Physicians More Likely To Report Drug Safety Information Through Electronic Health Records System

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(BUSINESS WIRE)--Pfizer announced today results of a survey the company recently sponsored that shows physicians are more likely to report side effects through an electronic health records (EHR) system, as compared to traditional paper methods. Nearly 60 percent of physicians who responded to the survey also agreed that adverse event reporting through an EHR system would improve patient care.

“Patient safety continues to be a top priority at Pfizer,” said Freda Lewis-Hall, MD, Pfizer’s chief medical officer. “This survey furthers our understanding about how we can best use electronic health records systems to collect critical information about the safe and appropriate use of our products so that we can improve patient safety.”

Of the 300 physicians surveyed, two-thirds utilized some form of an EHR system and one-third used a paper-based system. Half of all respondents and 60 percent of fully-functional EHR users reported that they would be much more likely to submit information about adverse events using an EHR system. Of those still using paper-based systems, 80 percent cited cost as a deterrent to investing in an EHR system.

Ipsos conducted the survey online among primary care physicians in the United States who were categorized as basic electronic health record users, fully functional electronic health record users or paper health record users. The research was conducted during September and October 2009.

As part of the company’s ongoing efforts to improve patient safety, Pfizer is collaborating with Brigham and Women’s Hospital, Partners Healthcare, CDISC, an international standards group, and CRIX International to improve the quality of data in safety reports. Earlier this year, the group conducted a pilot known as the ASTER (Adverse Drug Event Spontaneous Triggered Event Reporting) study, allowing physicians to use electronic health records to report adverse events directly to the Food and Drug Administration (FDA). By exploring a combination of standards, technology and a new business model, the group intends to help physicians better recognize and report adverse events.

“These survey results confirm what we saw in the Partners Healthcare ASTER study,” said Jeffrey A. Linder, MD, MPH, FACP an internist at Brigham and Women's Hospital in Boston. “The system we used in that study was well accepted by the participating physicians, who felt the adverse event reporting was unobtrusive and who saw the public health potential of this type of reporting. While most of the participating clinicians submitted no reports in the year prior to the study, they submitted hundreds of detailed reports during the five months of the study period."

Physician-reported adverse events are critical to the safety profiles of products by FDA. In the current adverse event reporting process, it can take physicians as long as 40 minutes to fill out required paperwork. By transitioning to an electronic health record system for reporting these events to the FDA, the process is completed in a matter of minutes. For physicians, it is important for EHR adverse event reporting to be easy to use, convenient and safe for patients.

“Adverse event reports are a key component of our ongoing efforts in patient safety,” said Dr. Lewis-Hall. “One critical goal is to increase the number and quality of the reports we receive. By making it easier and more convenient for doctors, we anticipate meeting this goal. ASTER is an impressive step in demonstrating how we can leverage EHRs to do just that.”

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Pfizer Inc. Media: Kristen Neese, 212-733-8926 or Investors: Jennifer Davis, 212-733-0717