

# Feds Push E-Prescribing With Medicare Bonuses

BY DIANA MAHONEY  
New England Bureau

BOSTON — “E-prescribing saves lives, it saves money, and it’s time we implement it,” according to Health and Human Services Secretary Mike Leavitt. Streamlining the bloated health care system “is an economic imperative for our country. We have to get down to making the system better, and [e-prescribing] is one piece of a large puzzle,” he stressed at a conference on e-prescribing sponsored by the Centers for Medicare and Medicaid Services.

After acknowledging that “change is hard,” especially change that requires substantial time and money, Secretary Leavitt assured attendees that the benefits of implementing an electronic prescribing system would quickly exceed the costs, thanks in large part to the incentive program provided by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Under MIPPA, physicians who use a qualified e-prescribing system for their Medicare patients will be eligible to receive a bonus of 2% of their Medicare revenue in 2009 and 2010. The bonus amount will decrease to 1% of total Medicare revenue in 2011 and 2012, and to 0.5% in 2013. Beginning in 2014, physicians who are not prescribing electronically will see their Medicare payments reduced by as much as 2%.

From the government’s perspective, the business case for e-prescribing is a “no-brainer,” according to acting CMS administrator Kerry Weems, as widespread implementation of the technology could save Medicare \$13 million–\$146 million between 2009 and 2013. The savings, he said, will be achieved through averted medication errors and the substitution of

less-expensive prescription drug alternatives. Specifically, “errors associated with illegible handwriting are eliminated and those linked to oral miscommunications are substantially reduced because the process is automated,” he said.

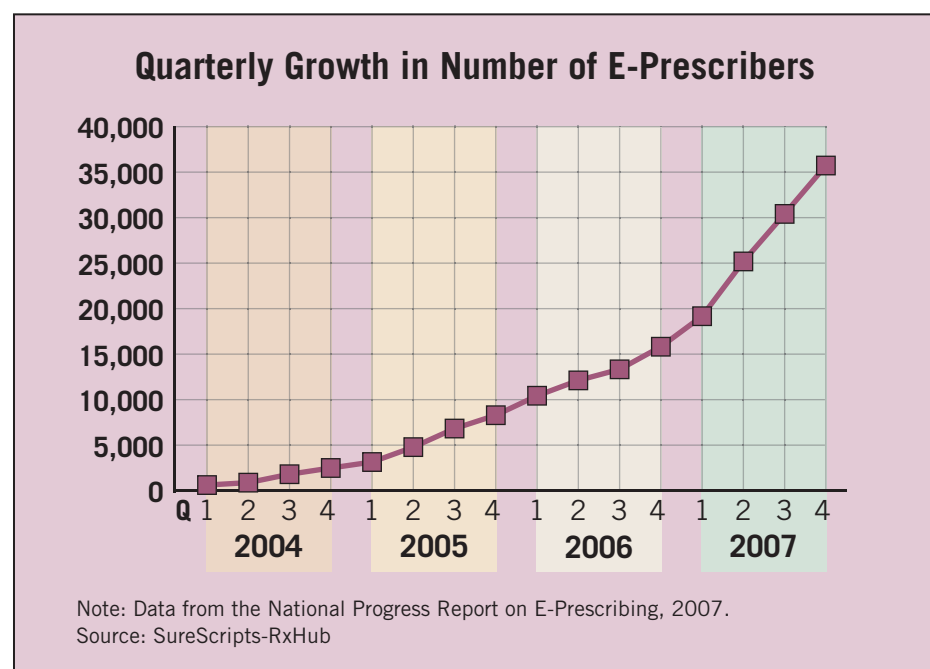
Additionally, e-prescribing software provides secure electronic access to each patient’s prescription history and automatically alerts physicians to dangerous drug interactions and allergies, thereby minimizing the potential for both.

E-prescribing also promises advantages that will have a positive impact on physician bottom line, Mr. Weems said. Automating the prescribing process reduces time spent on phone calls and faxes to pharmacies, speeds the prescription renewal request and authorization process, increases medication compliance, improves formulary adherence, allows greater prescriber mobility, and improves drug surveillance.

Together with the promised bonuses (and future penalties) for e-prescribing, the argument in favor of technology is gaining steam. “With MIPPA, Congress has helped us solve the business equation side of e-prescribing,” he said.

Without question, the financial incentives improve the case for converting from traditional to electronic prescribing, Mr. Weems said, noting that the average e-prescribing primary care doctor stands to collect between \$2,000 and \$3,000 in bonuses in 2009 and the cost of an e-prescribing system ranges from \$2,500 to \$3,000.

