

E-Prescribing: Trends, Drivers, Successes and Best Practices for Managed Care

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“E-Prescribing Results and Their Impact on Health Plan Profitability” – An AIS Audioconference

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Outline

- ePrescribing Overview
- Trends and Drivers
- Return on Investment
- Health Plan eRx Initiatives

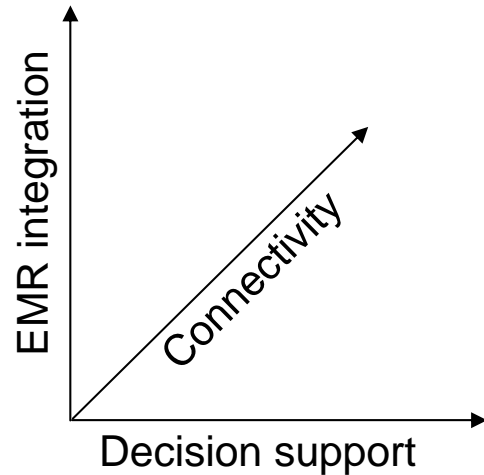


ePrescribing Overview

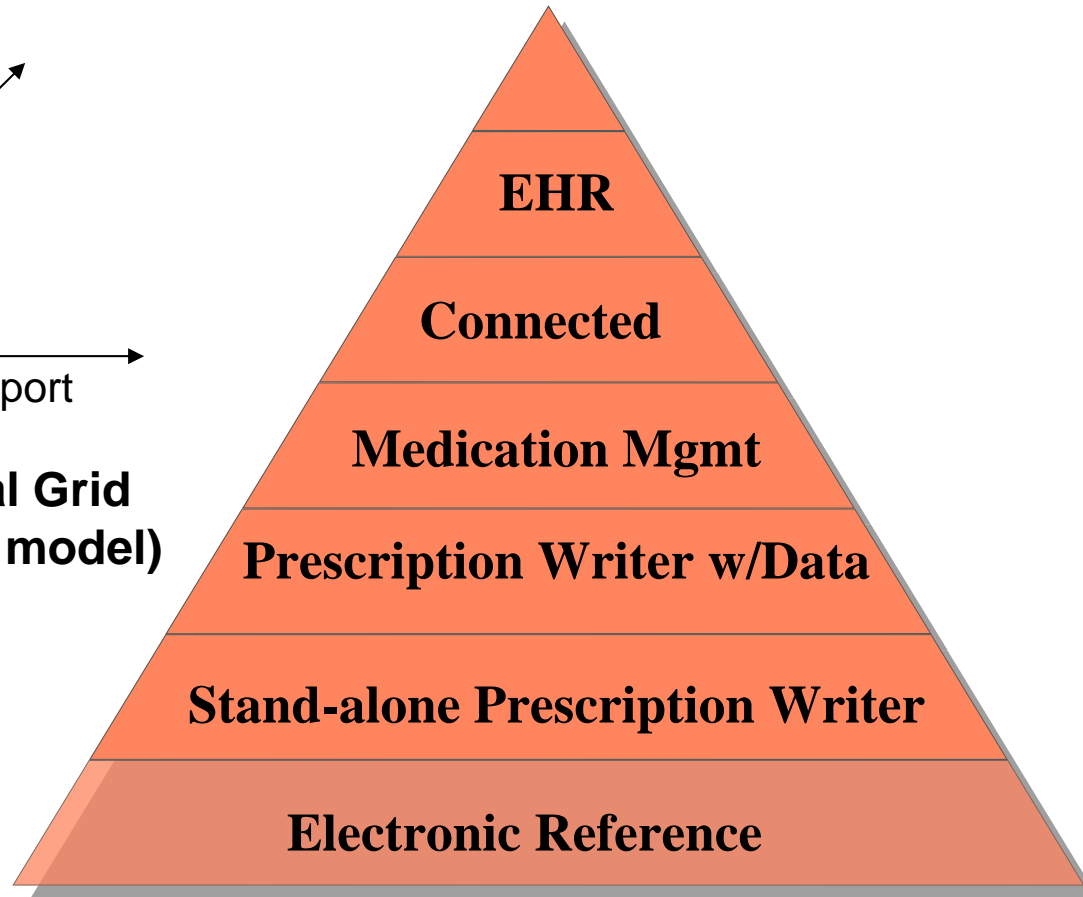


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What is ePrescribing?



