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e-Prescribing and Patient Safety: Results From a Mixed Method Study

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*Et al.*

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ABSTRACT

Objective: To describe ambulatory care clinicians’ perspectives on the effect of electronic prescribing (e-prescribing) systems on patient safety outcomes.

Study Design: Mixed method study of clinicians and staff in 64 practices using 1 of 6 e-prescribing technologies in 6 US states.

Methods: We used clinician surveys (Web-based and paper) and focus groups to obtain clinicians’ perspectives on e-prescribing and patient safety.

Results: Providers highly valued having medications prescribed by other providers on the medication list and the ability to access patients’ medication lists remotely. Providers thought that there will always be prescription or medication errors and that the implementation of e-prescribing software changes rather than eliminates prescription or medication errors. New errors related to the dosing or scheduling of a medication, accidentally prescribing the wrong drug, or duplicate prescriptions.

Conclusions: Lessons from the ambulatory care trenches must be considered as technology moves forward so that the hypothesized patient safety gains will be realized.

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scale. Including multiple vendors in multiple practice settings provided a unique opportunity to fully understand perceptions about patient safety with respect to e-prescribing in primary care settings.

The purpose of this study is to describe ambulatory care clinicians’ perspectives on the effect of electronic prescribing systems on patient safety.

METHODS
Study Sample

The Brown University Institutional Review Board approved the study protocol. SureScripts, LLC, the nation’s largest e-prescribing network, identified states with the highest e-prescribing activity on their network in the fall of 2005. To provide geographic diversity while considering practical and logistical issues, we selected the 6 states with the highest volume of e-prescribing transactions to be targeted for inclusion in the study: Florida, Massachusetts, New Jersey, Nevada, Rhode Island, and Tennessee. Within these states, SureScripts, LLC, identified physician software vendors with substantial activity who agreed to participate in the study: OtcCallData, InstantDX, LLC (Gaithersburg, Maryland) in Rhode Island; PocketScript, Zix Corporation (Dallas, Texas) in Massachusetts and New Jersey; Rcopia, DrFirst, Inc (Rockville, Maryland) in New Jersey; Care360, Medplus, Inc (Mason, Ohio) in New Jersey and Florida; eMPOWERx, GoldStandard Multimedia, Inc (Tampa, Florida) in Florida; and Touchworks, AllScripts, LLC (Chicago, Illinois) in Nevada and Tennessee.

All physician software systems were required to assist in recruitment of ambulatory care practices with a patient mix of at least 25% Medicare-eligible patients. We developed participation agreements (approved by the Brown Institutional Review Board) and provided recruitment packets and training of information in the recruitment packets for each company. The resulting practices represented a convenience sample, as companies approached practices with which they had positive relations and which had participated in research previously. Thus, we were unable to estimate participation rates among potentially eligible practices. The data for the current study were derived from clinician surveys and focus groups. All data were collected before any changes to the e-prescribing software were made to accommodate the e-prescribing standards.

Clinician Surveys

Clinicians (n = 157) completed surveys available via the Web (75%) or paper (25%) in advance of or during the site visit. The survey captured perceptions of the impact of e-prescribing on efficiency, work flow, and quality, as well as clinician views on patient communication regarding medication issues (Appendix A). The survey included 2 questions regarding the impact of e-prescribing on patient safety and quality of care (see Figures 1 and 2). We estimated the clinician responses to the drug- alerting questions for each physician software system. Vendor-specific results are presented without identifying the name of the vendor. To provide context in which to evaluate differences in these proportions, we described the software in relation to frameworks on recommended best practices for e-prescribing software.6,7 Two trained interviewers who had received one-on-one instruction regarding the functionality of all of the software products independently evaluated each product in relation to the 60 recommendations. They coded each recommendation as being fully implemented, partially implemented, not at all implemented, or not applicable. Summary proportions for each conceptual domain were estimated from the 60 recommendations.

Focus Groups

Two highly trained research assistants held focus groups (with a meal provided) before hours, at lunch, or after hours at the discretion of each practice between April and August 2006. A total of 276 clinicians and staff members participated in 64 focus groups after providing written informed consent. A sign listing the main topics for discussion was placed on the table for participants to view (Table 1). We used an open-ended approach to elicit information about the benefits and drawbacks of e-prescribing, as well as the features often embedded within the e-prescribing software. Participants were encouraged to describe their experiences with e-prescribing software and to provide suggestions for improving e-prescribing. Probes included questions about what aspects of e-prescribing were valuable, what

PRACTICAL IMPLICATIONS

Clinicians viewed the following aspects of electronic prescribing (e-prescribing) to be most beneficial for improving patient safety:

