HIT Standards Committee

Implementation Workgroup

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OMNI Shoreham Hotel, 2500 Calvert Street, NW, Washington, DC

Surescripts Testimony

Presented by Rick Ratliff, EVP Customers and Markets
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My name is Rick Ratliff, and I am the Executive Vice President of Customers and Markets for Surescripts. As the Chief Operating Officer of the legacy SureScripts organization and the Co-CEO of the new merged organization with RxHub in mid-2008, I have been involved in the development of an operational national health information exchange for prescription information now called Surescripts.

As most of you know, Surescripts is the Nation's E-Prescription Network which connects prescribers in all 50 states through their choice of e-prescribing software to the nation's leading payers, chain pharmacies and independent pharmacies. Through our work in standards, certification, education and collaboration at the national, regional and state levels, we have established a national digital healthcare infrastructure for the exchange of prescription information. Interoperability is at the core of our mission, focus and success.

I want to thank the HIT Standards Committee for the opportunity to comment on our implementation experience in building the national backbone for e-prescribing. My comments will draw from our experience over the past 8 years.

First, I think that it's important to quickly establish the definition of e-prescribing and interoperability at least from the perspective that will be used to support my comments. E-prescribing supports the shift to a paperless and more informed way for prescribers, payers and pharmacists to communicate. E-prescribing occurs when a prescriber uses a computer or handheld device with software that enables him or her to:

- Electronically access that patient's prescription benefit information (or formulary),
- With a patient's consent, electronically access that patient's prescription history,
- And, to electronically route the prescription to the patient's choice of pharmacy. Further, when the patient runs out of prescription refills, his or her pharmacist should be able to electronically send a prescription renewal request to the physician's office for approval.

Surescripts delivers these capabilities to end users via certified systems enabled for the core Surescripts e-prescribing services:

- **Prescription Benefit** – The Prescription Benefit service puts eligibility, benefits and formulary information at a prescriber's fingertips at the time of prescribing.

- **Prescription History** – The Prescription History service is made possible by Surescripts' ability to securely access and aggregate patient prescription history data from community pharmacies and patient medication claims history from payers and pharmacy benefit managers.

- **Prescription Routing** – The Prescription Routing service replaces old, error-prone approaches to sending new prescriptions with the secure computer-to-computer exchange of prescriptions between prescribers and pharmacies. This service also enables two-way communications between pharmacies and prescribers by electronically processing of prescription renewals.

As represented in the 2008 National Progress Report on E-Prescribing released earlier this year, these services are operational in physician practices and pharmacies across the country. In fact, the adoption and utilization of these services is growing at a rapid pace. As of today:

1) Approximately 150,000 physicians utilize the Surescripts network on a daily basis
    a. Using any of over 250 certified e-prescribing and EMR solutions
    b. Over 70% of the users on the network are utilizing EMR solutions
    c. We believe that most of the activity is medium to larger practices

2) Over 85% or 52,000 (of 61,000) retail pharmacies are processing prescriptions electronically
    a. Using any of over 40 certified pharmacy management systems
    b. Prescription renewals represent over 20% of the volume

3) Six of the top 10 mail order pharmacies are online and processing prescriptions electronically

4) Prescription Benefit information is available on over 220 million individuals in the United States

    a. Over 25 payors are participating in this service
    b. The formulary information is specific to the patient and accessed in a distributed manner utilizing a master person indexing technology that is tuned to industry best practices for probabilistic matching

5) Prescription History information is available on over 220 million individuals in the United States
    a. The prescription history is available to users of a certified system where patient consent is on record
    b. This information is available through a hybrid model utilizing the same master person index functionality

The Surescripts network success is grounded in a focus on neutrality, transparency and the use of industry standards. As a result, our network is now being utilized to support new interoperability use cases or requirements such as medication reconciliation processes within hospitals and the transmission of continuity of care record (CCR or CCD) documents across the network to support documentation for transitions of care.

With that as a foundation, I will now turn to the specific questions of the committee.

When working with your clients, what business problem (e.g., clinical issue, health outcomes problem, etc) were you helping them solve with implementing interoperability across organizational boundaries?

Eight years ago, the nation's leading payors/PBMs and community pharmacies embarked on a vision to create a neutral, national network for electronic prescribing. Leaders from these two important segments of healthcare sought to utilize technology to improve the safety, quality and efficiency of a key component of the healthcare system, medication management.

What standards did you use and why?

The core services on the network have been developed to support industry standards such as:

1) **NCPDP SCRIPT** – The Surescripts network currently utilizes NCPDP SCRIPT 8.1 for new prescriptions, prescription renewals and medication history requests. Other transactions such as prescription changes and prescription cancellations have limited deployment on the network, however this is expected to grow over

the next 12-18 months. As stated in a recent public announcement, we will begin certifying systems on the network to Surescripts' implementation of NCPDP SCRIPT 10.6 in May of 2010.

