

12 MR. GROOM: Thank you, Kate. Thank you
13 Governor Douglas and the entire group here today. We
14 appreciate the opportunity. Kate and I have done
15 this numerous times, been able to talk about e-
16 Prescribing. I think it's a compliment for you to
17 have us both here. I think we can provide some
18 additional information.

19 My role here is to not really duplicate
20 what Kate talked about because I agree with
21 everything she said, but maybe complement it a little
22 bit and talk about a couple of things. I want to

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1 share some information with you as far as the
2 readiness in the country for e-Prescribing and also
3 talk to you a little bit about some of the best
4 practices.

5 As you think about e-Prescribing, I
6 consider it a triangle of getting physicians through
7 the technology partners in one corner and the payers
8 in one corner, which really provide the data and
9 certainly the pharmacies to be able to route that
10 information. If you look at that triangle, it's
11 really trying to get everybody focused on the
12 initiative at the same time. I think what we've seen
13 throughout the country is that there have been
14 pockets of success, not necessarily all players who
15 are at the table doing the same amount of work at the
16 same time.

17 I think this group can provide a wonderful

18 leadership to these communities and really a call
19 from the governors of state Medicaid programs or even
20 the employees to really focus on what e-Prescribing
21 needs to be done in the state can be tremendous. I
22 think one good example of that would be the work that

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1 we did in Southeast Michigan. We were called in by
2 General Motors. It takes leadership. And if you
3 look at the leadership, they said, you know, we've
4 got the other two autos are willing to work with us.
5 We want to promote electronic prescribing. And
6 because of their awareness of the marketplace and
7 their determination to do it they did a wonderful
8 job. We rolled up our sleeves and helped out.

9 What we saw was a significant increase in
10 the volume of e-Prescribing that took place. We
11 certainly saw that in Massachusetts and other
12 initiatives certainly -- EPrescribe Florida, we've
13 been working with them -- of focused effort in a
14 marketplace. With goals and measurable goals and
15 communication you can do tremendous work. We were
16 very excited to go into Detroit and really roll up
17 our sleeves and get that done.

18 When I look at this audience, and the
19 platform, that this can be done across the country.
20 The timing is right. Why is the timing right? You
21 all know where we are from the e-prescribing
22 perspective. You talk about some of the numbers. We

1 have a lot of opportunity. The good news is the
2 infrastructure's there. Between ourselves and
3 SureScripts we have that infrastructure in place.
4 We've got the critical mass that's necessary for e-
5 prescribing today. RxHub has today a master patient
6 index of approximately 200 million Americans. The
7 technology partners and physicians offices can get
8 patient level clinical decision support in the hands
9 of the physicians as it pertains to eligibility,
10 formulary, medication history.

11 Again, there's secure infrastructure
12 leveraging patient consent and leveraging standards--
13 standards today that are in place. I know there are
14 some additional transactions that are going to become
15 standards as it pertains to prior auth. But I'm here
16 to tell you that no one needs to wait for those to be
17 standards. The standards that we have today around
18 eligibility, formulary, medication history and script
19 authorization for NCPDP transaction sets are the
20 baseline of what we need to be successful from an e-
21 prescribing perspective. In fact, we've been using
22 these transactions for six-plus years through

1 hundreds of technology partners today.

2 I have some handouts and I just want to
3 share--I'm not going to go through the entire thing,
4 but I want to share a couple of data points with you.

5 I think we have it on the screen as well.

6 (Slide.)

7 MR. GROOM: Look at the recipe for success
8 for e-Prescribing. I provide some type of advise to
9 this group. Look at it in this way I think this
10 actually falls very well into what Kate was saying.
11 First of all, it takes leadership. There needs to be
12 somebody that wants to make e-Prescribing happen and
13 to get the community involved. We thought in E-
14 Prescribe Florida Representative Harrell has been
15 very much a vocal person in e-Prescribing and the
16 folks in Florida certainly have looked to our
17 leadership and appreciate everything that she's done.
18 We've seen it in other places. Kate talked about
19 Arizona and other governors have stepped up and said
20 e-Prescribing is something we want to do. That's
21 very valuable and very important.
22 Education and communication--this gets

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1 back to if everyone is going to do e-Prescribing at
2 the same time, we need to make sure that we've got
3 mayors there. We need to make sure that the
4 technology partners are there and the physicians want
5 to adopt and that the pharmacies are connected. When
6 everyone is aware that that is the goal, it is
7 amazing how successful e-Prescribing can be. And I
8 think one of the important things, certainly, are
9 incentives but also the ability to educate. From a
10 clinic perspective, there's a workflow change.

