Online Tool May Help Revive Family History

BY HEIDI SPLETE
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A revised high-tech tool from the Department of Health and Human Services may 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, he said.

"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 wide variety of serious medical conditions like cardiovascular disease, diabetes, and many types of 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 fail to collect family history during an office visit.

"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 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.

"Importantly, 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."

But how easy is it for clinicians to promote the tool to patients, and use it in practice? "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.

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. ■

POLICY & PRACTICE

Blacks Unaware of Kidney Trouble

The higher rate of kidney failure in African Americans is due in part to less awareness in that population of early stages of the disease, according to a study in the February American Journal of Kidney Diseases. Contributing to the problem may be that some physicians aren't adequately testing for chronic kidney disease, lead author Dr. Michael F. Flessner said in a statement. "Most physicians were trained in an era in which serum creatinine was used as an absolute indicator of kidney disease," while proteinuria or reduced glomerular filtration rate is now considered a better test, said Dr. Flessner, director of nephrology at the University of Mississippi Medical Center in Jackson. The researchers interviewed and examined more than 3,400 African Americans who were part of the Jackson Heart Study. Overall, 20% of study participants were found to have chronic kidney disease, but fewer than 15% of those affected were aware they had it.

Group Pushes Swipable Cards

The Medical Group Management Association has launched an effort to persuade providers and health insurers to adopt standardized, machine-readable insurance cards by next January. The initiative, dubbed Project SwipeIT, would save an estimated $1 billion annually that is currently spent on "wasteful, redundant administrative tasks," said William F. Jessee, MGMA president. For example, since most people's health insurance cards have no machine-readable elements, providers usually photocopy the cards and then manually enter the information into their computers, a process prone to error. Many health insurance cards also feature photos, illustrations, and shading that make legible photocopying difficult. Machine-readable cards would automatically enter patient information correctly and cost-effectively, according to MGMA. The organization has developed a Web site to promote the initiative at www.SwipeIT.org.

VA Accepts POWs' Osteoporosis

Officials at the Department of Veterans Affairs are proposing to extend benefits to former prisoners of war who suffer from disabling osteoporosis. In a proposed rule issued last month, the VA seeks to establish a presumption of service connection for osteoporosis that's at least 10% disabling in veterans held at least 30 days as POWs. Several studies have shown that POWs suffered serious bone loss following captivity because of dietary deficiencies during their imprisonment. Osteoporosis has not been a major health issue among former POWs until recently, according to the VA, because the condition doesn't typically emerge until late in life. Most former POWs are now in their 80s, according to the VA.

FDA Approvals Increase

The FDA approved 21 new molecular entities and 4 new biologic drugs in 2008, compared with 17 NMEs and 2 biologics in 2007. Four of the 2008 approvals came in December. In 2006, the FDA approved 22 new drugs and biologics. The agency has increased the annual number of novel therapies approved in recent years but is still failing to meet statutory deadlines for reviewing and approving products. The FDA said it did not meet the 2008 target of reviewing 90% of approval applications within the time limits set by law. The agency attributed many of the delays to resource constraint. There have been 800 new people hired by the FDA to review drug and biologic applications, which should help reduce delays, according to analyst Ira Loss at the firm Washington Analysis. But delays may persist for new diabetes therapies and opioids, he said, noting that the potential for cardiac toxicity and abuse hangs over those products.

E-Rx Systems Boost Savings

Electronic prescribing systems that allow doctors to select lower cost or generic medications can save $845,000 per 100,000 patients per year and possibly more, according to a study funded by the Agency for Healthcare Research and Quality. The researchers examined the change in prescriptions written in community practices before and after two Massachusetts insurers launched e-prescribing systems. Although they found that the doctors prescribed electronically only 20% of the time—generally relying on traditional prescription pads—those who used e-prescribing with formulary support increased generic prescriptions by 3.3%. "Our results likely represent a conservative estimate of the potential savings," said lead author Dr. Michael Fischer of Brigham and Women's Hospital in Boston. Physicians who wrote electronic prescriptions were slightly younger and more likely to be female than those who did not.

PhRMA Revises Ad Guidelines

The Pharmaceutical Research and Manufacturers of America recently advised drugmakers to state when actors portray medical professionals in direct-to-consumer drug advertisements and to acknowledge any compensation given to real medical professionals in ads. In addition, the new, nonbinding guidelines support the inclusion of "black box" warnings in the ads, and reinforce that companies shouldn't promote off-label uses. Rep. John Dingell (D-Mich.) commended PhRMA for the new guidelines but noted that the organization hasn't endorsed a 2-year prohibition on such ads for newly approved drugs, as recommended by the Institute of Medicine.

—Joyce Frieden