

Feds Seek Physicians to Test Electronic Records

BY MARY ELLEN SCHNEIDER
Senior Writer

Officials at the Centers for Medicare and Medicaid Services are seeking physicians to test electronic health record software originally developed by the Department of Veterans Affairs and adapted for use in physicians' offices.

CMS is releasing a test version of the software—called VistA-Office—in an effort to assess its effectiveness, usability, and

potential for interoperability in small physician practices, the agency announced late last month.

"The release of an evaluation version of VistA-Office will provide a testing laboratory for interoperability and will supplement efforts by the American Health Information Community to establish a certification criteria and process," CMS Administrator Mark B. McClellan, M.D., Ph.D., said in a statement.

The goal is to refine the software based

on the results of the test period and develop a version of the VistA-Office electronic health record (EHR) that could be certified under a process recognized by the Department of Health and Human Services.

The VistA-Office EHR was adapted from the hospital information system of the Department of Veterans Affairs (VA). The VA system is used in 1,300 sites and has been in use for more than 20 years.

The test version of the software in-

cludes core functions such as clinical order entry, standard progress note templates, and results reporting. It also includes features designed specifically for physician offices including interfaces to existing practice management and billing systems, quality measure reporting capabilities, clinical reminders for disease management, and templates for ob.gyn. and pediatric care.

The VistA-Office test software will not be free. The first-year costs (cost of software, licensing fees, and support) are estimated to be about \$2,740 for a group of one to seven users, according to a CMS spokesman, who added that practices are likely to incur added office staff costs associated with implementing the EHR.

Health information technology experts welcomed the testing of a new office-based EHR product, but cautioned that not all physician practices are suited to becoming a beta-test site.

"It's good for physicians to have more choices," said Mark Leavitt, M.D., Ph.D., chair of the Certification Commission for Healthcare Information Technology, a voluntary, private-sector initiative to certify health information technology products.

But Dr. Leavitt says that participating in a beta test isn't for everyone. Generally in such a test, practices are not supposed to rely on the new software, so physicians would have to run the test software parallel with their paper systems. That extra step can make the practice in terms of time and money, he said.

"A beta test definitely stresses the office," he said.

The best candidates for a beta test are physicians who are technically savvy and who have the extra time and interest to devote to the project, Dr. Leavitt said.

Physicians should carefully review the VistA-Office product before volunteering to test it and not just choose it because it is less expensive than some other options on the market, said Joe Heyman, M.D., secretary of the board of trustees of the American Medical Association and a gynecologist in solo practice in Amesbury, Mass.

As with any other EHR, it's important for physicians to survey their own office and work flow, he said.

Continued on following page

References: 1. Faraone SV, Biederman J. A controlled study of functional impairments in 500 ADHD adults. Presented at: 157th Annual Meeting of the American Psychiatric Association; May 5, 2004; New York, NY. 2. Data on file, Shire US Inc., 2005. 3. ADDERALL XR[®] [package insert]. Shire US Inc., 2005. 4. Claxton AJ, Cramer J, Pierce C. A systematic review of the association between dose regimens and medication compliance. *Clin Ther.* 2001;23:1296-1310.

BRIEF SUMMARY: Consult the full prescribing information for complete product information.

ADDERALL XR[®] CAPSULES

CII Rx Only

AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY. MISUSE OF AMPHETAMINE MAY CAUSE SUDDEN DEATH AND SERIOUS CARDIOVASCULAR ADVERSE EVENTS.

INDICATIONS

ADDERALL XR[®] is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). The efficacy of ADDERALL XR[®] in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12, one controlled trial in adolescents aged 13 to 17, and one controlled trial in adults who met DSM-IV[®] criteria for ADHD, along with extrapolation from the known efficacy of ADDERALL[®], the immediate-release formulation of this substance.

CONTRAINDICATIONS

Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS

Psychosis: Clinical experience suggests that, in psychotic patients, administration of amphetamine may exacerbate symptoms of behavior disturbance and thought disorder.

Long-Term Suppression of Growth: Data are inadequate to determine whether chronic use of stimulants in children, including amphetamine, may be causally associated with suppression of growth. Therefore, growth should be monitored during treatment, and patients who are not growing or gaining weight as expected should have their treatment interrupted.

Sudden Death and Pre-existing Structural Cardiac Abnormalities: Sudden death has been reported in association with amphetamine treatment at usual doses in children with structural cardiac abnormalities. ADDERALL XR[®] generally should not be used in children, adolescents, or adults with structural cardiac abnormalities.

