## POLICY & PRACTICE

### Programs Cut Smoking Rates

State tobacco control programs are effective at cutting adult smoking rates, according to researchers at the Centers for Disease Control and Prevention and RTI International. The researchers observed a decline in the prevalence of adult smoking, from more than 29% in 1985 to less than 19% in 2003. Among individual states, declines in adult smoking prevalence were directly related to increases in state per-person investments in tobacco control programs. Such programs use educational, clinical, regulatory, economic, and social strategies to establish smoke-free policies and social norms, to help tobacco users to quit, and to prevent people from starting to smoke. The study was published in the February issue of American Journal of Public Health.

### Individual Mandates Necessary

Unless the United States adopts a single-payer health system, it will not be possible to achieve universal coverage without a mandate that requires individuals to purchase health insurance, a new report from the Urban Institute concluded. A system that encouraged but did not require people to get health insurance would tend to enroll disproportionate numbers of individuals with higher cost health problems, the report said, noting that this could create high premiums and instability in the insurance pools that enroll those individuals. Also, the government would have difficulty redirecting current spending on the uninsured to offset some of the cost associated with a new program without universal coverage, according to the report, "Do Individual Mandates Matter?"

### Recertification Could Improve Care

The quality of care provided to patients with hypertension appears to erode as the time since the physician's last board certification increases, a study published online in Circulation found. The researchers analyzed treatment of more than 8,000 patients with hypertension and comorbid diabetes who were treated by 301 internists, looking at patient visits with documented blood pressure of at least 130/85 mm Hg. The frequency of pharmacologic antihypertensive treatment intensification decreased from about 27% for physicians who were board certified the previous year to about 7% for those who were board certified 31 years before the visit. For physicians recertified more than 10 years ago, the treatment intensification rate was about 22%, compared with 17% for those recertified in the last decade.

### Part D Costs Drop

The projected cost of providing Medicare beneficiaries with a prescription drug benefit through private health plans has dropped again, according to the Centers for Medicare and Medicaid Services. CMS said in its fiscal year 2009 budget documents that the overall projected cost of the Part D drug benefit is $117 billion lower over the next 10 years than it estimated last summer. The difference results from the slowing of drug cost trends, lower estimates of plan spending, and higher rebates from drug manufacturers, CMS said. Compared with original projections, the net Medicare cost of the drug benefit will be $243.7 billion lower over the 10 years ending in 2013.

### Patient Safety Goals Updated

The Joint Commission has released a preliminary version of its 2009 National Patient Safety Goals for hospitals and critical care facilities, and is seeking to add several new requirements to its list of priorities. According to the draft, the commission would like to add a requirement specifically highlighting the need to eliminate transfusion errors related to patient misidentification. In addition, the commission would add a requirement that acute care facilities implement best practices to prevent the spread of multiple drug–resistant organisms. Last, the draft specifies new requirements for using best practices to prevent catheter-associated bloodstream infections and surgical site infections, and also refines points to work toward the commission's goal of reconciling patient medications across the care continuum.

### Top 10 Cost Half a Trillion

The nation's 10 most expensive medical conditions cost about $500 billion to treat in 2005, according to the Agency for Healthcare Research and Quality. Heart disease topped the list at $76 billion, with trauma second at $72 billion, and cancer third at $70 billion. Mental illness, including depression, cost $56 billion, and asthma and chronic obstructive pulmonary disease cost $54 billion. Hypertension cost $42 billion to treat, type 2 diabetes cost $34 billion, and osteoarthritis/joint diseases also cost $34 billion. Back problems and normal childbirth rounded out the list at $32 billion each. The agency counted money spent on office visits, clinic and emergency department use, hospital stays, home health care, and prescription medicines.

### CMS May Cover Artificial Heart

CMS has proposed covering artificial heart devices in Medicare beneficiaries who are enrolled in Food and Drug Administration–approved studies, reversing a 20-year-old policy. The use of artificial heart technology has not been available to Medicare beneficiaries because of a 1986 noncoverage policy. But since that policy was implemented, two artificial heart manufacturers have run clinical trials studying the safety and health outcomes of using their devices, CMS said. The agency said that it now believes there is sufficient scientific evidence on the use of artificial hearts to allow coverage of these devices for beneficiaries "in the carefully controlled clinical environment of an FDA-approved study." A final coverage determination is expected in May.

