A goal of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act is to encourage the use of electronic prescribing of medications: e-prescribing. This requires parties to establish standard nomenclature and to exchange standard messages. Creating this environment in the postacute and long-term care (PA/LTC) world is turning out to be slow and difficult for a couple of reasons.

First, e-prescribing is a subset of computerized provider order entry. The HITECH Act set specific standards for physician offices and hospitals— but not for the PA/LTC environment. It was either overlooked or ignored. This presents a problem for vendors who want to design and sell software to facilities. These companies can offer only products that their clients find useful. Inventing a standard for PA/LTC and then writing one is something that software companies are reluctant to do because they know that, sooner or later, PA/LTC standards will be set.

Second, PA/LTC facilities are not required at this point to follow any standard. The Certification Commission for Health Information Technology, which in the past has created very high standards for hospitals and ambulatory physician offices, has developed standards for PA/LTC, but these have yet to be recognized by the government. In the absence of official standards, most facilities and their pharmacies have not supported e-prescribing. More than 90% of facilities do not use any electronic health record (EHR) system that conforms to a national standard. In fact, most PA/LTC patients come from the hospital, and their drug orders come with them on paper. But the first public standard is beginning to penetrate the realm of PA/LTC. This standard, which comes from the National Council of Prescription Drug Programs 10.6, is required by November 2014 if PA/LTC facilities choose to support e-prescribing. It’s essentially an updated standard that includes more elements that are necessary for prescriptions in the PA/LTC world, such as room number, specific medication dispensing times, and so forth.

In another encouraging development, the Centers for Medicare & Medicaid Services, in updating options for satisfying the e-Prescribing Incentive Program, has made the Group Practice Reporting Option (GPRO) much simpler to enroll in and to satisfy. I’m usually a critic of the needless complexity of these programs, but this one is a winner.

One large PA/LTC physician group with which I work finished its 2013 e-prescribing for the year on March 7. Not only was that prior to the date in past years when the members had started fulfilling their qualification for e-prescribing incentives, but there was also essentially zero administrative time spent in the pursuit of this compliance. This is a huge contrast to the years when each prescriber had to be helped over the barrier of 10 e-prescriptions by June 30 to avoid penalty, and then 25 total prescriptions by Dec. 31 to achieve the small bonus.

How did this compliance miracle occur? Simple. The GPRO e-prescribing option became easy to administer, and the practice set up a competition. It had to report 625 instances of e-prescribing before June 30 to avoid the 1.5% penalty and to earn the 0.5% bonus. Providers who participated in achieving the target (set at 1,000 patient encounters to ensure that more than 625 were with Medicare B beneficiaries) were given a pro rata share of the estimated $20,000 in incentive payments. That proves two things: You can e-prescribe in nursing homes, and carrots work better than sticks; and the entire process was made easy because all the physicians and extenders use a certified EHR with integrated e-prescribing.

However, a physician group doesn’t have to use a certified EHR to e-prescribe. I also work with a large physician group that includes members who comply with the requirement by e-prescribing through nursing homes’ clinical EHR systems. The group will get over its 2,500 e-prescribing hurdle by using the facilities’ systems. Other PA/LTC groups should examine this option if they haven’t yet deployed their own certified EHRs. There is a decent Centers for Medicare & Medicaid Services (CMS) description of the GPRO program on its website.

CMS should adopt GPRO for as many programs as possible. It gets administrative staff (who run these things) to focus on systems instead of individual compliance. Truth is that it’s technical barriers, not disinterest, that turn some physicians into e-prescribing laggards.

The only shortcoming to this program is that to get in on the 2012 program, practices had to register to participate by Jan. 31. That deadline passed before most groups even knew GPRO existed. CMS stated that the option would again be available in 2014, so watch for this in the final 2014 Medicare Physicians Fee Schedule.

By Rod Baird

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Patient-Consent Tools Are Available

BY MARY ELLEN SCHNEIDER

Federal health officials have developed videos and other tools to gain patient consent for sharing medical information electronically.

While state laws and regulations create a patchwork of different requirements for when patient consent is required to release information for treatment, federal officials are encouraging physicians to develop a “meaningful consent” process that includes education about how the information is shared, gives patients time to review the educational materials, and allows them to change or revoke their consent at any time. The effort deals specifically with information shared through health information exchange organizations and is available at www.healthit.gov/providers-professionals/patient-consent-electronic-health-information-exchange/econsent-toolkit.

“As patients become more engaged in their health care, it’s vitally important that they understand more about various aspects of their choices when it relates to sharing their health in the electronic health information exchange environment,” Joy Pritts, ONC’s chief privacy officer in the Office of the National Coordinator for Health Information Technology, said in a statement.

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