

Physicians May Not Embrace Health IT Incentives

BY JOYCE FRIEDEN

WASHINGTON — Government health officials are hoping that most physicians will get on the “meaningful use” bandwagon, but that’s not likely to happen easily, according to Dr. Len Lichtenfeld, deputy chief medical officer of the American Cancer Society.

“I don’t think [health care] professionals have any idea what’s coming,” Dr. Lichtenfeld said during a panel discussion at an eHealth Initiative conference. “I think [federal officials] are risking failure because doctors will say, ‘Are you kidding? I don’t want to have anything to do with this.’ I hope that isn’t what happens, but I tell you, be prepared.”

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of last year’s federal stimulus law, physicians who treat Medicare patients can be awarded up to \$44,000 over 5 years for the meaningful use of a certified health information system. For physicians whose patient populations are at least 30% Medicaid patients, the incentive is as much as \$64,000.

But physicians who already have computers may find that they won’t meet the requirements for the incentive, Dr. Lichtenfeld said. “Doctors have invested in these systems and now they’re worthless. They don’t have the time, they don’t have the money, they don’t have the expertise. And to have to get [a new sys-

tem] up and running in 2-3 years—they won’t do it. Something simpler would’ve gotten us to where we have to go.”

Despite a few patient-driven efforts (see box), no one has figured out how to use information technology as a way to get patients more involved in their care, Dr. Lichtenfeld contended. “A couple of years ago, personal health records ... were the talk of the town. They were going to get everybody on board. Patients were going to run to various Web sites and fill out their health information. Health plans were going to get together and figure out how to bring their data so it would be downloadable and easily accessible.”

But none of that has yet come to pass, he said. “Personal health records landed with a thud. We need to figure out that sometimes we have to keep it simple.”

In the meantime, the Department of Health and Human Services is trying to get physicians to meet some meaningful use criteria that aren’t even written yet, said Dr. Steven Stack, an emergency physician and member of two workgroups of the department’s HIT Policy Committee. He noted that two criteria “were supposed to be finished on Dec. 31, 2008, by statute. It’s 2010 and they’re not done, and it may be a year before we get something. A lot of these things aren’t ready for prime time.”

Instead of requiring physicians to meet lots of criteria, “if we focus on the smallest of things, then doggedly persist un-

til we knock down those barriers, and then require people to meet those [expectations]—with the proper incentives, we can make a really great step forward,” said Dr. Stack, who is a member of the American Medical Association board of trustees.

In contrast, Steven Findlay, senior health policy analyst at Consumers Union, expressed impatience with the process. “We ought to try to push as far as we possibly can with the 2011 mean-

ingful use criteria,” he said. “We ought to be exquisitely sensitive to what’s doable in 2011 ... but shouldn’t be running from time to push. We’ve been talking about this stuff for 10 years, and for the good of patients and consumers, we need to do this.”

The conference was sponsored by sponsored by Ingenix, the AMA, and other industry groups. The speakers reported that they had no conflicts of interest relevant to their presentations. ■

Site Collects Patient-Reported Data

Patients can play a role in providing useful health information, Dr. Stack emphasized. As an example, he cited www.patientslikeme.com, a Web site for patients with life-threatening or chronic illnesses such as amyotrophic lateral sclerosis (ALS), HIV, mood disorders, and fibromyalgia.

Visitors to the site can sign up for a free account and a screen name, which they use to post their comments and health statistics. “People voluntarily post their own health data. Some are very open about it—they post every pill they’re on, the dose, the frequency, what’s happening to them,” said Dr. Stack. In the ALS community, members developed “a patient population and a data set

that was so robust that if [community members] put in enough of their own variables, [the site] could predict when you’d be in a wheelchair within a week and when you’d be on a ventilator within a week. It was that precise. We could never replicate that in a prospective, double-blind randomized controlled trial. We could never get an institutional review board to [accept it] and never get people to do it.”

But for patients such as these, “the motivation of your own health and the fear of death through your own illness is a motivator we can’t replicate with money or incentives,” he said. “When you are properly motivated, you’ll seek out” available tools.