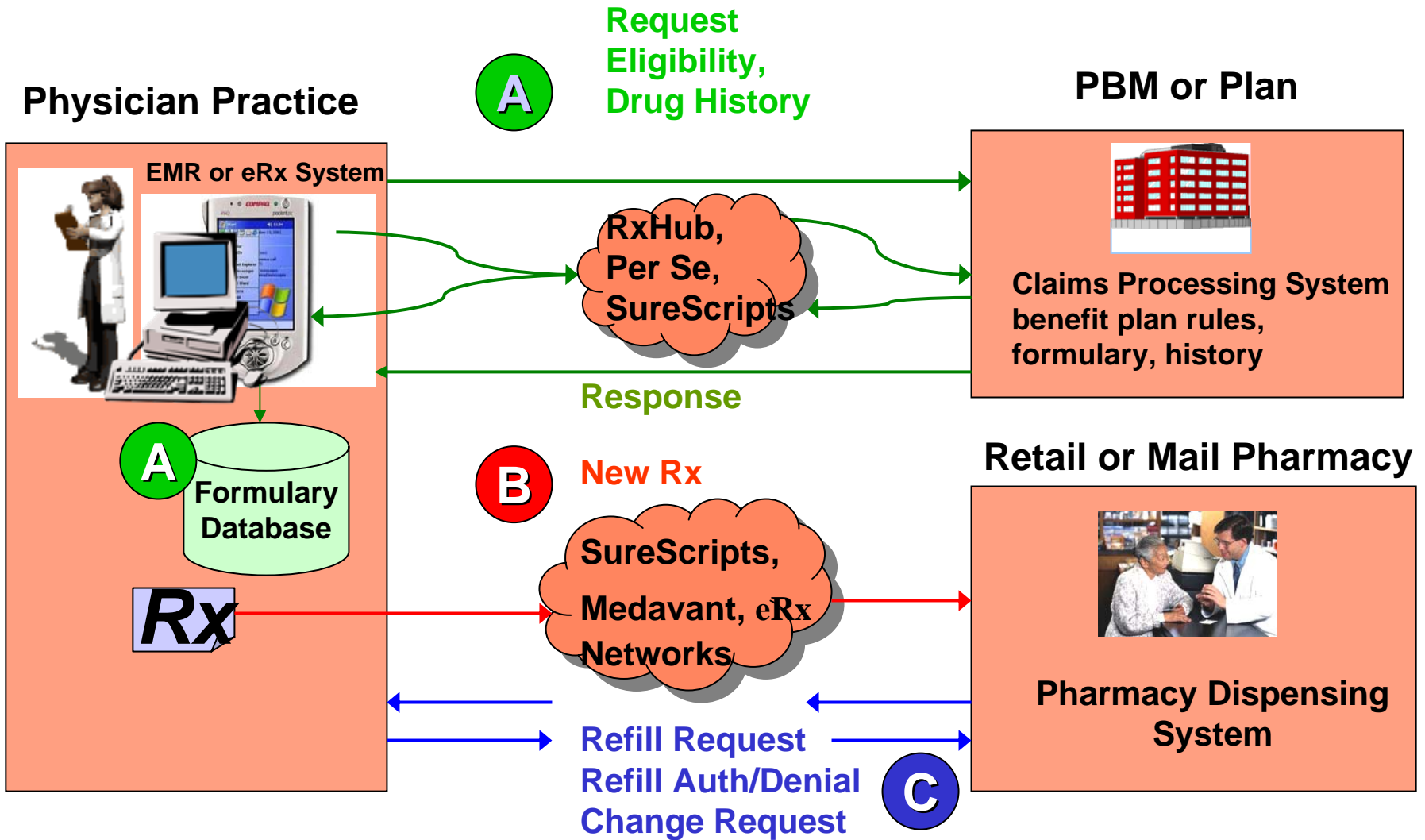
**3 Dimensional Grid
(more realistic model)**



Source: eHealth Initiative



Data Flow of Interoperable ePrescribing



A Partial List of eRx Companies

- AllScripts
- Gold Standard
- Dr. First
- ZixCorp
- Medavant
- iScribe
- MedPlus
- Purkinje
- eHealth Resources
- Instant Dx
- RxNT
- HealthVision
- EZ Script
- Relay Health
- Axolotl
- Recare
- Phytel
- RxRite
- SafeMed
- Prematics
- Synamed
- DAW Systems
- OA Systems
- Bluefish
- H2H Solutions