- e-Prescribing enabled remote access to medication lists.
- e-Prescribing allowed clinicians to see what other providers were prescribing for their patients.
- While e-prescribing eliminated handwriting errors in the prescribing process, clinicians feared a new generation of errors related to the technology.
participants found difficult, suggested improvements in office procedures and software functionality, and other potentially valuable resources. Research assistants also used facilitative (eg, “Can you tell me more about that?” or “Any other opinions?”) and clarifying (eg, “When you say..., what do you mean by that?”) probes. Participants spontaneously addressed patient safety issues in the context of these discussions. Focus groups were recorded using 2 digital recorders with Pressure Zone Microphones. Once all digital recordings were transcribed, research assistants double-checked every transcript for potential errors.

Qualitative methods are useful for studying complex phenomena such as communication, thoughts, expectations, and meaning, and for investigating people’s experiences. An extensive hierarchical coding structure was initially developed to handle the large volume of qualitative data (Appendix B). This initial structure was based on the focus group protocol and review of initial transcripts, and was revised during active coding. Fifteen different parent nodes were defined to code all of the qualitative data. For this article, we honed in on the analysis of 2 nodes: (1) impact on clinical practice and (2) software features, because many e-prescribing software packages had additional features that may influence patient safety. Coders were instructed to include any comments regarding patient safety in a subnode specifically for this purpose. We also evaluated text coded under “quality of care,” as patient safety issues were sometimes referred to in the context of quality of care.

Coders were trained in coding definitions and overall coding structure. A code book defined all codes and their relationships. All quotes were derived from the focus groups and individual interviews. We did not include information on drug alerts as part of this analysis, as the extensive nature of the findings related to drug alerts warranted a separate analysis.

Consistency in the coding across team members was ensured by extensive training, coding meetings, a common code book, and group exercises. We also had 2 members of the coding team independently code approximately 20% of transcripts and compared reports to identify any areas of coding that were not consistently applied by coders and for which additional training was required. A qualitative data review of the double-coded transcripts revealed that passages coded by each coder commonly appeared twice, indicating effective coding among those transcripts by the research staff. Management and analysis of the data were conducted with NVivo qualitative analysis software (Version 7, QSR International, Melbourne, Australia).

RESULTS
Sample Characteristics
Overall, all software vendors fully implemented at least half of the best-practices recommendations (range of 63%
Electronic Prescribing and Patient Safety

Figure 2. Perceptions of the Impact of e-Prescribing on Quality of Care, Overall and by e-Prescribing Technology Solution

Table 1. Focus Group Discussion Topics

- Experiences with electronic prescribing and e-prescribing software
- How did your practice change when e-prescribing software was implemented?
- What do patients think of electronic prescribing?
- Thoughts about medication history; thoughts about adherence?
- Thoughts about formulary and benefits features?
- Suggestions for improvement and other ideas
One participant noted, “[A patient] was basically on everything he had before except for one…he didn’t remember, but I knew it from the list…it helps in reduction of errors. It helps in compliance because you see when they get it and when they don’t get it.” Another highly valued e-prescribing software feature was the ability to know what medications were prescribed by other providers. One participant claimed to “love the fact that you get the drugs that were prescribed in urgent care on the list because 9 of 10 patients when they come in for their follow-up—which urgent care always tells them to do—they don’t remember which medicine they were put on.”

Although participants clearly articulated the patient safety value of having a medication list at the point of prescribing, the accuracy of the lists was questioned by some. Complaints about short-term medications (such as antibiotics) remaining indefinitely on the lists varied according to the specific e-prescribing software. Complaints about not having complete information on all of the patients were common. Overall, participants greatly valued the ability to access medication lists remotely. Clinicians commented on the need to prescribe after hours or away from their patients’ records. Remote access to the medication list was believed to improve patient safety. Some participants reported printing the medication list for their patients. According to one participant, “It really helps because at least they can take it home and call us back and clarify any differences between the two.”

Improved legibility was also perceived as a major benefit of e-prescribing. However, participants felt that there will always be prescription or medication errors, and that the implementation of e-prescribing software would change rather than eliminate errors. A major type of error related to the dosing or scheduling of a medication. Other types of errors included accidentally prescribing the wrong drug or duplicate prescriptions. As one participant reported: “I’ve seen things where the staff handled a refill request and picked the wrong drug, a similar sounding name…I could have very easily prescribed the wrong drug or the wrong dosage.” Participants reported that errors occurred because of difficulty distinguishing between items in menus or because of errors in selecting options. Factors leading to selecting the wrong agents included the small size of handheld devices and columns too close together on the display. One participant noted that a prescription “somehow got switched…the viewing screen on that handheld is small, and it was a combination medicine. I couldn’t see all the components…he was getting one that contained aspirin instead of acetaminophen. He was somebody who shouldn’t be getting aspirin. And he had a serious complication from that.”