THE OFFICE

Is This the Year to Try E-Prescribing?

Electronic prescribing was supposed to be standard practice by now.

With all the predictions of increased efficiencies and cost savings, policymakers and health plan administrators were sure physicians would quickly adopt the new technology—but the associated costs and hassles dissuaded most. And many didn’t see any benefits, either for patients or for themselves.

The Centers for Medicare and Medicaid Services thought it could turn the tide last year by adding a financial incentive: a 2% bonus on Medicare Part B payments. That didn’t do the trick either; accessibility and cost issues remained, and the various “G” codes that had to be added to Medicare claims to document e-prescribing were confusing and annoying.

As 2009 ended, only 10%-15% of American physicians were e-prescribing.

If you’re in the prehistoric majority, 2010 may be the year to reconsider: CMS has made it much easier to collect the 2% bonus with a minimum of e-prescribing effort; plus, a consortium of tech companies has made the technology readily accessible and free.

This year, if you can show that you are using a qualified e-prescribing program on only 25 Medicare claims over the course of the entire year, you’ll get the 2% bonus on every Medicare Part B claim you file in 2010.

In addition, CMS has simplified the reporting process by eliminating all add-on codes except G8553, the one that indicates you have a qualified e-prescribing program and you used it to provide at least one prescription at the visit being billed.

Of course, CMS is hoping you won’t quit after only 25 claims; they’re betting you’ll notice a decrease in paperwork, simplification of record keeping, fewer misspellings and handwriting misreads, and a greater awareness of contraindications and drug interactions, plus simplified access to patients’ medication histories. And they hope you’ll see a decrease in pharmacy phone calls, prior authorization nonsense, and treatment delays because of formulary issues. Further, they hope, your patients will appreciate seeing their prescriptions filled faster, with fewer errors.

To address cost and accessibility problems, a coalition of insurance and technology companies, the National e-Prescribing Patient Safety Initiative (NEPSI), has provided \$100 million in funding to offer free e-prescribing technology to all physicians nationwide. NEPSI members include Allscripts, SureScripts, and NaviMedix, as well as Google, Dell, Cisco, Fujitsu, Microsoft, Sprint, Aetna, Horizon Blue Cross/Blue Shield, WellPoint, and Wolters Kluwer Health.

Thanks to the efforts of NEPSI and others, e-prescribing is now quick and easy for most practices to set up and use. Pharmacies have already done most of the work to make themselves compatible; about 70% of U.S. pharmacies can now handle electronic prescriptions. You can incorporate e-prescribing into many electronic health record systems, or set it up as a separate, stand alone system.

In most cases, all you need to get started is an Internet-enabled computer with a high-speed connection (not dial-up), and a database of patients.

A nonprofit foundation called eHealth Initiative has released an excellent guide for physicians who are considering making the switch to e-prescribing, as well as for those who have already switched. You can find it at www.ehealthinitiative.org/basics-what-electronic-prescribing.html.

You can learn more about NEPSI and sign up for their free, online-based prescribing software at their Web site, www.nationalerx.com.

A list of other companies that currently offer e-prescribing software, along with links to their respective Web sites, can be found at www.eprescribing.info/eprescribe/companylist.aspx.

Details of the CMS incentive program are available at www.cms.hhs.gov/ERxIncentive/. The 2% incentive will decrease to 1% in 2011 and 2012, then to 0.5% in 2013. But beginning in 2012 there will be a 1% penalty for not e-prescribing, increasing to 1.5% in 2013 and 2% in 2014 and thereafter.

With cost, accessibility, and hassle roadblocks removed, bureaucrats hope 75% of us will be prescribing electronically by 2014, 90% by 2018. And that, in turn, they claim, will save the government \$22 billion over the next decade due to increased use of generic drugs and decreased prescribing errors.

Maybe, maybe not. But with only 25 e-prescriptions required to collect the 2% bonus this year, it’s a “no-brainer” to give electronic prescribing a try. ■

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