



**April 2006**

*Mission: to transform the health care system through information and technology to improve patient safety and health care quality, lower costs, and coordinate care.*

**In This Issue:**

1. [National Coordinator for Health IT David Brailer Resigns](#)
2. [HHS Issues Contract for RHIO Best Practices](#)
3. [Hearing Examines Small Physician Groups' Adoption of EHRs](#)
4. [Legislative Wheels Beginning to Turn for Health IT in House?](#)
5. [House Members Weighing in For Health IT Investments](#)
6. [Odd Bedfellows Raise Privacy Concerns](#)
7. [Study Finds IT Improves Quality of Care at Large Hospitals](#)
8. [The National Quality Forum and National Committee for Quality Health Care Join Together](#)
9. [CMS to Launch Nursing Home Pay for Performance Project](#)
10. [AHRQ Launches Web-Based Tool for States of Measure and Compare Health Care Quality](#)
11. [Patient Safety Study Shows Increase in Hospital Incidents and Wide Gaps Among States and Hospitals](#)
12. [Studies: U.S. Health Care System Lags in Health Care Quality, Equity](#)
13. [Health Care Costs Taking Bigger Bite of Family Incomes](#)
14. [Residents of Massachusetts First in Nation Required to Carry Health Insurance](#)
15. [Caucus Hosts America's Top Hospitals](#)
16. [Congressman Murphy Releases "The State of the Union's Health Care"](#)
17. [FDA Bar Code Compliance Date Arrives](#)
18. [Aetna Says Laptop With Member Information Was Stolen](#)
19. [AHRQ to Examine Role of Simulation in Improving Care](#)
20. [IHI's Promising Practice of the Month: Medication Reconciliation](#)

**National Coordinator for Health IT David Brailer Resigns**

National Coordinator for Health IT Dr. David Brailer on Thursday, April 21, announced his resignation, citing family reasons and saying the program now is "mature and moving in the right direction." For the last two years, Brailer has commuted weekly to Washington, D.C., from his home in San Francisco.

"It is with regret that I have accepted Dr. Brailer's resignation as the National Coordinator for Health Information Technology," said Mike Leavitt, secretary of the US Department

of Health and Human Services. "Over the past two years, David has made significant progress in advancing the President's health IT agenda and laying the building blocks for future progress. While I will miss him here at HHS, I am pleased that David has agreed to serve as Vice-Chair of the American Health Information Community, which is charged with making recommendations to the Secretary of HHS to facilitate the development and adoption of standards-based health IT."

Until a replacement for David's position is announced, the work of the Office of the National Coordinator will continue under the leadership of the four permanent directors of the Office.

### **HHS Issues Contract for RHIO Best Practices**

The Office of the National Coordinator for Health Information Technology has issued a [contract to compile information about successful state-level models of regional health information organizations](#) (RHIOs). The contract, awarded to a foundation associated with the American Health Information Management Association (AHIMA), is intended to produce research about RHIOs' governance, structure, financing, and data exchange policies; a methodology for describing different approaches to those functions; and recommendations for how most effectively to disseminate information. The National Conference of State Legislatures is a partner in the contract and will help convene a conference on sharing best practices. The sole-source contract is worth \$500,000 and lasts for six months.

### **Hearing Examines Small Physician Groups' Adoption of EHRs**

On April 6, the [House Committee on Small Business](#) Subcommittee on Regulatory Reform and Oversight held a hearing entitled, "Can Small Healthcare Groups Feasibly Adopt Electronic Medical Records Technology?" The Subcommittee members' questions focused heavily on privacy and whether and how the Government should be creating standards. Congressman Phil Gingrey (R-GA) also testified regarding his bill, H.R. 4641 (ADOPT HIT Act), that would create tax breaks for health IT acquisitions by providers. Others providing testimony included Christopher Normile, MD, for the American Academy for Family Physicians, and Joan Magruder, vice president of development and planning, BJC Healthcare.

