Momentum Building to Boost Health IT Adoption

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More than 2 years after President Bush issued his call to action on the adoption of electronic health records, experts say there is growing pressure on physicians to heed that call.

Although physician adoption of EHRs remains low—especially in small practices—the movement toward pay for performance could start to drive adoption, said Mureen Allen, senior associate for informatics and practice improvement at the American College of Physicians. And the certification of electronic health records by an independent body, which is slated to begin this summer, should help too. "The paradigm to some extent is changing."

This month, many of the biggest players in health information technology will gather in Washington for National Health IT Week. More than 40 groups are slated to participate in this first-ever event, including medical professional societies such the American Academy of Family Physicians, government agencies, a regional health information organization, and other public and private organizations.

The series of events follows on the heels of more than 2 years' major actions in the health IT landscape starting with President Bush's State of the Union address in January 2004 in which he called for the widespread adoption of interoperable EHRs within the decade.

A few months later, the Health and Human Services secretary appointed Dr. David J. Brailer as the first National Health Information Technology Coordinator. Dr. Brailer resigned from the post last month saying that he only planned to stay in the job for 2 years. Dr. Brailer said there is still a lot work to be done in closing the adoption gap between large and small physician practices. His office has been focused on three strategies to close the gap—lowering costs, raising the benefits, and lowering the risks involved in purchasing an EHR system, he said during a teleconference announcing his resignation.

Last fall, HHS Secretary Mike Leavitt established the American Health Information Community, a federally chartered commission to advise the secretary on interoperability issues. HHS proposed allowing hospitals and other entities to give physicians health IT hardware, software, and training. HHS also awarded three contracts to public and private groups to create processes for harmonizing information standards, certifying health IT products, and addressing variations in state laws on privacy and security practices.

And starting in January, prescription drug plans participating in the Medicare Part D program were required to begin supporting electronic prescribing. The regulation is optional for physicians and pharmacies.

Most recently, the Food and Drug Administration adopted the Systematized Nomenclature of Medicine (SNOMED) standard as the format for the highlights section of prescription drug labeling. The format will be required starting on June 30 for all new drugs and drugs approved within the last 5 years. The use of the SNOMED standards will make it easier for electronic systems to exchange FDA-approved labeling information, according to the agency.

One of the most significant developments has been the establishment of the Certification Commission on Health Information Technology (CCHIT). This group was formed in 2004 by the American Health Information Management Association, the Healthcare Information and Management Systems Society (HIMSS), and the National Alliance for Health Information Technology to develop criteria for the certification of EHRs.

CCHIT received a 3-year grant from HHS last fall to certify products in the ambulatory and inpatient settings, and to certify the systems' networks. The announcement of the first certified products in the ambulatory setting is expected in late June or early July.

The means for objectively comparing EHR systems is "about to become a reality," said CCHIT Chair Mark Leavitt.

Current estimates put physician adoption of EHRs at around 14%. Dr. Leavitt said he hopes that by taking some of the risk out of buying an EHR product it will boost those adoption figures.

"I think we are on track," said Dave Roberts, vice president of government relations at HIMSS. While physicians still need to be educated about the value of EHRs, there are some other encouraging signs. For example, many states are becoming more interested in health IT and are helping to form regional health information organizations, he said.

These groups, called RHIOs, help to standardize the various regulations and business policies surrounding health information exchange. The federal government has funded more than 100 of these regional projects, and more efforts, supported by private industry or state governments, are underway, according to HHS.

"The states are really buying into this whole initiative," Mr. Roberts said.

For the majority of physicians, it just hasn't made financial sense to purchase an EHR system, Dr. Allen said. However, some physicians are beginning to see a strategic advantage in the adoption of technology. One advantage stems from regulations that encourage electronic prescribing.

EHR adoption is inevitable, Dr. Allen said, if only because so many younger physicians were trained on EHRs and it is not acceptable to them to go back to a paper system once they enter practice. And older physicians recognize that the change is coming, she said.