Participants suggested ordering medications in ascending or descending order to prevent mistakes. Participants reported that medication errors stemming from e-prescribing were typically caught by the pharmacists, error checking within the e-prescribing software, or patients. Table 3 summarizes key issues emerging from the focus groups.

**DISCUSSION**

This multistate, multivendor study confirms the value of e-prescribing for patient safety. Consistent with a recent study based on only 1 e-prescribing product in 1 state, our study found that the majority of clinicians reported...
at least some improvements in patient safety and quality of care with e-prescribing. Our study extends previous work by identifying the concerns of users regarding new forms of medication errors resulting from e-prescribing. Participants provided clear areas for improvement, as well as suggestions for preventing medication errors.

An estimated 7.6% of outpatient prescriptions have prescribing errors,13 and 4.1% of new e-prescriptions and 2.1% of refill e-prescriptions require pharmacist intervention.14 Our findings echo the work by Gandhi et al,15 who argued that basic computerized prescribing systems may not be adequate to reduce errors. Our participants noted problems with dosages and directions, issues also brought up in interviews with pharmacy personnel.15 An audit of pharmacist medication interventions found that among e-prescriptions requiring intervention, 32% were due to missing information and 17.7% were due to dosing errors.14 While these data support the notion that more advanced systems with dose and frequency checking are needed to prevent potentially harmful errors, the extent to which such systems will be overridden remains unknown.11 Another strategy to reduce errors in instructions and dosing is to develop and implement standards for terminology to code clinical drugs (RxNorm) and standards for medication instructions (structured and codified SIG). Indeed, a recent expert panel concluded that the lack of unambiguous drug identifiers in proposed standards suggests that more work is needed.16

Our study demonstrated that specific aspects of the software and hardware (eg, screen size, drop-down menus, order of choices) may contribute to the selection of wrong dose and drugs. Best practices should be identified by understanding the relationship of errors to characteristics of the software and hardware used for e-prescribing, with methods such as those conceptualized by Bell et al,9 operationalized via consensus method with an expert panel,7 and evaluated in a field study.17 The human factors engineering approach to the development of tools such as e-prescribing may identify potentially dangerous usability flaws.18,19

Participants in our study believed the availability of a medication list as part of the e-prescribing software improved patient safety. Our finding that participants used the medication list to reconcile medications with their patients confirms previous work indicating that use of e-prescribing systems in a standardized way to ensure accurate medication lists leads to significant patient safety gains.20 However, in another setting, when such data were provided, they were only accessed in 0.6% of clinical encounters involving prescriptions.21 Our participants reported that medication lists were often incomplete or they did not have information on all of their patients. This is not surprising, because the extent of bidirectional flow of medication history data from comprehensive data sources is highly variable and is hampered by product limitations and external challenges related to implementation, including state variations in regulation of data and sharing of information across providers.22 Our data suggest that clinicians believe that further patient safety gains could be realized if comprehensive, accurate medication lists were available at the point of prescribing.

Our study is not without limitations. While nonresponse bias is possible, we do not know whether participants were overly supportive of e-prescribing or overly negative. It is likely that this convenience sample captured participants who were representative of the most experienced e-prescribing users in primary care settings. Because they were not new users, it may be that these participants liked the software enough to continue using it. Second, the data included in this report were from a geographically diverse group of physician practices using 1 of 6 e-prescribing products. The variability in the e-prescribing software may give rise to interesting hypotheses to be explored in future research. Concerns may exist over the purposeful sampling in this study. Yet for qualitative analysis, purposefully selecting an informative sample is a valid approach and

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**Table 3. Summary of Key Advantages and Concerns About e-Prescribing That Emerged From Focus Groups**

<table>
<thead>
<tr>
<th>Patient Safety Advantages</th>
<th>Patient Safety Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value in doing medication reconciliation at point of prescribing</td>
<td>Validity and completeness of the information regarding medication</td>
</tr>
<tr>
<td>Knowing medications prescribed by other providers</td>
<td>Accidentally prescribing duplicate medications</td>
</tr>
<tr>
<td>Remote access to patients’ medication lists so when clinician prescribes new medications off-site, it is done with knowledge of medication regimen</td>
<td>Drop-down menu issues resulting in wrong drug or dose being prescribed</td>
</tr>
<tr>
<td>Ability to share list of medications with patients so they can use it at home to check against actual medicines</td>
<td>Small screen size on handheld devices leads to wrong drug or dose being prescribed</td>
</tr>
<tr>
<td>Reduces errors due to illegibility of handwriting</td>
<td>Order of drop-down menus leads to wrong drug or dose being prescribed</td>
</tr>
</tbody>
</table>
can increase the quality and information of the data. Nevertheless, even among e-prescribing users who are familiar with the technology, the findings did not appear to be overly optimistic regarding the impact of e-prescribing on patient safety in the ambulatory care setting.

