Surf’s Up! New Electronic Health Records Initiative Creates Waves

Stephen Barlas

Pharmacy benefit managers and health insurers will probably hop aboard the train with enthusiasm; hospitals, however, might be more hesitant to computerize health records. In 2002, hospitals were using electronic health records at a rate of only 13%. Some hospitals that have waded into the electronic age have found themselves sinking in a sea of added costs.

For example, an article in the *American Journal of Health-System Pharmacy News (AJHP News)* from August 1, 2004, described two Health Alliance hospitals in Cincinnati, Ohio, that would have to spend $2 million to comply with a state regulation concerning computerized prescriber order entry (CPOE). The regulation requires the use of a private personal identifier, such as a password, whenever a magnetic card or bar code is used to access a mechanical or automated system, similar to the requirements of most automated teller machines.

Charles H. F. Youngs III, CPOE Pharmacy Consultant and Director of the Pharmacy Practice Residency Program, said that the built-in security for Health Alliance’s health care information system—LastWord (IDX Systems Corporation)—consists of a log-in and a password. That level of security, he learned last summer, does not satisfy Ohio’s requirement for the positive identification of persons initiating, changing, or stopping medication orders.

Richard Coorsh, spokesman for the Federation of American Hospitals, said that the objective of CPOE is correct. “But you cannot buy those systems off the shelf,” he explains. “They have to be adapted for each user, and there are implementation issues.”

These kinds of reservations explain why David Brailer, MD, PhD, tried to inject some reality into the Thompson press conference of July 21. He is the national coordinator for Health Information Technology (HIT) and was responsible for *Framework for Strategic Action*. This report lists a number of actions that various components of DHHS will be taking over the next year to accelerate medicine’s embrace of electronic records.

“This is a framework,” he emphasized. “It is not a full-blown, strategic plan. It is intended to stimulate dialogue.”

Dr. Brailer was implying, between the lines, that DHHS was well aware of the cost implications of the Health Information Technology initiative, and he planned to do everything within reason to allay concerns by physicians, hospitals, and health insurers on that score.

One of the ways in which Secretary Thompson might be able to allay the concerns of those groups would be to appoint a Health Information Technology Leadership Panel. The membership would be composed primarily of industry executives who would report to him, by the end of this fall, on specific options for reaching the general objectives in the Brailer strategic framework. However, although Secretary Thompson repeatedly stated his desire to “get the train out of the station,” that panel had not been named by the time of the July 21 conference; one week later, its membership was still not in place. A staffer in Dr. Brailer’s office said that there was no timetable for announcing the membership.

I guess Secretary Thompson forgot to get all the train’s cars coupled up. ■