Statement of

SureScripts, LLC

Before

The Senate Committee on Commerce, Science, and Transportation
Subcommittee on Technology, Innovation, and Competitiveness

June 21, 2006

Presented by:
Kevin D. Hutchinson, President & CEO

Accelerating the Adoption of Health Information Technology

Statement of
SureScripts, LLC
Before
The Senate Committee on Commerce, Science, and Transportation
Subcommittee on Technology, Innovation, and Competitiveness
June 21, 2006
Presented by:
Kevin D. Hutchinson, President & CEO
Accelerating the Adoption of Health Information

Chairman Ensign, Ranking Member Kerry, and distinguished Subcommittee members, thank you for the opportunity to testify today on behalf of SureScripts on the important topic of accelerating the adoption of health information technology in the United States.

My name is Kevin Hutchinson, and I am the president and chief executive officer of SureScripts. In addition, I am a member of the Board of Directors of the eHealth Initiative, and I am a commissioner, appointed by Secretary Leavitt of Health and Human Services, to the American Health Information Community.

Speaking on behalf of SureScripts, I thank the Subcommittee for inviting me to share our experiences and conclusions gleaned from our ongoing effort to deploy electronic prescribing connectivity nationwide through the SureScripts Electronic Prescribing Network™, and to share our vision of the future.

SureScripts was created by the National Community Pharmacists Association ("NCPA") and the National Association of Chain Drugs Stores ("NACDS") in 2001. Our mission is to improve the overall prescribing process and to ensure, among other things, neutrality, patient safety, privacy and security, and freedom of choice of a patient's choice of pharmacy and a physician's choice of therapy. Under the leadership and with the backing of the pharmacy industry, SureScripts has created an open, neutral, and secure information system that is compatible with all major physician and pharmacy software systems.

SureScripts was created to *improve the overall prescribing process* by focusing on the efficiency, safety, and quality of medication decisions made as part of that process. This is an important point that I would like to touch on for just a moment. We have found that all too often, the popular but narrowly focused term "e-prescribing" has caused confusion and misunderstanding about the true scope of what we hope to accomplish for patients and the health professionals who care for them. As with all health information technology, the solution must be comprehensive, taking into account all aspects of the work flow in the providers' office and care setting. The prescribing process is not just the act of writing a new prescription or a refill request. Moreover, the prescribing process does not begin merely when the physician's pen first touches the prescription pad, nor does the process end when the pharmacist hands the medication to the patient.

Looking at the prescribing process from the standpoint of the physician, one can see there are numerous indispensable steps that occur before the creation of the prescription. The patient's chart is pulled and reviewed, the patient is interviewed and examined, a diagnosis is decided upon, and a course of therapy is contemplated and then decided upon. If it is decided that medication therapy is an appropriate choice for the patient, it is at this point that a prescription is created and noted in the patient's chart.

When it comes time to authorize a refill renewal request for the patient, many of these activities are repeated. All in all, considerable time, effort, expertise, and judgment are invested in these activities, and we believe there are several points in the process that can be improved by a comprehensive and interoperable health information technology solution beyond the simple act of generating a prescription.

At the pharmacy end, much more is involved in dispensing a prescription medication than simply placing tablets or capsules in a vial and handing the vial to the patient. You would be hard pressed to find a pharmacy anywhere in the United States that does not store all of its patient records electronically today. Electronic pharmacy patient records include allergies and existing medical conditions. Prescription insurance information must also be entered and updated periodically. Upon receipt of a prescription for a

patient, the prescription information also is entered in the pharmacy computer, which immediately performs a drug interaction check against medications listed in the patient's pharmacy record. Once the pharmacist has reviewed any potential drug interactions flagged by the pharmacy system, the prescription is billed to the insurer; during the billing process an additional interaction check is performed by the pharmacist against the insurer medication records; any resultant payer issues, whether financial, claim, or clinically related, are resolved by the pharmacist; the prescription is dispensed to the patient; and the patient is counseled on its use by the pharmacist. In the future, pharmacies and pharmacists will play a much greater clinical role in the care of the patient, providing medication therapy management services and assisting in medication adherence and reconciliation programs.

My point in going into all of this detail is to emphasize to the Members of the Subcommittee that our goal as a nation, and certainly ours as a Company, must be to *improve the overall prescribing and care giving process.* From our perspective, to focus too narrowly on just the act of generating a prescription and transmitting it to a pharmacy ignores many opportunities to enhance the level of safety and quality of health care delivered to patients.

The case for electronic prescribing is compelling. According to the Center for Information Technology Leadership (CITL), every year, more than 8 million Americans experience Adverse Drug Events (ADEs). CITL's research estimates that, by addressing ADEs caused by preventable medication errors, e-prescribing systems with a network connection to pharmacy and advanced decision support capabilities can help avoid more than 2 million ADEs annually -- 130,000 of which are life-threatening.

