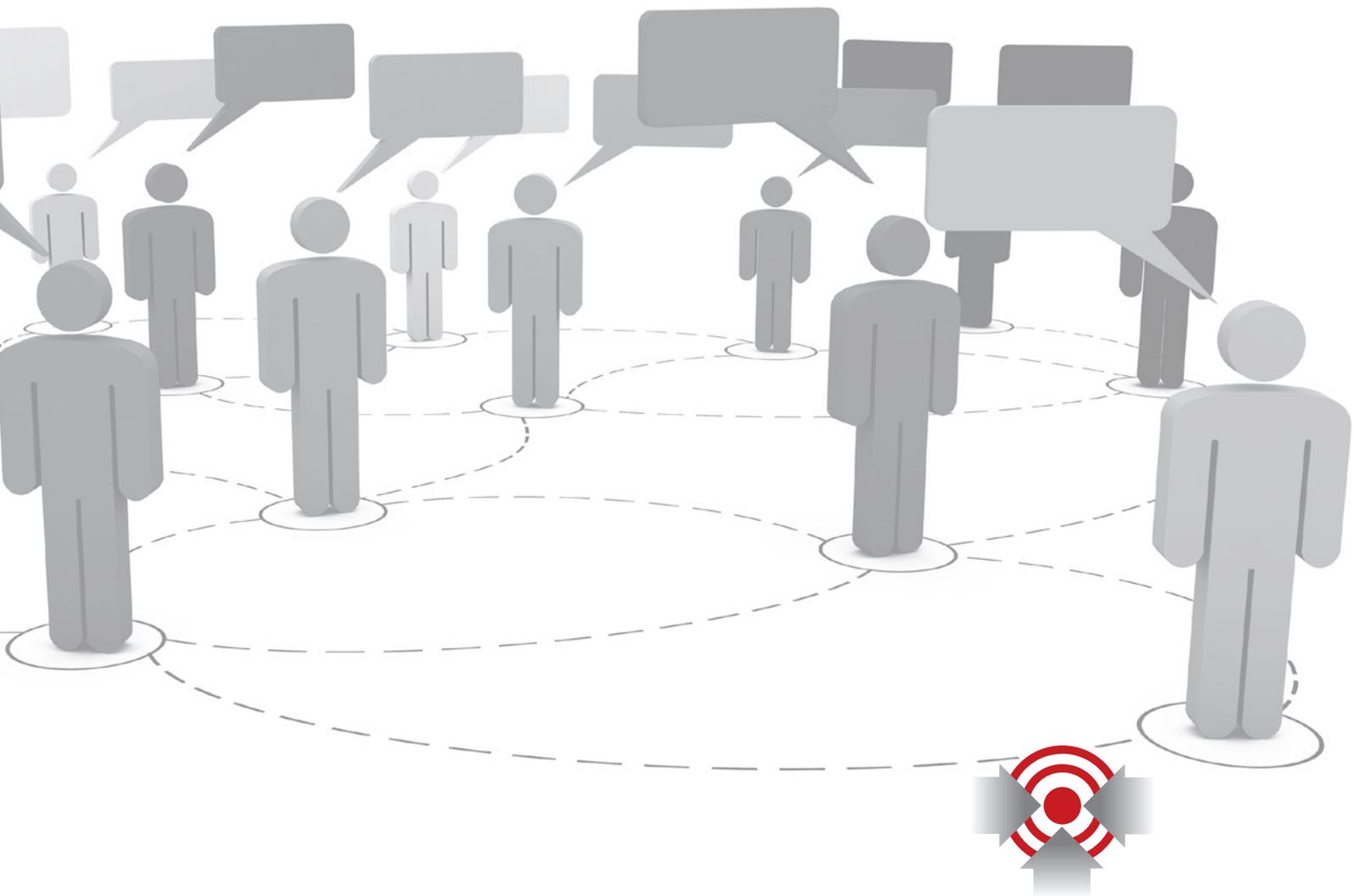


E-Prescribing and EPCS: Connecting the Dots for the Right Conversation with Patients



POINT-OF-CARE PARTNERS
Health IT Management Consultants

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Contents and Background

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BACKGROUND OF E-PRESCRIBING AND EPCS

