Snags on the Road to 'E-Prescribing'

BY JENNIFER LUBELL
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Without the proper technology, physician practices may find it difficult to participate in Medicare's new "e-prescribing" standards under the Part D drug benefit, physician groups claim.

"Most primary care physicians will be unable to afford to implement this technology on their own, particularly with the projected cuts in Medicare physician payments of 4.4% in 2006 and a cumulative 26% reduction from 2006 to 2011," Neil Kirschner, Ph.D., senior associate for regulatory and insurer affairs with the American College of Physicians, said in an interview.

The Centers for Medicare and Medicaid Services in a final rule established the set of standards for electronic prescribing, or e-prescribing, of drugs covered by Medicare's prescription drug benefit that started Jan. 1, according to the Federal Register.

CMS also plans to pilot test initial e-prescribing standards, which may be included in a final rule to be issued by April 2008.

"These standards will allow Medicare, physicians, hospitals, group practices, other health providers, and prescription drug plan sponsors and Medicare Advantage organizations to take advantage of e-prescribing technology to improve medication prescribing for Medicare beneficiaries that participate in the new prescription drug program," said Mike Leavitt secretary of the Department of Health and Human Services.

For the most part, medical organizations expressed support for the agency's e-prescribing initiative.

"Having standards is good. It will provide a common language for anyone using this method," Dr. Mary Frank, board chair of the American Academy of Family Physicians, said in an interview. E-prescribing would also reduce errors, increase patient safety, and when it is fully interoperable, increase quality in health care as well, she said.

Unfortunately, few practices are currently employing this technology, Dr. Kirshner said. "Surveys vary, but the percentage of practices using it ranges somewhere from 5% to 18%." The number is even lower for the typical small practice, he added.

Until there is some financial support to help doctors implement this technology, its use will not be widespread, she said.

Even if a physician does have the money to adopt e-prescribing, "he or she is at risk of purchasing a system that might not integrate" with a future electronic health record system, she said.

Dr. Kirschner noted that the recent release of safe harbor antikickback and Stark exception rules allowing hospitals, group practices, and Medicare Part D drug plan sponsors to provide necessary e-prescribing technology to physicians may help facilitate its use.

E-prescribing as an isolated technology, however, "just won't cut it," Dr. Frank said. "It is only a small piece in the safety-quality continuum." While it may eliminate issues such as bad handwriting and sound-alike medications, it doesn't necessarily address issues such as drug interactions, alerts about possible problems related to existing illnesses, or abnormal lab results.

"We really have to push for a more integrated approach if we really want to improve care," she said.

E-prescribing is optional for physicians and pharmacies under the new standards, but as of Jan. 1, 2006, Medicare required drug plans participating in the new prescription benefit to support electronic prescribing.

Jeff Trewhitt, a spokesperson for the Pharmaceutical Research and Manufacturers of America, said PhRMA supported the development of a standardized e-prescribing system. In addition to reducing errors and the administrative costs associated with health care, the system would also promote more effective care of drug therapies for chronic conditions.

He agreed, however, that such a system must be designed and implemented correctly. "Keep in mind that the systems needed to convert to an e-Rx system don't even exist yet."

CMS's new standards for e-prescribing include the following technology:

▶ NCPDP SCRIPT, Version 5.0, for transactions between prescribers and dispensers for new prescriptions, refill requests and responses, prescription change requests and responses, prescription cancellation requests and responses, and related messaging and administrative transactions.

▶ ASC X12N 270/271, Version 4010 and addenda, for eligibility and benefits queries and responses between prescribers and Part D sponsors.

▶ NCPDP Telecommunication Standard, Version 5.1, and supporting NCPDP Batch Standard, Version 1.1, for eligibility queries between dispensers and Part D sponsors. ∎

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Physicians Can Take Small Steps to EHR

WASHINGTON — Physicians are often reluctant to leap into an EHR system because of its complexity and the expense involved, Dr. Daniel Sands said at a health care congress sponsored by the Wall Street Journal and CNBC.

