005, the group raised its generic rate to 73%, Morrow notes, translating into substantial savings for the payer arm of Sierra Health Services.

"Every percentage point improvement in the generic rate saves 1.5% of our total drug expenditure," Morrow says. "We estimate we saved \$4.75 million annually by improving our generic rate."

Other savings are less direct, such as those from electronic prescription renewal, but no less valued. When a patient contacts a pharmacy for a refill, the pharmacy sends an e-mail to Southwest Medical. "It comes into our computer and the average refill is completed in 20 seconds," Morrow says, compared with about four-and-a-half minutes the old way of documenting the refill in a paper chart and calling the pharmacy. "We're saving our nurses four minutes times 9,500 renewals a year. At a conservative pay rate of \$18 an hour, that translates into soft savings of about \$209,000."

Sierra Health's initial investment in e-prescribing technology in 2003 was just over \$700,000, which increased an undisclosed amount with the addition of more clinics and the EMR system. The organization's success with e-prescribing prompted it to underwrite the cost of the software and make it available to all 5,000 physicians in the state via the Clark County Medical Society.

The program, which began last October, made Allscripts software accessible to any doctor in Nevada at an undisclosed discounted price. Medical society physicians are eligible for a free, 10-year software license and up to two years of monthly maintenance services.

Other physicians will receive free software, but will have to pay an undisclosed monthly fee. Physicians must provide their own hardware.

Tepid start

The e-prescribing initiative has been slow to spread to physicians outside Southwest Medical Associates, says Darren Sivertson, vice president and COO at the managed care division of Sierra Health Services. "It started slowly, but it started."

Although only a few doctors outside the group practice have signed on, Sivertson hasn't set any target numbers for expansion. "We'll take it as comes. This is a way to eliminate a financial roadblock to physicians using information technology. There is a lot of inertia regarding I.T."

Funding is a key roadblock to enlisting physicians in the e-prescribing campaign, observers say.

Proponents of e-prescribing believe it eventually will take off among most providers and be the source of dramatic savings and improved patient safety. But two formidable obstacles stand in the way.

First, the cost of the technology tends to turn off many physicians. Second, there is general reluctance to adapt to and master the new technology once it's in place.

Both conditions have spurred payer organizations, and in some cases employers and providers, to offer incentives to physicians to test and use e-prescribing technology.

In addition to free or discounted hardware and software, some payer organizations are offering cash incentives for physicians to use toward the purchase of e-prescribing technology. Blue Cross Blue Shield of Massachusetts concurs with the state's e-prescribing collaborative view that to get prescribers engaged they need upfront funding, Fefferman says.

That includes software licensing, hand-held computers, even Internet connectivity in some cases. "But Blue Cross Blue Shield of Massachusetts feels we need additional incentives to ensure people are using the technology," she explains.

The health plan has several pay-for-use rates to encourage physicians to use e-prescribing technology. Individual rates were not shared, but in 2005 the Blues plan paid \$1.5 million in total to drive adoption of the technology, Fefferman adds.

Getting doctors to use e-prescribing technology is both a behavioral and technological challenge, says Stoessel at CareFirst. Erratic performance of technology can cause doctors to drop it without a second thought. And although physicians are "not averse to change, they are cautious," he says. "Anything seen as somehow disruptive of their practice can cause doctors to become very timid toward it."

Payer organizations realize the limitations they face and are not trying to convert the whole provider world at once. CareFirst, for example, is trying to achieve incremental change in the way medicine is practiced, Stoessel notes.

"We're not going to get the full network of providers, but we can get a piece so that when larger scale I.T. projects come along they are better informed."