



LTC HIT Summit

Advancing Technology in Aging Services

**Incorporating Physician Input
to Improve LTC E-Prescribing**

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Context



An E-Prescribing definition

Goals: Fewer adverse events, improved care
Increased efficiency
Lower costs for patient and providers

Through: Informed prescribing decisions
Facilitated prescription processes
Standard electronic communication
between the care setting and pharmacy

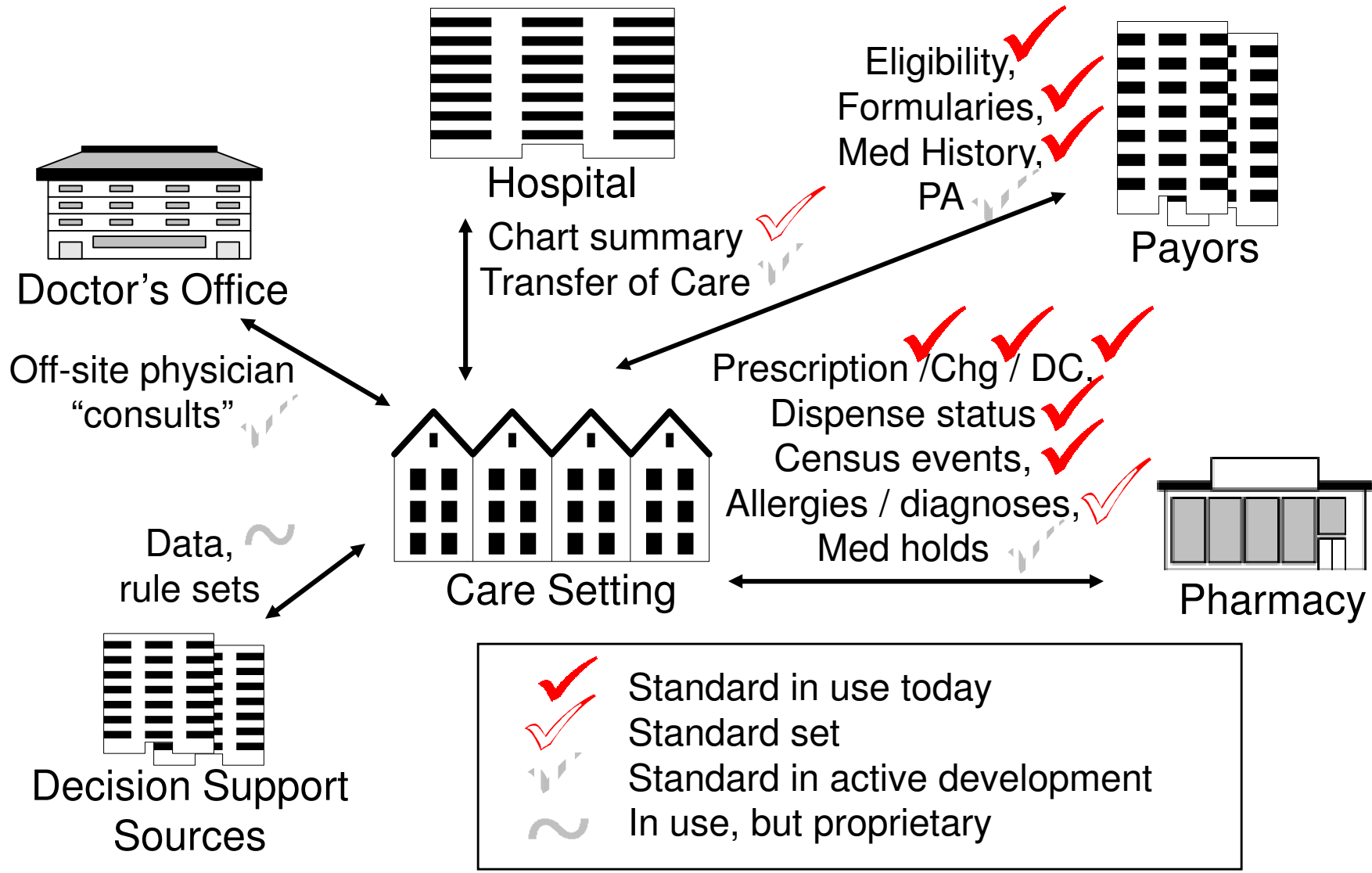
Context (2)



Current state of E-Prescribing in LTC

- Reaching stability, a base for growth
 - Consensus on SCRIPT messaging standard
 - Vendor and network support is expanding
 - Couple years of production experience
- Adoption has begun
 - Facilities and pharmacies getting benefits today
 - Used mostly by nurses, but also MDs and NPs
 - Part of facility's electronic medical record

Context (3)



Context (4)



- Experience is driving improvement
 - Seven LTC messaging enhancements in the last year, submitted by the NCPDP LTC EHR group
 - Focus on facility-to-pharmacy communication to improve safety; e.g., allergy, diagnosis profiles
 - A network of LTC stakeholders engaged in standards groups and initiatives (HITSP, HL7, LTC EHR-S Functional Model, advocacy orgs...)
 - Remarkable cooperation within the industry on standards and technology strategy

Impetus for Engaging Physicians



We sensed a developing industry consensus...

- Facility-to-pharmacy messaging is on a steady course
- Prescriber adoption is the next, greatest challenge and opportunity
 - The key to achieving the biggest benefits
 - Needed for broadest adoption
- Stakeholders are ready to tackle it now

Initiative, Goals and Approach



- Sponsor: NCPDP (LTC EHR Task Group)
- Supporting: AMDA, ASCP, NASL
- Initiative's goals and approach:
 - Engage physicians and nurse practitioners
 - Five sessions (to June 25) plus industry input
 - Challenges and opportunities in their own words
 - Evaluate needs: What's not being addressed?
 - Propose approaches to pursue further
 - Supporting organizations evaluate conclusions
 - Use as direction for continued work

A Progress Report



In the prescribers' and NP's words, re.: **safety**

- “A huge amount of care for patients you’ve never seen, medications you didn’t originate, nurses who don’t understand the complexity of the case”
- Availability of clinical context...“Would allow more rational prescribing”
- “Chances are very high that [the medication] decision may be to the detriment rather than the benefit [of the resident]” without sufficient resident information
- “Do because it’s a quality enhancement,” not because it’s faster

A Progress Report (2)



In their words, re.: **communication, workflow**

- “Well over 50% [of care decisions] provided from outside the facility.” “10-20% even with a doc and NP in the building at all times”
- “Absolutely dismissed use of the retail model” [in which communication bypasses the facility]
- “Nursing judgment is a key component for... optimizing therapeutic regimen, med selection”
- MD/NP “counter-signing is, in theory, good. But in practice, fails miserably.” It takes too long before you can see the order and patient details

A Progress Report (3)



Approaches to pursue further...

- Priorities that are bubbling up:
 - Availability of clinical context information
 - Collaborative prescribing: Messaging and “inbox” workflow to facilitate recommendations from internal and external consulting roles, NP, staff and external information sources
 - Off-site prescribing: Enabling direct access to resident clinical context and prescribing process (web access, messaging / interoperability)
 - MD / NP review and counter-sign process

Final Thought



From a participating doctor

“The spin doesn’t need to be *‘faster.’*
‘Safer’ is the benefit.”

Thank you

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