A Partial List of Ambulatory EMR Vendors

- Allscripts/A4Health
- EPIC
- GE Centricity
- NextGen
- Misys EMR
- Allmeds EMR
- AthenaHealth
- ComChart EMR
- Companion Tech
- Docs, Inc.
- Digichart
- eClinicalWorks
- Greenway
- iGreat
- iMedica
- Emdeon Intergy
- JMJ
EncounterPro
- LSS EMR
(Meditech)
- Physician
Microsystems
- Medent
- MediNotes
- Synamed
- Acermed
- Bond
- Wellogic
- Digichart
- MedicWare
- Pulse
- MDanywhere
- Chartconnect



ePrescribing by the numbers...

13% MDs prescribing electronically

(Secretary Leavitt, 2006)

85% Pharmacies enabled for ePrescribing

(SureScripts, Medavant, eRx Networks, RxHub)

5% US hospitals using CPOE for Rx orders

(KLAS, 2005)

24% Outpatient EMR use

(National Center for Health Statistics, 2006)

170 million Lives for whom formulary &
benefits are available through RxHub

\$29 billion Potential annual ePrescribing savings

(Center for Information Technology Leadership, 2004)



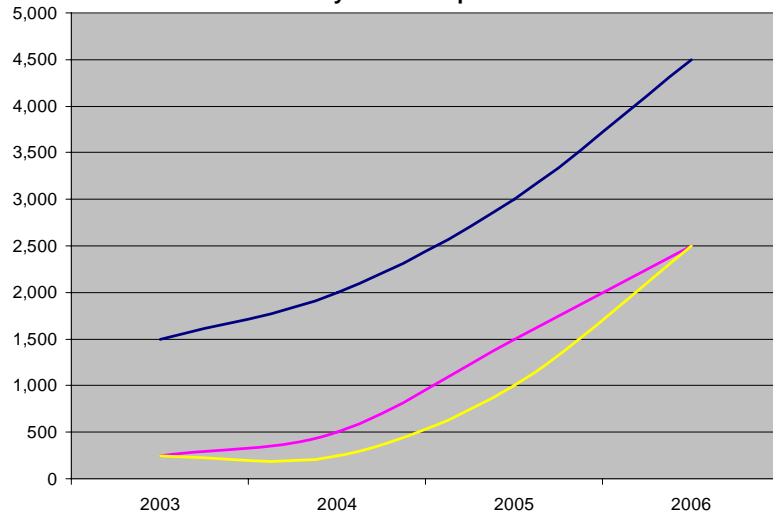
Trends and Drivers



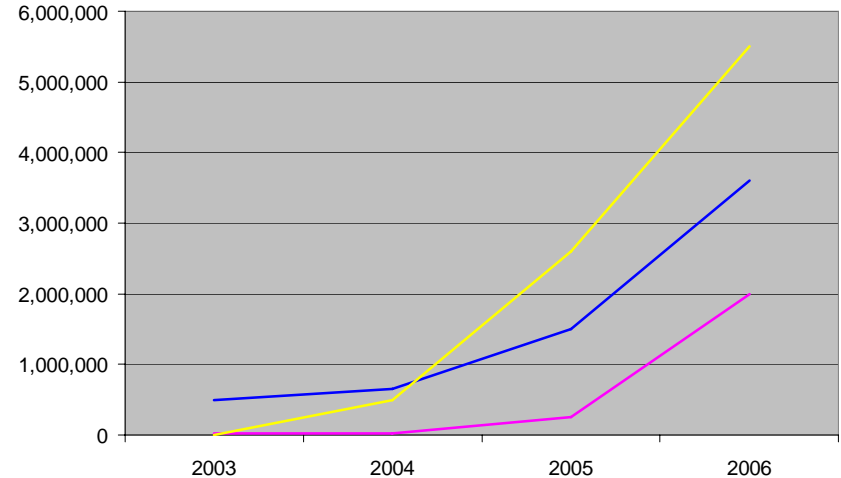
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Adoption & Utilization Trends

