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BUSINESS

Is IT ready to pay for itself? (HIMSS meeting)

As information technology becomes a greater force in practices, physicians are wondering if the return on investment outweighs the initial costs and hassles.

By Tyler Chin, *AMNews* staff. March 13, 2006.

If you had to shell out $20,000 to $50,000 per physician for start-up costs and endure six months of operational hiccups in hopes of boosting your income 1%, would you buy an electronic medical record?

That's the question most health plans, corporations and others adopting pay-for-performance programs are asking, in hopes of encouraging physicians to use EMRs.

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Some pay-for-performance programs directly reward physicians for buying EMRs, while most ask physicians to provide information that's much easier to capture and organize electronically.

At several sessions held during February's Annual Healthcare Information and Management Systems Society Conference & Exhibition, there was widespread recognition among industry professionals that 1% probably isn't enough of a pay-for-performance bonus to convince physicians EMRs can pay for themselves. HIMSS is a Chicago-based industry group that produces the largest health care information technology conference in the country, luring more than 25,000 people and more than 860 health care technology companies touting their products at the San Diego Convention Center.

But while many at HIMSS thought the current incentives probably aren't enough, there was no consensus on what will get physicians to act.

Physicians "need more money because that's the only way they are going to be able to adopt systems and processes that are going to transform the way they can manage care," said Francois de Brantes, program leader for

health care initiatives at General Electric Co., a Fairfield, Conn.-based conglomerate that is a key player in the Bridges to Excellence pay-for-performance program run by a consortium of large corporations.

Based on the experience of Bridges to Excellence, it will take bonuses amounting to 5% to 10% of a physician's annual income to promote wide adoption of EMRs, de Brantes said. "We noticed that physicians at individual practices need to be at the higher scale. Physicians that participate in large groups can be at that lower scale."

Others, however, have proposed a much lower incentive bar. In 2005, Congress considered but failed to pass several bills authorizing the Centers for Medicare & Medicaid Services to offer pay-for-performance bonuses of 1% to 2% to physicians and hospitals, said Christine Bechtel, director of government affairs at the American Health Quality Assn., during a session at the symposium.

A "meaningful" incentive for Louis Civitarese, DO, a family physician at 35-doctor Preferred Primary Care Physicians in Pittsburgh, would be approximately $25,000 per physician. That is about what his group paid to implement its EMR two years ago.

Dr. Civitarese, however, recognizes it would be cost prohibitive for health plans or employers to cover the start-up costs of every group in the country, especially since smaller practices would see substantially higher per-physician costs. He'd settle for incentives that would cover the group's EMR maintenance, which is about $11,000 annually per physician. "I don't think pay-for-performance has to pay for the whole thing. But it has to pay for part of it."

Several groups in the Pittsburgh region have visited his group to check out its EMR. Without fail, their first question is whether Preferred Primary Care has recouped its investment after two years. His answer: Not yet.

"It takes the wind out of their sails," Dr. Civitarese said. "I think if physicians saw a realistic plan with regards to pay-for-performance to even allow them to recoup their investment and ongoing maintenance costs, then I think they would be much more willing to jump in."

It's been four years with an EMR for Prairie Cardiovascular Consultants Ltd., of Springfield, Ill., and the 44-doctor cardiology group still hasn't recouped its money.

"We see pay-for-performance as an opportunity to at least get some return on investment for the cost, efforts and sacrifices that we made to try to improve quality," said Frank L. Mikell, MD, practice president.

To prepare to participate in pay-for-performance initiatives, Dr. Mikell's group is implementing an internal program to reward doctors who achieve certain measures on quality, adherence to information technology and patient satisfaction.

The group's partners have agreed to set aside 5% to 10% of their income into a pool, to be awarded physicians who meet the performance criteria.

The group independently concluded a few years ago that the incentive had to be this high "because otherwise people wouldn't be motivated to do it," he said.

Whatever the size of the pay-for-performance bonus, the bottom line is that physicians must first know the concrete financial benefits as well as the costs for improving performance, AHQA's Bechtel said during her session. "It's got to pass the smell test for each practice."

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ADDITIONAL INFORMATION:

Exploring the fine print

If you've ever bought a computer system, you know health care technology companies don't invite contract concessions. However, you're not entirely at their mercy. Diana J.P. McKenzie, an attorney at Neal, Gerber & Eisenberg LLP, Chicago, offered to *AMNews* several contract negotiation tips while speaking at February's Healthcare Information and Management Systems Society convention in San Diego.

