Physicians Seek Federal Funds to Finance EMRs

BY ALICIA AULT
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WASHINGTON — Several individual physicians and professional organizations urged members of Congress to extend tax credits or deductions and small business loans to physicians who purchase information systems and to require Medicare to offer an incentive payment to physicians who make the move to electronic medical records.

Adopting electronic medical records (EMRs) can make practices more efficient, but the initial expense—both monetary and in staff training—can be devastating to small physician offices, the witnesses told the panel members at a House Small Business Subcommittee on Regulation, Healthcare and Trade hearing.

Subcommittee chairman Charles Gonzalez (D-Tex.) agreed that the federal government should give physicians some kind of financial carrot to invest in health information technology.

"Right now there are inadequate incentives for health care providers to adopt many of these technologies," Rep. Gonzalez said.

"Without changes in the way we promote health IT, small physician practices will be left behind the technological curve, and as a result, patients will fail to benefit from the quality of care electronic health records provide," added Mr. Gonzalez, who recently reintroduced his National Health Information Incentive Act. The bill was aimed at assisting smaller practices but would also direct Medicare to make add-on payments for office visits facilitated by EMRs.

The American College of Physicians has called for just such a payment for several years, Dr. Lynne Kirk, ACP president, said at the hearing.

Mr. Gonzalez also noted that the full Small Business Committee recently passed the Small Business Lending Improvements Act of 2007 (H.R. 1332). That bill would let small practices borrow from the Small Business Administration to finance information systems.

Coming up with the capital for health IT is particularly tough for smaller physician groups, Dr. Kirk noted. One 2006 study showed that only 13%-16% of solo practitioners had adopted health IT, she said.

Small practices are the lifeblood of internal medicine, she said, adding that 20% of internists are in solo practices and 50% are in practices of five or fewer physicians.

Acquisition costs average $44,000 per physician and yearly upkeep amounts to about $8,500 per physician, according to a 2005 study published in Health Affairs, Dr. Kirk said. To help defray both the initial investment and ongoing maintenance costs, ACP advocates an add-on payment from Medicare scaled to the complexity of the technology. The initial capital costs could be offset by grants, loans, or tax credits from the federal government, Dr. Kirk said.

The lack of reimbursement for using health IT is a major obstacle to adoption, said Dr. Mark Leavitt, chairman of the Certification Commission for Healthcare Information Technology (CCHIT), a publicly funded agency that has been vetting hardware and software systems.

CCHIT has certified 57 office-based systems, he said. Some payers are now offering financial incentives to physicians who use these certified systems, Dr. Leavitt said. The Hawaii Medical Service Association (Blue Cross and Blue Shield of Hawaii) announced in November 2006 that it was setting aside $20 million to help individual physicians buy EMR systems, though it required those investments to be in CCHIT-certified systems. ■

Senate Panel Votes 5-Year Renewal of Best Pharmaceuticals for Children Act

BY ALICIA AULT
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The Senate Health, Education, Labor and Pensions Committee has voted to fund another 5 years of the Best Pharmaceuticals for Children Act.

Companies that conduct pediatric studies of their products are eligible for additional patent life under the law, which expires Oct. 1.

The new 5-year program will extend a drug's patent life by 3 months if sales of the product are more than $1 billion and by 6 months if sales are less than $1 billion.

An amendment to strip the patent-life-extensions was defeated.

Under the Best Pharmaceuticals for Children Act, the Government Accountability Office found that drug sponsors have initiated pediatric drug studies for most of the on-patent drugs for which the Food and Drug Administration has requested studies.

About 87% of drugs studied had labeling changes, often because the pediatric drug studies found that children might have been exposed to ineffective drugs or dosing, overdosing, or previously unknown side effects.

The federal government can order manufacturers to conduct pediatric studies, but that almost never happens because the bureaucratic hurdles for making such a request are so high, according to the Health, Education, Labor and Pensions (HELP) committee, so an amendment was added to streamline the process.

In other drug matters, the HELP panel completed its version of the 5-year reauthorization of the Prescription Drug User Fee and Modernization Act, but generally without any restrictions on drug advertising or a requirement that most drugs have a risk management program—proposals that had been championed by Committee Chairman Edward Kennedy (D-Mass.) and his colleague Sen. Michael Enzi (R-Wyo.).

