

# Making Connections

## Chapter FastFACTS

- 1. Physicians can participate in both the EHR and e-prescribing incentives for Medicaid, but must choose one or the other for Medicare.**
- 2. Medicare's 2012 penalty for not e-prescribing is 1% of allowable charges, increasing to 1.5% in 2013 and 2% in 2014.**
- 3. The Drug Enforcement Agency recently began allowing e-prescribing for narcotics and other controlled substances.**
- 4. Health information exchanges allow physicians to access patient information from any provider in any given state.**
- 5. Widespread use of EHRs and health information networks will increase the risks in protecting health record privacy.**

**A** significant part of meaningful use involves connecting—with patients, other physicians, hospitals, pharmacies, and government entities. This chapter addresses some of those ways to connect and the issues associated with them.

The core meaningful use criteria include electronic prescribing (e-prescribing) and electronic exchange of key clinical information among providers. In the long term, the federal government, state governments, and many healthcare providers envision a nationwide health information network. Several of the choices on the “menu” (from which practices must pick five out

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of ten for Stage 1 of meaningful use) involve transmitting data, such as giving patients electronic access to their records and submitting immunization and syndromic surveillance data to public health authorities. Note that these choices will likely become EHR requirements by Stage 3 of the incentive program.

### **The Year for E-prescribing**

If you haven't yet ventured into e-prescribing, 2011 is the year to try it—especially if you have a lot of Medicare patients. Medicare is offering an incentive payment of 1% of allowable charges for successful e-prescribing in 2011 to physicians who aren't participating in its EHR incentive program. If you are going for the Medicare EHR incentive, you can't do the e-prescribing one, too; but if you're in the Medicaid EHR incentive program, you can do both. Medicare plans to penalize physicians who don't embrace e-prescribing. The penalties won't start until 2012, but they'll be based on e-prescribing activity (or lack of it) in 2011. The 2012 penalty is 1% of allowable charges, increasing to 1.5% in 2013 and 2% in 2014.

Last year about 300 million prescriptions (18% of all prescriptions written) were transmitted electronically, according to SureScripts, Arlington, Va., which maintains the electronic network used for most e-prescribing. One out of three office-based physicians can e-prescribe, and about 90% of pharmacies can receive e-prescriptions. One barrier to universal e-prescribing fell last June when the Drug Enforcement Agency (DEA) began to allow it for narcotics and other controlled substances (see “New Rule for E-prescribing Controlled Substances”).

### **Patient Portals**

Having an EHR makes it easier for your practice to have a patient portal—a place on the Internet where your patients can interact with you the same way they probably do with their bank. A portal can dramatically reduce real-time interactions between a practice and its patients, making better use of everyone's time.

Depending on the portal software and the type of access you choose to give your patients, they may be able to fill out forms, view test results, request appointments and referrals, request prescriptions, download immunization records, look at their EHR,

## New Rule for E-prescribing Controlled Substances

Physicians who want to e-prescribe will no longer have to maintain a paper-based system for controlled substances thanks to a new DEA rule that went into effect June 1, 2010. According to that rule, e-prescribing software, whether stand-alone or part of an EHR, will have to be revised to conform to DEA requirements for auditing prescriptions and verifying the prescriber's identity.

For example, the rules require some form of identification in addition to a password: either a biometric ID like a fingerprint or a "hard token" like a swipe card or a fob. As a result, paper documentation is no longer required. (The regulations now in effect are part of an "interim final rule" that may change again as the agency receives feedback from the public, affected professionals, and its own agents; but at this writing, no date had been set for issuing a final rule.)

For more information, go to <http://www.gpo.gov/fdsys/pkg/FR-2010-03-31/pdf/2010-6687.pdf>.

and send and receive secure messages. "You can answer most questions in a sentence or two," says David Steinberger, MD, an internist with Infinity Primary Care, Livonia, Mich. This practice has used a portal from EHR vendor NextGen since 2007. Most major EHR vendors include a patient portal in their product lines, and that's probably the simplest approach, though there are also stand-alone portals, like Google Health, that work with medical practices to connect with their patients.

## Health Information Exchanges

The most basic benefit of an EHR is being able to find a patient's information—at least, the information that your practice maintains. Some practices can also access inpatient data from the EHRs of hospitals they're associated with, but not if the patients visit other emergency rooms or physicians. That's where health information exchanges (HIEs) come in. An HIE gives its users access to patient information from all providers in a state, metro area, or region. Some are spearheaded by an integrated delivery network or a consortium of providers, but more often an HIE is operated by either a state agency or a not-for-profit organization working under a government contract.

