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June 26, 2009

Office of the National Coordinator for Health Information Technology
200 Independence Ave., SW
Suite 729D
Washington, DC 20201
Attention: HIT Policy Committee Meaningful Use Comments

Re: HIT Policy Committee Meaningful Use Definition, Notice and Request for Comment

Dear Sir/Madam:

The American Society of Health-System Pharmacists (ASHP) is pleased to submit comments pertaining to the Health Information Technology Policy Committee's draft description of Meaningful Use (draft definition). For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient safety. The Society's 35,000 members include pharmacists and pharmacy technicians who practice in inpatient, outpatient, home-care, and long-term-care settings, as well as pharmacy students. Pharmacists in hospitals and health systems are experts in medication use who serve on interdisciplinary patient-care teams. Pharmacists work with physicians, nurses, and other health-care professionals to ensure that medicines are used safely and effectively.

ASHP strongly supports and advocates the key decision-making roles pharmacists play in the planning, selection, design, implementation, and maintenance of pharmacy information systems, electronic health records, computerized provider order entry systems, and e-prescribing systems to facilitate clinical decision support, data analysis, and education of users for the purpose of ensuring the safe and effective use of medications. The Society, with input from its Section of Pharmacy Informatics and Technology membership group, has extensive expertise regarding how "meaningful use" should be applied to the medication-use process.

ASHP strongly recommends that the definition of "meaningful use" include the following three elements focused on the medication-use process:

1. The definition of “meaningful use” must address the interoperability of medication orders and prescriptions. To receive Medicare and Medicaid incentive payments under the American Recovery and Reinvestment Act of 2009, providers will be required to demonstrate “meaningful use” of a certified electronic health record (EHR). In demonstrating “meaningful use,” the communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable¹ with pharmacy information systems. A common medication vocabulary must be mandated by the Office of the National Coordinator for Health Information Technology (ONC) to promote the semantic interoperability of medication use across the continuum of care. This is essential for comparative research, communicating medication information, and performing medication reconciliation.
2. Medication decision support and continuous improvement should be included within the definition of “meaningful use.” Medication decision support must include allergy, drug interaction, duplicate therapy, and dose-range checking as a minimum. Such a decision-support service must include an ongoing, continuous improvement process to attune the decision-support service to the needs of the providers.
3. The ability to report and quantify improved patient safety, quality outcomes, and cost effectiveness in the medication-use process, particularly related to quality measures that are endorsed by the National Quality Forum, is essential. Antimicrobial and adverse drug event surveillance is also essential.

ASHP further recommends that the definition of meaningful use be part of the effort to harmonize standards, particularly with the increasing globalization of various components of health care.

Regarding the specific elements included in the draft recommendations for the term “meaningful use,” ASHP offers the following comments and recommendations:

Objectives

2011 Goal – The Policy Committee should include, as a 2011 objective, interoperability of all pharmacy systems with computerized provider order entry (CPOE) and/or e-prescribing systems. Electronic ordering of medications without interoperability within an electronic pharmacy information system will not prevent transcription errors.

¹ In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, to exchange data accurately, effectively, and consistently, and to use the information that has been exchanged. (Source: The National Alliance for Health Information Technology, adapted from the IEEE definition of interoperability, and legal definitions used by the FCC (47 CFR 51.3), in statutes regarding copyright protection (17 USC 1201), and e-government services (44 USC 3601)).

2011 – Use CPOE for all order types including medications –While ASHP supports the inclusion of this goal for 2011, the Policy Committee should be aware that this is a complex issue, particularly due to the complexity of chemotherapeutic protocols, where vendors are currently developing software to facilitate the ordering of these agents. The use of CPOE for parenteral nutrition orders is another complicated ordering procedure that lacks standardization. While CPOE for these types of orders may not be accomplished by 2011, this goal will eventually be met, and vendors' software will meet practitioners' needs in the adult, pediatric, and neonatal settings. The use of CPOE within a hospital setting should include all patients in all practice settings, including emergency departments, procedural areas, radiology, infusion treatment centers, and others. The use of CPOE for investigational medication research studies should be encouraged, but the standards and certification criteria may not be available until after the 2011 time frame.