11 There's a database to e-Prescribing and there's a
12 change of work that needs to take place. You cannot
13 underscore the importance of the work, to go in and
14 work with physicians to adopt electronic prescribing.
15 The focus that Henry Ford in Southeast Michigan, I
16 think, are a great example of best practices.

17 They recognized that, sure, there's got to
18 be incentives. Sure, there's got to be an awareness.
19 But you really have to handle it a little bit.
20 They've done a tremendous job. They realized the
21 first thing you need to do when you walk into a
22 clinic is just to make sure that they have their

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1 prescribing management process in place. If they
2 don't have that in place, automating it isn't going
3 to help at all. It's going to create confusion and
4 frustration. So they spent the time and the
5 technology partners have spent the time to make sure
6 e-Prescribing sticks. Some will tell you it takes
7 maybe 50, maybe 75 prescriptions before a physician
8 adopts that technology and will stick with it. These
9 are important things to remember when you're rolling
10 out electronic prescribing--the ability to execute on
11 the plan, having a plan, having a goal to do
12 electronic prescribing in support, understanding what
13 the responsibilities are for all the stakeholders,
14 what work needs to be done is very valuable. And I
15 will share with you--we will be publishing here
16 shortly a blueprint on e-Prescribing. Something that

17 we want to hand to the community or quite frankly,
18 hand over to you so that you can use it with your
19 discussions to really take a look at what it takes to
20 do electronic prescribing. I think there's a
21 misconception of how easy or how difficult it is. We
22 have put together a blueprint for that.

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1 Lastly, making sure you can identify where
2 your successes are--I think the folks in SureScripts
3 have done a wonderful job of really highlighting the
4 fact of where e-Prescriptions are being utilized for
5 electronic prescribing.

6 I'm part of a reporting company for e-
7 Prescribe in Florida and we've been looking at some
8 additional efforts to really help pinpoint the value
9 of e-Prescribing. Let me just share a couple of
10 things with you. As I had mentioned, and I've got a
11 slide behind for you folks back there.

12 (Slide)

13 MR. GROOM: With a view of where our
14 lives are today with 200 million member records at
15 our master patient index, we have done a very good
16 job on identifying where our lives are. That's been
17 through a process of working with payers and getting
18 to know where the docks are and finding that
19 connectivity. We've seen significant growth. Last
20 year we added 50 million lives and we see that the
21 payers are really stepping up to the plate, not only
22 for e-Prescribing but also--if you look at the slide.

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1 (Slide.)

2 MR. GROOM: This is again an area of great
3 opportunity. We've seen states--New Mexico is a
4 great example where they are taking a leadership
5 role. They're right up there with the leaders in e-
6 Prescribing to make sure that those Medicaid lives
7 were available for electronic prescribing.

8 The slide I have in front of you is the
9 other working slide of how the Medicaid lives get
10 connected. Fee-for-service lives they are
11 particularly through a fee-for-service processor. We
12 have worked out, to the best of our knowledge, where
13 those connectivity pieces are and have established
14 relationships with the docks and the NMIS vendors
15 that would support electronic prescribing on behalf
16 of the fee-for-service lives for Medicaid.

17 (Slide)

18 MR. GROOM: The next slide shows you where
19 we're at from a relationship standpoint. We have
20 built connectivity with folks like HTS and we're
21 working with CVS and First Health. These are really
22 the folks who can do the connections and get the work

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1 done. We can look at e-Prescribing and see that it's
2 a difficult task. We have done a lot of the heavy

3 lifting, if you will, of getting the relationships
4 built and really working on connectivity. As an
5 example, New Mexico had come to us last summer and
6 said they had a transformation grant for e-
7 Prescribing. They wanted to get moving forward. We
8 thought that this was going to be a multi-year
9 process. Well, the grant dollars were spent that
10 year. They allowed us to quickly build a
11 relationship with their processor, ACS. We went
12 through an implementation process and probably 60 to
13 now more than 90 days to get their lives connected to
14 us and they were in production before the year ran
15 out.

16 It's a great example. There's focus and
17 there is a process that's fairly straightforward to
18 get connected, but it can be done; and the ability to
19 leverage the state employee lives as well as the
20 Medicaid lives in the discussion. Certainly, from a
21 physician perspective there's a gap when we don't
22 have the Medicaid lives. And when we do, e-

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1 Prescribing, one of the data components of e-
2 Prescribing is medication history. We have a service
3 that actually provides e-Prescribing to provide that
4 medication history. So as Medicaid members go to an
5 emergency room or get admitted to a hospital, we can
6 share that medication profile so they're not asking
7 questions about what color pills they're taking or
8 how many because we have a snapshot. We can have

9 that information available to us.

