Electronic Prescribing Is Gaining Momentum

BY MARY ELLEN SCHNEIDER
Senior Writer

Medicare officials have proposed new uniform standards for electronic prescribing that will govern transactions between prescribers and dispensers of prescriptions.

Under the proposal, the standards would take effect in January, to coincide with the beginning of the new Medicare Part D prescription drug benefit. The proposed standards apply to transactions between prescribers and dispensers of new prescriptions, refill requests, prescription changes, and cancellation requests. In addition, the standards govern eligibility and benefits inquiries between prescribers and drug plans and Part D sponsors.

Additional electronic prescribing standards will be developed by 2008.

Electronic prescribing is voluntary for physicians, but the aim of the standards is to make it easier and more attractive for physicians to use the technology.

"These proposed e-prescription rules would set standards to help Medicare, physicians, and pharmacies take advantage of new technology that can improve the health care of seniors and persons with disabilities," Health and Human Services Secretary Mike Leavitt said in a statement.

One of the most successful strategies for getting physicians to adopt electronic prescribing in their offices is to provide ongoing reimbursement, said Jonathan Teich, M.D., chief medical officer at Healthvision, an Internet health care company, who chaired the Electronic Prescribing Project of the eHealth Initiative.

Over the last few years, there's been a lot of work in both the public and private sectors examining what drives adoption of e-prescribing. What they have found is that there is money to be saved through the use of the technology, but it's usually saved by the payer, not by the physician, Dr. Teich said.

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But payers and others can provide incentives to physicians by supplying the technology up front, giving increased reimbursement per visit for the use of electronic prescribing, or incorporating electronic prescribing into a pay-for-performance program, he said.

A group of health plans in Massachusetts has joined forces to cover the costs of electronic prescribing for physicians interested in integrating the technology into their practices.

Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and the Neighborhood Health Plan have partnered with the technology vendor ZixCorp to provide physicians in Massachusetts with the hardware and software needed for electronic prescribing.

The project is called the eRx Collaborative, and from October 2003 through the end of 2004, nearly 2,700 physicians and their clinical staff members signed up to participate in the project. At the end of last year, more than 1,500 doctors had incorporated the technology into their practices.

The collaborative plans to cover the costs of the e-prescribing technology through the end of this year.

The project uses ZixCorp's PocketScript e-prescribing system. This technology allows physicians to create new and refill prescriptions electronically and allows for real-time access to a patient's prescription history, as well as formulary and eligibility information. Physicians can access the program either through a secure Web site or a handheld device.

This year, physicians will also be able to choose to use DrFirst Inc.'s Rcopia electronic prescription management program.

Facilitating the adoption of electronic prescribing is a way to try to curb both high pharmacy costs and medication errors, said Robert Mandel, M.D., vice president of eHealth for Blue Cross Blue Shield of Massachusetts.

And electronic prescribing seems like a good solution because it would be easier to incorporate into the physician's workflow than an electronic health record, Dr. Mandel said. But he said he hopes that physicians will choose to move to a fully functional electronic health record in the future.

"We do believe that this is a transitional technology," he said.

The project, which is the largest of its kind, could be a model for how to drive adoption of this technology, Dr. Mandel said.

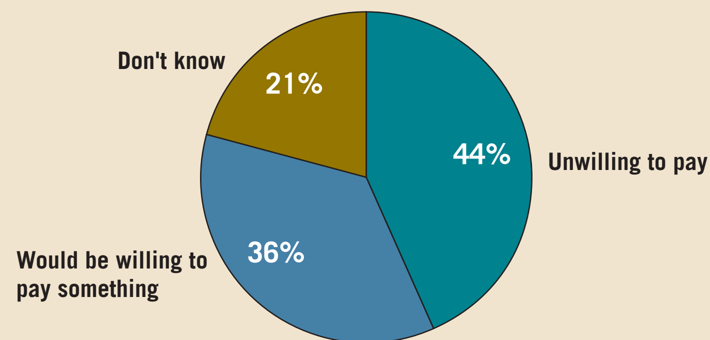
James Whitman, M.D., a pediatrician in Framingham, Mass., and one of the physicians who received the electronic prescribing technology through the eRx Collaborative, said it's shown him how easy it can be to use.