### **Legislative Wheels Beginning to Turn for Health IT in House?**

Perhaps in a sign that legislative action on health IT is forthcoming, the Health Subcommittees of both Energy and Commerce and Ways and Means recently held hearings within weeks of each other. While neither formally examined particular legislation, both sessions zeroed in on key policy issues that have been the subject of debate. The protection of consumers' privacy was a key subject of [the Energy and Commerce hearing](#). The [Ways and Means hearing](#) was specifically intended to address issues other than privacy, and featured lively discussion of the merits of open source software and the role of the VA's existing electronic health record system. During both

hearings, Members raised questions about standards to promote interoperability, whether and how to create safe harbors from anti-kickback and Stark laws, and how to spur adoption by providers. House leaders have indicated that they hope to bring health IT legislation to the Floor in June.

### **House Members Weighing in For Health IT Investments**

Although Congress did not fully fund the Administration request for health information technology spending in fiscal year 2006, increasing numbers of Representatives are going on the record to push for more such investments in the future. Writing to Budget Committee Chairman Jim Nussle (R-IA) and Ranking Member John Spratt (D-SC) on March 21, a bipartisan group of 15 members of [the 21<sup>st</sup> Century Health Care Caucus](#) [urged that the budget include a reserve fund](#) to ease the consideration of health IT legislation. "We must transform our 20<sup>th</sup> century paper file system to catch up with 21<sup>st</sup> century medical care," they wrote. A similar group of Caucus members wrote to Appropriators in support of the President's funding request of \$169 million. More recently, the New Democrat Coalition also [wrote to the House Budget Committee](#) and [Appropriations Committee](#) echoing those requests. The NDC letters were signed by 22 and 35 members, respectively. The budget resolution reported out of the House Budget Committee did not include a reserve fund, and it is uncertain whether the resolution will come to the floor for a vote. The Appropriations Committee has not yet scheduled consideration of its legislation to fund the Department of Health and Human Services.

### **Odd Bedfellows Raise Privacy Concerns**

It is probably not common that the Family Research Council and the National Center for Transgender Equality join forces, but they were among the [26 groups that signed a letter to Congress](#) urging strong privacy protections as a component of any health IT legislation. The letter urged that any bill include provisions like ensuring patient consent, allowing individuals to opt out of health information networks, and requiring notifications when security is breached. The coalition was organized by the Patient Privacy Rights Foundation and included the ACLU, the American Conservative Union, the Christian Coalition, Common Cause, and others.

### **Study Finds IT Improves Quality of Care at Large Hospitals**

*From National Journal's American Health Line (4/19/06):*

Health care information technology improves the quality of care provided at large hospitals, according to a report released last week by the [Agency for Healthcare Research and Quality](#), the [Orlando Sentinel](#) reports. The "Costs and Benefits of Health Information Technology" report, which examined studies conducted through 2003, finds that health care IT can improve the "efficiency, cost-effectiveness, quality and safety" of care, although such improvements "have occurred primarily within large health care systems that created their own health IT systems." Smaller hospitals and medical practices, where most care is provided in the U.S., will have to use commercially available health care IT systems, and more information about such systems is required, the report finds. Over the

next 18 months, researchers will complete studies on the use of commercially available health care IT systems by smaller hospitals and medical practices, and the results "will be shared broadly to help all health care providers more successfully adopt health IT," AHRQ Director Carolyn Clancy said. However, the [Patient Privacy Rights](#) coalition raised concerns that health care IT systems could threaten patient privacy. "Unless patients are assured of security, they will avoid treatment, lie about their symptoms and health issues, omit critical medical data and delay care, endangering their health and the health of others," according to the coalition (Wessel, *Orlando Sentinel*, 4/17).

### **The National Quality Forum and National Committee for Quality Health Care Join Together**

On April 1, 2006, two national healthcare quality organizations merged to focus on bridging and integrating diverse efforts across the country to enhance performance of the nation's healthcare system. Under the direction of CEO and President, Janet M. Corrigan, PhD., MBA, key programs of the National Quality Forum and the National Committee for Quality Health Care will be enhanced, and strategic alliances with other organizations will be pursued to bring more alignment and coordination to the quality movement. The merged entity will go under the name of the [National Quality Forum](#).