By eliminating paper from the prescribing process, e-prescribing has also been proven to offer significant time-savings by eliminating the need for phone calls and faxes, allowing prescribers, pharmacists, and their staff more time to care for their patients. A study by the Medical Group Management Association's (MGMA) Group Practice Research Network (GPRN) estimated that administrative complexity related to prescriptions costs a

practice over $15,000 a year for each full time physician on staff. Multiplying that figure by an estimated 527,000 physicians currently practicing in a physician office environment and prescribing medications in the United States reveals an opportunity to save more than $8 billion from conversion to e-prescribing.

SureScripts was founded in late 2001. During its first two years, the Company focused on development of its technology necessary to transmit prescription information electronically. The Company's services were first put into production, sending and receiving electronic prescription transactions, in January, 2004. Today, more than 90% of the nation's retail pharmacies have now tested and certified their pharmacy applications on the SureScripts Electronic Prescribing Network, and physician software vendors whose customer base represents over 150,000 prescribing physicians today have contracted with SureScripts, and most have completed the process of certifying their applications on the SureScripts Electronic Prescribing Network. The remaining physician software vendors contracted will complete certification by the end of this year.

The first step for improving the prescribing process was focused on new and renewal requests, and accompanying response messages. We have now started rolling out Step 2 to include other prescription messages, including a message confirming that a prescription has been dispensed, known as the prescription fill, and messages related to change requests. The prescription fill message can be used to let physicians know when patients pick up their medications or let a patient know their prescription is ready to be picked up. We also are rolling out the exchange of patient medication history between pharmacies and physicians, and formulary/eligibility messages between payors and physicians. All of this information, delivered in a secure and private manner to the point of care, will make the healthcare delivery system more efficient, more cost effective, and will save lives.

We are proud to say that the rate of adoption of electronic prescribing technology is increasing at a rapid rate. In fact, recently, community pharmacies, including NACDS and NCPA, sponsored the SafeRx Award. The annual SafeRx award recognizes the top

ten e-prescribing states in the nation, along with three physicians in each winning state who have demonstrated outstanding leadership through their use of e-prescribing technology. The winning states in 2006 included the home states of several members of this Subcommittee, including Nevada, Massachusetts, Virginia, and Florida.

But much more needs to be done. The technology exists and is readily available today. The problem is that there are other barriers to the adoption of healthcare information technology. Traditionally, outside of electronic prescribing, these include a lack of interoperable standards, a lack of appropriate financial incentives to adopt technological advances, and a resistance on the part of providers to change the historic modes of operating and workflows.

In implementing our electronic prescribing network, we selected the nationally recognized NCPDP SCRIPT Standard to serve as the foundation for our network. The NCPDP SCRIPT Standard was developed by the National Council for Prescription Drug Programs, or NCPDP, an ANSI-accredited standards development organization, to facilitate the electronic, bidirectional transmission of prescription information between prescribers and pharmacies. It is our experience that the use of the NCPDP SCRIPT Standard improves patient safety, quality of care, and efficiency, without presenting an undue administrative burden on prescribers and pharmacists. We believe that NCPDP SCRIPT is the best standard to meet the e-prescribing needs of patients and the physicians and pharmacists who serve them. This opinion was further endorsed when the Medicare Modernization Act of 2003 adopted the NCPDP SCRIPT standard as the standard for the electronic transmission of prescriptions for patients under Medicare Part D.

The NCPDP SCRIPT Standard was developed through a consensus process among community pharmacy organizations, pharmacy software vendors, database providers, and other stakeholders. Currently, the standard addresses the electronic transmission of new prescriptions, prescription refill requests, prescription fill status notifications, formulary

lookups, cancellation notifications, and medication history exchange – the nuts and bolts of e-prescribing, if you will.

Future enhancements will address other possibilities that may include patient eligibility, compliance, lab values, diagnosis, disease management protocols, patient drug therapy profiles, and/or prescription transfers.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the Secretary of Health and Human Services to conduct a one year pilot project in 2006 to test the standards that will provide for the HIPAA-compliant transmission, on a real-time basis, of information on eligibility and benefits, medication history, and other prescription information. The Secretary is obligated to report to Congress the results of the pilot programs by April, 2007. SureScripts was awarded a grant by the Agency for Healthcare Research and Quality to conduct one of the pilot programs, and we are providing pharmacy connectivity in three other programs. The pilot programs will play an important role in further increasing the interoperability of health information technology.

There are several bills pending before Congress related to the adoption of healthcare information technology. The time is now for the adoption of meaningful legislation that will promote healthcare information technology as well as the President's goal of making electronic health records available to all Americans by 2014. We support legislation that would:

1. Codify the Office of the National Coordinator of Health Information Technology.
2. Encourage the adoption of interoperability standards by a certain date.
3. Provide financial assistance, whether through grants, pay-for-performance payments, loans, or tax incentives, to those providers who adopt healthcare information technology that meet certain standards.

4.   Create exceptions and safe harbors to the anti-kickback statute and what is commonly referred to as the Stark law to encourage the adoption of health care technology, all while protecting against the abuse that those statutes were enacted to address.

Further standards development to encourage the interoperability of health information systems across a broad spectrum is certainly needed. We encourage the Congress to help facilitate and encourage the standards setting process. The private sector has the expertise and capability to develop standards as necessary, and the private sector has the capability to react to market conditions in an effective, yet prudent, manner to revise and update standards as the circumstances warrant. A collaboration between the public and private sectors to adopt interoperability standards on a timely basis is key top the widespread adoption of health information technology.

