Processing Forms Takes 3 Weeks Yearly

BY JOYCE FRIEDEN

Physicians and their staffs spend the equivalent of weeks—and $31 billion—each year processing health insurance paperwork, according to a study funded by the Commonwealth Fund and the Robert Wood Johnson Foundation.

The survey of 895 physicians and practice administrators nationwide asked respondents about the amount of time their practice's staff spent on various administrative activities, including prior authorization, drug formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.

The researchers found that physicians spent an average of 3 hours a week—or nearly 3 weeks a year—on administrative activities. Nursing staff spent more than 23 weeks per physician per year, and clerical staff spent 44 weeks per physician per year, interacting with health plans. More than three in four respondents said the costs of interacting with health plans have increased over the past 2 years (Health Affairs doi:10.1377/hlthaff.28.4.w533). Overall, the cost of these interactions amounts to $31 billion annually.

"While there are benefits to physician offices' interactions with health plans—which may, for example, help to reduce unnecessary care or the inappropriate use of medication—it would be useful to explore the extent to which these benefits are large enough to justify spending 3 weeks annually of physician time … on physician practice–health plan interaction," the study's lead author, Dr. Lawrence P. Casalino of Cornell University, said in a statement.

"It would also be useful to explore ways to make the interactions more efficient, both on the health plan side and in physician offices."

Physicians in solo or two-person practices spent many more hours interacting with health plans than did those in practices with 10 or more physicians; this was especially true in primary care, the researchers found.

And all physicians and staff members spent much more time on authorization, formularies, claims and billing, and credentialing than they did on submitting quality data or on reviewing quality data provided by health plans.

"To get to a health care system that is high-quality and delivers better value for everyone, we have to address the skyrocketing price of health care's administrative costs," Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation, said in a statement.

"Administrative costs will never be zero, but we need to make sure that administrative interactions improve the quality of care by working to make care safer and more efficient, and rewarding health care providers who successfully reduce excessive care and provide the right treatment at the right time." ■

New Health IT Czar: We Are 'Counting on Peer-to-Peer Influence'

Dr. David Blumenthal, a Harvard professor and a senior health adviser to President Obama's campaign, was appointed in March to the position of National Coordinator for Health Information Technology in the Health and Human Services Department. He is assuming the post at a critical time, with Congress recently setting aside billions in incentives for physicians and hospitals to adopt health IT as part of the American Recovery and Reinvestment Act.

DAVID BLUMENTHAL, M.D.

One of Dr. Blumenthal's challenges will be how to define the "meaningful use" criteria mentioned in the law, a definition that will play a major role in determining who is eligible to receive incentives.

In an interview with this news organization, Dr. Blumenthal talked about some of the challenges and progress so far.

CLINICAL PSYCHIATRY NEWS: What do you see as the biggest challenge for physicians in adopting interoperable electronic health records by 2014? Cost? Misaligned incentives? Products that don't meet their needs? Security?

Dr. Blumenthal: Surveys have shown all of those to be issues. I think security is a lesser issue, according to the surveys that my group did at Harvard when I was there. But the cost of acquisition, the lack of return on investment, [and] concern about the usefulness of products all ranked high in our survey results. So I think all are important issues for physicians right now.

CPN: The Recovery Act includes about $17 billion in incentives for physicians and hospitals to adopt health IT. What impact do you expect this to have on the sluggish adoption rate and the health IT marketplace?

Dr. Blumenthal: Let me first make a minor correction in the number: $17 billion is a Congressional Budget Office number, and it is actually a combination of two numbers: a spending number and a cost savings number. Both are estimates. The actual CBO projections of spending are about $29 billion, and they project a $12 billion savings, which gets you to $17 billion. Some estimates of the spending are that it will be considerably higher than that, and how much is spent depends on how many physicians adopt, how many hospitals adopt, and how fast they adopt. So if we think more on the order of $30 billion or even more than that, I do think that's enough to change the dynamic in the marketplace.

We are also counting on peer-to-peer influence and on a growing appreciation among physicians of the value of health information technology and of the fact that it will be difficult to practice up-to-date, high-quality, professional medicine in the 21st century without an electronic health record. We are counting to some degree on professionalism to complement the incentives.

If physicians were only about money, it would be a much less happy world, and the quality of care would be much lower than it is. Physicians don't expect the government to help them buy stethoscopes, examining tables, treadmills for stress tests. They know these are essential to their work as professionals, and I think that is where we are heading with electronic health records as well.

CPN: Everyone is curious to see how HHS defines the "meaningful use" criteria outlined in the Recovery Act. Is there a consensus building around this term, and what is the schedule for issuing a definition?

Dr. Blumenthal: I think there is a consensus building. We haven't pinned it down finally. We [are] discussing this issue before our Health Information Technology Policy Committee. I think at that point some of the major options will be on the table for review and for public comment. We will ultimately have to go through a regulatory process to finally determine the effective definition, but I'm hoping that over the summer, the HHS view of the definition will become clear. It will then have to go through the government clearance process and the regulatory process, which will include copious public comment and undoubtedly will result in some modifications.

CPN: Can you say where there is consensus so far?

Dr. Blumenthal: I don't want to get into specifics, but I will tell you that I think the consensus is clear around one thing, and that is that we should concentrate on performance and usability rather than on technical specifications. We should be constantly linking our definition of meaningful use to clinically meaningful capabilities and performance attributes.

CPN: You and the president frequently have said that health IT is a tool, not a fix for our health care system. What can we reasonably expect to achieve through the widespread adoption of health IT in terms of reducing health care spending? And can physicians expect to realize any of those savings within their own practices?

Dr. Blumenthal: I think you've correctly captured my view of the role of health information technology. There are three essential components for achieving the president's goal and the administration's goal and, I think, the public's goal for a higher-performing health system. The first is better information on what works and what doesn't in the daily practice of medicine.

The second is the ability to apply that knowledge rapidly to practice. And it's in that setting that I think health care information technology becomes a vital tool. It enables practitioners to access in real-time and have the benefit of. . . the latest information that is approved by their peers and recognized by their peers as valid and useful for patient care. And it helps overcome the human factors that limit the ability of clinicians to do their best at all times and in all places. Of course, it provides better information about individual patients to factor into decision making as well.

The third element is changes in the financing and organization of care that make it more valuable and more rewarding for physicians and easier for physicians to take cost and quality into account when they make their decisions.

Health information technology is the major part of the second [component], but can't function optimally unless all three are in place. So we are vitally dependent for the savings and the quality improvement that could come out of HIT, we are vitally dependent on health care reform more generally.

If physicians are going to realize savings in their practice and gain the benefit of those savings, there will have to be some change in the way that we pay for care and some change in the way that we recognize excellence in medicine so that physicians, as well as their patients, feel very directly and personally the benefits of making the health care system a better health care system.

CPN: The Recovery Act provides for incentives for HIT adoption starting in 2011, but there are many areas where there are still not uniform standards. Can the industry keep up with this aggressive timetable, and what is the government doing to accelerate that process?

Dr. Blumenthal: Frankly, I think we have most of what we need in the way of standards to permit the physicians to get to meaningful use as it is likely to be defined by 2011. I also think that the industry can reconfigure their software in time to make it possible for physicians to meet those standards. I'm not very concerned about that. What I'm mostly concerned about is that—in recognizing those standards and in certifying the software and hardware that we need to certify—we also make certain that we are laying the groundwork for a dramatically improved set of technologies as we go forward. We are looking very hard at how we [can ensure] that when we certify a system and we set a set of standards, we are leaving room for innovation and improvement.

—Interview by Mary Ellen Schneider