Interoperability Standards May Silence EHR Babel

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Eliminating "the stupid clipboard" may be the simplest, most straightforward benefit that would come from electronic interoperability standards designed to allow physicians' offices to communicate with hospitals, labs, insurers, and each other, according to Dr. John Halamka, the chairman of the Health Information Technology Standards Panel.

HITSP just delivered its first set of harmonization standards to the federal Office of the National Coordinator for Health Information Technology. The panel was convened just over a year ago by the American National Standards Institute (ANSI) under a Health and Human Services department contract to assist in the development of a Nationwide Health Information Network (NHIN).

The panel is developing a series of interoperability specifications that offer a road map for every vendor, hospital, and other stakeholder who wants to implement electronic health records that conform to a nationally recognized standard, Dr. Halamka said at a health care congress sponsored by the Wall Street Journal and CNBC.

The panel sifted through 700 standards, including X12, HL7, NCPP, and the Continuity of Care record, whittling that down to 30. It was an emotional process that incorporated the best of all of those standards in what the panel calls a Continuity of Care Document, he said.

This is a work in progress, Dr. Halamka added. "As the industry begins to test these interoperability specifications we know there are going to be refinements. There are going to be areas of ambiguity that we need to clarify."

"What's going on at the [American Health Information] Community, at HITSP, at the Certification Commission [for Healthcare Information Technology] are essential ingredients to successful transformation of health care," said Dr. Michael Barr, vice president of practice advocacy and improvement at the American College of Physicians.

As reimbursement becomes increasingly pegged to quality, electronic records will be indispensable for documenting measures expected by payers.

Unlike hospitals and other large institutions, small medical practices have not had the resources to adopt electronic health records or other information technology, he said.

"There are knowledge barriers; there are cost barriers. There is just so much information to digest," said Dr. Barr, adding that it is extremely difficult for these physicians to figure all this out while running their practices.

But health information technology does pay for itself, and as reimbursement becomes increasingly pegged to quality, electronic records will be indispensable for documenting measures expected by payers, he said.

Physician groups that have adopted EHR systems expect them to make it easier to adapt to new payment requirements in the long run, but they offer the near-term benefits as well, said Bruce Metz, Ph.D., chief information officer for Thomas Jefferson University in Philadelphia.

The University's 500-physician group practice has spent the past 3 years implementing an $18 million electronic records system with an expected 16%-30% return on investment. Insurance companies are not yet ready to pay the group a premium for the efficiencies the system brings, but because of improved documentation, the system has already allowed significant upcoding, he said.

Although more physicians are becoming convinced of the benefits of EHR adoption, the government may be moving forward too aggressively, Dr. Barr said.

Congress wants Medicare to implement pay for performance now, although the industry is still struggling to identify appropriate measures. "The policy is well ahead of the practicality," he said.

If the experience with HIPAA Administrative Simplification proved anything, it was that having standards is only the beginning of the process, said Dr. Halamka. The next step is to work out a logical time frame for compliance, what the incremental phases are along the way and how to test compliance. ■

Software Speeds Research Process Required for Prescription Refills

BY BRUCE K. DIXON
Chicago Bureau

How would you like to reduce your practice's patient data research load by 12 hours a week? That's precisely what Dr. Alan Brush did for his multispecialty practice in Cambridge, Mass.

"Using the EpicCare electronic medical record system's SmartPhrases feature, I created what we call 'RxRefill phrases' for all formulary drugs where lookup of essential information is required for a refill," Dr. Brush said in an interview. "The process of making sure that lab tests, blood values, and mammogram results are current takes about 5 minutes per prescription. I do 100 refills a week in a practice that is about 60% full time."

Dr. Brush's office is 1 of 14 sites in the Harvard Vanguard group, all of which are served by EpicCare. "In moving from paper to EpicCare's EMR system, I noted little improvement in the efficiency of refilling medications; it was just a shift from paper to electronic medium. When refills required essential data such as creatinine and potassium and last blood pressure values for diuretic refills, someone still had to spend time looking up and communicating the information to the clinician ultimately responsible for that prescription," he explained.

As the leader of the Harvard Vanguard group's Internal Medicine Design Team, Dr. Brush helps to modify medical records so they're user friendly to clinicians. While on a flight home from a meeting 3 years ago, he decided to do something about the refill problem. "I started working on a catalog of formulary drugs that had relevant tests that you needed, or parameters that you would use at the time of refill. Now, all my assistant has to do is type 'Rx' followed by the name of the drug—for example, 'RxSimvastatin'—and all the data are generated. These phrases contain the request for the drug, as well as data links that automatically bring the required lab tests and clinical information into the refill request," Dr. Brush explained.

The right electronic health record software can reduce research by 12 hours weekly.

DR. BRUSH

When the test is overdue or the last blood pressure test is beyond the time for a reasonable refill, the medical assistant or nurse requesting the clinician to sign off knows to first arrange the appropriate appointment or tests and to request a refill that lasts just beyond that date, he said.

When the timing is up to date, the request automatically includes the essential data for the clinician to view. This information becomes part of the medical record at the time of the refill, indicating that it has been reviewed, Dr. Brush added.

"Not only does the medical assistant or nurse save time in looking up the essential information, but the clinician sees [only] refill requests that are already adequately researched, much simplifying his or her work," said Dr. Brush, who has no financial interest in EpiCare.

"When I receive a prescription refill request now, if everything has been done, all the necessary data appear on the screen. To complete the process I hit 'approve,' and 'close encounter,' and the refill process is complete." ■

New Part D Program to Target Top 3% of Prescription Fillers

BY MITCHEL L. ZOLER
Philadelphia Bureau

PHILADELPHIA — Starting next year, Medicare Part D will feature a new wrinkle in the drug insurance program: medication therapy management.

A medication therapy management (MTM) program was mandated for 2007 by the Centers for Medicare and Medicaid Services (CMS) for selected Medicare beneficiaries who are participating in Part D coverage. MTM programs are targeted to beneficiaries who have multiple chronic diseases, use multiple medications in Part D, and have anticipated Part D costs for 2007 of more than $4,000, Mary Dorholt said at a conference sponsored by the American Society on Aging.

The program, as it's currently structured, will apply to about 3% of Medicare beneficiaries who enroll in Part D, said Ms. Dorholt, vice president for Medicare client support at Medco Health Solutions Inc. in Maple Grove, Minn., a Part D sponsor.

The minimum criteria for beneficiaries to qualify for an MTM program include having at least five chronic conditions, with at least two from this list: hypertension, elevated serum cholesterol, heart failure, diabetes, or chronic obstructive pulmonary disease. Beneficiaries also need a history of claims for at least six different medications that are covered under Part D. But the CMS policy also states that Part D sponsors can lower their eligibility standards so that more beneficiaries qualify for their MTM program.

Medco has developed a profile of the anticipated profile of chronic diseases that will occur in beneficiaries who qualify for their MTM program. The most common illness is hypertension, which is anticipated to affect about 90% of qualifying beneficiaries, Ms. Dorholt said.

Although the CMS requires that Part D sponsors offer an MTM program next year "to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes" and to reduce the risk of adverse drug effects, the specifics of each program has been left to each Part D sponsor. ■

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