The expanded influence of health information technology (HIT) is evident in many areas of health care today. Electronic prescribing of medications—one of the core capabilities of today’s Electronic Health Records (EHRs)—for example, has been available for decades, but was primarily deployed in acute care settings for most of this time.¹ In the last seven years, physicians and hospitals around the United States have rapidly moved to adopt e-prescribing, electronic health records (EHR) and other forms of HIT as standard practice workflow tools. By 2013, 78% of physicians and 94% of hospitals reported use of certified EHRs.² Over the same period, other forms of HIT, including prescription monitoring programs (PMP) and disease registries, have begun to be more widely deployed.

EHRs are not just e-prescribing tools. At their core, they enable the rapid, discrete, and secure exchange of clinical information and support a range of patient-centric outcome improvement strategies. When EHRs, PMPs, disease registries, and other sources of health data are combined and integrated into the EHR, the result is a rich pool of opportunities for targeted population health management. This is of particular importance in addressing the emerging epidemic of prescription drug abuse. This paper will provide tips and tools on how providers can leverage emerging technology options to identify and support patients around prescription drug abuse.

¹ The Impact of Information Technology on Managed Care Pharmacy: Today and Tomorrow, *Journal of Managed Care and Specialty Pharmacy*, October 29, 2014. Accessed at <http://www.amcp.org/JMCP/2014/November/18721/1033.html>.

² Burwell, Sylvia M. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care, *New England Journal of Medicine*, March 5, 2015 372(10):897. Accessed at <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>.

Introduction

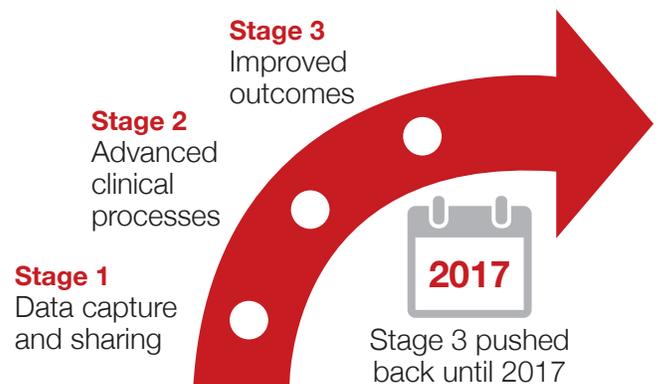
Funding for Health IT Adoption

Much of the EHR adoption since 2008 was driven by the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. This act—a significant component of the American Reinvestment and Recovery Act (ARRA)—created and funded a range of HIT adoption and support programs under the auspices of the Office of the National Coordinator for Health Information Technology. It also created the statutory authority for the Electronic Health Record Incentive Program, a program administered by the Centers for Medicare and Medicaid Services (CMS).

The EHR incentive program makes additional reimbursements for the adoption and meaningful use of certified EHR technology available to certain providers and hospitals. In order to qualify for these incentive dollars, providers and hospitals must attest to having met an increasingly difficult standard of “meaningful use” of EHR technology as defined in three stages. Broadly speaking, these three stages of meaningful use (see diagram right) move from enabling certain types of electronic exchange of clinical data (Stage 1), to using the electronic exchange functions (Stage 2), to using the electronic exchange functions to improve quality outcomes (Stage 3). Stage 3 of Meaningful Use requirements were released in March 2015 as proposed rules, and are not expected to be fully implemented until 2017.

The use of EHRs has built on and propelled a growing interest in population health management. Population health management involves the coordination of care delivery across a population to improve clinical and financial outcomes, through disease management, case management and demand management.³ It uses analytic techniques to look at groups of people on the basis of their health-related attributes. These attributes can include diagnoses (diabetes), lab results (H_gA₁C >9), prescriptions (Metformin), procedures (cardiac catheterization), or any other discrete component of a patient’s medical record that can be used to filter a population into target-able segments. This enables health care providers to address the unique needs of these segments, for example, by focusing on behavioral and therapeutic techniques that improve health outcomes.