Physician Adoption

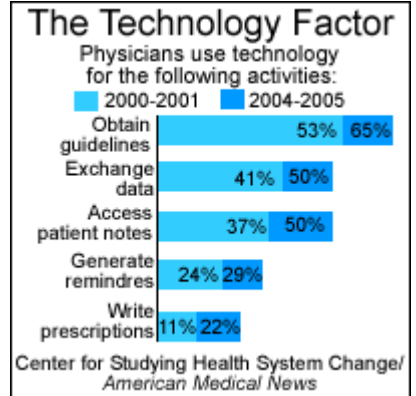


Annual Transaction Volume



RxHub Transaction Statistics

	2002	2003	2004	2005	2006e
Eligibility	1,696,381	3,993,101	7,491,437	26,000,000	40,000,000+
Med Hx (eRx)	146	100,552	416,304	2,500,000	5,000,000+



Source: iHealthBeat



Major ePrescribing Drivers

- ➔ President Bush has mentioned EHRs in his last three State of the Union addresses
- ➔ IOM Studies on Patient Safety
 - ➔ *To Err is Human: Building a Safer Healthcare Systems (1999)*
 - ➔ *Crossing the Quality Chasm: A New Healthcare System for the 21st Century (2001)*
 - 46,000 to 98,000 medication errors per year
 - ➔ *Preventing Medication Errors (2006)*
 - 1.5M preventable medication errors, not counting errors of omission
- ➔ Politicians want to be seen as “doing something” about medication errors
 - ➔ Since 2004, Feds have invested nearly \$200M in grants
 - ➔ In 2006, states have announced nearly \$90M in HIT grants
 - ➔ 10 bills in Senate, 9 in House



Other eRx Drivers

- ➔ Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)
 - ➔ Estimated cost of \$440B, \$534B, \$770B over 10 years
 - ➔ Establishes an ePrescribing program
 - ➔ Mandates chronic care programs encouraging HIT
- ➔ Trade group and alliance initiatives
 - ➔ Lobbying efforts have shaped government policy and regulations
 - ➔ Implementation guides have shaped software systems
- ➔ Sponsorships
 - ➔ Vendors are 'following the money'
 - ➔ Managed Care sponsorships leading the market
 - ➔ State and regional initiatives are focused on EMR



MMA (Medicare Part D) & ePrescribing

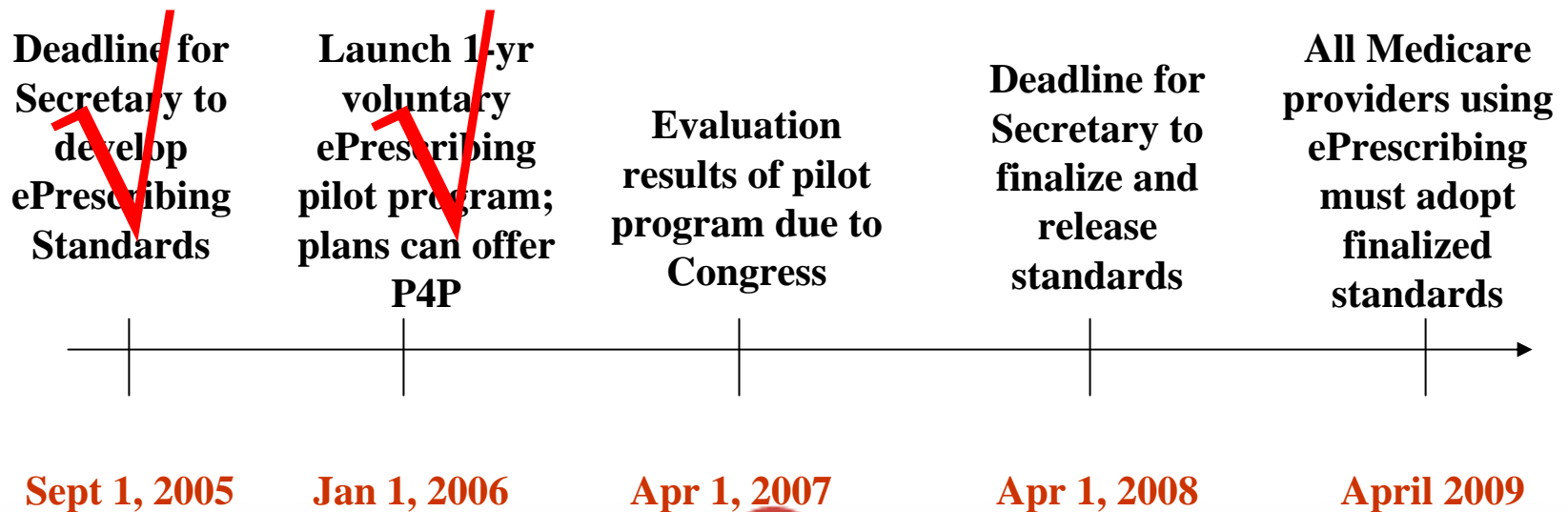
- ▶ MMA establishes a real-time ePrescribing program to be used by prescribers, plans, pharmacies and pharmacists who serve Medicare patients
 - ▶ No mandate, but if used, **standards must be followed**
 - ▶ Standards via National Committee on Vital and Health Stats (NCVHS)
- ▶ NCVHS tasked with identifying foundation standards required for January 2006 implementations.
- ▶ Directs HHS to conduct a voluntary eRx pilot project in 2006, for areas where industry experience is insufficient
- ▶ Other components:
 - ▶ Discretionary grants to be made available to prescribers
 - ▶ Plans, hospitals, groups may purchase hardware for MDs
 - ▶ Plans may pay additional fees for reduced medication errors, improved formulary compliance & fewer adverse drug events