PRECAUTIONS

General: The least amount of amphetamine feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose.

Hypertension: Caution is to be exercised in prescribing amphetamines for patients with even mild hypertension (see CONTRAINDICATIONS). Blood pressure should be monitored at appropriate intervals in patients taking ADDERALL XR[®], especially patients with hypertension.

Sustained increases in blood pressure should be treated with dose reduction and/or appropriate medication. In a controlled 4-week outpatient clinical study of adolescents with ADHD, isolated systolic blood pressure elevations ≥ 15 mmHg were observed in 17/64 (26%) patients receiving ADDERALL XR[®] 10 mg and 20 mg.

In a single-dose pharmacokinetic study in 23 adolescents, isolated increases in systolic blood pressure (above the upper 95% CI for age, gender and stature) were observed in 2/17 (12%) and 8/23 (35%), subjects administered 10 mg and 20 mg ADDERALL XR[®], respectively. Higher single doses were associated with a greater increase in systolic blood pressure.

All increases were transient, appeared maximal at 2 to 4 hours post dose and not associated with symptoms.

Tics: Amphetamines have been reported to exacerbate motor and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's syndrome in children and their families should precede use of stimulant medications.

Effects on Weight: Amphetamines have been associated with decreased appetite. Absolute weight increases in treated children over time, but the increases are smaller than expected based on CDC normative values. These reductions in expected weight attenuate over time and are greatest in the heaviest children. In the controlled trial in adolescents, mean weight change from baseline within the initial 4 weeks of therapy was -1.1 lbs. and -2.8 lbs., respectively, for patients receiving 10 mg and 20 mg ADDERALL XR[®]. Higher doses were associated with greater weight loss within the initial 4 weeks of treatment.

Information for Patients: Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or vehicles; the patient should therefore be cautioned accordingly.

Drug Interactions: *Acidifying agents*—Gastrointestinal acidifying agents (guanethidine, reserpine, glutamic acid HCl, ascorbic acid, etc.) lower absorption of amphetamines. *Urinary acidifying agents*—These agents (ammonium chloride, sodium acid phosphate, etc.) increase the concentration of the ionized species of the amphetamine molecule, thereby increasing urinary excretion. Both groups of agents lower blood levels and efficacy of amphetamines.

Adrenergic blockers—Amphetamines may produce a synergistic anticonvulsant action. *Phenytoin*—Amphetamines may delay intestinal absorption of phenytoin; co-administration of phenytoin may produce a synergistic anticonvulsant action. *Propoxyphene*—In cases of propoxyphene overdose, amphetamine CNS stimulation is potentiated and fatal convulsions can occur.

Veratrum alkaloids—Amphetamines inhibit the hypotensive effect of veratrum alkaloids.

Lithium carbonate—The anorectic and stimulatory effects of amphetamines may be inhibited by lithium carbonate. *Meprobamate*—Amphetamines potentiate the anesthetic effect of meprobamate. *Methamphetamine*—Urinary excretion of amphetamines is increased, and efficacy is reduced, by acidifying agents used in methamphetamine therapy.

Norepinephrine—Amphetamines enhance the adrenergic effect of norepinephrine. *Phenobarbital*—Amphetamines may delay intestinal absorption of phenobarbital; co-administration of phenobarbital may produce a synergistic anticonvulsant action. *Phenytoin*—Amphetamines may delay intestinal absorption of phenytoin; co-administration of phenytoin may produce a synergistic anticonvulsant action.

Propoxyphene—In cases of propoxyphene overdose, amphetamine CNS stimulation is potentiated and fatal convulsions can occur.

Veratrum alkaloids—Amphetamines inhibit the hypotensive effect of veratrum alkaloids.

Drug/Laboratory Test Interactions: Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amphetamines may interfere with urinary steroid determinations.

Carcinogenesis/Mutagenesis and Impairment of Fertility: No evidence of carcinogenicity was found in studies in which d,l-amphetamine (enantiomer ratio of 1:1) was administered to mice and rats in the diet for 2 years at doses of up to 30 mg/kg/day in male mice, 19 mg/kg/day in female mice, and 5 mg/kg/day in male and female rats. These doses are approximately 2.4, 1.5, and 0.8 times, respectively, the maximum recommended human dose of 30 mg/day (child) on a mg/m² body surface area basis.