CONCLUSIONS

Regardless of the e-prescribing software vendor, physicians representing diverse practice characteristics and locations overwhelmingly agreed that functionality included in many e-prescribing systems offers a patient safety advantage relative to other forms of prescribing. Given the conservative estimate of 530,000 preventable adverse drug events occurring in outpatient settings, clinicians must have full knowledge of the current drug regimen to avoid preventable adverse drug events. While e-prescribing may be one method to improve patient safety related to medication errors, it is important to further identify and promote best practices to minimize a new generation of medication errors resulting from the adoption of this technology.

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REFERENCES

Appendix A. e-Prescribing Previsit Web Survey: CLINICIAN SURVEY

This survey is part of a research project funded by the US Department of Health and Human Services (HHS) and supported by your employer. The purpose of the survey is to assess your opinions about electronic prescribing and how it has influenced how you do your job. The survey should take approximately 15 minutes to complete, and your responses will be kept confidential.

We greatly appreciate your cooperation. If you have any questions regarding this study, please contact me directly at [e-mail address] or call [phone number].

Thank you for your help.

1. What is your first name: ____________________________________________________________________________

2. In what state is your group/practice located: ________________________________________________________

3. What is the name of your group/practice: ____________________________________________________________

4. Which of the following e-prescribing software does your group/practice use?
   - a. OnCallData
   - b. eMPOWERx
   - c. TouchWorks
   - d. PocketScript
   - e. eMaxx
   - f. Rcopia

5. What is your gender?
   - a. Male
   - b. Female

6. What is the highest level of education completed?
   - a. Did not complete high school
   - b. High school diploma or GED
   - c. Vocational/trade school
   - d. Some college
   - e. Associate degree
   - f. Bachelor's degree
   - g. Postgraduate degree

7. Are you a clinician that prescribes medicines for patients?
   - a. YES
   - b. NO

8. What is your job?
   - a. Physician
   - b. Resident
   - c. Nurse Practitioner
   - d. Physician Assistant
   - e. Pharmacist
   - f. Other: ____________________________________________________________

How many minutes per day do you now (or did you prior to implementation of electronic prescribing software) perform the following:

9. Resolve prescription problems with the pharmacy? Please enter average time. No ranges.
   - _____ total minutes/day before e-prescribing
   - _____ total minutes/day after e-prescribing

10. Respond to and process pharmacy refill/renewal requests? Please enter average time. No ranges.
    - _____ total minutes/day before e-prescribing
    - _____ total minutes/day after e-prescribing

11. Obtain prior approval for drugs as specified in patients’ prescription plans? Please enter average time. No ranges.
    - _____ total minutes/day before e-prescribing
    - _____ total minutes/day after e-prescribing

12. Some e-prescribing technologies have computer-generated drug alerts. How often do you override computer-generated drug alerts?
    - a. Allergy alerts
    - b. Drug-to-drug interactions
    - c. Dose checks
    - d. Drug-to-food interactions
    - e. Drug-to-alcohol interactions
    - f. Health state interactions
    -

13. Are the alerts in the prescriber software system adequate? Please describe:
    - ____________________________________________________________________________________________
    - ____________________________________________________________________________________________
    - ____________________________________________________________________________________________

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14. Please rate these different methods of prescribing from your perspective:

<table>
<thead>
<tr>
<th>Method</th>
<th>Very Inefficient</th>
<th>Moderately Inefficient</th>
<th>Moderately Efficient</th>
<th>Very Efficient</th>
<th>Do Not Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Handwritten</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Faxed (fax machine)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Faxed (computer fax)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Sent electronically to the pharmacy's computer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Phone-in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Computer generated/printed out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

15. Do you use any aspect of the e-prescribing software (such as OnCallData, eMPowerX, TouchWorks, PocketScript, eMaxx, or Rcopia)?

a. NO (skip to question 17)  
   b. YES (continue with question 16)

