Group Pushes for Machine-Readable ID Cards

BY ERIK L. GOLDMAN

DENVER — Incorrect patient identification information is still the No. 1 reason for rejected insurance claims, and the majority of these errors—which cost the nation an estimated $2.2 billion in administrative waste—reflect the failure of the health care industry to embrace standardized, machine-readable magnetic ID cards.

The Medical Group Management Association (MGMA) is hoping to change that. Last year, it launched Project SwipeIT, a national, multistakeholder effort to push for full implementation of magnetic insurance ID cards in all public and private health insurance plans.

In its first year, Project SwipeIT garnered pledges of support from more than 1,000 physicians' organizations, insurance companies, and health information technology vendors who vow to issue, support, or accept machine-readable ID cards.

Standards for magnetic insurance ID cards were first developed in 1997. Yet today, health care transactions are still almost entirely dependent on paper or plastic ID cards. Each insurance company has its own card design and format, some of which can be difficult to read or copy. Stapling a photocopy of a patient's ID card into the medical chart or manually key-stroking information into the patient's record is still the norm in nearly all medical practices.

Reliance on paper-to-paper transfer of identifying information leaves a lot of room for error. Numerals are easily mistaken, names misspelled, benefits changed, and expiration dates unnoted.

The MGMA estimates that 98% of all claims generated by physicians' offices are not electronic, and approximately 5% of those claims are rejected because of incorrect ID information, leading to long and costly delays in physician reimbursement.

On average, it takes roughly 15 minutes of staff time to manually correct and resubmit an erroneous claim once the error has been identified.

The MGMA estimates that outpatient physicians nationwide could save as much as $290 million per year if all insurers used swipe cards in compliance with standards developed by the Workgroup for Electronic Data Interchange.

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DR. HEIM

"There's no reason we shouldn't have machine-readable cards at this point," said Dr. Lori Heim, president of the American Academy of Family Physicians. "We are very supportive of this project."

Dr. Heim attributed the failure to adopt swipeable ID cards to "procedural inertia." Though standards for creation of cards have been in place for more than a decade, it has taken more time to develop standards for reader devices, interfaces between card readers and electronic health record systems, and platforms for interoperability. "It is reflective of the broader problems we've seen regarding the adoption of health care [information technology] in general," she said.

Without strong consensus and commitment from all major insurers—or an unequivocal federal mandate—individual plans have been unwilling to take the first steps and implement their own swipe cards. And if the plans weren't going there, neither would physicians, even though both parties stand to gain.

Dr. Heim said that creating standards for transfer of ID card data into electronic health records will be critical for general success. "It's a complex issue because there are so many different EHR systems, and each has its own setup. In order to realize the savings potential, we need the patient ID information to transfer smoothly from the card reader to the right places in the EHR."

According to the MGMA, card readers cost around $200 per clinic, and the software upgrades needed to interface card readers with electronic practice management systems are minimal.

Dr. Heim said that she believes the implementation costs should be borne by insurers, who have much to gain by digitizing transactions and reducing errors. "It would significantly reduce the amount of money they have to pay to people for spending time on the phone working out disputes with doctors' offices."

In 2010, the MGMA and its partners plan to become more active in pushing the Project SwipeIT agenda. According to the group's Web site, the second phase of the project involves publicly recognizing payers that have met their pledges and issued standardized, machine-readable health ID cards, while publicly identifying those that have not. ■

IOM Eyes the Creation of a Continuing Education Institute

BY JOYCE FRIEDEN

A public-private institution launched by the Department of Health and Human Services would be the best way to raise standards and quality for continuing health education, according to a report issued by the Institute of Medicine.

There are serious flaws in the way that continuing education for physicians and other health professionals is "conducted, financed, regulated, and evaluated," concluded the authors of the 200-page report "Redesigning Continuing Education in the Health Professions." They added, "The science underpinning continuing education for health professionals is fragmented and underdeveloped."

"Establishing a national interprofessional continuing education institute is a promising way to foster improvements in how health professionals carry out their responsibilities," the authors said. The report was sponsored by the Josiah Macy, Jr. Foundation.

The 14-member Institute of Medicine committee that produced the report proposed the creation of a public-private entity that would involve the full spectrum of stakeholders in health care delivery and continuing education.

That new entity, which would be called the Continuing Professional Development Institute (CPDI), would look at new financing mechanisms to help avoid potential conflicts of interest. The institute also would develop priorities for research in continuing health education and recognize effective education models.

The medical community must move from a culture of continuing education to one of "continuing professional development … stretching from the classroom to the point of care, shifting control of learning to individual practitioners, and [adapting] to the individual's learning needs," said committee chair Dr. Gail Warden.

'There have been a lot of changes in CME ... that were completely overlooked by the committee.'

DR. KENNISON

"We believe that academic institutions need to be much more engaged than they have been in continuing education," Dr. Warden, president emeritus of the Henry Ford Health System, Detroit, said during a teleconference. "The system should engender coordination and collaboration among professions that should provide higher quality for a given amount of resources and lead to improvements in patient health and safety."

Continuing medical education (CME) vendors had mixed reactions to the committee's report.

Rick Kennison, D.P.M., president and general manager of PeerPoint Medical Education Institute, said that he agreed with the committee's recommendations in the area of traditional CME. Those types of programs, such as live meetings and society annual meetings, "are didactic in nature [and] don't meet the needs of participants as learners, and there is conflict and bias associated with them."

But a large problem with the report is that the committee reviewed continuing medical education as it used to be, Dr. Kennison said. "They wanted to evaluate a model of a car, but instead of using a 2010 model, they used a 2006 model," he said. "There have been a lot of changes in CME in the course of the last few years that were completely overlooked by the committee."

For example, Dr. Kennison said that his organization has already moved to performance-improvement CME, which is a goal outlined in the report. Performance-improvement CME, he explained, involves "direct learning by the participant—self-directed learning—in which the participant uses metrics and supplies data to help determine change and improvement in patient care.

"We've been doing this for more than 2 years now," he noted. "Because the group didn't evaluate performance-improvement CME, I think they missed a major stepping stone associated with the current status of CME."

Dr. Kennison said his company's CME programs are sponsored by the pharmaceutical industry. But the funding is in the form of general grants related to diseases and conditions, he noted, and does not involve sponsoring education initiatives that highlight specific drugs or classes of drugs.

Dr. Edmond Cleeman, a New York orthopedic surgeon and founder of TRIARQ, a medical education organization for orthopedists, physical therapists, and other health professionals in the orthopedic field, agreed with the committee's recommendation that continuing health education needs to be team based and multidisciplinary. In the TRIARQ program, which is still being developed, students taking the courses will pay the costs themselves.

On the other hand, there are several report recommendations that gave Dr. Cleeman pause.

"To form another government committee and force a single type of a mold, and add additional regulations on all medical subspecialties and on CME—that's not the right approach," he said. "Each discipline is very different, and the needs for each discipline should be determined by its own governing body. So, the idea of having one government committee saying, 'This is continuing education for all fields of health care'—that is going to be a problem. I think you're going to scare away innovation."

Instead, "I think it's a good idea to have a private organization, maybe like the American Medical Association," said Dr. Cleeman. "Their goal would be to assist in developing goals for continuing education." ■

The Institute of Medicine report, "Redesigning Continuing Education in the Health Professions," is available online at www.iom.edu/continuinged.