TESTIMONY
OF
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Standards and Security Subcommittee

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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 solutions. I have significant expertise and experience in health information technology including electronic prescribing, and serve as a member of the American Health Care Association's Health Information Technology and Clinical Practice Committees.

Today I offer testimony from the perspective of the long-term care providers as 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 proceed to talk about 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 that we represent is highly committed to the utilization of health information technologies—including the benefits of e-prescribing—to enhance our staff's efforts in providing the highest quality of care and quality of life for our residents and their families. We KNOW that using information technology will lead to a reduction in medical errors, an increase in patient safety, and the outcomes we all desire.

Some have stated that the long term care industry has been slow to adopt HIT, including e-prescribing—but we are NOT incapable. Long term care has, and will continue to be, and active participant in the Long Term Care HIT Collaborative, NCPDP, CCHIT, HL7, and other groups working together to accomplish Health Information Technology goals. Your examination of NCPDP SCRIPT 10.2 today, and the recommendations you will make in the future, will be a catalyst for HIT and e-prescribing expansion in long-term care.

The long-term care e-prescribing pilot that has been discussed today, not only demonstrated that the industry can do it, but what 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 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. It will actually serve to facilitate new efficiencies in facility workflow and shine a light at the end of the tunnel for lifting the nursing home exemption for computer-generated faxing of prescription orders.

As we learned from the e-Prescribing Pilot, 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, without requiring them to memorize every exception to each Part D or private insurer's existing formulary.

Our nurses will be able spend more time caring for their residents and less time tracking down physicians and pharmacies to discuss change orders. Pharmacies will achieve efficiencies in supply chain management.

Providers along the continuum of care will be able to know and understand each resident's complete medication history leading to targeted physician decision

support, and will all be able to engage in medication comparative effectiveness research for the long-term benefit of our residents.

Working quickly to establish 10.2 or higher version as the standard will allow the benefits of e-prescribing to be attained more quickly.

For providers who now use a computer for MDS only ... the establishment of standards for EHR and, in this case, for the e-prescribing component will create a confidence in providers who have great fears of making a costly wrong decision when investing, the limited resources they have, in technology. With 10.2 as a standard, e-prescribing making software purchase investment decisions will be easier and facilitate earlier adoption by providers.

We anticipate certification of long-term care electronic health record (EHR) products by the Certification Commission for Health Information Technology (CCHIT) in late 2009. It is important for the long-term care industry to adopt e-prescribing following the CCHIT roadmap and not be hindered by regulations counter to the certification process. Therefore, we advocate for a January 1, 2010 date to eliminate computer-generated faxes in long-term care with the following two exceptions: When transmitting to pharmacies and facilities without e-prescribing capabilities; and when prescribing controlled substances.

As I said in the beginning, the long-term care industry fully supports moving into the health information technology arena and adoption of e-prescribing standards that fit our unique needs is key. We are anxious to do so because of the care benefits it can bring to industry residents and because, 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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