- Ask for a "tiered one" performance effort rather than the routinely offered "commercially reasonable efforts." Getting that language means better service after the sale.
- Have a clear description of the functionality of the product. Insist the vendor describe, in the contract, exactly what you're buying and how it's supposed to work.
- Watch for "lethal" words --such as "solely" and "goal" -- used in relation to the vendor's maintenance and implementation obligations. These words provide an out for the vendor to refuse to handle your service. For example, "solely" means that if a problem is determined to be 99% the vendor's fault and 1% the customer's, the vendor isn't legally required to do anything.
- Check the penalty for late payments. A lot of older contracts set the rate at 12% to 18%, but "if you just ask, you almost always get 6% to 9%."
- Ask for an on-site meeting by a high-level executive from the vendor as the last step in a dispute resolution. "Key executives will always, almost inevitably, make sure that whatever the problem, it will be fixed before they come on site," because they don't like to visit unhappy customers.
- Delete or significantly curtail the scope of "*force majeure*" clauses. Typically, they referred to "acts of God," but vendors have broadened the clauses to include acts of terrorism and an inability to obtain supplies.
- Hire an attorney.

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They've got issues

Patient satisfaction is the top business concern for hospitals and health systems nationwide, though Medicare cutbacks rocketed up to a close second, according to the 2006 Healthcare Information and Management Systems Leadership Survey of more than 200 information technology executives representing more than 473 hospitals:

Business issue	2005	2006
Patient/customer satisfaction	44%	51%
Medicare cutbacks	35%	50%
Reducing medical errors	57%	44%
Cost pressures	40%	42%
Clinical transformation	36%	38%
Integration and interoperability	n/a	37%
Improving quality of care	42%	36%
Adopting new technology	31%	29%
Improving operational efficiency	40%	25%
Providing information technology to ambulatory facilities	21%	23%

Note: Respondents could choose more than one answer

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Tablet PCs marketed as the prescription for technology

One technology gaining traction among some physicians -- though not necessarily the ones vendors intended -- is bigger than a personal digital assistant and smaller than a laptop, and combines the traits of each.

The technology is the tablet PC. It's about the size of a piece of paper (except a little thicker, of course). Most come without keyboards, with information instead entered using a touch screen or through a PDA-style stylus for handwriting. They use a Windows operating system, so they're apt to be compatible with a practice's in-office computer system.

Tablet PCs are being marketed most heavily to hospital-based physicians. But it's the ambulatory environment where the technology is gaining the most ground, says Gregg Malkary, founder of Spyglass Consulting Group, a Menlo Park, Calif., mobile computing consultancy.

Malkary, speaking at February's Health Information and Management Systems Society meeting in San Diego, has done studies looking at mobile computing preferences among physicians. He said at HIMSS that the ambulatory physician's working environment had made it more

conducive to the adoption of tablet PCs.

Unlike hospitalists, ambulatory physicians don't have to carry the devices for five to six miles a day, every day, while doing rounds, Malkary said. Also, physicians in the ambulatory setting are more likely to have paid for them with their own money and are therefore more motivated to use them, he said. Malkary, in an *AMNews* interview, addressed the talk about the BlackBerry possibly being squished into virtual juice because of a patent fight and the recent introduction of similar, Windows-based device by Microsoft. Like other professionals, physicians aren't terribly worried about what happens if BlackBerry shuts down, though that's based less on their confidence in the product's survival and more on general disuse.

At press time, Research in Motion, the maker of BlackBerry, faced the prospect of having to shut down the handheld device's e-mail service because of a lawsuit by NTP, a patent-holding group. NTP accuses RIM of infringing on its patents in creating the BlackBerry.

Malkary said that although handhelds are popular among physicians, BlackBerry adoption has lagged because the device is used primarily for wireless e-mail, and few health care vendors have developed clinical applications to run on it.

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EMR systems to vie for seal of approval

Ready to buy an EMR? Well, help will soon be on the way. A new effort tries to lower the risk that you'll be throwing your money down a black hole.

Starting in June, physicians will be able to buy ambulatory electronic medical records bearing something akin to the *Good Housekeeping* seal. A nonprofit group called the Certification Commission for Healthcare Information Technology completed testing its standards for functionality, interoperability, security and privacy for EMRs on Feb. 28 and is holding a public comment period until March 31 on its certification criteria.

The goal of the certification program is to accelerate physician adoption of EMRs among small physician practices by letting them know that the products that meet its criteria are robust EMRs "that they can go and buy today," said Mark Leavitt, MD, PhD, chair of CCHIT, during a meeting at the Health Information and Management Systems Society's conference in San Diego.

In 2004, HIMSS, along with the American Health Information Management Assn. and the National Alliance for Health Information Technology, founded CCHIT to accelerate physician adoption of EMRs by developing certification standards. In September 2005, CCHIT was awarded a contract by the Dept. of Health and Human Services to develop certification standards and processes for outpatient and inpatient

clinical systems, as well as the networks through which they interoperate, as part of the Bush administration's effort to implement a national health network by 2015.

CCHIT will begin accepting applications from vendors in April, and the first round of products to be certified are expected to be announced in June.

Physicians who buy CCHIT-certified products "will know that they are functional and that the company has a program of support that should be able to meet their needs," said Karen Bell, MD, a director at the Office of the National Coordinator for Health Information Technology. But physicians shouldn't just buy any approved product, she said. "It does matter which one doctors buy, because there are different prices, and there's a different feel to each of them," Dr. Bell said. "You really have to sit down, drive it and kick the tires to find out which one works for you."

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