



**TESTIMONY
OF
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For the National Committee on Vital and Health Statistics
Standards and Security Subcommittee

January 29, 2008

Good afternoon. I'm Eileen Doll, President of Efficiency Driven Healthcare Consulting. My areas of expertise are based on almost 30 years of experience working in and with long term care facilities—as a Registered Nurse, Director of Nursing, Administrator and implementer of clinical information technology solutions. This combined experience allows me to serve as a member of the American Health Care Association's Health Information Technology and Clinical Practice Committees—and to offer information to you on our subject at hand.

My testimony is from the perspective of the long-term care providers who are represented by the American Health Care Association and the American Association of Homes and Services for the Aging. Together, these organizations represent those who provide care for million of Americans in assisted living, nursing homes, continuing care retirement communities, sub-acute centers, and for those persons with mental retardation and developmental disabilities.

Before I go into e-prescribing and NCPDP SCRIPT 10.2, I would like to offer my thanks to this committee for its focus on long-term care in this area. In recent years, discussions, debates, and decisions regarding health information technology and health information exchange were primarily focused on acute and ambulatory care. Long-term care—whether episodic or truly long-term—has an important role in using, adding to, and exchanging health information. The long-term care industry

The long-term care e-prescribing pilot that has been discussed today, not only demonstrated that the industry CAN e-prescribe, but what standards, AND changes in standards, are needed to ensure successful expansion.

NCPDP SCRIPT 10.2 the standard we feel should be used and further developed for communication of prescription information in long-term care. It addresses the barriers and recognizes the complicated and frustrating tripartite (three-way) prescribing system now in place in our nation's nursing homes—a system that closely ties doctors, nursing facilities and pharmacies together in the prescribing of medications. As Mr. McKinney mentioned earlier, SCRIPT 10.2 is the standard we “called out” as we created our LTC EHR-S Profile.

Adopting NCPDP SCRIPT 10.2 will create no disruption of the prescribing and distribution of drugs to long-term care residents. Instead, it WILL clarify the facility workflow and create new efficiencies. Faxing of computer-generated or handwritten prescription orders will no longer be required, by exemption, or otherwise. Only one barrier has not yet been resolved—the electronic prescription of controlled substances.

Obviously, maximum efficiencies are reached and the potential for prescription errors is dramatically reduced when doctors, nursing facilities and pharmacies are all actively linked.

Physicians will be able to concentrate on prescribing needed medications for each individual patient. The physician or other prescriber will not be required to:

- a. memorize every exception to each Part D or private insurer's existing formulary and accepted generic substitutions,
- b. recall current patient medications and possible drug interactions or specific patient allergies,
- c. know possible duplicative therapies or drugs currently on the Beers criteria as being possibly inappropriate for use in the elderly, etc.

Nurses will be able spend more time on actual care for our residents. The nurse will spend less time in:

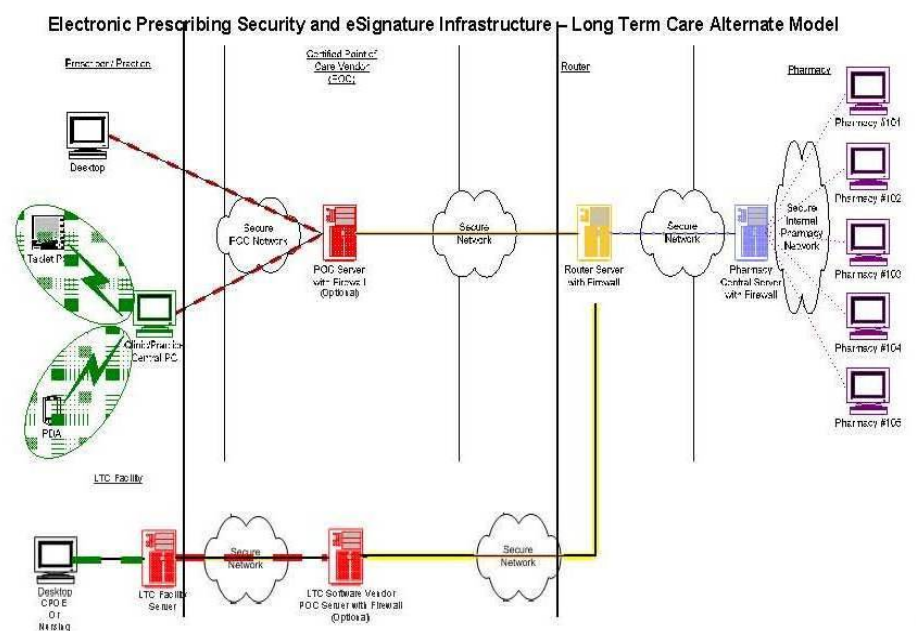
- a. resolving written physician orders,
- b. checking drug formularies,
- c. serving as the “communication conduit” and “tracking down” the appropriate party/parties, at any or all times, for any/all physician/pharmacy/insurer drug information, order clarification or changes needed,
- d. safe administration of ordered medications, etc.

The workflow will look a little different than what we saw before...

A.13 Appendix

Electronic Prescribing Security and eSignature Infrastructure – Long Term Care Alternate Model

The diagram below pictorially represents the LTC perspective and how security is invoked in the LTC environment.



Note: Security and authentication is the same as with the non-LTC model

NCPDP.org work document

As briefly mentioned before, there are some providers who are “slow movers” in the adoption of Health information technology. For these providers who now may use a computer for MDS only ... the establishment of standards for HIT, EHR and, in our discussions today, a standard for the e-prescribing component, will create confidence in providers that they will know what to look for when making a software vendor selection.

We anticipate certification of long-term care electronic health record (EHR) products by the Certification Commission for Health Information Technology (CCHIT) in late 2009. The EHR profile, as developed by a broad “working team” of long term care

professionals and interested parties, notes these requirements for SCRIPT 10.2 (below)

1. IF the facility and pharmacy exchanging electronic prescription information are not part of the same legal entity, THEN the system **SHALL** support the e-Prescribing functionality described in DC 3.2.2 through the use of NCPDP SCRIPT version 10.2 or higher.
2. IF the facility and pharmacy exchanging electronic prescription information are part of the same legal entity, THEN the system **SHALL** support the e-Prescribing functionality described in DC.3.2.2 through either NCPDP SCRIPT version 10.2 or higher, or HL7 messages.

We truly want and need for standards and regulations to be set and to “harmonize”. Long term care wants to stay on the “road”—the road map of CCHIT.

Therefore, we advocate for a January 1, 2010 date to eliminate computer-generated faxes in long-term care with the following two exceptions:

1. When transmitting to pharmacies and facilities without e-prescribing capabilities or in an emergency situation; and
2. When prescribing controlled substances (unless regulations are promulgated to eliminate this need).

We believe the adoption of STANDARDS, and in particular, the standard we are discussing today—**an e-prescribing standard which “fits” our unique needs—is a key to this plan.**

As I said in the beginning, the long-term care industry fully supports the use, and continual expansion, of health information technology.

We are anxious to do so—it brings clear benefits to the residents we care for daily. Simply, it is the right thing to do.

Let me thank you for this opportunity to speak. I am anxious to provide answers to your questions.

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