EHR Funding May Be a Problem for Pediatricians

WASHINGTON — The attention and funding given to electronic health records under the Recovery Act means that “it’s time for pediatricians to get involved,” said Janet Marchibroda, former chief executive officer of the Academy of Pediatrics.

Wider adoption of health IT “is definitely going to happen now—we’re there,” Ms. Marchibroda told attendees at the annual meeting of the American Academy of Pediatrics.

Outside of the meeting halls, however, there was skepticism that enough pediatricians would be candidates for the financial incentives provided through the Recovery Act to make a significant difference.

In an interview, Dr. Joseph H. Schneider, chairperson of the AAP’s Council on Clinical Information Technology (COCIT), said that requirements that practices demonstrate specific case mix thresholds in order to qualify for Medicaid EHR incentives mean that “for many pediatricians, this offer of money is really a hollow promise.”

The Recovery Act—formally known as the American Recovery and Reinvestment Act of 2009—set aside almost $45 billion of stimulus money to encourage the adoption of electronic health records through Medicare and Medicaid incentives that will be offered to providers who purchase a certified EHR system and make “meaningful use” of the technology, Ms. Marchibroda explained after the meeting.

Another $564 million will support statewide Health Information Exchange (HIE) Cooperative Agreements that will “help build HIE capacity,” she said, and $643 million will support approximately 70 health IT “regional extension centers” that will help health care providers select and implement E technology.

States and nonprofit organizations applied for grants for these programs this fall; both efforts should be underway by the end of the year, she said.

“A lot will be happening in your communities,” said Ms. Marchibroda, now chief health care officer at IBM. “It’s time to start a conversation with all the organizations with which you interact (from hospital systems to health plans and labs).”

Opportunities to purchase EHRs with Medicaid incentive money will come later, however—and only for those non-hospital-based pediatricians who have at least a 30% Medicaid patient volume or those who practice predominately in federally qualified health centers or rural health clinics and have at least 30% of the patient volume attributable to “needy” patients.

Pediatricians with a 20% Medicaid volume will be eligible to receive two-thirds of the incentives, but even this lower threshold will exclude many pediatricians.

Pediatricians with a 20% Medicaid volume will be eligible to receive two-thirds of the incentives, but even this lower threshold will exclude many pediatricians.

Another problem for pediatricians, Dr. Schneider said, lies with the “meaningful use” requirements. Such requirements will be defined nationally for incentives provided through the Medicare program, but for Medicaid-provided incentives, states have the ability under the Recovery Act to define their own meaningful use standards.

At least some states have been discussing the possibility of developing common definitions, and some have been waiting to see the draft Medicare regulations defining meaningful use that were expected from the Centers for Medicare and Medicaid Services last month. (A final
In clinical trials for bacterial conjunctivitis that included children as young as 12 months...

**BESIVANCE™** was proven effective against a broad spectrum of ocular pathogens

- 91.4% rate of microbial eradication† with BESIVANCE™ (n = 198) vs 59.7% with vehicle (n = 191) at Visit 2, Day 5 (P < 0.0001)‡1,2

† Microbiologic eradication does not always correlate with clinical outcome in anti-infective trials.

- 45.5% clinical resolution with BESIVANCE™ vs 33.0% with vehicle at Visit 2, Day 5 (P = 0.0084)‡1,2

‡ In the modified intent-to-treat population.

**Study design:** 957 subjects were randomized (389 subjects with culture-confirmed bacterial conjunctivitis) in this double-masked, parallel-group, vehicle-controlled clinical trial conducted at 58 sites in the United States. Primary efficacy endpoints: clinical resolution and microbial eradication of baseline bacterial infection at Visit 2 (Day 5 ± 1).2

Vehicle = 0.01% benzalkonium chloride (BAK) and inactive ingredients such as DuraSite®; microbial eradication = the absence of all ocular bacterial species that were present at or above threshold at baseline; clinical resolution = the absence of both ocular discharge and bulbar conjunctival injection.

- Formulated with mucoadhesive technology§1
- Developed exclusively for the eye
- DuraSite®.

**Important risk information about BESIVANCE™**

- **BESIVANCE™** is for topical ophthalmic use only, and should not be injected subconjunctivally or directly into the anterior chamber of the eye. As with other anti-infectives, prolonged use of BESIVANCE™ may result in overgrowth of non-susceptible organisms, including fungi. If super-infection occurs, discontinue use and institute alternative therapy

- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis or during the course of therapy with BESIVANCE™

- Although BESIVANCE™ is not intended to be administered systemically, quinolones administered systemically have been associated with hypersensitivity reactions, even following a single dose. Patients should be advised to discontinue use immediately and contact their physician at the first sign of a rash or allergic reaction

- The most frequently reported adverse event in clinical trials was conjunctival redness, reported in approximately 2% of patients. Other adverse events reported in approximately 1-2% of patients included: blurred vision, eye pain, eye irritation, eye pruritus and headache

- The safety and effectiveness of BESIVANCE™ in infants below one year of age have not been established

Now, Dr. Schneider said, the goals of the AAP’s COCIT and its new Child Health Informatics Center include working with the states to minimize variation in definitions of meaningful use, and working with the new regional extension centers to “provide a common approach to helping pediatricians” select and implement EHRs that are friendly to their patient populations and their workflow. Surveys done in 2006 showed that one-third of office-based pediatric practices had no plans to implement an EHR system; 70% of these were solo practitioners.

Will the Recovery Act’s incentives and technical assistance programs change their minds, or spur on those who are tetering? Ms. Marchibroda said she hopes so, though the goals, she admits, are high. “Congress’s intention in the Recovery Act is to grow the numbers to 90% adoption by physicians and 70% by hospitals,” she said. “So we have a long way to go.”

The organization that Ms. Marchibroda led until earlier this year—the eHealth Initiative—is a multidisciplinary nonprofit organization whose members include employers and purchasers, accrediting groups, physician groups, and patient and consumer groups.