“An HIE is like the interstate highway system for the medical economy,” says Laura Adams, president and CEO of the Rhode Island Quality Institute, which has led the development of a statewide HIE. She says it will not only allow physicians to access patient information from any provider in the state, but also enable large-scale analysis of the quality and effectiveness of care. Meaningful use-certified EHRs are required to be able to store and transmit data in an “HIE-ready” format, which will smooth the path to information exchange.

As of last year, there were 234 HIE initiatives in the country, according to the eHealth Initiative, a not-for-profit organization that promotes health information exchange. Most were in the planning stages; only 73 were transmitting data. Most states have at least one HIE initiative, and 33 have more than one. New York State has the most with 12, including several that target specific boroughs of New York City. The HITECH legislation should give those efforts a boost with some extra funding.

Dr. Manjunath of the Whitney Young Health Center in Albany is also on the board of directors for the Health Information Exchange of New York (HIXNY), which serves his region. At this writing the center was finalizing arrangements to upload data from its EHR to HIXNY. He looks forward to the day when he can use the HIE to download problem lists, medication lists, allergy information, lab results, and other basics directly into his patients’ electronic records. “Some of our patients go to multiple providers, and we don’t have good knowledge of what’s prescribed in other settings,” he says.

One challenge for the center will be making sure patients have consented to make their information available through the HIE. Dr. Manjunath says that while uploading is automatic, providers will need patients’ consent to download their data.

Another challenge for both HIEs and their users is the risk of information overload. “When health information exchanges become more prevalent, think of all the information that you might have access to,” says Dr. Troxel of The Doctors Company. “There might be multiple records from years back. How are you going to access all that [information] in the 15 minutes you have with a patient?”

Sometimes a service that bills itself as an HIE really isn’t one,

warns Dr. Kleeberg. “A number of systems claim that they’re sharing patient data, but essentially they’re just passing credentials so that you can remotely log in to another [EHR] system,” he says. With this type of system, physicians have to know that a certain piece of information is available on a certain system in order to find it. A genuine HIE can alert a physician to the presence of information that he or she wasn’t aware of previously, and it can show all available information on a patient regardless of its source.

### New Privacy Issues

Widespread use of EHRs and health information networks will increase the risk of personal health information’s getting hacked or stolen, and patients will almost certainly become more concerned about privacy breaches once they’re aware that their information is in an electronic form. Electronic information can be more secure than paper: No one ever needed a password in order to flip through a paper chart. But when electronic breaches occur, they can be massive (see “The Real World of Electronic Security Breaches”).

In recognition of that reality, the HITECH Act includes several changes to HIPAA. (For more information, see the AMA’s fact sheet at <http://www.ama-assn.org/ama1/pub/upload/mm/368/hhs-overview-changes.pdf>.) Among the changes:

- **Monetary penalties for privacy breaches** increase to a maximum of \$1.5 million annually, up from \$25,000.
- **The definition of “business associate”** has been expanded to include EHR vendors, HIEs, and other electronic partners.
- **There are new rules on selling health information** for marketing and using it for research. For example, practices may not sell a patient’s protected health information without written consent.
- **Providers must report to the HHS** whenever there’s a pri-

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## The Real World of Electronic Security Breaches

The computer security firm Infogard (also an approved certifying body for EHRs) analyzed 109 medical record privacy breaches reported to the HHS between September 2009 and June 2010. While paper records accounted for 46 of those breaches, the analysis found that fewer than 200,000 records were affected in all, and improper disposal accounted for most of the total.

In contrast, stolen or lost laptops accounted for 55 incidents and more than 1.5 million patient records breached, including 1.2 million in a single incident. Thirteen reports came from private practices; the others came from hospitals and health plans. Most involved theft of a desktop computer, a laptop, or some other portable device. None involved paper; and only one, affecting 2,000 patients, was attributed to a hacker's breaking into a system.

vacy breach that affects more than 500 patients' records.

Individual states may have adopted privacy provisions that are more stringent than HIPAA, says Bernadette M. Broccolo, a health IT attorney and partner with McDermott Will and Emery, Chicago. She also co-chairs the executive committee of the Health Information Exchange Task Force for Illinois. "A lot of EHRs have been designed with HIPAA in mind, but not the more restrictive state laws," she says. For example, Illinois has a separate confidentiality law relating to mental health records that applies even to discussions about depression or anxiety in the course of a primary care checkup. In addition, if your practice participates in an HIE, you may find that its own rules go beyond HIPAA's rules.

EHRs can provide many protections, such as an access screen that requires users to enter their reason for needing to see a record; and EHRs typically track who looks at what and when. EHRs can often segment access by function so that the user can see only the specific information that he or she needs in order to accomplish patient care. However, office policies and procedures need to back up any electronic safeguards built into the EHR, Ms. Broccolo says. For example, all staff should be required to agree that they will view only the records of patients whom they're treating.