### **CMS to Launch Nursing Home Pay for Performance Project**

The [Centers for Medicare and Medicaid Services](#) hopes to launch a demonstration project later this year that would [pay nursing homes more if they provide better quality of care](#). The design of the demonstration is still undetermined, but it is expected that to obtain bonus payments, nursing homes will earn quality points assigned in four categories: (1) staffing-e.g., nurse-to-patient ratios and staff turnover; (2) prevention of hospitalizations; (3) minimum data set (MDS) measures-e.g., percentage of residents who have bed sores and percentage of residents tied to their beds to prevent wandering; and (4) performance on state inspections. Bonus payments will be made to the top 20 percent in terms of point scores, as well as to the 20 percent of facilities that show the largest improvement. There will be no payment deductions assessed to facilities with lower quality care. This 3-year demonstration is expected to operate in 4 to 5 states, with approximately 50 facilities participating per state, and is estimated to cost \$3 million. However, the bonus payments will not come out of those funds, and the size of the bonus payment pool has not yet been determined. Upon its initiation, this demonstration project will join a family of [CMS initiatives focused on differentially paying for performance](#) to promote quality improvement.

### **AHRQ Launches Web-Based Tool for States of Measure and Compare Health Care Quality**

The DHHS [Agency for Healthcare Research and Quality](#) (AHRQ) recently released a new interactive web-based tool, [State Snapshot](#), for states to use in measuring and comparing their healthcare quality. The *State Snapshot* tool is based on data from the

[2005 National Healthcare Quality Report](#) and the [2005 National Healthcare Disparities Report](#). It provides states with:

- Tables ranking the 50 states and the District of Columbia on 15 healthcare quality measures;
- Summary measures of the quality for types of care (prevention, acute, chronic) and settings of care (hospital, ambulatory, nursing home, and home health); and
- Comparisons of each state's summary measures to regional and national performance, both in detailed data tables and in at-a-glance formats.

In addition, the *State Snapshot* tool features a special focus on each state's performance in the treatment of diabetes. In 2006, AHRQ is planning to partner with four states to develop a complementary guide to the *State Snapshot* Web tool that will assist states in using the information for priority setting and quality improvement.

### **Patient Safety Study Shows Increase in Hospital Incidents and Wide Gaps Among States and Hospitals**

[HealthGrades, Inc.](#), a healthcare ratings organization, recently released a [study looking at patient safety in hospitals across the nation](#). The study found that approximately 1.24 million patient-safety incidents occurred among the nearly 40 million hospitalizations covered by the Medicare program over the 3-year period of 2002-2004—a significant increase over number of incidents seen during the previous 3-year period (1.18 million). In addition, according to the study, these patient-safety incidents were associated with \$9.3 billion in excess costs during the years 2002-2004. Significant variation in the number of incidents was also found among hospitals and from state to state. Medicare patients going to hospitals ranked among the top 15 percent in terms of patient-safety incidents were found to have a 43 percent lower incidence of patient-safety incidents than those going to bottom-ranked hospitals. And Medicare patients in the top ranked state had an almost 30 percent overall lower risk of developing one or more patient-safety incidents when compared with the worst state. The study was based on 13 patient-safety indicators developed by the Agency for Healthcare Research and Quality.

### **Studies: U.S. Health Care System Lags in Health Care Quality, Equity**

[The Commonwealth Fund](#) has recently released two reports based on surveys of adult patients in the United States and Australia, Canada, New Zealand, the United Kingdom, and Germany. The first of these reports, [Mirror, Mirror on the Wall: An Update on the Quality of American Health Care Through the Patient's Lens](#), found that, overall, the U.S. healthcare system often performs relatively poorly from the patient perspective. When compared with the five other nations, the U.S. system ranked first on effectiveness; however, it ranked last on nearly every other dimension of quality, including patient safety, patient-centeredness, efficiency, and equity—despite having the highest health expenditures per capita.

The second report, [\*The U.S. Health Care Divide: Disparities in Primary Care Experiences by Income\*](#), found that among the countries surveyed, the United States stands out for income-based disparities in patient experiences, with below average income U.S. adults reporting the worst experiences on most measures of primary care access, coordination, and physician-patient relationships. Uninsured adults in the U.S. are particularly at risk for experiencing access barriers, coordination gaps, and other primary care deficiencies. However, even when insured, below average income American adults were more likely to experience access problems and delays than insured, above average income adults.