MMA (Medicare Part D) & ePrescribing

➔ Progress-to-date

- ➔ Issued Notice of Proposed Rule-Making (10/05)
 - Exception to Stark (Physician Self-Referral Prohibition)
 - Anti-kickback Safe Harbor
- ➔ Issued final rule naming foundation standards (11/05)
- ➔ Awarded 5 grants for ePrescribing pilots (12/05)



MMA Pilot Awardees

1. New Jersey ePrescribing Action Coalition

- ▶ RAND, Horizon, Caremark (PBM, mail, iScribe), Allscripts, RxHub, SureScripts, UMDNJ and Point-of-Care Partners

2. SureScripts

- ▶ SureScripts, Brown University, Allscripts, DrFirst, Gold Standard, MedPlus/Quest Diagnostics, ZixCorp, pharmacies in Florida, Mass, Nevada, New Jersey, Tennessee and Rhode Island

3. Achieve Healthcare (Long-term Care)

- ▶ Achieve, RNA Health Information Systems, Benedictine Health System, Preferred Choice Pharmacy, RxHub, Prime Therapeutics, BCBSMN

4. Brigham & Women's (Massachusetts)

- ▶ Brigham & Women's Hospital, Partners Healthcare, MA-Share, CSC, BCBSMA, RxHub, SureScripts

5. Ohio KePRO-UPCP

- ▶ University Primary Care & Specialty Physicians (UPCP), Ohio KePRO, InstantDx, NDC Health, RxHub, SureScripts, Qualchoice, Aetna, MGMA Center for Research and the University of Minnesota



Remaining MMA “To Dos”

- ➔ Discretionary grants to physicians
 - ➔ CMS said in Final Rule that they would be in ‘07
- ➔ Pay-for-performance for ePrescribing
 - ➔ Lots of P4P demonstration projects
 - ➔ CMS announced a relationship with Bridges to Excellence
- ➔ Additional rules
 - ➔ New eRx rules will come out of the pilots
- ➔ Additional pilots?
 - ➔ Hinted at in Final Rule



Return on Investment for Health Plans, Physicians



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CITL Study

➔ National Estimated Cost Savings from ePrescribing:	
➔ Medical Expenditures Annually	\$27B
■ Switch from brand-to-generic	
■ Switches within therapeutic class	
■ More appropriate drug utilization	
➔ Avoiding ADEs	\$ 2B
■ Reduced hospitalizations	_____
➔ Total	\$29B

Source: CITL Executive Preview: *The Value of Computerized Provider Order Entry in Ambulatory Settings*

➔ Take away: majority of savings accrues to payer



Benefits: Prescribers

Reduce Cost

- ◆ Reduce phone calls
- ◆ Reduce chart pulls
- ◆ More time for patient care
- ◆ Low impact to existing workflow

Improve quality of care

- ◆ Increased quality of care by enabling easy access to computerized medication history
- ◆ Decreases potential medication errors due to illegible prescriptions

