

Comments to Legislative Workgroup on E-Prescribing

eQHealth Solutions is a not-for-profit, physician sponsored health care organization operating in Louisiana, Illinois, Florida and Mississippi. It has served as the Louisiana Medicare Quality Improvement Organization (QIO) since 1986. The QIO Program is delivered locally through a national network of 53 independent QIOs under the direction of the Centers for Medicare & Medicaid Services (CMS). The QIO Program brings evidence-based best practices to the bedside, with the flexibility to respond to local needs.

Our objective is to improve the value of health care services delivered to Medicare beneficiaries in Louisiana. We do this by helping health care providers (physicians, extenders, hospitals, nursing homes and others) align care processes with national standards that are evidence-based and clearly linked to better patient outcomes. Because our work focuses on many common diagnoses and procedures, both in acute and long term care settings, QIO activities benefit all patients regardless of insurance or payer status.

Within the healthcare community, eQHS has assisted physicians with adoption of electronic health records (EHR) including the ability to E-Prescribe. In previous scopes of work or CMS initiatives, as well as our ongoing efforts in Health Information Technology (HIT) and prior DOQ-IT experience, eQHS has provided needed assistance in the selection, adoption, and implementation of HIT to more than 300 Louisiana physicians statewide. Drs. Edwin R. Bonilla and Chris Granger of the Family Health Clinic in DeRidder, Louisiana became the very first physicians in Louisiana and the seventh in the nation to successfully submit quality data electronically to the Doctor's Office Quality - Information Technology (DOQ-IT) data warehouse in 2007 with the help of eQHealth Solutions Quality Improvement Specialists.

We have also worked to improve health outcomes for disparate populations in Louisiana in order to reduce the higher health burden of diabetics on racial and ethnic minorities and have improved the reporting of core preventive measures in patient populations by physicians.

In our continuing effort to support physician quality improvement activities, eQHS is currently assisting a select group of primary care physicians with qualified EHRs who are participating in the Physician Quality Reporting System (PQRS) program. Individual eligible professionals who meet the criteria for satisfactory submission of Physician Quality Reporting quality measures data via one of the reporting mechanisms above for services furnished during a 2011 reporting period will qualify to earn a Physician Quality Reporting incentive payment equal to 1.0% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period.

Lessons learned through our work with these physician practices will be made available to at no charge to all physicians and interested stakeholders state-wide. We are now launching shared learning platforms including Learning and Action Networks (LANs). LAN participants will be drawn from all relevant settings including government agencies, educational institutions, private sector and direct care providers who will meet face-to-face and via virtual collaboration tools to share learning. By becoming contributors as well as consumers of learning, LAN participants are optimally positioned to spread indigenous quality improvement best practices.

eQHS will also work within other current initiatives to help identify and reduce Adverse Drug Events (ADEs) in particular in Patient Safety and Clinical Pharmacy Services Collaborative (PSPC). By such effort, these PSPC communities can achieve optimal health outcomes, thus preventing and eliminating potentially preventable patient harm in patients over the age of 65 years. Secondary benefit will be measured in the form of reduced emergency room (ER) visits and reduced hospital admissions and readmissions where the primary or secondary diagnosis is an ADE.

Further comments in regard specifically to E-Prescribing by providers include the following:

There are electronic systems for E-Prescribing available to providers yet many are not part of certified or qualified EHRs. Some systems are more sophisticated than others and despite a need for perfection, few meet that definition. Despite current Computerized Physician Order Entry (CPOE), system failures are known to occur; it is not a panacea. Koppel reported in the JAMA (2005) that CPOE is associated with 22 types of error risks due to poorly designed or poorly implemented systems. It has been reported that 75% of ADEs resulted from system failures and all errors could have been reduced by better information systems.

Even having a CPOE within a hospital setting, there can remain a risk for patient safety. Not many are connected to the entire electronic medical record (EMR) of each patient so that data in one system may not be known to the other, an innovation promised but yet to be delivered.