Three Stages of Meaningful Use



³ Population health management. (n.d.) *McGraw-Hill Concise Dictionary of Modern Medicine*. (2002). Retrieved from <http://medical-dictionary.thefreedictionary.com/population+health+management>.

Improving Health Care Quality

New reimbursement models that measure and pay for quality health care outcomes are driving provider interest in population health management—an interest that is enabled by the emerging technology infrastructure. Electronic health records and the data they generate are used to calculate clinical quality measures, and these measures, in turn, are used in new payment models to encourage the adoption of strategies and practices linked to delivering quality outcomes.

Practices that are looking to align with clinical quality measurement may consider quality improvement initiatives that bring together a range of internal—and sometimes external—stakeholders. These efforts might define a benchmark of performance, and then quickly move to explore clinical and operational changes to further improve performance.

One important tool for improving performance is known as clinical decision support, or CDS. Strictly speaking, CDS does not require the use of an EHR since it describes a wide range of tools or methods to support clinical decision-making by clinicians. However, CDS can be configured to leverage the trove of patient-specific data in an EHR. In these situations, the CDS becomes highly focused and, perhaps more importantly, integrates naturally into a provider's workflow. In this way, CDS supports the alignment of clinical practice on an individual patient level, with the clinical outcome and reimbursement incentive goals for a provider's entire practice.



“Clinical Decision Support is a process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and health care delivery. Information recipients can include patients, clinicians and others involved in patient care delivery; information delivered can include general clinical knowledge and guidance, intelligently processed patient data, or a mixture of both; and information delivery formats can be drawn from a rich palette of options that include data and order entry facilitators, filtered data displays, reference information alerts and others.”

Osheroff et al. “Improving Outcomes with Clinical Decision Support: An Implementer's Guide. 2nd Edition” HIMSS, 2012

Combating Prescription Drug Abuse

One population health issue that has grown significantly over the last several years is prescription drug abuse—especially for opioids. In 2014, the Centers for Disease Control and Prevention characterized prescription drug abuse and overdose as the second highest health threat in the United States. Deaths from opioid overdoses rose to more than 16,600 in 2010.⁴ States and the

Federal government are starting to recognize that HIT has a role in addressing this problem. Among HIT tools available today, states are increasingly looking at both Electronic Prescribing of Controlled Substances (EPCS), Prescription Monitoring Programs (PMPs), and EPCS/PMP combined to mitigate this growing public health problem.

In 2013
more people
died of
overdose from
prescription
painkillers*



**THAN FROM
ILLEGAL DRUGS**

16,600
PEOPLE DIED
in 2014
due to
prescription
painkiller
overdoses**



Enough painkillers
prescribed in
the U.S. in 2010
to medicate
every
American adult
around the clock
for a month***

In 2010
1 in 20
PEOPLE
IN THE U.S.
(age 12 or older)
reported using
prescription painkillers
FOR NONMEDICAL
reasons in the
past year***



* Centers for Disease Control and Prevention. National Vital Statistics System mortality data. Available from <http://www.cdc.gov/nchs/deaths.htm>

** Centers for Disease Control and Prevention. Available from <http://www.cdc.gov/vitalsigns/pdf/2013-07-vitalsigns.pdf>

*** Centers for Disease Control and Prevention. Available from <http://www.cdc.gov/vitalsigns/painkilleroverdoses/index.html>

⁴ CDC *Vital Signs*. Publication date: 7/2/2013. Accessed at <http://www.cdc.gov/vitalsigns/pdf/2013-07-vitalsigns.pdf>.

Role of EPCS

Electronic prescribing of controlled substances has the potential to significantly reduce prescription drug abuse, diversion and fraud by creating a secure, tamper-proof and auditable transaction. While controlled substances only account for 13% of all prescriptions issued,⁵ they are prescribed by 90% of prescribers,⁶ the majority of whom now use e-prescribing systems.

In 2010, long after e-prescribing of non-controlled medications became legal, the Federal Drug Enforcement Administration (DEA) issued the Interim Final Rule (IFR) for Electronic Prescriptions for Controlled Substances, which made EPCS legally possible. As part of this process, the DEA defined very specific criteria for writing an electronic prescription for a controlled substance.