Amphetamine, in the enantiomer ratio present in ADDERALL[®] (immediate-release) (d- to l- ratio of 3:1), was not clastogenic in the mouse bone marrow micronucleus test *in vivo* and was negative when tested in the *E. coli* component of the Ames test *in vitro*. d,l-Amphetamine (1:1 enantiomer ratio) has been reported to produce a positive response in the mouse bone marrow micronucleus test, an equivocal response in the Ames test, and negative responses in the *in vitro* sister chromatid exchange and chromosomal aberration assays.

Amphetamine, in the enantiomer ratio present in ADDERALL[®] (immediate-release) (d- to l- ratio of 3:1), did not adversely affect fertility or early embryonic development in the rat at doses of up to 20 mg/kg/day (approximately 5 times the maximum recommended human dose of 30 mg/day on a mg/m² body surface area basis).

Pregnancy: Pregnancy Category C. Amphetamine, in the enantiomer ratio present in ADDERALL[®] (d- to l- ratio of 3:1), had no apparent effects on embryofetal morphological development or survival when orally administered to pregnant rats and rabbits throughout the period of organogenesis at doses of up to 6 and 16 mg/kg/day, respectively. These doses are approximately 1.5 and 8 times, respectively, the maximum recommended human dose of 30 mg/day (child) on a mg/m² body surface area basis. Fetal malformations and death have been reported in mice following paroral administration of d-amphetamine doses of 50 mg/kg/day (approximately 6 times that of a human dose of 30 mg/day (child)) on a mg/m² body surface area basis or greater to pregnant animals. Administration of these doses was also associated with severe maternal toxicity.

A number of studies in rodents indicate that prenatal or early postnatal exposure to amphetamine (d- or d,l-), at doses similar to those used clinically, can result in long-term neurochemical and behavioral alterations. Reported behavioral effects include learning and memory deficits, altered locomotor activity, and changes in sexual function.

There are no adequate and well-controlled studies in pregnant women. There has been one report of severe congenital bone deformity, tracheo-oesophageal fistula, and anal atresia (vater association) in a baby born to a woman who took dextroamphetamine sulfate with lovastatin during the first trimester of pregnancy. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight. Also, these infants may experience symptoms of withdrawal as demonstrated by dysphoria, including agitation, and significant lassitude.

Usage in Nursing Mothers: Amphetamines are excreted in human milk. Mothers taking amphetamines should be advised to refrain from nursing.

Pediatric Use: ADDERALL XR[®] is indicated for use in children 6 years of age and older.

Use in Children Under Six Years of Age: Effects of ADDERALL XR[®] in 3-5 year olds have not been studied. Long-term effects of amphetamines in children have not been well established. Amphetamines are not recommended for use in children under 3 years of age.

Geriatric Use: ADDERALL XR[®] has not been studied in the geriatric population.

ADVERSE EVENTS
The premarketing development program for ADDERALL XR[®] included exposures in a total of 1315 participants in clinical trials (635 pediatric patients, 350 adolescent patients, 248 adult patients, 82 healthy adult subjects). Of these, 635 patients (ages 6 to 12) were evaluated in 142 controlled clinical studies, one open-label clinical study, and 19 single-dose clinical pharmacology studies (N=40). Safety data on all patients are included in the discussion that follows. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and listings that follow, COSTART terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed.

Adverse events associated with discontinuation of treatment: In two placebo-controlled studies of up to 5 weeks duration among children with ADHD, 2.4% (10/425) of ADDERALL XR[®] treated patients discontinued due to adverse events (including 3 patients with loss of appetite, one of whom also reported insomnia) compared to 2.7% (7/259) receiving placebo. The most frequent adverse events associated with discontinuation of ADDERALL XR[®] in controlled and uncontrolled, multiple-dose clinical trials of pediatric patients (N=595) are presented below. Over half of these patients were exposed to ADDERALL XR[®] for 12 months or more.

Table 1: Adverse events associated with discontinuation of treatment. % of pediatric patients discontinuing (n=595)

Adverse event: Anorexia (loss of appetite), Insomnia, Weight loss, Emotional lability, Depression.

In a separate placebo-controlled 4-week study in adolescents with ADHD, eight patients (3.4%) discontinued treatment due to adverse events (including 2 patients receiving ADDERALL XR[®] treated patients (N=233). These patients discontinued due to insomnia and one patient each for depression, motor tics, headaches, light-headedness, and anxiety.