**—Jane Anderson**

# Patient Portals Don't Mean Higher Workload

BY MICHELE G. SULLIVAN
*Mid-Atlantic Bureau*

NEW ORLEANS — Rather than unlocking a Pandora's box of nattering e-mails, an electronic patient portal that allows messaging and even access to test results can improve patient satisfaction and decrease patient visits.

"Many physicians think that this type of access is frightening," Dr. Gretchen P. Purcell said at the annual clinical congress of the American College of Surgeons. "They think they'll be barraged with messages, that patients will misinterpret their test results, and that physicians could even be held legally liable if they don't respond in time to an urgent message."

But health care providers, who are about 10 years behind the curve in the digital world, need to face up to the facts of the 21st century, said Dr. Purcell of the surgery department at the Children's Hospital at Vanderbilt in Nashville, Tenn. "Patients are demanding the same kind of online access to their medical information as they have for all other aspects of their lives. Those health care institutions that do not have a patient portal now probably will within the next 5 years."

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Patient portals can be designed to suit the needs of different practices and to fulfill various functions. At a minimum, they allow patients to pay bills, schedule or change appointments, and request prescription refills. Other portals are more robust and give patients the ability to review medical records, view test results, and send messages to their health care provider, said Dr. Purcell, who is also with the biomedical informatics department at Vanderbilt Medical Center.

Among the most controversial topics are messaging and the ability to access test results, she said.

"Messaging is probably the function physicians fear the most. Many think it's the equivalent of getting and sending personal e-mail, and this brings up all kinds of worries about security and privacy."

E-mail and messaging, however, are not the same things. Messages don't go to a personal e-mail account; instead, they go to a dedicated in-box. "This message box is routinely checked by an administrative assistant or nurse—someone who can often answer many of the questions, and who would involve the physician only when necessary—similar to phone call triage."

There also are concerns that these electronic exchanges aren't part of a patient's documented record. "Some portals can make messaging part of the medical record, and some physicians have found ways to charge for this 'online consultation,' " Dr. Purcell said.

It's important to set clear expectations about response time and emergency issues. Most messaging systems tell patients that they may have to wait 2-3 business days for a personal reply and advise them to call 911 for a medical emergency.

It's not unreasonable to assume that electronic communication could allow patients to bombard offices with questions and requests. Although data are still limited, the studies that are out there suggest just the opposite, Dr. Purcell said.

Two studies published in 2005 indicate that messaging increases patient satisfaction without a corresponding increase in workload. The first study randomized 200 patients to secure messaging or usual care. Only 46% of the patients who were given access sent any message; the average was just 1.5 messages per patient per year. Although messaging didn't reduce the number of telephone calls the office got, the number of office visits in the intervention group did go down (Int. J. Med. Inform. 2005;74:705-10).

The second study randomized 606 patients to a patient communication portal or to a Web site with general health information. Only 31% of the patients given access used the portal. The message box received only one message per day per 250 patients. Again, there was no difference in the number of office telephone calls between the groups, but the patients in the portal group reported better satisfaction with communication and overall care, even if they never used the portal (J. Med. Internet Res. 2005;7:e48).

The same study indicated that secure messaging probably would not overwhelm anyone during working hours, Dr. Purcell said. "Patients tended to use the portal during nonclinic hours—the most convenient time for them—with about 73% of messaging occurring from 5 p.m. until midnight."

Patients may even be willing to pay for the added convenience of messaging, the authors concluded. Of 341 patients surveyed, 162 (48%) were willing to pay for online correspondence with their physician, with $2 cited as the median payment they thought fair.

Patient access to test results is another area of clinician concern, she said. "Obtaining test results is probably the most commonly desired and most commonly used function of a patient portal, and one that makes physicians very nervous," Dr. Purcell said.

The MyHealthAtVanderbilt system has three tiers of test results—two can be available to patients online. "Some low-risk, high-value test results, such as cholesterol levels, are available immediately, and some results are available with a delay, such as tests that require interpretation in a specific clinical context," Dr. Purcell said. "But some results, such as cancer pathology and HIV tests, and others that require intensive patient counseling, are never available though the portal." ■