### **Health Care Costs Taking Bigger Bite of Family Incomes**

A new report from the Commonwealth Fund, titled [\*Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets\*](#), finds that from 1996 to 2002, the average American family's out-of-pocket healthcare spending rose nearly twice as fast as its income. As a result, by 2002, nearly one-quarter of all families devoted 10 percent or more of their income to deductibles, coinsurance or copayments, payments for services not covered by insurance, and premiums. Families with members age 65 or older were much more likely to have high out-of-pocket medical care costs relative to income than other families; however, the prevalence of these high out-of-pocket costs is growing most rapidly among fully insured, nonelderly families. The report draws on data from the [\*Medical Expenditure Panel Survey\*](#)-a household survey conducted by the government.

### **Residents of Massachusetts First in Nation Required to Carry Health Insurance**

On Wednesday, April 12, Governor Mitt Romney signed [legislation](#) designed to guarantee health insurance coverage for all Massachusetts residents, including the state's estimated 550,000 uninsured, by July 2007. Free coverage will be provided to individuals at or below the federal poverty line, and the state will subsidize coverage for those up to three times the federal poverty level. Individuals who can afford to buy coverage, but still refuse, will face escalating tax penalties. However, Gov. Romney vetoed a portion of the legislation that would have assessed a \$295 annual fee per worker on businesses that do not provide their employees with coverage. Lawmakers in the Massachusetts House and Senate have said they will work to override this veto, along with seven other items in the law also vetoed by the governor. The cost of this package is estimated at \$316 million the first year, rising to more than \$1 billion in the third year, with all but \$125 million annually coming from federal reimbursements and existing state spending on healthcare. A summary of the legislation can be found at [www.mass.gov/legis/summary.pdf](http://www.mass.gov/legis/summary.pdf).

### **Caucus Hosts America's Top Hospitals**

At a briefing on April 26, 2006 hosted by the 21<sup>st</sup> Century Health Care Caucus, top executives from every hospital that has won the prestigious [\*Malcolm Baldrige National Quality Award\*](#) made the case for health care systems change. The hospital CEOs and vice-presidents talked of their institutions' commitment to transparency, data

measurement, and accountability. In a freewheeling discussion, they discussed the role of information technology and public disclosure of quality measures, and the perverse incentives that hinder efforts to improve quality. Speaking at the briefing, Caucus Co-Chair Patrick Kennedy (D-RI) called the Baldrige winners "models for what health care can be" and called for policymakers to learn from their example. The five hospitals represented were Saint Luke's Health System (Kansas City, MO), North Mississippi Health Services (Tupelo, MS), Robert Wood Johnson University Hospital Hamilton (Hamilton, NJ), Bronson Healthcare Group (Kalamazoo, MI), and SSM Health Care (St. Louis, MO). The briefing was organized by the American Society for Quality.

### **Congressman Murphy Releases "The State of the Union's Health Care"**

Caucus Co-Chair Tim Murphy (R-PA) released a report, [Critical Condition: The State of the Union's Health Care](#), detailing some of the greatest challenges facing the nation's health care system. The document focuses on ten major contributors to increasing costs, and ten recommendations for Congressional action.

"To deal with growing costs, policymakers have focused on dealing with 'who' pays for the care, but this approach does not deal with the root causes of cost increases," Murphy states. "Fixing the system is not about 'who' is paying, it is about 'what' we are paying for. A broken system is not fixed by shifting payment to families, employers or taxpayers. Affordability must begin with fundamental reforms to quality and accessibility." The ten areas of reform are: 1) improving primary prevention; 2) reducing health care infection rates; 3) expanding access to community health centers; 4) increasing transparency of information within the health care system; 5) improving the accuracy of and secure access to medical records; 6) utilizing care management of chronic diseases; 7) removing barriers to mental health care; 8) eliminating defensive medicine; 9) lowering the cost of prescription drugs and 10) reducing obesity. Specific recommendations to reduce errors and improve care are offered for each category.

### **FDA Bar Code Compliance Date Arrives**

*From iHealthBeat:*

April 26 was the date for pharmaceutical firms to comply with a Food and Drug Administration rule mandating bar codes on most human drug and biological product labels.

Published in February 2004, the rule called for inclusion of bar codes with the National Drug Code number on most prescription drugs and on certain over-the-counter drugs that are commonly used in hospitals.

The rule also required the use of machine-readable information on container labels of blood and blood components intended for transfusion. These labels contain FDA-approved machine-readable symbols identifying the collecting facility, the lot number relating to the donor, the product code, and the donor's blood group and type.

