



eMedication Management

ePrescribing Safety Study Tells Different Story than Sensational Headlines

By Tony Schueth, Editor-in-Chief

Study findings in the July 6 issue of the [Journal of the American Medical Informatics Association \(JAMIA\)](#) made a big splash in the media. Headlines indicated that use of ePrescribing can result in errors — many that are potentially dangerous — and mistakes in ePrescriptions are roughly at the same rate as those found for paper prescriptions. As it turns out, the headlines were inaccurate and the findings sensationalized.

Thanks to some analysis by Surescripts and interaction with the study's authors, we learn the study has significant shortcomings. They jointly issued the following clarification:

- *“The study examined [3850] faxed and printed prescriptions generated by a computer rather than e-prescriptions. The more common use of faxed or printed computerized prescriptions in 2008 (the year the data was gathered) has led many to equate their use with e-prescribing. By today’s standards, e-prescribing refers to prescriptions that are generated using computers in practitioners’ office and sent electronically in coded form to pharmacies...”*

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Prescription Drug Monitoring Programs: Increasing Effectiveness Through HIT

By Mihir Patel, PharmD, RPh, Consultant

To counter illegal prescription drug diversion, the federal government has funded the development of prescription drug monitoring programs (PDMPs), which are statewide electronic databases that collect designated data on narcotics and other scheduled substances dispensed within individual states. Unfortunately, they are data silos that live in the world of paper prescriptions. Health information technology (HIT) could help improve their effectiveness, but that is easier said than done.

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Regional Extension Centers

REC Progress Update: Could ACO Formation be in the Future?

By David Bergman, Senior Consultant

Regional extension centers (RECs) have been up and running for about a year now, and they are all over the map (literally and figuratively) in terms of implementation. Since February 2010, the federal government has doled out \$700 million to create and support 62 RECs nationwide, which are collectively charged with bringing 100,000 providers to meaningful use (MU) of certified electronic health records (EHRs) by 2014...

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POCP Blog

Blog Roundup

The Point of Care Partners (POCP) Web site has a new look and some new features. One is the “Blog” section, on which we post unique insights to newsworthy items as they happen. Blogs aren’t meant to replace the longer and more analytical pieces in [HIT Perspectives](#), but they are another way POCP provides value by alerting readers...

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ePrescribing Safety Study Tells Different Story than Sensational Headlines

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Therefore, the results of the study should not be generalized to e-prescribing as there are clear and significant differences between these prescription transmission methods and the terms and technologies are not interchangeable.”

One concern with the authors' and Surescripts' clarification is that it makes it sound like the only good prescription is the one that's transmitted electronically. We concede that a prescription that is transmitted via EDI will have fewer errors.

But make no mistake: we believe that a prescription generated on a computer is better than a hand-written prescription, if for no other reason than because of the reduced incidence of handwriting misinterpretation. The study's authors didn't address this aspect of ePrescribing.

The study observed that the most common error was omitted information. So physicians aren't changing behavior – they're doing electronically what they do on paper. Here is where Surescripts is right. In the EDI world, we have standards with mandatory fields and we route prescriptions through intermediaries such as Surescripts and Emdeon. If key fields are omitted, then the ePrescription won't reach the pharmacy. If the prescription is faxed or printed, there is no such edit, unless it is done by the vendor.

Most reputable vendors require that certain fields be completed, regardless of transmission method — certainly those vendors with names familiar to all of our readers. However, these edits are not typically as robust as those performed by the intermediaries. We know that some of the vendors involved in the study were home-grown so may not be up to snuff in this area.

That said, even with true ePrescribing, some prescriptions do make it through with inconsistent or omitted data. Why would we allow a prescriber to submit such a prescription? The reason is that our focus has been on reducing barriers to adoption and utilization. Would physicians use our systems if we forced them to fill in every box and prevent them from typing free text? This has been the driving concern.

Yet now it's time to change our focus from adoption to quality. Give Surescripts credit – they are leading the way. But we can do more.

Recently there was a [study](#) released from the Center for Health System Change (HSC) which found that prescribers often are not using advanced ePrescribing functions such as DUR and formulary even when those features are available in their systems. Our own experiences validate this finding.

Keeping that in mind, note the *JAMIA* investigators mentioned a lack of drug utilization review (DUR) checking as a factor contributing to the adverse drug events (ADEs) found in the study. We know that for Stage 1 of meaningful use, DUR checking is optional, although that should be resolved in Stage 2. And the industry needs to redouble efforts to

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reduce DUR noise so that prescribers will not disable or ignore them. Where there is a will, there is a way!