But Dr. Allen advised physicians that they don't need to jump into a full-blown EHR system. Electronic prescribing systems and electronic patient registries may be easier to adopt than a full EHR system. Physicians can also purchase EHRs in a modular fashion so that they can ramp up over time, she said. ■

POLICY & PRACTICE

ACP, AMA Back 'Partnership' Bill

States would get federal support to experiment with covering the uninsured and pursuing disease management strategies under the bipartisan Health Partnership Act (S. 2772). The bill was introduced last month and has the support of the American College of Physicians, the American Medical Association, and the National Association of Counties, and would establish a Health Care Expansion and Improvement Commission at the Health and Human Services department. The commission could approve a variety of options that states could pursue to expand access to health care, including tax credit expansions, expansions of Medicaid or State Children's Health Insurance Programs (SCHIP), creation of pooling arrangements, single-payer systems, and health savings accounts. If the legislation were enacted, it would allow states to do an "end run" around Washington's gridlock on covering the uninsured, said Robert B. Doherty, senior vice president, government affairs and public policy, for ACP. Like the physician's code of "first, do no harm," the experiments could not result in diminished coverage for anyone, Mr. Doherty said.

More Employees Decline Coverage

More Americans are declining their employers' offer of health insurance as premiums continue to rise, according to a study by the Robert Wood Johnson Foundation. Approximately 3 million fewer workers who were eligible for employer-sponsored health insurance enrolled in 2003, compared with 1998. The national increase in individual premiums from 1998 to 2003 was $1,027, a 42% increase after adjustments for inflation. In 1998 dollars the amount was $2,454; with the adjustment it stood at $3,481 in 2003, the foundation said in a statement. States with the biggest percentage drops include New Jersey, –12%; Nebraska, –11%; Wisconsin, –9%; Colorado, –9%, and Iowa, –9%. The survey used trend data from 1998 to 2003 from the federal Medical Expenditure Panel Survey–Insurance Component, collected and distributed by the Agency for Healthcare Research and Quality (AHRQ).

Off-Label Scrips Common

More than one in five prescriptions (21%) for commonly used medications were written for off-label indications, according to a nationally representative study. Further, 15% of those off-label prescriptions lacked any scientific evidence of efficacy, David D. Radley of Dartmouth University, Hanover, N.H., and his colleagues wrote in the Archives of Internal Medicine. Off-label prescription was rare among medications for glycemic control in diabetes (less than 1%), infrequent among analgesics (6%), and in drugs to lower lipid levels (7%). Off-label prescription was most common among cardiac drugs (antianginals, 46%; antiarrhythmics, 39%; and anticoagulants, 46%) as well as anticonvulsants, 46%; and asthma drugs, 42%. "Off-label prescription with limited or no scientific support was more common than supported off-label use in all therapeutic classes except diabetes therapies," the authors wrote. However, many of the off-label prescriptions "represent a logical extension of the FDA-approved indications." Off-label prescribing can lead to innovative treatments, but "policy makers must begin to consider strategies for mandatory postapproval surveillance" to curtail dangerous or wasteful practices, the authors concluded. The study was supported by AHRQ.

Medicare Formulary Guidance

If officials at a Medicare Part D drug plan change the preferred or nonpreferred formulary drugs, remove dosage forms, or exchange therapeutic alternatives, they must allow beneficiaries currently taking the drug to be exempt from the changes for the rest of the year, according to guidance from the Centers for Medicare and Medicaid Services. Abby L. Block, director of the CMS Center for Beneficiary Choices issued a memo to Part D sponsors in April outlining policies for formulary changes made after a beneficiary has signed onto a plan at the beginning of the plan year. In addition, Part D plans can only change therapeutic categories and classes in a formulary at the beginning of each plan year, except to account for new therapeutic uses or newly approved drugs. CMS also noted that after March 1, Part D drug plans are only allowed to make "maintenance changes" to their formulary, such as replacing a brand name drugs with a new generic drug. All proposed formulary changes, except for expansions, must be submitted to CMS for review and approval, according to the memo. "Prescription drug therapies are constantly evolving, and new drug availability, new medical knowledge, and new opportunities for improving safety and quality in prescription drug use at a low cost will inevitably occur over the course of the year," Ms. Block said in the memo to Part D sponsors.

Rare Disease Studies

Officials at the National Institutes of Health have launched the first clinical studies that are part of its Rare Diseases Clinical Research Network. The network has received a total of $71 million in 5-year funding awards to study rare diseases. In the next few months, more than 20 studies are expected to open in sites around the world. In one example, an investigator at the Johns Hopkins Vasculitis Center in Baltimore will conduct a study of giant cell arteritis. "By studying the genetic component of these rare diseases, we hope to be able to better predict the course of the illnesses and provide more effective, personalized treatments for those afflicted," Dr. Elias A. Zerhouni, NIH director, said in a statement.

—Nancy Nickell