The two senators had been hoping to attach their proposals for improved drug safety to the Prescription Drug User Fee and Modernization Act (PDUFA) reauthorization, but most of their suggestions were defeated or watered down in committee.

The centerpiece of their bill was the risk evaluation and mitigation strategy (REMS) plan, which would have been required for all new chemical entities and biologics.

Instead the HELP committee voted to give Food and Drug Administration authority to determine when a new drug should have a REMS. The panel also voted to require FDA to set up a public-private partnership for routine surveillance of postmarketing drug safety.

The bill "establishes a new way to oversee drug safety that is flexible enough to be tailored to each new drug, yet strong enough to allow decisive action when problems are discovered," Sen. Kennedy said in a statement.

According to a statement by Sen. Enzi, the bill gives the FDA explicit new authority in the postmarketing area—which critics say the agency does not now have.

"Right now, the FDA has its hands tied behind its back when it tries to manage the risks of drugs already on the market.

"This bill will clarify and strengthen the FDA's authority and give it new tools to take measured and appropriate steps to protect the health and safety of Americans, when the agency's postmarket surveillance signals potential dangers from a drug or therapy," he said. "Pulling a drug from the market and denying patients who need it should not be the only tool available to the FDA."

As passed by the Senate panel, PDUFA would allow the FDA to collect $393 million in drug user fees in 2008, including a $30 million increase for postapproval drug safety programs.

The bill would also require drugmakers to publish a registry of all late-phase II, phase III, and phase IV trials, and to make all trial results available in a public database.

The PDUFA legislation still has far to go before it becomes law. The Senate package will now go to the floor for a vote, and the House is still in the early phases of work, with the Energy and Commerce Health Subcommittee continuing to hold hearings. ■

Moving Teens With Spina Bifida to Adult Health Care

DENVER — Lessons learned by clinicians at a multidisciplinary program regarding the transition of pediatric patients with spina bifida to an adult medical home can help others meeting the same challenges, according to a presentation at a meeting on pediatric neurologic surgery.

"As patients with spina bifida reach adulthood, there is an ongoing challenge," Dr. Hector E. James said. "Most of us know the difficulty of finding an adult medical home for patients we've seen for years in a multidisciplinary setting. There is a lack of knowledge amongst adult heath care providers as to the needs of the young adult with spina bifida."

Some answers may come from the Jacksonville Health and Adult Transitional Services (JaxHATS) program. Dr. James reported that JaxHATS has successfully transitioned patients from the spinal defects clinic at Wolfson Children's Hospital in Jacksonville, Fla., to an adult medical home. The program, launched in 2005, includes a pediatrician, internist, nurse-coordinator, unit manager, and medical social worker.

It can be a challenge to find neurosurgeons who are willing to become primary care providers for young adults with spina bifida. "I am obviously generalizing, but it's not an uncommon problem," he added at the meeting, which was jointly sponsored by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

A meeting attendee asked how the JaxHATS clinicians get "buy-in" from adult providers. "We were fortunate in finding a pediatrician and internist who were willing to do this," Dr. James replied.

These doctors assess the teenager and then educate the adult subspecialist about their special needs.

Also, "incorporating an educational component for residents at our academic institution helped gain acceptance from administrators," said Dr. James, a pediatric neurosurgeon at the Lucy Gooding Pediatric Neurosurgery Center at Wolfson Children's Hospital.

The adolescent and family are prepared for the transition process into adulthood during visits to the spinal defects clinic. Then intake information is taken by the JaxHATS staff. The clinic coordinator and nurse-coordinator prepare a "transition medical summary" for the pediatrician and internist. Insurance reimbursement must be established in advance, Dr. James said. "It is extremely important to have insurance paperwork done correctly for the first appointment. The social worker and manager assist families with this and follow-up appointments."

An initial 16 patients have successfully completed the transition. Although the JaxHATS program "is still a work in progress," Dr. James said, "it is a very rewarding experience. It may not be a model for everyone, but it worked for us."

—Damian McNamara