2011 – Implement drug-drug, drug-allergy, drug-formulary checks – ASHP recommends that each hospital, health system, or provider develop a multidisciplinary group to address the complexities of clinical decision support and its implementation into the workflow. The addition of drug-lab and drug-disease checks should also be considered. Dose-range checking should be used to validate appropriate doses for pediatric use and to validate appropriate doses in adults for drugs that are weight-based to prevent under- or over-dose situations. ASHP recommends that alerts and warnings for therapeutic duplications for high alert medications be considered for inclusion in this 2011 objective. For example, the duplication of anticoagulants (warfarin and enoxaparin) in a patient's medication therapy can have detrimental effects if administered concurrently for an extended period of time. All alerts and warnings should be evaluated and tested prior to use to ensure they are appropriate and do not hinder the provider's workflow.

2011 – Generate and transmit permissible prescriptions electronically (e-prescribing) – While ASHP supports the generation and transmittal of permissible (valid) prescriptions electronically, the Society has some concerns regarding whether this objective can be met by 2011, since the U.S. Drug Enforcement Administration (DEA) has yet to finalize its proposed rule relating to electronic prescriptions for controlled substances.

ASHP further supports the use of a structured and codified Sig format to facilitate communication between prescribers and pharmacists and help reduce potential errors. Additionally, the Society supports the exploration of the use of RxNorm for ordering medications and maintaining medication and allergy lists, adding to the interoperability of systems that use different drug nomenclatures.

Electronic transmission, structured and codified Sig, and RxNorm will not guarantee interoperability between systems. ASHP supports the certification of ambulatory and retail pharmacy systems included as a 2015 objective to assure the electronic data flows

through the pharmacy systems without the need for manual transcription. Many systems today require pharmacists to manually enter the prescription into the pharmacy system in order to dispense and label medications for the patient. This manual process of transcription creates additional potential for error, so the ultimate goal is for interoperability of systems reaching all the way to the patient.

2011 – Maintain active medication list – See comments regarding 2011 – Generate and transmit permissible prescriptions electronically (e-prescribing) above re: Structured and Codified Sig and RxNorm.

Additionally, Federal agencies, the pharmaceutical industry, pharmacy and medical software providers, and purveyors of clinical data repositories and drug databases should explore the potential benefits of supplementing or modifying the National Drug Code (NDC) with a coding system that can be used effectively to support patient care, research, and financial management; further, such a coding system should encompass prescription drug products, nonprescription medications, and dietary supplements and include both active and inactive ingredients.

2011 – Maintain active allergy list – See comments regarding 2011 – Generate and transmit permissible prescriptions electronically (e-prescribing) above regarding the RxNorm discussion. Additionally, see comment 2011 – Maintain active medication list, regarding modification of the NDC.

2011 – Perform medication reconciliation at relevant encounters – See comments regarding 2011 – Generate and transmit permissible (valid) prescriptions electronically (e-prescribing), regarding the RxNorm discussion.

2013 – Provide clinical decision support at the point of care (e.g., reminders, alerts) – This objective should be moved to 2011, since the use of reminders and alerts are currently available in most clinical decision support-enhanced electronic health records. ASHP encourages the ONC to develop a definition for clinical decision support (CDS) because CDS may be interpreted differently depending upon a provider's practice area. A physician, nurse, and pharmacist may expect entirely different alerts and warnings while managing orders and tasks within their daily workflow.

2013 – Conduct medication administration using bar coding – ASHP encourages health systems to adopt bar-code-enabled medication administration (BCMA) technology to improve patient safety as well as the accuracy of medication administration and documentation. ASHP agrees that bar-coded medication systems reduce pharmacy dispensing errors, and ASHP supports the documentation of medication administration with an electronic medication administration record (e-MAR). Many of the published studies demonstrate the added safety the e-MAR provides in medication administration.

Measures

2011 - % of orders entered directly by physicians through CPOE – The term “physicians” should be replaced with the term “providers with appropriate authority,” since many hospitals and health systems allow providers other than physicians to enter orders into CPOE systems. Physician assistants and nurse practitioners have prescribing authority in most settings, and prescribing authority is often granted to pharmacists through privileging processes and collaborative practice agreements.

2011 – % lab results incorporated into EHR in coded format – In addition, medication orders must also be incorporated into the EHR in a coded format. Communication of orders and electronic prescriptions must be demonstrated to be functional and semantically interoperable within pharmacy information systems. A common medication vocabulary must be mandated to promote the semantic interoperability of medication use across the continuum of care. This is essential for comparative research, communicating medication information, and performing medication reconciliation.

ASHP appreciates this opportunity to present its comments on the draft definition. Feel free to contact me if you have any questions. I can be reached by telephone at 301-664-8702, or by e-mail at jcoffey@ashp.org.

Sincerely,



Justine Coffey, JD, LLM
Director, Federal Regulatory Affairs

CC: ASHP Board of Directors