In one placebo-controlled 4-week study among adults with ADHD, patients who discontinued treatment due to adverse events among ADDERALL XR[®] treated patients (N=191) were 3.1% (n=6) for nervousness including anxiety and irritability, 2.6% (n=5) for insomnia, 1% (n=2) each for headache, palpitation, and somnolence, and, 0.5% (n=1) each for ALT increase, agitation, chest pain, cocaine craving, elevated blood pressure, and weight loss.

Adverse events occurring in a controlled trial: Adverse events reported in a 3-week clinical trial of pediatric patients and a 4-week clinical trial in adolescents and adults, respectively, treated with ADDERALL XR[®] or placebo are presented in the tables below. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied.

Table 1 Adverse Events Reported by More Than 1% of Pediatric Patients Receiving ADDERALL XR[®] with Higher Incidence Than on Placebo in a 584 Patient Clinical Study

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Table 2 Adverse Events Reported by 5% or more of Adolescents Weighing \leq 75 kg/165 lbs Receiving ADDERALL XR[®] with Higher Incidence Than Placebo in a 287 Patient Clinical Forced Weekly-Dose Titration Study^a

Table 2: Adverse Events Reported by 5% or more of Adolescents Weighing \leq 75 kg/165 lbs Receiving ADDERALL XR with Higher Incidence Than Placebo in a 287 Patient Clinical Forced Weekly-Dose Titration Study

Table 3 Adverse Events Reported by 5% or more of Adults Receiving ADDERALL XR[®] with Higher Incidence Than on Placebo in a 255 Patient Clinical Forced Weekly-Dose Titration Study^a

Table 3: Adverse Events Reported by 5% or more of Adults Receiving ADDERALL XR with Higher Incidence Than on Placebo in a 255 Patient Clinical Forced Weekly-Dose Titration Study

Note: The following events did not meet the criterion for inclusion in Table 3 but were reported by 2% to 4% of adult patients receiving ADDERALL XR[®] with a higher incidence than patients receiving placebo in this study: infection, photosensitivity reaction, constipation, tooth disorder, emotional lability, libido decreased, somnolence, speech disorder, palpitation, twitching, dyspnea, sweating, dysmenorrhea, and impotence.

^aIncluded doses up to 40 mg.

The following adverse reactions have been associated with amphetamine use: Cardiovascular: Palpitations, tachycardia, elevation of blood pressure, sudden death, myocardial infarction. There have been isolated reports of cardiomyopathy associated with chronic amphetamine use. Central Nervous System: Psychotic episodes at recommended doses, overstimulation, restlessness, dizziness, insomnia, euphoria, dyskinesia, dysphoria, depression, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome, seizures, stroke. Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. Anorexia and weight loss may occur as undesirable effects. Allergic: Urticaria. Endocrine: Impotence, changes in libido.

ADDERALL XR[®] is a Schedule II controlled substance. Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. There are reports of patients who have received the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Acidification of the urine increases amphetamine excretion, but is believed to increase risk of acute renal failure if myoglobinuria is present. If acute severe hypertension complicates amphetamine overdose, administration of intravenous phenolamine has been suggested. However, a gradual drop in blood pressure will usually result when sufficient sedation has been achieved. Chlorpromazine antagonizes the central stimulant effects of amphetamines and can be used to treat amphetamine intoxication.

The prolonged release of mixed amphetamine salts from ADDERALL XR[®] should be considered when treating patients with overdose. Dispense in a tight, light-resistant container as defined in the USP. Store at 25° C (77° F). Excursions permitted to 15-30° C (59-86° F) [see USP Controlled Room Temperature].

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New Orleans Neurologists Are Hit but Not Down

BY JENNIFER LUBELL
Associate Editor, Practice Trends

In the wake of the severe hurricane season on the Gulf Coast, thousands of displaced physicians are looking for ways to keep practicing medicine.

For some, this means relocating to another part of the country or holding down a temporary job in the hopes they'll someday reclaim their practice from flood-ravaged areas and regroup with their patients.

Pediatric neurologist Carmela Tardo, M.D., director of the epilepsy center at New Orleans' Children's Hospital, didn't return to the city for nearly 6 weeks after Hurricane Katrina made landfall in late August.