A system is defined as a set of interacting, integrated, or interdependent elements that work together in a particular environment to achieve a specific aim; in our workgroup discussion and directives, the aim is E-Prescribing, patient safety and patient care, and prior authorization of prescribed medications.

An essential need for future healthcare systems in Louisiana is to be interrelated and connected – from physician/provider office practices, ambulatory care facilities, and inpatient hospitals to home health care agencies, laboratory/diagnostics venues and pharmacies. This will require a sophistication of electronic systems yet to be achieved by most systems currently available.

Whereas providers may become E-Prescribers, not all pharmacies in Louisiana, especially local or independents, are yet electronically connected. These pharmacies still require paper fax transfer and communication by voice or fax. Any weak link in the processing for a patient can cause a failure in the procurement of a correct, safe and prompt prescription. It will take all steps in the E-Prescribing process to function to assure the patient is best served.

Some provider practices that early on instituted an E-Prescribing system may find that later connecting to a different EMR system can be costly or impossible to

accomplish, perpetuating the disconnect between current patient data and prescribing decisions. This is a provider concern and a patient safety issue.

In regards to Prior Authorization (PAu) for a patient's needed medication, the provider should be prepared to always advocate for their patient. Physicians and other prescribers will continually be called on to help patients traverse the shifting, ever changing prescribing policy terrain safely and successfully. Many patients may prefer to pay for improper foods, tobacco products, alcohol, pain pills and tranquilizers rather than preventive and chronic disease control medications essential for their health. For whatever reason, the very patient that needs particular medications to prevent health deterioration, crises, or death will not afford such or be able to afford the co-payments. The resulting cost of healthcare for that patient may far exceed the cost of medications they did not receive.

The inconvenience of PAu could prompt providers and patients to forgo the use of effective, appropriate, and safer drugs. The impact of PAu on the cost of health care is not known. It may offer savings and profit for payers in the short term, but bring about less than optimal clinical outcomes long-term and a reduced quality of life issue for patients.

The way in which PAu programs are designed and administered is likely to make a critical difference in their effectiveness and acceptability to the provider and the patient. When preferred lists are developed thoughtfully and based entirely on accepted clinical evidence, they can guide the clinicians to select the cheaper of equally effective drugs. The extra time required to refer to the preferred list for that payer before initiating a new prescription (Rx) for the patient is modest and time-saving compared to sending a prescription to pharmacy that is subsequently rejected for failure to be covered, not to mention the time lost having to later open the patient's EMR to choose an alternative.

Not all Medicare Part D or Part C plans are the same. Patients must choose once yearly which plan will cover their current medications and hope that these medications will not change in the coming 12 months due to progression of their illnesses or complications. Many payers and their prescription benefit

management programs (PBM) may change preferred name brands or generic alternatives of drugs whenever improved costs are of benefit to them. New evidence of potential harm to patients by prescribed drugs may necessitate a change in formularies either to a higher tiered drug or one not covered by the patient's plan. This, however, requires more provider time and decision-making often not covered by payer and may not be afforded by the patient. These formulary changes for whatever reason could impact patient costs until a new payer or plan can be chosen by the patient or reaching the "doughnut hole" under Medicare Part D sooner.

PAu may require documentation by provider of step-by-step use of alternatives prior to approving a brand name or non-covered drug. If approved, limits may be set on the number of pills prescribed. To accomplish electronic prior authorization (ePAu) is a noble goal and could be helpful for both providers and patients. But if by doing so, coverage of particular drugs are not approved or allowed, there needs to be in place mechanisms to promptly dictate and to help accomplish appeal mechanisms. To have a human-to-human interaction for the benefit of the patient and his/her medical needs will be essential beyond the ePAu. Appeal discussions between patient's physician with the physician medical director of the payer should be allowed to discuss what is best for the patient. Physicians are the primary advocate patients will have in this process.

This concludes these comments for the Legislative Workgroup on E-Prescribing as proscribed by Senate Resolution 81 of the 2011 Legislature.

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