2) **NCPDP Formulary and Benefit** – The Surescripts network utilizes this standard to support the delivery and display of patient specific formulary information within the workflow of certified solutions.

3) **ASC X12N 270/271** – This standard allows a certified prescriber system to request eligibility information about a patient, in this case, specifically for pharmacy benefit eligibility information. The response information contains keys to properly display the formulary data using the NCPDP Formulary standard.

Note that the NCPDP SCRIPT Medication History transaction set as well as the NCPDP Formulary and Benefit structure were initially developed and deployed by the legacy RxHub. As the transaction and file formats became more widely deployed and there was encouragement by industry and CMS, RxHub brought these to NCPDP for incorporation into the NCPDP standards development process for adoption as new industry standards.

Each of the standards mentioned above is utilized as they are widely supported across the industry and they are referenced in specific legislation such as the 2003 Medicare Modernization Act.

There is also limited use of HL7 standards on the network in support of medication reconciliation. Last, the continuity of care record / document standards are utilized to move broader clinical information over the network.

What were the outcomes they were looking for? Were these outcomes achieved?

The initial outcomes were focused on development of the network infrastructure and driving adoption and utilization of the core services. The desired outcomes have been achieved as highlighted in the introductory remarks and we continue to exceed expectations on network growth.

In addition, the payor and pharmacy organizations involved in the development of the Surescripts network were expecting improvements in quality, safety and efficiency of the medication management process:

- Prescriptions are now flowing electronically between physicians and pharmacies (both retail and mail order). This eliminates the hand written prescription as well as the re-keying associated with printed and faxed prescriptions. The result is a

safer process and improved efficiency due to a decrease in phone calls between pharmacies and physician practices.
- Utilization of electronic prescription renewals significantly improves efficiencies in the physicians practice due to a reduction in faxes and phone calls.
- We are starting to see the impact on customer convenience in both retail and mail order pharmacies due to electronic transmission and processing of prescriptions.
- Real time access to patient specific formulary has resulted in improved formulary compliance and better utilization of more cost effective medications.
- Access to the patient's formulary has also resulted in fewer phone calls between the pharmacy and physician practices due to an off formulary issue.
- A study completed by Walgreens and IMS suggests that electronic prescriptions increase the first fill rate of medications.
- Although we do not have hard evidence, we believe that the availability of prescription history within the electronic prescribing process is having a positive impact on both clinical decision support and monitoring of diversion.

What challenges do you see in adopting the standards that have been recommended by the HIT Standards Committee?

Surescripts has demonstrated that it is possible for various standards to be adopted and implemented for the purposes of sharing prescription information on a national scale. Our experience would suggest that it is very important to adhere to a few key principles:

1) Focus on those standards and components of the standards that are important in order to demonstrate real improvement in interoperability and value to the various healthcare stakeholders. Once real improvement and adoption are demonstrated, then move on to other standards or components of existing standards.
    a. For example, Surescripts did not implement the Change and Cancel transactions early on. These transactions are now being introduced.
2) The applicable standards need to be established / adopted with a reasonable timeframe for implementation, certification and deployment. Given the quantity of standards and the speed of change in the standards (based on real world experience), it is imperative that there is good coordination between the relevant Standards Development Organizations (SDOs), NCVHS and CMS for adoption of standards.
    a. For example, Surescripts has worked with government and the industry to prepare for migration from NCPDP SCRIPT 8.1 to 10.6. The process for migration will begin in May of 2010 and proceed for 12-18 months. There are already new enhancements beyond NCPDP SCRIPT 10.6.
3) Provide a reasonable amount of flexibility with regard to practical implementation of the applicable standards within production network environments.

   a. There are optional fields within a given standard that should be made mandatory or restricted (within the standard definition) in order to ensure clarity among the participants and to optimize workflow. As an example, date of birth is optional according to NCPDP SCRIPT, however it is a required field in the Surescripts network in order to optimize the workflow in the pharmacy and decrease potential phone calls to the practice.

4) Do not forget about workflow and usability. Incorporation of the standards into the workflow of the clinical solutions is critical to effective utilization and maximum impact. This is likely one of the most important factors in driving wide-spread use of the standards and interoperability.
   a. As an example, the display of formulary must follow the natural workflow of the prescribing process so that the best economic alternative medication can be easily selected for the patient. It must be fast and it must be easy to follow / use.
   b. The utilization of prescription history information within the prescribing process has the potential to significantly improve clinical decision support. However, this information must be properly presented and/or utilized in the process of writing the prescription.

Were there challenges associated with trying to implement standards between large entities with significant IT capabilities and those that were less well provisioned? What compromises had to be made?

There are participants on the Surescripts network ranging from large Fortune 500 organizations and leading software vendors to small independent pharmacies, start-up EMR vendors and single physician practices. All participants must certify to the same standards in order to participate on the network. In this way, one participant does not have to be concerned with other participants in order to fully participate on the network.