Although this rule made EPCS for schedules II-V controlled substances legal from a Federal perspective, States still had to enact rules and legislation to make EPCS legal according to State law and in accordance with Federal law. For example, the DEA requires that prescribers use a system that is certified for EPCS. Additionally, providers must invest in technologies and establish processes to meet identity proofing, access controls, dual authentication and digital signature requirements. State laws must be consistent with these requirements, but in some cases may be (and are) more stringent than the federal requirements.

Nationwide, EPCS adoption and the availability of EPCS-compliant software is still low. In 2013, less than 1% of controlled substances were prescribed electronically.⁷ However, EPCS adoption is increasing as states enact legislation enabling EPCS, and EHR and e-prescribing vendors release technology platforms in accordance with DEA requirements. From July 2012 to December 2013, the total number of EPCS increased by an average of nearly 3,000 scripts every month according to an ONC study.⁸ Since then, the number of certified HIT products has grown substantially. By early 2015, 48 states had legalized EPCS, and more than 50 technology vendors were certified to support EPCS.⁹ With so many new products, EPCS is expected to continue its significant growth.

Role of Prescription Monitoring Programs (PMPs)

PMPs are statewide electronic databases that receive controlled substance drug dispensing data from pharmacies and contain clinically useful information for prescribers and pharmacies. PMPs include data for controlled substances dispensed across a state and sometimes include data from bordering states. They are established by states to curb prescription drug abuse and typically may only be accessed by authorized health care professionals, except in New York where patients may access their own dispensing data. A key means through which PMP programs support the identification of at-risk patients is the use of communications to alert prescribers when patients exceed a use threshold. For example, according to the Arizona State Board of Pharmacy, prescribers receive a letter when a patient fills controlled substance prescriptions from seven prescribers at seven pharmacies within the past 30 days. The letter contains the information a prescriber needs, such as the patient's name and date of birth, to access the PMP database and review the patient's dispensing history.



⁵ National Association of Chain Drug Stores (NACDS) 2013 dispense data for all new prescriptions, refills, and renewals in the US.

⁶ Parks Thomas Cindy, Kim Meelee, McDonald Ann, et al. In Prescribers' Expectations and Barriers to Electronic Prescribing of Controlled Substances. *J Am Med Inform Assoc.* 2012;19(3):375-381.

⁷ Surescripts presentation at NCPDP November 2014 Work Group meeting and Point-of-Care Partners compiled data.

⁸ Meghan Huftader Gabriel, PhD; Yi Yang, MD, PhD; Varun Vaidya, PhD; and Tricia Lee Wilkins, PharmD, PhD. Adoption of Electronic Prescribing for Controlled Substances Among Providers and Pharmacies. *Am J Manag Care.* 2014;20(11 Spec No. 17):SP541-SP546. Published online November 17, 2014.

⁹ E-Prescribing of Controlled Substances (EPCS). *Surescripts.* Available at www.surescripts.com/epcs. Accessed March 1, 2015.

How State PMP Programs Vary¹

Sixteen states mandate use of the state's PMP in some circumstances:

- Eight states (KY, MA, NM, NY, OH, TN, VT and WV) have triggers that require the PMP to be accessed by prescribers before the initial prescribing or dispensing of a controlled substance and at designated periods after the initial fill.
- Six states (CO, LA, MN, NC, OK and RI) require certain prescribers to access the PMP for specific drugs.
- Delaware and Nevada require the prescriber to access the PMP if there is a "reasonable belief" that the patient wants the prescription for a nonmedical purpose.



PMP databases contain data for all controlled substance prescriptions, regardless of whether they're purchased using cash or through a patient's prescription benefit. Cash transactions are not always made available through the medication history view provided in EHRs and e-prescribing tools, which populate pharmacy claims. Today, pharmacies in all states except Missouri must report every dispensed controlled substance to their PMP, typically monthly, except in New York where the data must be submitted within 24 hours of dispensing or within 72 hours of shipping mail orders.

The American Academy of Family Physicians (AAFP) considers PMPs to be a key mechanism for addressing prescription drug abuse in the United States. In their 2012 position paper,¹⁰ Pain Management and Opioid Abuse: A Public Health Concern, the AAFP urged all states "to implement prescription drug monitoring programs and the interstate exchange of registry information as called for under the National All Schedules Prescription Electronic Reporting (NASPER) Act of 2005."

