

**HIT Policy Committee
Information Exchange Workgroup
Hearing on E-Prescribing
Panel 3: E-Prescribing and Meaningful Use
January 25, 2010
9:00 a.m. – 1:15 p.m.
Health & Human Services – Humphrey Building
200 Independence Avenue, SW
Washington, DC**

**Chuck Frederick
Vice President – Clinical Applications
e-MDs**

Good morning members of the Information Exchange workgroup. Thank you for this opportunity to share some thoughts about e-prescribing in the context of meaningful use of electronic health records. My name is Chuck Frederick and I am the Vice President for Clinical Applications at e-MDs, an ambulatory EHR solutions provider based in Austin, Texas. Our company has extensive experience in implementing EHRs in small and solo primary care practices—the segment of physician population that provides healthcare for most Americans and yet is the least implemented on electronic health records. Our experiences with the needs of these physicians and my training as a pharmacist and developer of EHR systems provide a unique perspective on e-prescribing that encompasses both ends of the process. With that in mind, I would like to share with you e-MD's view of the Meaningful Use criteria related to e-prescribing.

Meaningful Use

Identifying requirements to encourage the industry and healthcare providers to adopt technology is not a simple task. Although the desire to select cutting edge solutions can be tempting it is critical to remember that change management occurs over time. Change can be difficult for busy providers and keeping the bar at a reasonable level in order to promote adoption is a requirement for successful acceptance early in the process. e-MDs feels that the current requirements for e-prescribing related to meaningful use in 2011—Stage 1-- are a realistic and practical compromise for providers. There is no doubt that our clients would like to see more functionality rather than less but taking a pragmatic view we also know that these frontline providers cannot be overburdened with more technology than they can easily transition to. The initial criteria certainly provide an attainable goal for most physicians considering the current state of technology.

The current objectives that require providers to enter orders electronically, to submit prescriptions electronically when appropriate, and to perform medication reconciliation at transition of care are all basic functionalities of any comprehensive EHR product. Furthermore, CCHIT certification over the last three years has virtually guaranteed that these types of features are included in any product with reasonable expectations of selling to providers who are becoming increasingly aware of e-prescribing.

Although we find the e-prescribing functionality and criteria achievable for both system developers and physician users, we would also like to address some issues that we find problematic.

As has been previously identified in the work of the FACA's, there currently are restrictions to electronic submittal of controlled substances. This issue must be considered as a potential barrier to e-prescribing adoption. Physicians already feel that the transition to electronic systems is challenging; adding an additional barrier by requiring different workflow depending on the type of medication being prescribed amplifies this challenge. While we realize this issue is outside of the purview of the committee we feel it is important to point out its potential as a disincentive for

adoption. In addition, as the government considers eventual resolution to this issue, we ask that the solution will not be overly burdensome on either provider or the system developer.

We would also like to highlight that differences in state laws can be a barrier to smooth adoption of this technology. As with the discrepancies in privacy laws from state to state, we see that some states have decided to be more restrictive than the DEA and designate certain drugs that are not considered controlled substances by the DEA as controlled at the state level. We understand the desire for better control over these issues consequent to e-prescribing of controlled substances, but the reality is that the drug reference data currently used by system developers is based on federal restrictions; it is a substantial resource burden to manage the permutations in functionality based on state regulations. As another example, some states require separate certification for vendors to be qualified to generate prescriptions both electronically and by fax. An overall national standardization effort for these issues would go a long way towards alleviating these problems.

Concerning e-prescribing features, while we feel that the current requirements for 2011 are a good compromise, we have some concerns about potential delays in adoption of other needed functionality. E-prescribing message types for cancellation or discontinuation of prescriptions, Fill Notification which allows pharmacies to notify providers when patients have picked up their medications, a true end to end verification to ensure that messages reach their intended end points, Structured and Codified Sig for consistent expression of directions for use of medications, and interactive electronic communication between pharmacists and providers are some of the features that need to be strongly considered sooner than later. The market will certainly drive development of some of this functionality but making these required as part of the program would spur adoption. Additionally, it is critical to understand that it takes both sides of the e-prescribing equation for these features to be successful. The pharmacies are participating and will certainly continue to do so but if there is no legislated requirement for pharmacies similar to that for the providers and EHR vendors the adoption rate for new functionality is not guaranteed to happen at an equivalent pace. Eventually market forces will drive everyone to adopt but none of the current requirements seem to consider these other players. As an example, past CCHIT certification required EHRs to be able to accept electronic lab results using standardized LOINC codes; however, there was no requirement for the lab systems to send LOINC codes. In our experience, none of our lab interfaces have ever received any LOINC codes outside of testing environments. The healthcare industry consists of many different players and true success will only occur when every segment is incentivized to participate. Only when providers, EHRs, labs, pharmacies, payors and others are all participating at the same level will success be attainable.

Concerning medication reconciliation, we strongly agree that medication reconciliation is a critical feature of meaningful use. In working with our clients, we hear some concerns around assurance that ALL of the medication information for a patient is available. In today's environment, not all claims and pharmacy prescription data is available to the provider and this needs to happen for a provider to feel confident in relying on the information received for clinical decision-making. We also have some concerns about lack of specific direction on what defines medication reconciliation. While we appreciate the position of not dictating how a feature will work in order to facilitate innovation and creativity for system developers, we remain concerned about expectations from other stakeholders such as the Joint Commission. More clarification on or an example of what medication reconciliation should look like in terms of a physician workflow would be welcome.

Lastly, our interpretation of the documentation leads to some concerns about the requirements for CPOE. We are unsure about whether the requirement for CPOE is to have providers themselves physically and directly enter the orders. If so this would be a concern. Our experience as practitioners and from interaction with our customers shows that this could be a deterrent to adoption. If you consider that in busy practices many physicians, in both the inpatient and ambulatory settings, are used to delegating some of these tasks to other medical staff within the care setting you being to realize that if the requirement is truly interpreted to be direct data entry

by physicians then significant changes in workflow would be required and those changes could be a major deterrent to adoption.

In conclusion, we thank you for the opportunity to share our experiences and thoughts on e-prescribing and meaningful use. We reiterate that the current Meaningful Use requirements for Stage 1 are an achievable compromise for both developers of EHRs and physicians and we encourage the Information Exchange workgroup to examine more fully the additional issues we have identified that we feel impact the transition to the full Meaningful Use of e-prescribing functionality.