Improve patient satisfaction

- ◆ Reduced waiting time at pharmacy
- ◆ Aura of high tech



Published Studies: Practice Efficiency

Study	Results
Medco 2003	42% reduction in pharmacy calls to practice
Health Management Technology 2003	\$48,000 saved per year by a practice that automated refills
Tufts Healthplan 2002	2 hours per day saved per physician, 30% reduction in phone calls
BCBS Hawaii 2000	50% reduction in pharmacy phone calls
Kokomo Family Care 2000	42% reduction in pharmacy-related calls; 84% reduction in calls related to formulary



Benefits: Payers/PBMs

Improve quality of care

- ◆ Decreases potential medication errors due to illegible prescriptions

Reduce cost

- ◆ Reduced phone calls
- ◆ Better utilization of cost-effective alternatives
- ◆ Increased generic prescribing
- ◆ Reduced medication errors

Improve customer satisfaction

- ◆ Employers: lower premium growth due to reduced drug spend
- ◆ Prescribers: Fewer hassles over coverage and prior authorization
- ◆ Consumer: Reduced wait time at pharmacy



Published Studies: ROI to Health Plan

Study	Results
Affinity Health 2005	Avg costs ↓ \$4.12 for new Rx; PMPM ↓ 57¢ vs control; target drugs were 17.5% lower
Aetna 2005	No change in formulary compliance
Tufts Healthplan 2002	Wide-spread deployment of eRx could mitigate rising pharma costs by 2% or more
Medco 2002	15.3%↑ in generic substitution; 8.1% ↑ in generic dispensing
Allscripts 2000	Aggregate impact by plan varied, ranging from 75¢ to \$3.20/Rx



Milliman/RxHub Study

- ➔ Objective:
 - ➔ Estimate financial impact of eRx on drug spend of Medicare providers and the implications for physician incentives
- ➔ Summary of findings:
 - ➔ More than 70% of potential drug spend is controlled by PCPs
 - ➔ ePrescribing has the potential to:
 - Reduce a payer's drug spend inflation by 1% per year
 - Mitigate patient customer service issues on up to 32% of prescriptions under a highly restrictive formulary
 - ➔ ePrescribing has the potential to significantly lower drug spend on Medicare beneficiaries:
 - Up to 15% of total drug spend on minimally restrictive formulary
 - Up to 8% of total drug spend under moderately restrictive formulary

Source: "Potential Impact of Electronic Prescribing on Medicare Prescription Drug Spend," October 25, 2005, Milliman, courtesy of RxHub



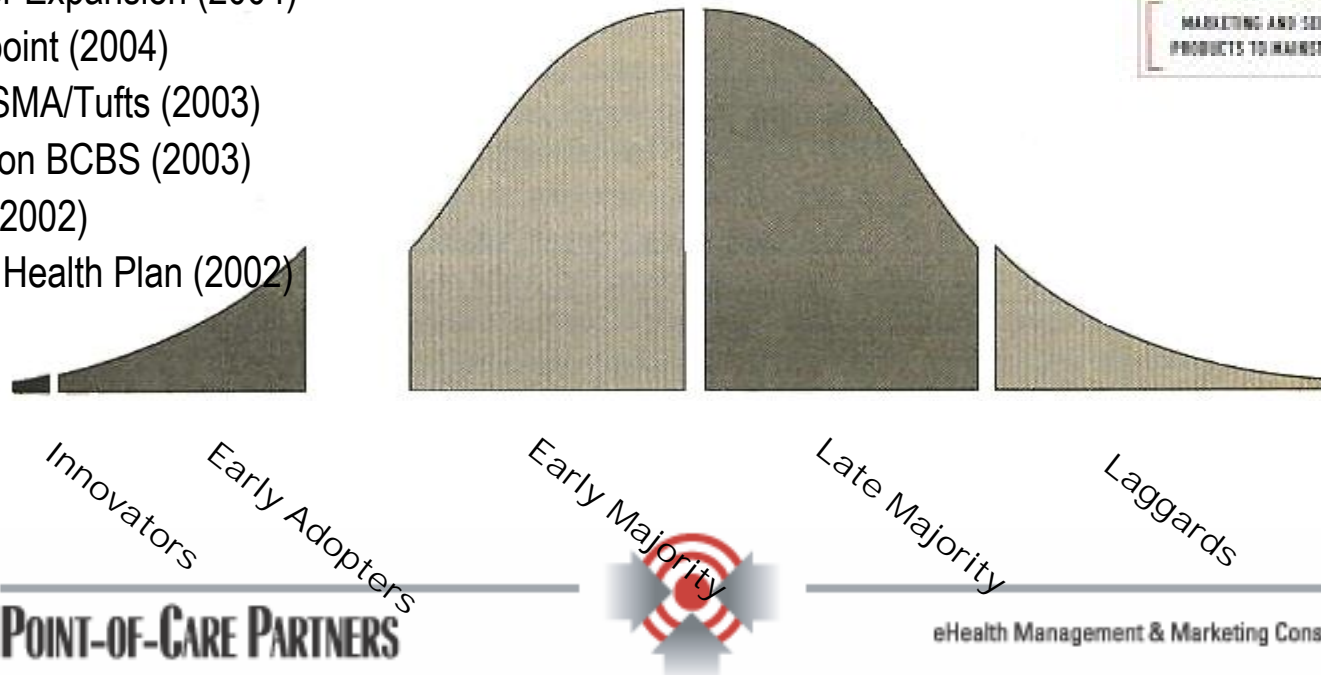
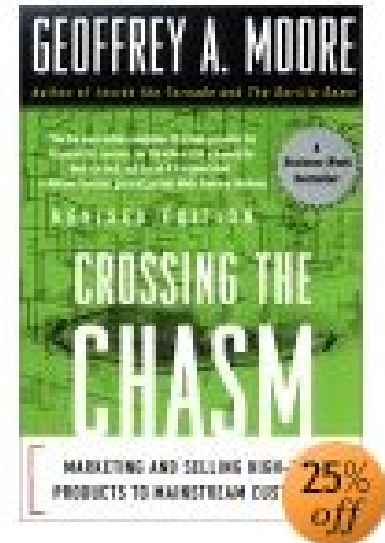
Health Plan eRx Initiatives