More recently, at their 2014 State Legislative Conference,¹¹ the AAFP reported that all states except Missouri have a PMP and 27 states share PMP data between them. However, the use of PMP data among prescribers remains low. According to Martyr Allain, J.D., director of Indiana's PMP, which is known as INSPECT, for every 10 [EPCS] prescriptions that are written in Indiana, the PMP database is checked once. Even though participation is low from prescribers, Indiana has reported a 20 percent decrease in patients who had a high volume of controlled-substance prescriptions, indicating that even marginal use of PMPs can have a significant impact on rates of prescription drug abuse.

PMP programs can be a powerful tool to reduce prescription drug abuse and tragic deaths. The reporting and monitoring each state provides enables collaboration among prescribers, pharmacies and law enforcement officers and encourages informed conversations and interventions with patients.

¹⁰ American Academy of Family Physicians Pain Management and Opioid Abuse: A Public Health Concern. Position Paper. Published May 14, 2014 at http://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/opioid-abuse-position-paper.pdf.

¹¹ Michael Laff. State Legislative Conference Panel: Quashing Prescription Drug Abuse Demands Community Effort. AAFP. December 2, 2014. Accessed at <http://www.aafp.org/news/practice-professional-issues/20141202statelegopioids.html>.

Eyes on New York: I-STOP

On August 27, 2012, the Internet System for Tracking Over-Prescribing, or “I-STOP,” became law in the state of New York. Considered bold legislation by many industry observers, I-STOP affects nearly all of New York’s 80,000 plus prescribers and contains five (5) distinct parts¹² intended to combat drug misuse and abuse in the state. I-STOP effectively brings together critical components of e-prescribing and a PMP under the rubric of a provider mandate. The electronic prescribing mandate will be the last of the five components of I-STOP to go into effect when it becomes enforceable on March 27, 2016.

According to Attorney General Eric Schneiderman, “I-STOP will be a national model for smart, coordinated communication between health care providers and law enforcement to better serve patients, stop prescription drug trafficking, and provide

treatment to those who need help.” The mandate to move to full e-prescribing—including for controlled substances—takes effect on March 27, 2016, and failure to comply may subject practitioners to a range of financial, criminal, and license-related penalties.¹³



¹² Internet System for Tracking Over-Prescribing (I-STOP) Act. *New York State Office of Alcoholism and Substance Abuse Services*. Accessed February 2015 at <http://www.oasas.ny.gov/StopRxMisuse/ISTOP.cfm>.

¹³ New York Public Health - Title 2 - § 12-B Willful Violation of Health Laws. *Oncle.com*. Accessed February 2015 at http://law.onecle.com/new-york/public-health/PBH012-B_12-B.html.

Connecting the Dots: A Use Case Example

PMPs currently contain comprehensive information about past filled prescriptions for controlled substances—information as reported by pharmacies. However, the process of looking up this information can be challenging for prescribers. In New York State, for instance, prescribers seeking to check the PMP are required to have a Health Commerce Account. Then, to check the PMP, they must first remember their obligation to check the PMP, go outside their normal EHR's workflow to open a browser, enter their credentials, and then look up the patient. Prescribers find this process cumbersome, and as described earlier by the Indiana PMP director, the number of providers actually checking the PMP is low.

One solution would be to leverage existing and emerging standards to integrate PMP information into an EHR. The Security and Interoperability Framework of the Office of the National Coordinator for Health Information Technology is piloting this integrated concept in several states: Arizona, Kentucky, Wisconsin, Virginia, New Mexico, and Washington. This approach will enable providers to review PMP information within the context of their existing EHRs, thereby eliminating a major objection of providers. If successful, this could pave the way for other states—like New York—to support EHR integration of PMP data, potentially leveraging it for clinical decision support.

The Five Parts of I-STOP

PART A:

Prescription Monitoring Program. Since August 27, 2013, practitioners (with limited exceptions) have been required to consult the PMP prior to prescribing/dispensing Schedule II, III, or IV controlled substances. Pharmacies report their dispensing data in real-time, enabling prescribers to immediately discern if patterns of abuse exist.

