Second National Doctors of Nursing Practice Conference: Defining Ourselves

e-Prescribing: Business Case for DNP Adoption

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Objectives

1. Define e-prescribing initiatives
2. Define stakeholders and their benefits
3. Describe financial implications and limitations
4. Discuss Medicare Incentive Program
5. Develop a business case for adoption
6. Describe stages of project implementation for office setting

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Definition

- Using computer technology to send and receive prescriptions (Rx) electronically

Overview

- 4.5 billion Rx written annually
- 1.5 million preventable medication errors and 7,000 deaths annually from med errors

Kohn, Corrigan, & Donaldson, 2000

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Overview

- July 2006, Institute of Medicine (IOM) recommended all Rx be transmitted electronically by 2010
- Effective Jan. 1, 2009 – computer generated faxes no longer counted as e-prescribing per Medicare

Adler, 2009

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Stakeholders include:

- Patients and families
- Providers
- Pharmacies
- Payers
- Society

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Stakeholder benefits

- Patients- safety, efficiency, lower co-pays, compliance, satisfaction
- Providers-efficiency, safety, improved quality of care, security, patient satisfaction, incentives, & integrated EHR
- Pharmacies-efficiency, improved quality and patient satisfaction, access to medication history cross providers, cost savings

Evidence on costs and benefits of HIT, 2008

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Stakeholder benefits

- Payers-increased formulary usage, efficiency, Rx compliance, reduced adverse drug events, cost savings
- Society- safety, improved quality of care, reduced ER visits, national cost savings estimated to be 27 billion

Evidence on costs and benefits of HIT,

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Financial implications

- Patient – no fees
- Pharmacy - installation of hardware and software, annual software upgrades, license fees, network and Internet access, staff training, and transaction fees for each electronic prescription and refill

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Financial implications

- Providers – installation of hardware and software (full EMR software with e-prescribe module averages $10,000 – $45,000 per provider), annual software upgrades, license fees, network and Internet access, staff training and technical support
- Temporary decrease in office productivity during workflow redesign (averaging 1-6 months)

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Limitations

- Significant initial cost
- Organizational “buy in” with diverse providers resulting in hold outs or partial implementation
- Decreased productivity and work flow changes during implementation
- Controlled substances Rx

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Limitations

- Lack of complete patient information-OTC's
- Complacency – every visit ask for medication list, prescribed and OTC, and allergies
- Alert Fatigue – excessive alerts

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Business Case for DNP Adoption

- Financial investment
- Improved safety and quality for stakeholders
- Leverage with health plans, pharmacies and other incentive opportunities with Medicare, P4P
- Improves provider efficiency and reduces cost
- Improves patient satisfaction
- Integrated electronic health records meeting IOM recommendations

Englebardt & Nelson, 2002

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Utilization

- Expected to become standard of care
- 2008 – 12% of medical offices
- 97% of chain pharmacies accepting e-Rx
- Nonparticipating pharmacies may accept a faxed or printed Rx from the e-prescription software but not counted as
  e-prescribing per Medicare

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Privacy of personal health information

- Protected by Health Information Portability and Accountability Act (HIPAA), secure transmission
- Information may be shared only for purposes of providing care or paying insurance claim

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Quality

- e-prescribing quality measure will be removed in 2009
  from Physician Quality Reporting Initiative (PQRI)
- Will become quality measure in the e-prescribing Incentive Program

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Medicare

- Bonus to providers who e-prescribe (2% of charges billed to
  Medicare in 2009 and 2010, 1% in 2011 and 2012 and declines by 0.5% by 2013)
- Estimate of yield - $1,700-$3,500 a year per provider during
  bonus period
- Penalty of 1% reimbursement beginning in 2012, increasing
  to 2% in 2014 and beyond

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Medicare Incentive

- Participate as a Medicare Part B provider
- Additional information, visit www.cms.hhs.gov/PQRI and select “E-prescribing Incentive Program”

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Eligible Providers

- Nurse Practitioner
- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Anesthetist
- Clinical Nurse Specialist

*As per state practice laws

- PT, OT, ST*
- Clinical Social Worker*
- Clinical Psychologist*
- Registered Dietitian*
- Nutrition Professional*
- Qualified Audiologist*

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To become a successful e-prescriber :

- Bill using your usual denominator codes:
  ie. 99211, 99212, 99213, 99214
- Use a G code for the numerator: G8443, G8445, G8446
  on the same claim form as the denominator

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To become a successful e-prescriber : numerator codes

- G8443: e-prescribing for all prescriptions
- G8445: have e-prescribe but didn't need a Rx
- G8446: have e-prescribe but laws require paper Rx
- G8446: have e-prescribe but pt. requested paper Rx
- G8446: have e-prescribe but pharmacy can't receive e-Rx
- G8446: have e-prescribe but controlled substance written

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Example

- If using e-prescribing for all prescriptions, G 8443 code entered on claim form by provider or billing in numerator
- Report e-prescribing quality measures through Medicare Part B claims on at least 50% of applicable cases during reporting year

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What's next?

- Penalties begin in 2012 for not e-prescribing and reporting to Medicare

Projected reimbursements:

- 99% in 2012
- 98.5% in 2013
- 98% in 2014

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Status Report

- January 1, 2009, CMS began providing incentives for successful e-prescribers

Future

- Penalties begin in 2012 for not successfully e-prescribing and reporting to Medicare

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Project implementation in an office setting

- Develop project proposal; obtain board support
- Research, evaluate and purchase EMR with e-prescribe module; Timeline 3-6 months
- Install hardware, software and Internet connection
- Computer literacy is critical
- Develop and test back up plan for IT failures

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Project implementation in an office setting

- Provider and staff EMR training; Timeline 4 to 8 hours minimum
- Go live with EMR; Adjust office work flows
- Evaluate and re-educate staff; Timeline 1-3 months

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Project implementation in an office setting

- Educate patients about e-prescribe rollout
- Provider and staff training; Timeline 1 to 2 hours minimum
- Go live with e-prescribe
- From idea to implementation in a small office; 7 months (August to March)

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Project implementation in an office setting

- End user evaluation of process implementation
- Survey providers, patients and pharmacies;
  Timeline 1 month
- Adjust process and re-educate; Timeline 1-2 months

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Deliverables

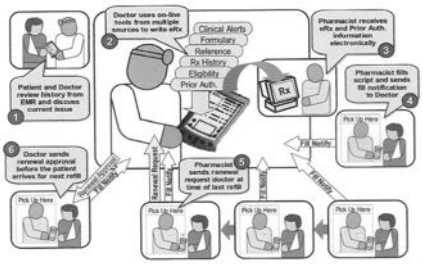
- Patient safety
- Improved health care quality
- Improved medication management far all stakeholders
- Secure, convenient, efficient for patients
- Enhances provider efficiency and reduces cost
- Integrated plan of electronic health records

Englebardt & Nelson, 2002

steps

e-prescribing - 6 steps

Courtesy of Pfizer



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Kohn, L., Corrigan, J., Donaldson, M. (Eds). (2000) T*o err is human: Building a safer health system.* Washington, DC: National Academies Press.

Web Resources

www.cms.hhs.gov/EPrescribing – bonus information

www.get Rxconnected.com – readiness assessment

www.ehealthinitiative.org- for providers

www.learnaboutprescriptions.com – for consumers

www.nationalalerx.com-National e-Prescribing Patient Safety Initiative

www.thecimm.org-the Center for Improving Medication Management