16. In a typical week, how often do you use these features of the e-prescribing software?

<table>
<thead>
<tr>
<th>Feature</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Entering/revising patient information</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Entering new prescriptions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Approving and/or submitting new prescriptions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Entering information for refills/renewals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Approving and/or submitting refills/renewals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Reviewing patients’ medication history</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Reviewing drug reference information</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Reviewing formulary information</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. Entering over-the-counters, supplements</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j. Entering samples given to patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>k. Checking and/or updating medication list with patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>l. Checking lab values in relation to medication use</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>m. Printing patient drug info sheets for patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>n. Accessing patient data from other locations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>o. Ordering prescriptions from home, hospital, or other locations</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>p. Building a medication favorite list</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>q. Entering medications administered in MD office (ie, immunizations)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>r. Printing reports for the patient’s chart</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>s. Printing other reports</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

17. The next question addresses how you believe e-prescribing has impacted your workplace. From your perspective, how does using the e-prescribing software compare to previous methods in the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Much Worse</th>
<th>Somewhat Worse</th>
<th>No Change</th>
<th>Somewhat Better</th>
<th>Much Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient safety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Quality of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Efficiency of care (eg, increased work flow and productivity)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Communications with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Communications with the pharmacy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Overall relationship with the patient</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Overall relationship with the pharmacy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
18. The next few questions address issues of communication with respect to medication use.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How often do you have discussions with other other prescribers ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. How often do you have discussions with patients regarding lack ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. How often do you have discussions with patients regarding ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. How often do you discuss the costs of medications with your ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. How often would your patients tell you if they did not want ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. How often would your patients tell you if they did not plan ...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

19. Based on your own experience, please rate your overall satisfaction with these different methods of prescribing:

<table>
<thead>
<tr>
<th>Method</th>
<th>Very Unsatisfied</th>
<th>Somewhat Unsatisfied</th>
<th>Somewhat Satisfied</th>
<th>Very Satisfied</th>
<th>Do Not Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Handwritten</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Faxed (fax machine)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Faxed (via computer)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Sent electronically to the pharmacy's computer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Phone-in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Printed from computer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

20. **OVERALL**—how would you say that the use of the e-prescribing software has affected your job compared to previous methods?

<table>
<thead>
<tr>
<th>Impact</th>
<th>Never</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Made my job much more difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Made my job a little more difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. No change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Made my job a little easier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Made my job a lot easier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Please enter what you feel is the biggest positive impact e-prescribing software has had on your work:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

22. Please enter what you feel is the biggest negative impact e-prescribing software has had on your work:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

THANK YOU!
Appendix B. e-Prescribing Code Structure

**Benefits Problems Suggestions**

**Impact on Clinical Practice**
- Patient Care
  - Med Hx
  - Pt Relationship
  - Adherence
  - Rx Drug Abuse
  - Med Decisions
    - Rx Decision
  - Pt Education (Rx)
- Pharmacy
  - Ordering Meds
    - New Rx
    - Refill/Renewal
    - Rx Problems
  - Pharm Relations
    - Mail Order Pharm
    - Other
- Other
  - Phone Calls
    - From Pharm
    - To Pharm

**Prescribing Methods**
- Computer-Based Prescribing
  - e-Prescribing
  - Computer Fax
  - Printed for Pt

**Software Features**
- Drug alerts
- Remote access
- Add/edit patient info
- Enter new prescription
- Approve waiting Rxs
- Process waiting refills/renewals
- Patient drug info sheets
- Access formulary & benefits
- Access medication history
- Medication Favorites List
- Reports

**Impact on Work Flow**
- Technology
  - Software
    - Updates
  - Hardware
  - Training
  - Vendor Relations
  - Cost
  - Other
- Reports
  - Drug reference info
  - Designate pharmacy
  - Active medication list
  - Other

**Impact on Jobs**
- Technology
  - Workload
  - Staffing
  - Satisfaction
- New/Shifting Duties
- Time Costs
- Time Savings
- Other

**Medicare**
- Part D
  - Office Administered
  - Prescription
  - Control Substances

**Types of Drugs**
- Medicare
  - Prescription
  - OTC
  - Other
  - Controlled Substances

**Medical Supplies**
- Office Administered
  - Workarounds
  - New Rx
  - Refill/Renewal

**Prescribing Policies**
- Prescribers
  - MD
    - Community
    - Attending
    - Resident
  - NP
  - PA
  - Other

**Personnel**
- Office Staff
  - Office Manager
  - Reception
  - Secretary
  - Billing
  - IT
  - Other

Auth indicates authorization; Hx, history; IT, information technology; NP, nurse practitioner; OTC, over the counter; PA, physician assistant; Pharm, pharmacy; Psych, psychologist; Pt, patient; Rx, prescription.