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Partial List of Announced Payer Initiatives

- ▶ Taconic IPA (2004)
- ▶ BCBSTN (2004)
- ▶ Affinity Health (2004)
- ▶ Florida Medicaid Expansion (2004)
- ▶ CareFirst (2004)
- ▶ Kaiser Expansion (2004)
- ▶ Wellpoint (2004)
- ▶ BCBSMA/Tufts (2003)
- ▶ Horizon BCBS (2003)
- ▶ GHI (2002)
- ▶ Tufts Health Plan (2002)
- ▶ North Carolina (2006)
- ▶ Aetna – New Jersey (2005)
- ▶ Highmark (2005)
- ▶ IBC (2005)
- ▶ CareFirst Expansion (2005)
- ▶ Horizon BCBS Expansion (2005)
- ▶ Fallon Clinic (2005)
- ▶ GM, Ford, DaimlerChrysler (2005)



Model Alternatives

- ➔ Business Models
 - ➔ Primary Health Plan (Go it Alone)
 - ➔ Multiple Health Plan (Coalition Model)
 - ➔ State Government/Regional Initiatives
- ➔ Economic Models
 - ➔ Full Sponsorship
 - ➔ Physician Subscription
 - ➔ Pay for Performance
- ➔ Single vs Multiple Vendors



Lessons Learned - Methodology

- ➔ Spoke to either plan or vendor reps from:
 - ➔ Aetna – New Jersey (ZixCorp)
 - ➔ Affinity Health (Purkinje)
 - ➔ CareFirst (DrFirst)
 - ➔ Horizon (iScribe, Allscripts, InstantDx)
 - ➔ GHI (ZixCorp, DrFirst)
 - ➔ Southeastern Michigan – SEMI (multiple vendors)
- ➔ Read published findings from initiatives
- ➔ Objective: aggregate lessons learned



Lessons Learned – Program Set-up

- ➔ “Never underestimate the power of collaboration,” regardless of the business model you choose. “In addition to plans and employers, be sure to involve CDOs, medical societies, state Medicaid programs, etc.”
- ➔ “It helps to have a MD champion in the marketplace – or a strong, well-respected medical director at the plan” helping put the program together and championing the project.
- ➔ “Physician level of misunderstanding of eRx and technology is alarming – they’re ill-prepared to make intelligent choices” so you need to help them make the right ones.”
- ➔ “The value to plans varies by plan – by what their need is. Then you need to negotiate with the right vendor mix – the vendors that have the experience and features/functions that you need.”



