

Online Tool Could Help Doctors Predict Risk

BY HEIDI SPLETE

A revised high-tech tool from the Department of Health and Human Services might make filling out a pre-exam checklist in the doctor's office obsolete, if doctors and patients will use it.

"We know that a large percentage of our risk for developing certain diseases is related to genetics and related to our family histories," acting Surgeon General Steven Galson said in an interview.

In the future, clinicians will predict risk and plan therapy based on information obtained from a drop of blood, but that future is still far off, Dr. Galson said. "We know that today, by using family history, we can get a lot of information that can help clinicians," he emphasized.

The online tool, called My Family Health Portrait, collects information in a standard way that's easy for family members to share and for clinicians to use. "We'd like to see every single American have the opportunity to input their data into this tool and enable their physicians to treat them with a better understanding of family history," he added.

"Family history can provide important insights into future risk of developing a variety of serious medical conditions like cardiovascular disease, diabetes, and [some] cancers," Dr. Greg Feero, a senior adviser for genomic medicine at the National Institutes of Health, said in an interview. But many time-strapped clinicians don't collect family history during office visits. "The tool offers doctors

and patients a convenient way to collect and organize an expanded range of family history information outside of the time constraints and pressures of the office visit," Dr. Feero said.

My Family Health Portrait was introduced in 2004 as a form that patients could print and take to their medical appointments. But the revised version (available at <https://familyhistory.hhs.gov>), lets

'My Family Health Portrait,' which can be accessed at <https://familyhistory.hhs.gov>, should allow physicians to treat patients with 'a better understanding of family history.'

individuals input, save, and download their information. One person can share the file with other family members and allow them to add their own information if they choose, and they can send it to their physicians via a secure connection. Call it "wiki history"—and it has potential benefits for both doctors and patients.

For example, if you create a file with your own history, you are prompted to note the dates when you had certain diseases (if any) or to add diseases not on the default list. You can also add health information about your immediate family members (siblings, parents, children, aunts, and uncles) with options to add more family members. If you give your brother the file, it asks him whether he is a family member and reorients the data

around him. This prevents the duplication of data; your brother would only need to input health data that are unique to him.

According to the Department of Health and Human Services, building the basics of a family health history should take about 15-20 minutes. Beyond that, the more family members someone includes, the longer it takes. The history may be downloaded onto a patient's own computer, and it is not automatically accessible by the government or by any health care provider without the patient's permission.

Doctors who start an exam with an accurate family history at hand can spend their time reviewing and interpreting the information, rather than collecting it, Dr. Feero said.

"The new tool is designed using accepted data standards, so that the data file it creates has the potential to be shared electronically with electronic health record and personalized health record systems," Dr. Feero noted. "Ultimately, this same standards-based design should allow the development of automated tools to help clinicians interpret the information the patients provide them."

"If the clinician currently uses a paper-based patient family history intake form for new patients, or for yearly physicals, the provider could simply ask patients to complete the new tool online and supply them either with the data file or a paper version," Dr. Feero explained. "If secure e-mail systems are available to the patient and provider, this might be another option for transferring the information."

Alternatively, the entire program is

available for downloading and customizing at no charge. Providers can install the My Family Health Portrait software as part of their health information technology system. Patients could complete the information at a kiosk or laptop in the waiting room, and have the electronic file sent directly to their physicians for review.

An electronic family history is potentially useful, Dr. Charles Scott, a pediatrician in private practice in Medford, N.J., said in an interview. But it would have to be reviewed and incorporated carefully, so that patients would not be able to access medical files other than their own if they completed the history in a doctor's office, he said. Software compatibility could be a problem in some practices, he added.

And it's important to remember the personal touch, no matter how much electronic media become part of medical practice. "My fear is that we may get so involved with our data entry in the e-chart that we will forget to warmly interact face to face with our patients," Dr. Scott said.

Clinicians can continue to remind patients to provide as much family history as possible, but it might take time to resolve technical and privacy issues before an electronic family health history becomes a seamless part of an electronic medical record, he said.

Dr. Scott had no financial conflicts to disclose. Dr. Feero is an employee of the National Institutes of Health, which is part of the Department of Health and Human Services. ■

HHS Finalizes Plans for Transition to Expanded ICD-10

BY MARY ELLEN SCHNEIDER

In less than 5 years, physicians and other health care providers will be required to begin using a new system of code sets to report health care diagnoses and procedures.

Under a final rule published in the Federal Register, the Health and Human Services department is replacing the International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used with a significantly expanded ICD-10 code sets. Providers and health plans will have until Oct. 1, 2013, to implement the new code sets.

In addition, HHS also issued a final rule adopting new standards for certain electronic health care transactions. The rule requires health care providers to come into compliance with the updated X12 standard, Version 5010, which includes updated standards for claims, remittance advice, eli-

gibility inquiries, referral authorization, and other administrative transactions. Use of the updated standard is necessary to use the ICD-10 code sets, according to HHS. Providers and health plans must be in compliance with the updated transaction standard by Jan. 1, 2012.

At press time, the Obama administration was in the process of reviewing and approving all new and pending regulations written under the previous administration, including the ICD-10 rules. However, a spokesman for the Centers for Medicare and Medicaid Services said that until the review is complete, it is not possible to determine which regulations are affected.

The move to the new code sets was necessary, according to HHS, to replace the outdated ICD-9 code sets. The ICD-9-CM contains about 17,000 codes, compared with 155,000 codes in the ICD-10 code sets.

The final rule gives health care providers and plans almost

2 extra years to implement the Version 5010 transaction standard and a full 2 years to switch to ICD-10, compared with the timeline originally proposed last year. HHS officials said they decided to allow extra time for implementation in response to concerns that a short implementation phase would result in high implementation costs and inadequate time for training and testing.

Physician groups praised HHS for providing additional time for implementation but said other issues persist.

Officials at the American College of Physicians said that they believe that the benefits of switching to the ICD-10 code sets in the ambulatory setting do not outweigh the collective costs, said Brett Baker, director of regulatory affairs. The costs and administrative burdens related to adopting ICD-10 could slow adoption of health information technology and make it more difficult for physicians to engage in quality improvement

efforts, according to ACP.

ACP is urging the Department of Health and Human Services to explore alternatives to the implementation plan outlined in the final rule. For example, the department could delay implementation of ICD-10 in the outpatient setting until a certain percentage of physicians adopted interoperable electronic health record systems.

Since electronic health records would ease the adoption burden for physicians, it makes sense to wait until adoption of health information technology reaches a certain threshold point, Mr. Baker said.

The Medical Group Management Association also expressed concern that physician practices will struggle to implement the new code sets. The association is calling on the federal government to develop some type of implementation assistance program to help physicians, especially those in small practices and rural communities.

If the value to the health system is as significant as HHS estimates, government officials should be prepared to invest that savings early on to ensure implementation runs smoothly, said Robert Tennant, senior policy advisor at MGMA.

HHS also should extend its outreach to the vendor community, Mr. Tennant said, since they will be the ones to provide updates to the practice management software. HHS also needs to work with private health plans to ensure there is no disruption in payments. For their part, Mr. Tennant advised physician practices to get started by becoming familiar with the requirements and the compliance dates.

Next, reach out to vendors of practice management software and find out their plans for updating the software, including the timeline and costs. With that information in hand, practices can formulate a budget for implementation that includes training and testing, he said. ■