"[In early October] we were given the go-ahead to return to Children's Hospital ... which fortunately was located in an area uptown and did not flood," Dr. Tardo, a clinical professor of neurology at Louisiana State University, said in an interview.

During those weeks in limbo, Children's Hospital stayed busy, opening up a temporary corporate office and an outpatient clinic in Baton Rouge 2 weeks after the hurricane. Another clinic was established in Lafayette. "We've had to adapt by becoming more mobile," said Dr. Tardo.

Both of these facilities will remain in operation.

For now, the hospital in New Orleans is nowhere near full capacity, she said. "We had maybe 35 patients yesterday, where we normally would have 150. We're very pleased we're getting things [back to normal]. But many of our patients may not be here anymore."

Faculty at LSU had dispersed "everywhere" after Hurricane Ka-

trina—to Alabama, California, Georgia, or South Carolina—said Dr. Tardo. Evacuating the city before the hurricane hit, Dr. Tardo had stayed in Houston before temporarily relocating to Baton Rouge for a few weeks, then finally moving back home. "Dur-

up those 10 floors to carry down sometimes as much as 100 pounds of documents at a time. "I've been relocating records for patients, who are asking them to be forwarded to another doctor."

Dr. Happel's private practice is part of a group of eight neuro-

logists that share overhead and jointly negotiate managed care contracts. At press time, Dr. Happel is living in his home and commuting to one of the group's offices in Covington, La., on the north shore of Lake Pontchartrain. "My average monthly [patient] volume is 5%-10% of what it once was," he said, referring to his current patient base. For now, he sees about 3-5 patients a day. "I'm pretty much living day to day," said Dr. Happel, who's look-

ing to open a new practice in Metairie, to replace the one in Chalmette, and has applied for hospital privileges in that area. "I'm committed to trying to stay [in Louisiana] and make it work, but it's difficult," he said. Nancy Michaelis, M.D., an internist from Chalmette, La., obtained a temporary license to practice in Virginia. Overall, she's had three job offers, but in an interview said she's "desperately trying to get back to New Orleans." For now, it looks like she'll be practicing in Virginia for quite some time.

"My house survived quite well ... [but] St. Bernard Parish was completely destroyed. The two hospitals that I went to—Chalmette Medical Center in St. Bernard and Pendleton Memorial Methodist Hospital in New Orleans East—are not operational anymore. Furthermore, the population I used to see is not there anymore."

If group practices felt the impact of the hurricanes, "the worst toll has been with physicians in individual practices, who have lost their house and practice," Dr. Tardo commented.

Some physicians are considering a more permanent relocation. Otolaryngologist Michael Ellis, M.D., whose practice in Chalmette was flooded during Hurricane Katrina, is considering a move to North Carolina. Through

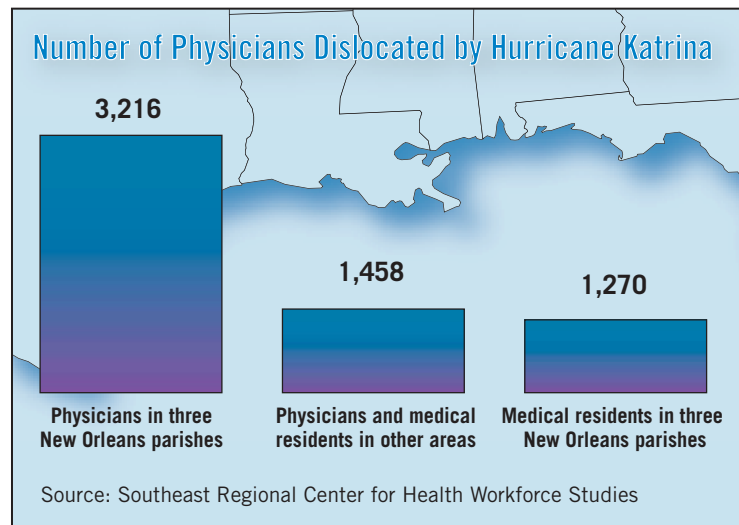
his contacts in organized medicine, Dr. Ellis said he's been offered positions, both in private practice and in academic medicine, throughout the country.

"I've gotten job offers from North Carolina, Virginia, Tennessee, Chicago," he said in an interview.

Many physicians like Dr. Michaelis thought they'd practice at a temporary location then come back to New Orleans, "but that's less likely to happen as time goes on," said internist and infectious disease specialist Michael Hill, M.D.

