James L. Holly, M.D.

Surescripts 2015 Annual Report
Interview with Dr. James L. Holly
Your Life Your Health
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Surescripts connects pharmacies, care providers, benefit managers, and technology partners to get the right information to the right place at the right time. Surescripts partners with more than 700 EHR applications used by over 900,000 healthcare professionals and more than 1,000 hospitals, impacting more than 270 million insured lives. Surescripts processes more than 6 billion transactions each year, including nearly 700 million medication histories, more than 1 billion e-prescriptions and nearly 10 million clinical messages.

Surescripts in its 2015 Annual Report, visited with Dr. James Holly about the biggest problems facing physicians and the digital tools that are helping to fix them.

Surescripts: What are the main problems physicians face in their daily work?

Dr. Holly: The two biggest problems in healthcare are 1.) maintaining a complete, accurate and up-to-date “problem” list, and 2.) maintaining a complete, accurate and up-to-date “medications” list. So much is expected of doctors, but electronic versus manual workflows are the difference between doing things correctly and not doing them at all.

Surescripts: Tell us more about what’s expected of doctors and how electronic workflows make it easier to do a task properly than not at all.

Dr. Holly: Convenience is the new word for quality. The number of tasks a provider can be expected to complete during a patient visit depends on the answers to these questions:

- How important is the it?
- How much time will it take?
- How much energy will it take?

For doctors and other healthcare providers, time and energy are two separate measures. For example, if you’re calculating Framingham risk scores, which produce values to assess the future risk to patients’ health, this comprises 12 risk factors. If you add a “what if” scenario to each, which allows you to show a patient how risk changes when his or her health improves, it

multiplies the complexity times five calculations for each of the 12 risk scores. The task is indeed important, but doing it manually is time and energy-intensive. Doing it electronically takes a complex task—72 computations—automates it, and delivers the data in one second, requiring virtually no time or energy. It's the difference between completing one task or 40 tasks during an office visit.

Another example of this has to do with health conditions that we are required to report to the Texas Department of State Health Services. In Texas, there are 78 of them. Very few doctors, if any, can remember all 78, let alone report them manually. So I designed an electronic replacement for this process. My IT staff input all 78 diseases, as well as their categories for timing and reporting requirements. We made the workflow interactive, so that when the provider made a diagnosis which was one of the 78, the information was auto-populated into the "Reportable Conditions" template. At once, care coordination was flagged to automatically notify the state and then report back to the provider once the task was complete. This took one of the most complex, time and energy-consuming tasks and, again, made it effortless.

Surescripts: What do electronic workflows mean to patients?

Dr. Holly: They make all the difference. They empower patients like nothing else. Electronic workflows produce comprehensive and customized reports—one for the nurse, one for the doctor and one for the patient—summarizing everything that's been scheduled and ordered. This report provides a paragraph with each item, explaining its meaning, significance, where the patient stands score-wise, risk factors and actions to improve his or her health. It's an extremely personal document. Having an instant, complete, accurate and personalized visit summary has profound effects on patient behavior. They feel ownership of their health and enter into a "contract" of sorts with their doctors to collaborate on improving it.

A powerful example of this is a SETMA patient whose young son had a standard well-child visit. The EHR produced a customized visit summary with action steps to improve the child's health, including the fact that the child is exposed to environmental tobacco smoke from the father smoking in the house. This child's mother left the report on the seat of the family vehicle, and when the father stepped out to buy a pack of cigarettes, he saw the report with his child's name prominently at the top. In that moment, he realized that this was important information, customized for his child only. He read the entire report, and was really upset when he saw that his child's exposure to second-hand smoke was likely causing health issues and putting the child at serious risk. He brought the report into the house, told his wife that he'd just then realized what he'd been doing to their child, and never smoked another cigarette.

Patients need a sense of individuality and control. So, I focus on what I can give them control over so that they can begin to contribute to their own health.

Surescripts: It seems like there's a strong emotional or compassionate aspect of care that empowers patients. The opposite, then, would be care that disempowers them. Can you explain this?

Dr. Holly: Absolutely. Take controlled substances, for instance. The only thing more dangerous than controlled substances is not prescribing them. Years ago, I met an acutely ill patient who is a military veteran. He'd become upset and combative. He was so angry that he said, "I'm going to kill the next doctor who walks through that door." So, for better or worse, the staff sent me in to help.

The first thing I did was ask him, "May I listen to your chest?" He immediately calmed down and talked to me for a full 32 minutes about his illness and symptoms. As we visited, it occurred to me that nobody had asked him for his permission to examine his body—ever. He felt violated and helpless. That simple human gesture gave him agency over his body and his situation. He ultimately needed two controlled substances as part of his treatment. Given his past experiences, it was even more important for him to get his meds with little to no runaround. Convenience is power. This patient needed the minimum amount of intervention and unnecessary follow-ups. Today, when he needs a med refilled, he sends me a secure text. Then, I use Electronic Prescribing of Controlled Substances (EPCS) to refill it instantly, from anywhere in the world, using my smart phone and two-factor authentication. And the really, really cool thing is that he and I have been friends for years now.

Surescripts: Controlled substances seem to pose a lot of tough problems. What are the biggest ones' providers are facing?

Dr. Holly: In Texas, providers are questioned when they prescribe controlled substances. They're also questioned when they don't. The regulatory burden falls squarely upon the provider, and that can adversely affect patients. So, in some cases, providers are less willing to prescribe controlled substances.

Surescripts: How does EPCS help fix this rock-and-a-hard-place that providers are in when it comes to regulatory scrutiny?

Dr. Holly: With EPCS, every single step of the decision-making process as it relates to prescribing a controlled substance is documented automatically. In other words, now, we document it as we prescribe it. When a provider is audited, EPCS helps produce the required documentation in an instant, rather than having to manually track everything, which is virtually impossible due to the time and energy involved.

In the past, these medications required providers to input data redundantly in both the Electronic Medical Record (EMR) and a manual triplicate form. Again, convenience is power. E-prescribing controlled substances enables physicians to transition patients from being imposed upon to being cared for. With EPCS, patients don't have to grovel and repeatedly explain why they need their medications. Before EPCS, if you realized you needed a refill and the office was closed, you were out of luck. Now, physicians can easily take care of it, no matter where they are in the world. There are no boundaries. We have a clinic or pharmacy without walls. I feel strongly that once providers adopt this technology, they'll be addicted—ironically enough—to the capability and the facility it provides to give patients excellent care efficiently and without delay.

Surescripts: You mentioned how EPCS creates a pharmacy without walls. How are pharmacies responding to EPCS?

Dr. Holly: Pharmacies love it. When my organization surveyed them to see if they had the capacity to receive e-prescriptions for controlled substances and/or if they were interested in using it, they all either really wanted the capability, or were already using it. EPCS creates a stronger partnership between providers, pharmacies and patients.

Surescripts: You sound really optimistic about where EPCS is going. What's most exciting to you about this industry shift?

Dr. Holly: The greatest thing about all of this is that it's all true and it all works. Our stories are true. They give substance to what we're about, and we need to tell these stories. With electronic capabilities, diagnoses, urine drug screens for utilization monitoring, e-prescribing, auditing of provider prescriptions and patient use—as well as a documented discussion with patients about these medications and usability from multiple sites—it all resides in the same tool (EMR), making compliance with state, federal and practice standards simple and measurable.