10 (Slide)

11 MR. GROOM: The next slide I have up here
12 is showing where we have patient events. This just
13 identifies, through technology partners that are
14 connected to us, we have the ability to get patient-
15 level decisions in the hands of physicians. You can
16 see where e-Prescribing is today. I will tell you
17 Michigan, always wanting to do it, would have been--
18 it would probably be a salmon color. Once they got
19 engaged and started it, we saw the uptake. It worked
20 tremendously.

21 (Slide)

22 MR. GROOM: This is just a view on the

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1 blueprint educating stakeholders in e-Prescribing--on
2 what e-Prescribing is, on what it takes to convene
3 the stakeholders, how you need to work on incentives,
4 how you need to roll out programs, who needs to
5 educate and sell, if you will, the physician to adopt
6 technology partners and what state organizations and
7 associations really need to be at the table to be
8 helpful to this.

9 Again, this is something that we'll
10 probably be releasing next week. We have an e-
11 Prescribe symposium next week at the St. Regis with
12 PCMA and we'll be talking a little bit more about
13 this.

14 (Slide)

15 MR. GROOM: Lastly, we'll have a 50-page
16 addendum. It will be basically a snapshot of the
17 states. We've done a lot of work in Florida, so I
18 gave a snapshot of what we've done there. Really, if
19 you look at the triangles, if you will--the triangle
20 points--the payers we've got an example of the number
21 of lives that we have in here and it's a combination
22 of commercial and certainly Medicare and Medicaid

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1 lives. We talked about technology partner--there's a
2 list of technology partners that are already e-
3 Prescribing in Florida.

4 Then lastly, coupled with the information
5 that SureScripts has--they have a pharmacy
6 connectivity and the work that is taking place there.
7 We feel this would be a good view for your group to
8 really see where the prescribing is at the state
9 level. There's a great deal of prescribing up in the
10 Northeast and certainly starting in the Southeast.
11 There's pockets across the Midwest and heading West,
12 but there's great opportunities. There are great
13 discussions that are taking place to really make this
14 happen. And again, through the leadership of this
15 group, you can celebrate those discussions.

16 (Slide)

17 MR. GROOM: Lastly, I just want to share
18 some information that Dr. Sullivan shared with the e-
19 Prescribe forum. Why do you measure e-Prescribing?
20 It's really for them to identify the factors that can

21 affect the state for e-Prescribing and use them as
22 part of their strategic planning and making sure that

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1 we are staying on board and obviously they want to
2 compare other states and rankings.

3 (Slide)

4 MR. GROOM: We've shown some of the
5 numbers thanks to SureScripts and we've provided them
6 with that state readiness.

7 (Slide)

8 MR. GROOM: I just want to talk a little
9 bit about the metrics. If you had the ability to get
10 all the peers involved so that the majority of the
11 time when the physicians takes a patient, they can
12 get patient-level information--highly valuable to
13 everybody. That's one of the key success factors
14 that makes e-Prescribing happen. Second, physician
15 connectivity--who's connected and who hasn't been
16 connected.

17 Then lastly, from a pharmacy perspective,
18 what pharmacies are connected, whether they're on the
19 retail side or on the mail order side. We've
20 established some data points here that we can measure
21 above and beyond what's being measured today and
22 actually create a power ranging. This is something

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1 that you could certainly adopt the language from a
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2 state perspective or inside the state if there are
3 communities that you want to measure and make sure
4 people are on track. You can do that as well.

5 We feel that e-Prescribing, at some point,
6 now that the ROI is here the business model has been
7 defined. There are incentives that are in place or
8 in process that I think can make the adoption happen.
9 It's time to really roll up our sleeves and get to
10 work on executing the plan and certainly measuring
11 it.

12 As we've worked with different
13 organizations, we've taken best practices and tried
14 to roll them up into a process that will hopefully
15 work for all. Thank you.

16 GOVERNOR DOUGLAS: Thank you both for your
17 presentations this morning. It was great to have
18 your experience come to this table so that we can
19 continue our deliberations in fashioning some
20 recommendations to other governors. Obviously, a lot
21 of this happened in many parts of the country. We
22 look forward to greater progress to come.