Telephone service has been spotty in some areas, and it's been difficult for patients to navigate around the New Orleans area and get care, Dr. Hill said. His practice is trying to communicate with patients through newspaper ads and its Internet site, "which has updated where we are." At press time he was working at his group practice's offices in Covington, located north of Lake Pontchartrain, and in Slidell, La. Two other physicians in the practice are working in the North Shore.

He and Dr. Ellis have been trying to organize a summit with members of Congress to establish a medical health care system within New Orleans. "We want to make sure that organized medicine has a voice" in this effort, he said. ■



ing this period, the seven pediatric neurologists, all LSU faculty, were in touch with each other through e-mail and phone calls," she said. All have since returned to Louisiana to practice medicine.

Michael Happel, M.D., a neurologist who lost his practice in New Orleans, is trying to reestablish his practice and build up his referral base in a new area.

His home in Metairie, La., survived, but the private practice in Chalmette, in Orleans Parish, flooded, he said in an interview. The rented office "looks like the inside of a toilet bowl," he said. Fortunately, his paper records escaped the flooding—they were being stored at a nearby office on the 10th floor. "I know some physicians who lost 20 years of records," said Dr. Happel.

Whenever he needs his records, however, he has to hike

able to the mainstream, he said. The Certification Commission can help spur incentives, he said, because then government payers and health plans will know that they are paying for something robust.

"All the signs are pointing the right way," Dr. Leavitt said. ■

Physicians who are interested in being part of a beta test should contact an approved vendor who will actually run the test of the software. Vendors will select a small number of physician practices to participate. A list of approved vendors is available online at www.vista-office.org. A video demonstration of the Vista-Office software is available online at www.vista-office.org/software/demo.

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The test software provides a reasonable cost option for physicians, said Arthur McDowell III, M.D., a cardiologist in Middletown, Conn., who has already implemented an EHR in his practice.

Government-sponsored pay-for-performance programs will spur adoption of EHRs, Dr. McDowell said.

The current discussion about incentives from the federal government is very promising, said Dr. Leavitt. Physicians want to see incentives that offer extra payment or lower the cost or administrative hassle, he said. While there are some pilot projects that offer incentives, the challenge is to make them avail-

6,000 Physicians Displaced in Gulf Coast Region

A recent study from the University of North Carolina at Chapel Hill estimates that Hurricane Katrina and flooding in New Orleans may have dislocated up to 5,944 active, patient-care physicians, the largest single displacement of doctors in U.S. history.

It's expected that Hurricane Rita may boost the total to an unknown degree, according to the as-yet-unpublished study.

Approximately 6,000 "physicians doing primarily patient care in the 10 counties and parishes in Louisiana and Mississippi have been directly affected by Katrina flooding," said the study's author Thomas C. Ricketts III, M.D., deputy director for policy analysis at the university's Cecil G. Sheps Center for Health Services Research.

Data for the analysis were drawn from the American Medical Association's master file of physicians for the month of March and FEMA-posted information, as well as data from the American Association of Medical Colleges, Tulane University and Louisiana State University medical schools, the Texas Board of Medicine, and the state of Louisiana.

In an interview, Dr. Ricketts said most of the calls he's gotten to date have either been from physician recruiters or from practices in various parts of the country, asking for names of physicians who need a job.

Locum tenens or temporary positions have

been an option for many of these physicians, according to Phil Miller, a spokesman for Merritt, Hawkins & Associates, a physician search firm based in Irving, Tex.

Staff Care Inc., the locum tenens agency of the Merritt, Hawkins group, has been placing physicians all over the country—in Texas, Oklahoma, the Carolinas, and Florida—Trey Davis, executive vice president for the agency, said in an interview. Hospitals and state licensing boards have facilitated this effort by making some exceptions to normal guidelines to process state licensing and hospital privileges, he said.

"We had a physician who contacted us a couple of days after Katrina hit. He flew his small, private plane to a location in Oklahoma and did a face-to-face interview with a government facility. Within 4 days, we pushed his privileges through, and he was seeing patients in less than a week."

Not every physician is looking to reestablish a practice or begin a new one, Dr. Ricketts pointed out. Some will decide to retire instead. "We don't know what this is going to mean to health care. We've never had to deal with something like this before."

Mr. Davis said his agency has been receiving a large number of calls for physicians to extend their contracts in their locum tenens jobs for as long as 6 months.