Hospital Pharmacists Worry about Definition of ‘Meaningful Use’

Will They Be Eligible for Federal Electronic Health Record Grants?

Stephen Barlas

Hospitals are fighting hard to restrict the reach of electronic health records (EHRs) that they will have to install before they can receive federal grants approved as part of the American Recovery and Reinvestment Act (ARRA). ARRA, the stimulus bill passed by Congress last winter, provides approximately $19 billion for physician offices and hospitals that will have met “meaningful use” health information technology (HIT) requirements starting in 2011. The Department of Health and Human Services (DHHS) is now in the process of setting these standards.

Karl Gumpper, RPh, Director of the Section of Pharmacy Informatics & Technology at the American Society of Health-System Pharmacists (ASHP), said in an interview, “This is not going to be an easy process, but we have to start somewhere.”

DHHS Secretary Kathleen Sebelius must set up interim requirements by the end of this year, based on recommendations from two new advisory committees established by the ARRA: (1) the HIT Policy Committee, which published a draft of meaningful use requirements for hospitals that would take effect in 2011, 2013, and 2015; and (2) the Standards Committee, which will review industry comments on that draft and make final recommendations to Dr. Sebelius, the final arbiter.

The proposed requirements for EHRs in these three years are heavy with rules for prescriptions and with implications for pharmacies. For example, pharmacists would have to have electronic access to all formularies by 2013. By 2011, computerized prescriber order entry (CPOE) would be mandatory for all prescriptions, clinical documentation of patient demographics (e.g., race, ethnicity, insurance type), lists of patients’ problems, medication lists, and decision-support tools to provide drug–allergy and drug–drug alerts.

Mr. Gumpper explains that the drug–drug alerts that pharmacists receive today—which announce potential drug–drug interactions for a given patient—are often irrelevant and lead to a significant number of pharmacist overrides. Thus, a pharmacist who generally ignores those alerts might miss the one warning that should have been noticed. “You really need good alerts that mean something,” he adds, implying that it makes more sense to upgrade electronic standards for drug–drug interactions before they are required to be included in a definition of meaningful use. For example, he suggests that it might make sense to subject the most potentially severe interactions to a mandatory alert.

In terms of pharmacy connectivity to formularies, most pharmacies will have to deal with the proposed 2013 deadline. According to a 2007 ASHP survey, only 20% of hospital pharmacies had electronic prescribing capability; furthermore, only a percentage of those had e-prescribing systems that are approved by the Certification Commission for Health Information Technology, which guarantees the functionality of the National Council for Prescription Drug Programs (NCPDP) and a connection through the Surescripts hub to all formularies.

Hand-held CPOE devices for physicians are almost always connected to hospital pharmacies, of course, but rates of adopting the technology in hospitals are also low. Steve Ahnen, President and Chief Executive Officer of the New Hampshire Hospital Association, says:

CPOE adoption levels in hospitals are very low, and CPOE relies on other EHR systems for successful implementation. For example, electronic nursing documentation, medication bar coding, and formulary availability in the pharmacy are considered building blocks of CPOE and must be in place prior to its implementation.

He echoes what many other hospital executives, many of them primed by the American Hospital Association (AHA), are saying—that a 2011 CPOE requirement is unrealistic. He emphasizes:

We suggest [that] the definition of meaningful use in 2011 should first aim to get the majority of hospitals up and running with the basic components of an EHR system, which, once in place and operating, can be built upon in a deliberate and achievable manner.

The AHA is pushing for the goal of 100% CPOE to be delayed until 2015 or later. This organization doesn’t have a problem with some other aspects of the HIT Policy Committee’s proposed meaningful use elements for 2011, including documentation of patient demographics; patients’ problems; medication lists; hospital discharge summaries; and viewing of all patients’ laboratory, radiology, and diagnostic results.

In addition to specifying certain electronic tasks, the definition of meaningful use will also necessitate that hospitals must submit quality data electronically to the Centers for Medicare and Medicaid Services (CMS), the agency charged by the ARRA with reviewing the data. The HIT Policy Committee draft on this matter has also raised hackles, mainly because the hospitals don’t think they can meet any standards in this area by 2011. The two hospital groups responsible for coming up with industry-quality-reporting measures—the National Quality Forum and the Hospital Quality Alli—continued on page 613

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ance—are nowhere near ready to announce standards: it is not clear that the DHHS has the electronic capability to actually receive and evaluate them, and there is no defined set of pharmacy quality data for in-hospital pharmacies or retail pharmacies. A group called the Pharmacy Quality Alliance was initiated by CMS in 2006, but so far, it has gotten only as far as piloting the standards. Like the hospital quality groups, it seems to be a long way off from establishing final standards.

John M. Coster, PhD, RPh, Senior Vice President of Government Affairs at the National Community Pharmacists Association, believes that a definition of “meaningful use” should be as robust as possible and should not simply be considered “an electronic substitute for a paper prescription [that] provides no additional clinical or cost benefit.”

REFERENCES