"If you're a doctor, what do you do? How do you get that [EHR] if you can't take the one big leap?" he said.

Start by using electronic communications with patients and with office staff, he said. "Why don't you get rid of those stupid yellow Post-It notes you use for phone messages? A simple step like that is a good way to get people engaged with technology," said Dr. Sands of Harvard University, Boston.

Electronic prescribing is another way to bridge the gap, said Dr. Sands, who is also chief medical officer of ZixCorp, a Newton, Mass., company that sells electronic prescribing software. Medications can be prescribed using various electronic devices, including desktop and laptop computers, handhelds, and even mobile phones. Since studies have shown that electronic prescribing can reduce medication errors substantially, "this should be the standard of care," he said.

Another step is to use online clinical reference materials, Dr. Sands continued. "We have lots of data showing that physicians are often faced with questions when taking care of patients, and they can't find the answers because they don't have time, so they just move on. And that's really scary."

Rather than looking for answers "in a book that's out of date as soon as it's printed, maybe looking online would be a great place to start," Dr. Sands said.

—Joyce Frieden

HHS Aims to Spur Electronic Biosurveillance System

BY MARY ELLEN SCHNEIDER
Senior Writer

WASHINGTON — Government officials and health information technology leaders plan to spend this year laying the groundwork for a system that would allow for the electronic transfer of ambulatory, emergency department, and laboratory data to public health agencies in less than a day.

Over time, officials would like to implement a real-time nationwide public health monitoring system. "The system we have is simply not adequate," Mike Leavitt, secretary of the Health and Human Services department, said at a meeting of the American Health Information Community. The U.S. faces not only the possibility of a bioterrorist attack but of a pandemic, he said.

Mr. Leavitt said he would like to get a "spotty net" of surveillance off the ground quickly by collecting a few key indicators from as many electronic data sources as possible. Getting just 2-4 basic data points from all available sources would be a "quantum leap forward," he said.

Information from small and medium-sized primary care practices will be key to any electronic biosurveillance system, said Dr. David Kibbe, who represented the American Academy of Family Physicians at the meeting. The American Health Information Community is an advisory committee to the Health and Human Services department.

"There is widespread agreement that information technology can substantially improve surveillance both for ongoing public health and for health emergencies," said Dr. Thomas R. Frieden, commissioner of the New York City Department of Health and Mental Hygiene, who presented information on current electronic surveillance programs at the meeting.

Currently, there is a wide range of biosurveillance activities underway at the federal, state, and local levels, and in the private sector, Dr. Frieden said. For example, the Centers for Disease Control and Prevention operates the Public Health Information Network, which provides an architecture for public health information technology. Mostly recently, the agency established the BioSense program which is aimed at supporting the connection of clinical care to public health and supporting "situational awareness" at the national level.

A number of state and local health departments have begun electronic reporting either from clinical laboratories or clinical information systems. In New York City, the health department uses electronic reporting data on a daily basis. The system, which has been operating for more than 5 years, collects information from ambulance dispatches, emergency department visits, pharmacy purchases, outpatient visits, and other sources. The system also collects free text, which allows officials to evaluate information they might not have thought about otherwise.

Currently, 50 hospitals—representing about 90% of emergency department visits in the city—report daily.

The electronic reporting system has proved helpful in the early detection of pockets of influenza. The electronic syndromic system consistently picks up influenza activity 2-3 weeks before any other system.

North Carolina has a statewide, hospital-based real-time clinical data monitoring system of inpatient, outpatient, and emergency department data.

But there are major needs that must be addressed to reach the goal of a nationwide system, Dr. John Loonsk of the federal Office of the National Coordinator for Health Information Technology said at the meeting.

Data need to be standardized so they can be compared across reporting organizations, privacy and confidentially must be ensured, and improvements need to be made in the current patchwork of state and local health information technology capability. Electronic reporting of lab results could be implemented rapidly, Dr. Loonsk said. This has value both to public health and for the routine use of clinicians, he said. ∎