Formulary also has an element of patient safety. It is commonly believed that formulary is all about financial arrangements but the reality is that pharmacy and therapeutics (P&T) committees look at the safety and efficacy of drugs, as well, when choosing which medications that they will cover. We need to continue to improve the quality and usability of formulary data at the point of care so prescribers will find it beneficial.

And we must redouble our efforts to get the standardized Sig up and implemented — an idea/issue where there is disagreement among ePrescribing stakeholders. Some systems have structured Sig while others just use text boxes. Gathering a Sig in a structured format and transmitting it electronically to systems where the structured data elements can be uploaded without human entry will improve patient safety.

There still are legacy and homegrown systems out there that will continue to cause the kinds of problems identified in this study. Believe it or not, a lot of providers still think legacy systems, homegrown systems, and computer-generated faxes will qualify them for MU subsidies. We all must work to educate prescribers about significant variations in vendor offerings and levels of sophistication.

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Prescription Drug Monitoring Programs: Increasing Effectiveness Through HIT

By Mihir Patel, PharmD, RPh, Consultant
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To be sure, we support any and all efforts to thwart illegal diversion of prescription drugs. This is a national problem that affects us all. And it kills. In Florida, for example, drug-related deaths continue to rise, jumping from 6,767 in 2003 to 8,556 in 2008, the most recent year for which data are available. Drug diversion also leads to addiction, crime and fraud — all of which cost us dearly as taxpayers.

In theory, the PDMP is a good thing. In most states, providers are required to report prescriptions for drugs on Schedules II-V to the PDMP and pharmacies must submit information to the PDMP each time they fill such a prescription by a certain date. So far, 35 states have operational PDMPs; another dozen or so (plus the District of Columbia) have plans for them or have ones that are not fully operational. They are run by a number of agencies, depending on the state, such as the Department of Public Health or the Board of Pharmacy. Federal funding for PDMPs totals roughly \$7 million annually.

In reality, there's a lot to be desired. Due to privacy concerns in many states, practitioners can only ask patients for permission to access their prescription drug history from the database during an office visit. Pharmacists often are unable to access the system prior to filling a prescription, and the databases can have a several-month lag. PDMPs generally cannot share prescription histories across state lines — partially because of technology issues but mainly because of variations in state law as to what data may be collected and who can have access. Then, of course, there's just plain-old state centrism: some states don't necessarily play nicely together when it comes to sharing data. In many cases, law enforcement, state attorneys general and others do not have direct access to PDMP data and must request them from the PDMP program manager, who can only release data under certain circumstances (such as if an active investigation is in place or a subpoena has been issued). This can be a convoluted, time-consuming process. In the meantime, the bad guys have filled a lot of bogus prescriptions and set up shop in another state.

It may be a stretch at this point but eventually ePrescribing and HIT might be able to help. Now that we have ePrescribing for controlled substances, data from those medications feed into patients' medication histories. ePrescribers can see what was prescribed and where, without time lags. The same holds true for pharmacies. This means we can prevent problem prescriptions from the get-go and recognize "doctor shopping" sooner.

Questions remain as to how this information can promptly get into the hands of law enforcement and whether there will be a need for PDMPs further down the road. Improved HIT and interoperability should make PDMPs more efficient, help improve the quality of care, prevent adverse drug events and more quickly identify possible "doctor shoppers" and complicit providers.

These conversations were in play when the Drug Enforcement Administration began developing its rule for ePrescribing for controlled substances. They didn't get too far at the time, but that was then and this is now. Maybe it's time to reopen the discussions and bring some states in as well. We all have an interest in working to address this national problem.

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Regional Extension Centers

ACO Formation: A Future Possibility for Regional Extension Services?

By David Bergman, Senior Consultant

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How are they doing and what's next?

As might be expected, the RECs vary in meeting their operational milestones. Massachusetts, for example, recently became the first state to meet recruitment targets, and a handful of others are coming close, if they haven't done so already. While some RECs are struggling, the vast majority are somewhere in the middle — well on their way with recruitment, but perhaps making slow progress toward their respective goals.

Importantly, physician enrollment in RECs is only the first — and by many accounts the easiest — milestone. Most RECs are in the midst of a difficult transition from mere enrollment of providers to actual service delivery: helping providers with successful EHR implementation and, ultimately, documenting achievement of the 25 MU criteria.

Of course, Stage 1 MU is only the start. Although current federal funding for RECs only supports achievement of Stage 1 MU, two subsequent stages are expected to roll out in the next three years. With the real possibility of little or no additional federal funding on the horizon, many RECs are exploring plans for long-term sustainability. After all, what can RECs do to stay in business as well as provide value-added services to their communities? Helping with the formation of accountable care organizations (ACOs) may be just what the doctor ordered.