Through electronic prescribing, he and his office staff have saved time, and his patients like it because they don't have to carry around prescriptions, he said.

Dr. Whitman and his colleagues plan to make the jump to full electronic health records when they replace their practice management system. "Our experience with this system makes it a little less scary," Dr. Whitman said. ■

DATA WATCH

Nearly Half of Patients Unwilling to Pay for Online Communication With Their Physician



Note: Based on a nationwide survey of 2,387 adults conducted Feb. 4-8, 2005. Percentages do not add to 100% because of rounding.
Sources: Harris Interactive, Wall Street Journal Online

KEVIN FOLEY, RESEARCH

Medical Records: No Longer Sacrosanct Tools, Ethicist Says

BY CHRISTINE KILGORE
Contributing Writer

The long-held perception that medical records should never be altered at a patient's request is quickly becoming erroneous, according to health lawyer and ethicist George Annas.

"We can delete (items from the record), as long as we note that something has been deleted and who did it," said Mr. Annas, chairman of the department of health law, bioethics, and human rights at Boston University.

In a webcast sponsored by the National Institutes of Health, he braced physicians for a future in which patients will increasingly ask them to correct, delete, or change items in the medical record that are either errors or items that they are concerned may pose harm to them.

"The real reason patients don't ask to make deletions [now] is because most people don't look at their records," he said. But with the advent of the Health Insurance Portability and Accountability Act (HIPAA), "now there's a federal right of access to medical records."

Moreover, President Bush's current emphasis on electronic medical records (EMRs) embraces "the idea that patients should be in control," and patients are generally much more concerned about the content of electronic records than paper records, said Mr. Annas, who is also professor of sociomedical sciences and community medicine at Boston University.

The Bush administration has not addressed, in the context of its EMR proposals, whether "a patient [should] be able to delete accurate, factual information [from medical records]," he said.

The bottom line, however, is that "we're in the process of radically changing the medical record … into the patient's record," Mr. Annas said.

There are "lots of mistakes in medical records," making it likely that many changes made in the future will address actual errors. Debate about other types of alterations will ensue, but under this new climate "you could argue that patients should be able to change anything," he told the physicians.

HIPAA addresses the issue of corrections to medical records, saying that "patients have a right to request corrections in the record, and if there's no response, they can write their own letter and have it added," Mr. Annas explained.

The physicians who attended the NIH session reviewed a case in which a patient presented at the National Institute of Neurological Diseases and Stroke to enroll in a sleep study. He had a chief complaint of insomnia but, during a visit with an NIH clinical social worker, he also reported symptoms of severe depression and a history of drug use.

The day after the social worker evaluated the 37-year-old unemployed man, he requested that the information entered in the computerized record be deleted. "He was vague in his request, but he was concerned that someone would illegally obtain access … and use [the information] against him," said Elaine Chase, of the social work department at the NIH Clinical Center, Bethesda, Md.

Mr. Annas said that if he were the provider faced with this request, he would agree to delete the information most disconcerting to the patient. "And if he wanted it out of a paper record, I'd still say yes," though, in the interest of research integrity, the patient should then be excluded from the NIH study, he said.

He offered his verdict on the case example after a free-ranging discussion in which some physicians voiced concern that a move from "physician's record" to "patient's record" would hinder communication among providers.

"Part of the purpose [of the medical record] is it helps individuals plan care," said one physician. "So from this standpoint, you can't just delete things. … Or if there's going to be a patient medical record, maybe there needs to be another record [for providers]," she said.

It's true, Mr. Annas said, that "defense attorneys still say today that your best defense is a complete medical record."

Still, physicians, overall, "take the record too seriously" and, although questions remain, they are going to have to be more willing to consider patient requests to alter the medical records, Mr. Annas told this newspaper.

Theoretically, at least, the doctor and patient should review the content of the record before the visit ends, he said. "It makes sense that when you take a history, you should go over it with the patient and ask, 'Is this what you tell me? Is it right?' " ■