The psychological obstacles, on the other hand, may be tougher to knock down, according to Secretary Leavitt. “There’s always going to be resistance to change, and in this case, some of it is well thought out: I’ve got training costs; there’s likely to be



a productivity dip; do I really want my business to go through this? Those are the kinds of things that are part of any sort of business process change, and such change doesn’t happen overnight,” he said.

To help facilitate the change, the eHealth Initiative, in collaboration with the American Medical Association, the American Academy of Family Physicians, the Medical Group Management Association, and the Center for Improving Medication Management has published “A Clinician’s Guide to Electronic Prescribing,” which offers practical information on planning, selecting, and implementing an e-prescribing system.

The guide “is an invaluable resource that provides substantial detail not only on how to get started but what challenges to expect and how to overcome them,” said

Dr. Steven E. Waldren, director of the AAFP’s Center for Health Information Technology.”

Other challenges hindering widespread adoption of e-prescribing, according to the guide, include workflow changes, continued need for improved connectivity and technology, state regulatory restrictions (such as the New York State Medicaid requirement that the “dispense as written” instruction be handwritten), and the need for reconciled medication histories. ■

For a copy of “A Clinician’s Guide to Electronic Prescribing” visit [www.ehealthinitiative.org](http://www.ehealthinitiative.org). For more information on the conference and the e-prescribing initiative, visit <https://www.epsilonregistration.com/er/EventHomePage/CustomPage.jsp?ActivityID=378&ItemID=1133>.

## Transitioning to E-Prescribing: Careful Planning Can Smooth the Way

Moving from paper prescribing to electronic prescribing can dramatically improve the workflow in a busy practice setting, but the transition can be difficult, according to AAFP’s Dr. Waldren.

Technology-averse staff may resist the new processes; productivity may temporarily dip as users become accustomed to the new system; and frustrations may mount as a result of the inevitable impact on established roles and responsibilities, he said at the conference.

Dr. Waldren identified the following predictors of a successful transition:

- ▶ Commitment to the technology. “Everyone has to be on board with [the transition],” Dr. Waldren stressed. “You don’t want a dual system where some doctors are still using a prescription pad and others use a computer. There needs to be a blanket adoption.”
- ▶ Vision of a paperless prescribing process. “If you dabble in the technology, or do it only some of the time,” the transition will be more difficult, he said.
- ▶ Good intraoffice communication.

▶ Strong leadership and management in the practice.

▶ Proactive outreach to pharmacies and patients.

When planning the switch to e-prescribing, it’s important to set realistic, measurable goals, said Dr. Waldren.

“Maybe you want the 2% bonus from Medicare, or maybe it’s reducing the number of phone calls from pharmacists by 75%, or getting by with one less front desk person.” Whatever goal you adopt, he said, “stay focused [on it].”

Next, evaluate your practice’s long-term goals and short-term needs in order to identify the e-prescribing system that will best meet both, said Dr. Waldren.

One of the first considerations when shopping for a system is deciding whether to purchase stand-alone software, which can be acquired for, on average, \$2000–\$3000 per physician, or a full-function electronic health record (EHR) system with an e-prescribing component, which can cost up to \$50,000.

“Each has its pros and cons,” said Dr. Waldren. Stand-alone systems are rela-

tively inexpensive and easier to implement than a full EHR, “but you’re still stuck with paper charts,” he said. “EHRs automate your entire practice,” but they’re relatively expensive.

Because full-blown EHRs will likely be a requirement down the line, “if you’re looking at a stand-alone system, think of it as one of the first modules to deploy in an electronic health record,” said Dr. Waldren. For this reason, system interoperability should top the list of requisite features, he said.

Other considerations with respect to system selection include making sure the solutions being considered meet the Medicare definition of e-prescribing and that they connect to the pharmacy industry’s SureScripts RxHub, Dr. Waldren advised.

Additionally, evaluate the user friendliness of the various systems, and try to visit other practices that have implemented the systems you’re interested in “to see the products in real-world action,” he said. “A salesman’s demo is not enough.”

After selecting a system and negotiating pricing with the vendor, create a

team within the practice to lead and manage the transition and develop a reasonable “go-live” strategy that clearly specifies the nature and timing the transition, advised Dr. David Allard, physician director of the Henry Ford Health System’s Royal Oak (Mich.) Medical Center.

Training needs and expectations should also be well defined, he said. “In our practice, [software] trainers remained on site for 3–5 days and training was done in groups organized by function [doctors, nurses, front desk].”

Hands-on training should take place close to the “go-live” date to keep the information fresh, Dr. Allard said.

Also, “training should be revisited a few weeks later to address advanced functionality and address any issues that have come up,” he advised.

Finally, in anticipation of the transition, “contact local pharmacies and notify them that you are moving toward e-prescribing,” said Dr. Waldren.

Additionally, inform patients that the prescribing and renewal processes will be changing and let them know how it will affect them, he said.