It turns out that RECs are uniquely positioned to provide the kinds of analytical services that individual practices and hospitals will need to facilitate ACO formation. A critical element of the ACO shared savings model is the sophisticated use of analytics to identify high-utilization individuals with low adherence to clinical quality standards and provide them with better organized, quality care. Yet, the mere identification of these individuals will only go halfway, and here is where RECs can really show their stuff.

A major element of REC work is linking technological changes created through EHR adoption with their actual use in practices. This includes, for example, working intimately with practices to both understand and modify actual workflows in ways that support the efficient and effective use of the EHR tool. RECs by design are positioned to support the “last mile” of technological implementation. In this way, they will help elevate EHR use from a potential technology boondoggle to a nimble tool for practice transformation.

When ACOs shine a spotlight on individuals with ambulatory care-sensitive conditions, outpatient providers will need tools to understand how to identify appropriate individuals, what to do with them and how to best connect them with a bevy of important wraparound services. It will be the RECs' role to help practices integrate these initiatives into their day-to-day practice by modifying workflows, adapting and optimizing.

As provider organizations — including hospitals, specialists and primary care providers — start looking for partners for ACO creation, RECs are a great place to start. With on-the-ground experience connecting the dots between technical innovation and service delivery,

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RECs could be the linchpin that holds together various provider groups and puts them well on the way to becoming a successful ACO.

POCP Blog

Blog Roundup

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of what's happening in the media, HIT, government and the health care industry. Check it out!

Here's a sample of recent posts to whet your appetite:

[Documenting Bad Encounters of the ePrescribing Kind](#). The Alliance for Patient Medication Safety (APMS) has relaunched a Web Portal to help pharmacies document their encounters with ePrescribing and provide feedback on improving the process. We support efforts to identify problems and improve the ePrescribing process. Our sense is that the portal wasn't used much before, hence the relaunch. Our hope is that the impact of the process will be constructive change, not ePrescribing bashing.

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[Taking the Steam Out of ePrescribing?](#) Rep. Renee Ellmers, R-NC, is attempting to take the “steam” out of ePrescribing, having introduced the Stripping the E-prescribe Arbitrary Mandates (STEAM) Act on June 3. While POCP is sympathetic to small business owners and others chafing at government mandates, it’s been a hard sell to get late adopters and laggards on board with ePrescribing, despite its benefits. That’s why we support federal incentives and penalties to expand ePrescribing adoption—negative and government imposed as they may be.

[Not So Fast, PCAST.](#) Last December, PCAST – a heavy-duty federal advisory panel – suggested we throw the baby out with the bath water. All we’d have to do is essentially trash the data standards and quality work that has been ongoing for more than a decade and replace them with a new “universal data exchange language” to support interoperable “tagged data elements” and data element access services (DEAS) — a mechanism to index, search and access health information across the universe of systems where such information resides. Following industry analysis, reactions are pouring in. They include comments from the National Committee on Vital and Health Statistics (NCVHS), which shared PCAST’s transformative vision but did not agree with its radical path to getting there. POCP agrees. A wholesale change in directions for healthcare data policies and technologies in the next 3 to 5 years is neither workable nor advisable. We need to keep the transformative vision in mind while we refine and build on the huge foundation we’ve created so far.

[AMA Offers Free Online Resources on Health IT Adoption.](#) The American Medical Association (AMA) recently introduced a [new series of online tutorials](#) to help physicians adopt health information technology (HIT). The series of six short, narrated modules, developed under contract with Point of Care Partners (POCP), provides step-by-step instructions to help physicians select, purchase and implement the best technology systems for their practice.

[“Delays” for Meaningful Use Stage 2? Better Read the Fine Print.](#) The Health IT Policy Committee — a powerful federal advisory committee packed with big names in HIT — recently recommended a “conditional” one-year delay, or extension depending on how you look at it, for MU Stage 2. It is applicable only to those who apply for MU in 2011, who now would have an extra year before beginning MU Stage 2. But providers need to read the fine print to figure it out. If they don’t understand the complexities, they could miss incentives and adoption milestones, and ultimately get their payments dinged for being clueless.

[Upon Further Review: Answering the eHI ePrescribing Questions Differently.](#) The eHealth Initiative (eHI) held a June 13 Webinar to review the AMA’s new Clinician’s Guide to ePrescribing. It was followed by a very useful question-and-answer period. However, there were some questions that POCP would have answered a differently, specifically about which state laws govern ePrescribing, whether ePrescribing data can be sold, whether MIPPA-qualified ePrescribing systems are listed anywhere and how ePrescribing interacts with state-run prescription drug monitoring programs (PDMPs).

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