PART B:

Electronic Prescribing. Requires that all prescriptions, controlled and non-controlled, from practitioners to pharmacists be made by electronic transmission by March 27, 2016, with limited exceptions.

PART C:

Controlled Substance Schedules made hydrocodone, tapentadol, and oripavine Schedule II controlled substances, and it added tramadol, ezogabine and lacosamide to Schedule V.

PART D:

Prescription Pain Medication Awareness Program expanded the scope of New York's Prescription Pain Medication Awareness Program in 2012 and appointed additional members to its supporting Workgroup representing addiction treatment providers, consumer advocates, health care practitioners, and law enforcement agencies.

PART E:

Safe Disposal required DOH to establish a program for safe disposal of unused controlled substances as well as their anonymous surrender without threat of prosecution.

Enabling the Right Conversations with Patients

Making PMPs effective is a function of both using PMP information to **identify** patients with possible problems, and to **engage** patients who may be abusing or diverting their controlled substance prescriptions. How to engage a patient depends largely on whether the PMP data suggests abuse, diversion, or something less nefarious but equally serious like the risk of overdose. The New York State PMP, for example, displays at the patient level, the number of controlled substance prescriptions by provider, but offers no clinical guidance regarding why, what to look for or how to use the information. For this reason, providers may be unsure when action is recommended.

The first step is to differentiate suspicious and non-suspicious PMP history. The Centers for Disease Control, for example, recommends that providers look more closely at adults younger than 65 who are being treated with opioids for more than six weeks by two different prescribers. A more exacting method is recommended by the Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP-TTAC) which recommends calculating the Morphine Milligram Equivalents (MMEs), a method for identifying patients at risk for an overdose of opioids.

Some recommendations are not directly related to a PMP, but may still provide guidance to providers, particularly around drug-seeking behavior that could derive either from diversion or

abuse. For example, the New York State Department of Health identifies possible drug-seeking behavior as:

- “Patient shows unusual knowledge of controlled substances, gives evasive or vague answers to questions regarding medical history, or gives medical history with textbook symptoms.
- Patient is reluctant or unwilling to provide reference information and usually has no regular doctor or health insurance.
- Patient requests a specific controlled substance and is reluctant to try a different drug.
- Patient generally has no interest in diagnosis, fails to keep appointments for further diagnostic tests or refuses to see another practitioner for consultation.
- Patient exaggerates medical problems and/or simulates symptoms.
- Patient exhibits mood disturbances, suicidal thoughts, lack of impulse control, thought disorders or sexual dysfunction.
- Patient exhibits physical signs of drug abuse; tremors, profuse sweating, anxious behavior, unusually dilated or constricted pupils, skin tracks and related scars on the neck, axilla, forearm, wrist, foot or ankle.”¹⁴

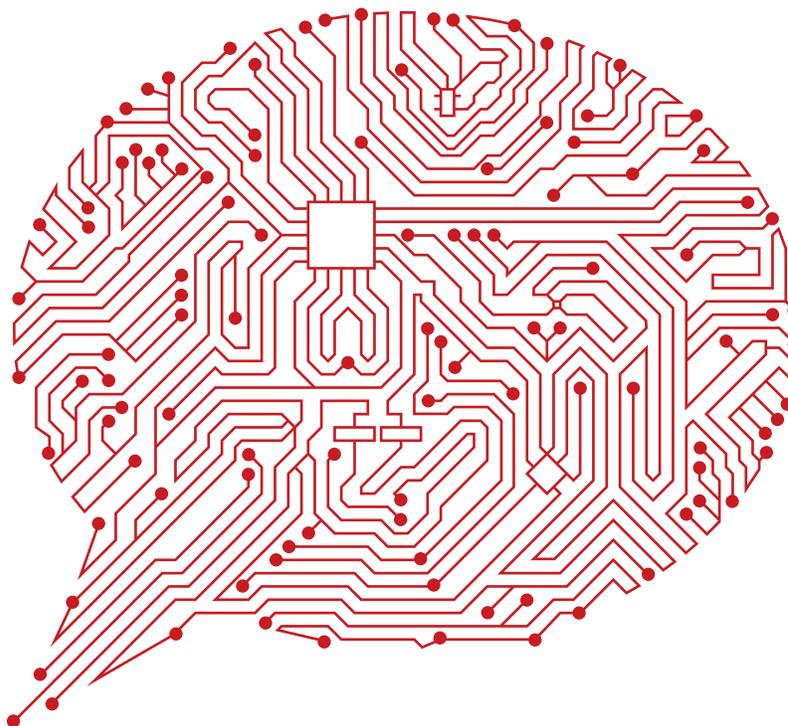
To achieve the best results, providers should use both the PMP data as well as their own professional judgment.