Existing drugs and blood products must comply now with the rule; new products must comply within 60 days of their approval date.

Following publication of the proposed rule, drug firms asked the FDA to exempt very small unit drug doses from the bar code mandate. The final rule included a limited general exemption provision that can be granted at the FDA's initiative or as a result of a formal request to exempt a product. Firms requesting an exemption would have to show why bar coding would not be technologically feasible, or would affect the drug's safety, effectiveness, purity or potency.

Surveys by the Health Information and Management Systems Society in Chicago show bar coding for medication management has become a major information technology priority for hospitals in recent years, says Debbie Murphy, a member of the HIMSS Auto ID Task Force. The group advocates adoption of RFID and bar code technology to improve automated identification of patients, medications, specimens and assets. Murphy also serves as global practice leader for life sciences at Zebra Technologies, a Vernon Hills, Ill.-based vendor of bar code and RFID technologies. The company has seen a "very strong" increase in the purchasing of bar code printing products by hospitals in the past two years, she notes.

### **Aetna Says Laptop With Member Information Was Stolen**

*From iHealthBeat:*

Aetna on Wednesday announced that a laptop computer with information for approximately 38,000 members was stolen, [Reuters](#) reports.

The laptop, which was stolen from an employee's locked car, contained names, addresses and Social Security numbers of the affected members. It did not, however, contain personal banking or health claim information, according to Aetna spokesperson Cynthia Michener.

The members are employees of two companies, but Aetna declined to name those companies. Michener said the two companies "wanted all of their employees to have received their notifications directly before releasing their name."

Aetna said it has no reason to believe the member information has been accessed and that it will pay for credit monitoring services for all affected members. It also said the laptop theft was the result of an employee not following corporate policies (MacMillan/Davies, [Reuters](#), 4/26).

### **AHRQ to Examine Role of Simulation in Improving Care**

The Agency for Healthcare Research and Quality has issued a [request for proposals](#) to study how medical simulation can improve the quality of care. Simulation is a technique that puts providers in realistic scenarios to provide guided experiences in fully interactive

environments, just as pilots might use a flight simulator to safely mimic dangerous situations encountered in the cockpit. The Agency intends to issue eight to ten grants, totaling \$2.4 million to explore the effectiveness of various simulation strategies.

### **IHI's Promising Practice of the Month: Medication Reconciliation**

It's a challenge to create and maintain a comprehensive record of every medication a patient is prescribed, but it's critical to preventing medication errors and, sometimes, serious harm. Medication reconciliation is a formal process to ensure that in transitions from home to hospital, between departments, and back home, a comprehensive, accurate list of current medications is maintained. Information technologies like electronic prescribing and electronic health records can play an important role, but are not indispensable. [Read about](#) how a growing number of hospitals in IHI's 100,000 Lives Campaign that are making significant headway with Medication Reconciliation.

*The House 21<sup>st</sup> Century Health Care Caucus thanks the following organizations for their contributions to this newsletter:*

*HIMSS (Healthcare Information and Management Systems Society) is the healthcare industry's membership organization exclusively focused on providing leadership for the optimal use of healthcare information technology and management systems for the betterment of human health. HIMSS frames and leads healthcare public policy and industry practices through its advocacy, educational and professional development initiatives designed to promote information and management systems' contributions to ensuring quality patient care. On the web at [www.himss.org](http://www.himss.org). (Items 1-3)*

*The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Boston, MA, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action. Thousands of health care providers participate in IHI's groundbreaking work. To find out more, go to [www.ihl.org](http://www.ihl.org). (Item 20)*

*The National Quality Forum (NQF) is a private membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. NQF's mission is to dramatically improve quality of care. Its portfolio includes the endorsement of performance measurement consensus standards, educational programs for health care leaders on key environmental trends, and award recognition programs. NQF, a non-profit organization with diverse stakeholders across the public and private health sectors, was established in 1999 and is based in Washington, DC. [NQF's Executive Institute](#) works to assist healthcare leaders in making quality health care the key business strategy of their institutions and the healthcare enterprise overall. To find out more, go to [www.qualityforum.org](http://www.qualityforum.org) and [www.NQFExecutiveInstitute.org](http://www.NQFExecutiveInstitute.org). (Items 8-14)*