It is important to note that Surescripts has completed over 750 certifications since 2005. We will complete over 200 new certifications and 400 re-certifications as we migrate participants from NCPDP SCRIPT 8.1 to 10.6 over the 18 month period beginning in May of 2010. In order to continue to support a live / production network while moving participants to a new version of a standard, it is important to implement a migration approach that supports the time and resource constraints of participants on the network.

What considerations would you suggest when it comes to standards with respect to the small practice market where adoption has been low and where the IT capabilities may be lacking?

I would suggest that the issue with the small practice is not related to standards at all. The key issue is providing flexibility with regard to support of solutions that meet the

critical standards and final definitions of meaningful use. It is possible that a small practice doesn't need a fully functional EMR solution to meet the needs of their practice, as well as the goals of improved interoperability and health outcomes. Approximately 30% of the users on the Surescripts network utilize standalone e-prescribing solutions and represent that they are satisfied with these solutions.

In cases of low adoption of the proposed standard, are there alternative standards that should be allowed if they support the goals of meaningful use, privacy or security?

We have not seen an issue of low adoption of the specific standards supported on our network. In fact, there are over 150 additional clinical systems currently in our certification queue.

As a result, the majority of all clinical solutions that support electronic prescribing as a feature of their particular solution have adopted the standards mentioned in my comments and have completed certification processes that demonstrate that these solutions meet the required standards. It is important to note that certification of a solution is not enough. It is critical that the certified solutions are installed in physician practices and that all relevant features associated with interoperability are properly installed, configured, and utilized.

We are seeing inconsistencies in the deployment of systems that have been certified. For those certified systems that are deployed, there are often inconsistencies with regard to installation, configuration and training of required features. This results in confusion amongst the providers and significantly diminishes the value of interoperability.

How did implementing interoperability between organizations help your clients achieve their goals, or did it inhibit progress toward achieving their goals? What role did the standards play?

The standards referenced in my comments today form the foundation for The Nation's E-Prescription Network. The open and transparent collaborative process that we have implemented over the past 8 years has enabled us to work with the participants on the network to evolve the standards such that they support the practical realities of a production implementation of a national digital healthcare architecture.

The implementation of these standards in the network and by the participants, as well as the intense focus on measurement and utilization have helped the participants to realize the initial goals related to improved safety, quality and efficiency.

What is an example of the greatest success and the most frustrating issue from your clients' implementations?

As we launched the network in Rhode Island in early 2004, we recognized the importance of collaboration and working with stakeholders in the community. The Rhode Island Quality Institute represented the major stakeholders in the community and led the charge with the Rhode Island Department of Health. As a result of their focus on e-prescribing as a first step in enabling a digital health infrastructure in the state, they are now able to say that they have 100% of the community pharmacies in the state on the network, over 60% of the physicians are e-prescribing, the major hospital systems and health plans are engaged, there is prescription benefit and history information available at the point of care for over 80% of the Rhode Island population and over 30% of prescriptions are written electronically each month. Even more, this platform is now a critical part of an H1N1 monitoring solution that we announced this week.

There are many other examples that are making a similar level of progress such as the Massachusetts initiative, SEMI in Michigan, etc.

What would you have done differently based on this experience if you knew what you know now?

We would have implemented a certification compliance function much earlier in the process in order to ensure that network participants are effectively implementing the same systems that being certified. This same function helps to ensure that as systems change they are re-certified to minimize negative impacts of software changes that may not have been effectively quality assured.

What advice would you give to help others mitigate problems or accelerate adoption of interoperable health information technology to improve health care quality and cost effectiveness?

It is important to understand that while standards are important, they are only the starting point. It is also important to note that we should not make the perfect, the enemy of the good. Launch from a good starting point and evolve the capabilities of the network within a framework something similar to the following:

1) Identify the initial value proposition
2) Identify the standards that will support implementation of solutions to achieve the value proposition
3) Develop implementation guidance deliverables and best practices
4) Develop an open, transparent certification process that will ensure that solutions participating in the network support the required standards

5) Implement and monitor a deployment program that will ensure certified solutions are effectively deployed into the network
6) Create programs that will review workflow and drive utilization
7) Continually measure adoption, utilization, quality, etc. and improve standards, implementation, deployment and other operational processes to deliver on the initial value proposition

This approach must be supported by an open and transparent collaborative process that captures the lessons learned, best practices and operational improvements in running and operating the network in order to scale in an efficient and quality manner. Done correctly, this process will identify enhancements to existing standards as well as support the development of new standards as mentioned earlier. Surescripts runs two Participant Workshops each year. The working sessions are very well attended and are a key component to the success of the Surescripts network.

As you would expect, delivering on interoperability requires collaboration amongst all of the participants. This process may start with the standards development, however it must continue through to implementation and production operations.