The implementation of healthcare information technologies requires a capital commitment on the part of pharmacies, physicians, and other providers. Physicians in particular might not always be in a position to devote the capital resources necessary to implement the software and hardware needed to permit electronic prescribing. In addition, funding to support efforts by pharmacies to implement new patient care tools, such as medication therapy management and new medication adherence/compliance approaches, is necessary. Accordingly, we encourage governmental financial incentives to promote and foster the adoption of healthcare information technologies that satisfy certain standards, including those of interoperability.

In addition, we believe that there are a number of stakeholders that have an interest in promoting healthcare information technology and the safety and efficiencies that come with it, and in particular such stakeholders are willing to fund the technology necessary to promote electronic prescribing. Accordingly, we wholly support the government's current attempts to provide a clear framework in which the stakeholders with the financial resources to promote the electronic healthcare infrastructure may donate hardware, software, training, and other services in order to foster and promote the

8

implementation of electronic healthcare information technology. For instance, because of the value that laboratories convey in the data they transmit, they pioneered the provision of secure, efficient IT solutions to order and transmit laboratory tests to physician offices and hospitals throughout the country. These same tools could be expanded to include additional clinical functions like electronic prescribing at low or no cost to a physician. As the Administration and Congress seek to expand the permissive donation of healthcare information technology, we strongly recommend that laboratories be included among the list of permissible donors to facilitate the exchange of their current offerings (i.e. lab test requisition and results) as well as other healthcare information.

Any discussion and legislation about healthcare information technology must address privacy and security of patient data as well as user authentication requirements. There must be adequate laws regarding the privacy and security of healthcare information, vigorous enforcement of those laws, and the public must have faith and confidence that the laws will protect their privacy and the security of their information. Privacy and security is an important policy matter that must be addressed. The HIPAA Privacy Rule is the benchmark for patient privacy, and establishes the minimum standards for the protection and security of personal healthcare information. Many states have laws that go further than HIPAA. While we applaud the efforts of the states to maximize the protections afforded to their citizens, the reality is that the patchwork of federal and state privacy laws, both statutory and common law, creates a barrier to the rapid adoption of healthcare information technology in the United States. In order to identify the various applicable laws and assess the impact the various laws have on health IT adoption, the Health Information Security and Privacy Collaboration, a partnership consisting of a multi-disciplinary team of experts and the National Governor's Association, pursuant to a contract with the Department of Health and Human Services, will work with 34 states and territories to address variations in state laws that affect privacy and security, and pose challenges to interoperable health information exchange. We believe this is an extremely important effort, and are pleased with the federal and state collaboration in this effort.

The adoption of healthcare information technology not only is a matter of the nation's health, but we believe it is also a matter of national security. There is an acute need for reliable healthcare information to be available to healthcare providers in the event of a national emergency, whether man made, such as a terrorist attack, or caused by nature, such as a hurricane or an influenza pandemic. The experiences after Hurricane Katrina exemplify the acute need for healthcare information to be readily available to care givers throughout the nation. Hurricane Katrina destroyed millions of medical records, and approximately 40% of the 1.5 million evacuees were taking a prescription drug. Many of these evacuees fled their homes and were displaced without knowing what drugs they were taking, or their medication regimes. Following Hurricane Katrina's landfall near New Orleans last August, a group of private and public health and information technology experts created www.KatrinaHealth.org, an online service for authorized health professionals. The web site provided access to evacuees' medication information in order to renew prescriptions, prescribe new medications, and coordinate care. KatrinaHealth.org provided authorized users with access to the medication history of evacuees who lived in the areas affected by Hurricane Katrina, with data or prescription information made available from a variety of government and commercial sources. Sources included electronic databases from community pharmacies, government health insurance programs such as Medicaid, private insurers, the Veterans Administration, and pharmacy benefits managers in the states most affected by the storm.

Privacy and security were central to the design of KatrinaHealth.org. KatrinaHealth was accessible only to authorized healthcare providers and pharmacists who were providing treatment or supporting the provision of treatment for evacuees. In addition, consistent with many state privacy laws, highly sensitive personal information was filtered from the site.

This site was implemented after the fact, in response to the Hurricane – and we were pleased to play a role in this effort, but almost one year later, and now 21 days into the 2006 hurricane season, while we and others have the technology in place to replicate these efforts immediately upon the occurrence of another national emergencies, there are

insufficient policies and procedures in place to quickly operationalize the system in an effective and meaningful manner in the event of another national emergency.

Much work has been done, and there is enormous momentum both in the public and private sectors with respect to the adoption of healthcare information technology. But much more needs to be done – and lives are at stake. We applaud the leadership that Secretary Leavitt and David Brailler have demonstrated in this area, and we are thankful for the Subcommittee's attention to this very important national healthcare and security issue. We at SureScripts thank the Subcommittee for the opportunity to share our experiences with respect to electronic healthcare, and it would be my pleasure to answer any questions that you might have.