Lessons Learned – Vendor Selection

- ➔ “Hardware support is something that you need to think about ahead of time. If an eRx vendor has a deal with a hardware company, that can be a plus.
- ➔ “Having a hand-held product extension and wireless is a must. The physician doesn’t want to have to back to the computer after the encounter.”
- ➔ Potential Partnership Criteria
 - ➔ Successful payer strategy that yields ROI
 - ➔ Proven success with MD office implementations
 - ➔ Migration path to more robust EMR
 - ➔ Other



Lessons Learned - Adoption

- ▶ “The key is getting through to both decision makers and influencers” not just one of them. In every practice they’re different.
- ▶ “Physicians are interested in (1) improving quality, (2) enhancing workflow and/or (3) saving money. The program doesn’t have to do all three but it had better do at least two.” If it costs more money, however, forget about it.
- ▶ “Influencing physicians starts with a needs assessment because you have to meet their needs almost on an individual basis. There’s no cookie cutter.”
- ▶ “We initially made the mistake of going after high prescribers. That’s the wrong way to segment because they may be too busy to use the system. It’s better to start with the thought leaders, and go after the high prescribers later.”



Lessons Learned - Utilization

- ▶ “Without utilization, no one wins. The key is constant monitoring and follow-up. You can keep an eye on them and intervene without being perceived as ‘Big Brother.’”
- ▶ “It’s not as easy to change behavior as one might think. The equation is something along the lines of the right tools + incentives = utilization.”
- ▶ “Physicians can fall off after the initial training. The key is ongoing training, and incentives to continue utilization.
- ▶ We use a bi-annual survey. If they’re over a certain threshold, we provide an honorarium.” “You have to make sure there’s a champion within each office. You train them, and they’ll train others.”
- ▶ “You want to make sure your vendor is integrated with a practice management system. It is the source of patient data.”



Lessons Learned – Other

- ➔ “One of the challenges is that the data is all over the place. The key is to get a normalized quality data stream.” This is easier when there’s just one vendor.
- ➔ “To state the obvious, you’re going to see greater improvement from some prescribers than others, and in some areas over others. In New Jersey, you can’t do step therapy or pre-certification at the point of sale because you’re not allowed to put edits in after the fact, so there’s more opportunity for improvement.
- ➔ “Adversarial relations between physicians and payers runs deep. Make sure that you have thought leaders and provider relations involved to mitigate.



Summary

- ➔ While adoption and utilization of ePrescribing is low, it's on the increase industry-wide.
- ➔ There are more than 25 ePrescribing companies and hundreds of EHR vendors.
- ➔ The major driver today is the Federal government, under Medicare Part D.
- ➔ The return on investment in ePrescribing is both real and substantial, supported by studies and experience.
- ➔ More than 18 announcements of health plan eRx programs or expansions have been made since 2002.
- ➔ Lessons learned from these initiatives can help you to not make the same mistakes as your predecessors – but you need to have a plan.



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Appendix



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The difference between EMR & EHR

Electronic Medical Records

- Legal record of the care delivery organization (CDO)
- A record of clinical services for patient encounters in a CDO
- Owned by the CDO
- Sold by Enterprise Vendors
- May have patient access to some results info through a portal — but not interactive;
- Does not contain other CDO encounter information

Electronic Health Records

- Subset of information from various CDOs where patient has had encounters
- Owned by patient or stakeholder
- Community, state, or regional emergence today – or nationwide in the future
- Provides interactive patient access as well as the ability for the patient to append information
- Connected by National Health Information Network (NHIN)



Barriers to Widespread Adoption Still Exist

- ➔ Who pays? There are still outstanding questions about the business model for ePrescribing
- ➔ Which vendors will succeed? No one wants to repeat the dot.bomb experience
- ➔ Standards development takes time
 - ➔ Stakeholder objectives often at odds
 - ➔ Development and approval process is painstaking
- ➔ Adoption/utilization still lagging. Critical mass exists in only a few regions
- ➔ ePrescribing is not yet an expected standard of care



Foundation & Initial Standards

Foundation Standards

- ▶ SCRIPT (new Rx, renewal, change, cancel, admin functions)
- ▶ ASC X12N 270/271
- ▶ NCPDP Telecommunication

Initial Standards

- ▶ Medication History
- ▶ Formulary & Benefits
- ▶ Structured & Codified SIG
- ▶ Prior Authorization (X12N 278)
- ▶ RxNorm (new Rx, renewal, cancel)
- ▶ SCRIPT (fill status)