¹⁴ Abuse and Treatment: Information for Practitioners. New York State Department of Health. Accessed February 9, 2015 at <https://www.health.ny.gov/publications/1063/>.

It is not always easy for providers to engage with patients concerning their prescribing history for controlled substances, especially where there is a suspicion of diversion or abuse. But rather than avoid the problem, providers will want to approach patients — albeit carefully — in these important discussions. The American Academy of Orthopedic Surgeons recommends a five-point strategy when discussing drug-seeking behavior with patients:

- “Be empathetic and acknowledge the patient’s suffering and conflicting emotions about pain medication use.
- Do not be paternalistic; be willing to admit to personal inadequacies in managing a drug problem. This opens the door for referral to pain management or to a tertiary facility to confirm and support the diagnoses.
- Be firm and confident in the presentation of information and encourage honest responses by using simple, open-ended questions.
- Maintain privacy and strict confidentiality to make patients comfortable and open to sharing their concerns.
- Most importantly, document everything and assess the patient’s understanding of any agreements.”¹⁵

Additionally, prescribers have a range of resources to call upon to help individuals who are ready for some form of treatment. If patients are open to treatment, New York State providers can call the Office of Alcoholism and Substance Abuse Services at 1-877-846-7369, or by visiting www.oasas.ny.gov to help find treatment programs. Providers in other states should consult their state agency responsible for substance abuse services, or the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration directory of state agencies.¹⁶



¹⁵ Michael R. Marks, MD, MBA; Donna Phillips, MD; David Halsey, MD; Andrew Wong, MD, “Tips for Dealing with the Drug-seeking Patient” in *AAOS Now*, March 2014.

¹⁶ SAMHSA Directory of Single State Agencies (SSA) for Substance Abuse Services. Published February 24, 2014. Accessed February 2015 at <http://www.samhsa.gov/sites/default/files/ssadirectory.pdf>.

Conclusion

Electronic health records and other forms of HIT are rapidly transforming how health care providers do their work. In addition to enabling more effective care coordination between providers, pharmacists and other care providers, HIT — particularly EHRs — enable care providers to align individual care delivery with broader population health management strategies. These twin trends of care coordination and population health management mean that providers have a growing set of resources to address critical issues like prescription drug abuse. Prescription Monitoring Programs (PMPs), which are now operational in 50 states, are one of these resources and New York's I-STOP initiative has taken things one step further by requiring providers to regularly check a PMP and to prescribe controlled substances electronically. Armed with this information, providers will be able to more effectively engage patients in distress.

PMP programs alone have already been demonstrated to drive down prescription drug overdoses and unnecessary prescriptions. The next step will be to address drug-seeking behavior by patients. The problem of addiction unfortunately won't go away. But by using these tools and approaches, patients can get the care and support they need, which will reduce the negative consequences of addiction.

About Point-of-Care Partners

Point-of-Care Partners (POCP) is a leading management consulting firm assisting health care organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. Our accomplished health care consultants, core services and methodologies are focused on positioning your organization for success in the integrated, data-driven world of value-based care.

POCP specializes in two areas: eCare Management and eMedication Management.

- eCare Management incorporates health care quality and cost that benefit from the recording, storing, transmitting, accessing, integration, sharing and use of clinical and administrative health information.
- eMedication Management covers the effective, efficient and appropriate use of pharmacy and life sciences information to improve clinical outcomes and eliminate unnecessary expenses.

For more about how POCP can advance EPCS in your state, please contact Tony Schueth at tonys@pocp.com or 954-346-1999.



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