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

1. [VA's Kolodner Named Interim Health I.T. Czar](#)
2. [Brailer Emphasizes Importance of Portability](#)
3. [Most Americans Want to Email Their Doctor, But Few Can](#)
4. [Scorecard Finds U.S. Health Care Quality Low Among Industrialized Nations](#)
5. [AHIC Meeting Focuses on State Health Information Exchange Efforts](#)
6. [GAO Report Finds Outsourcing and Privacy Breaches in Health Information](#)
7. [HHS Released Report on QIO Program](#)
8. [Health I.T., Physicians' Medicare Payments in Congressional Endgame](#)
9. [House Subcommittee Approves Federal Employee Health I.T. Bill](#)
10. [Study: Nurses Lack I.T. Training](#)
11. [Transparency Initiative Sparks Funding, Implementation Concerns](#)
12. [Study: Medical Technology Extends Life Expectancy](#)
13. [Aetna Expands Access to Physician Cost and Quality Information](#)
14. [CMS Launches New Hospital-Physician "Gainsharing" Pilot](#)
15. [Proliferation of Hospital Quality-Reporting Programs Limits Benefits for Patients](#)
16. [IHI Promising Practice of the Month: Simulation for Perinatal Care](#)

VA's Kolodner Named Interim Health I.T. Czar

The chief health informatics officer at the Veterans Administration, Dr. Robert Kolodner, has been [detailed to HHS to serve as the interim National Coordinator for Health Information Technology](#), filling a vacancy created when David Brailer returned to private life last spring. Kolodner has overseen the VA's highly-regarded electronic health record system, VistA, and his appointment was applauded by industry groups.

Brailer Emphasizes Importance of Portability

In an op-ed piece published in the *New York Times*, former National Coordinator for Health I.T. David Brailer wrote that ["the key to digital health care is portability"](#) and emphasized that any bill passed by Congress should include interoperability standards. He criticized the House bill that created exemptions to Stark and anti-kickback laws

without requiring that donated health I.T. is interoperable. According to Brailer, that approach "would make it harder to allow your information to follow you throughout your health care treatment." The terms of a possible Stark and anti-kickback exemption has been a major sticking point in negotiations between the House and Senate regarding health I.T. legislation.

Most Americans Want to Email Their Doctor, But Few Can

[A new poll](#) by the Wall Street Journal and Harris Interactive finds that three-quarters of Americans would like to be able to schedule doctor appointments online or receive email appointment reminders, but few have the opportunity. Seventy-four percent of respondents also said they would like to be able to consult with their physician by email and two-thirds would like to be able to receive test results by email. Fewer than five percent of patients have access to any of these services, the poll found. Market forces could ultimately change the numbers, however. The poll found that 54% said that whether a doctor used electronic medical records would influence their choice "a great deal" or "to some extent."

Scorecard Finds U.S. Health Care Quality Low Among Industrialized Nations

From American HealthLine (9/21/06)

The U.S. has the highest infant mortality rate and lowest life expectancy rate for residents older than age 60 among almost two dozen industrialized nations worldwide, according to a [report published September 20 on the Web site of the journal Health Affairs](#), *Gannett/Hattiesburg American* reports (Wheeler, *Gannett/Hattiesburg American*, 9/20). For the report, researchers for the Commission on a High Performance Health System at the [Commonwealth Fund](#) examined 37 indicators of health outcomes, quality, access, equity and efficiency developed by the [Institute of Medicine](#), [HHS](#), the [Agency for Healthcare Research and Quality](#), the [National Committee for Quality Assurance](#) and other experts. According to the report, the U.S. overall scored an average of 66 out of a possible 100 on the health indicators and did not score highest on any of the indicators (Carey, *CQ HealthBeat*, 9/20). The report finds that the U.S. spends twice as much on health care as other industrialized nations in relation to gross domestic product. In addition, the report finds that 61 million U.S. residents lacked health insurance or did not have adequate coverage in 2003 (Young, *Bloomberg/Miami Herald*, 9/21). The report also finds:

- One-third of U.S. patients reported a medical, medication or laboratory error in the past two years;
- Almost one-fourth of U.S. adults reported that they had to wait at least six days before they received health care (*Gannett/Hattiesburg American*, 9/20);
- Only 17% of U.S. physicians use electronic health records, which can prevent medical errors; and

- About 115 per 100,000 deaths in the U.S. are preventable with proper health care, compared with 75 in France and 81 in Japan (*Bloomberg/Miami Herald*, 9/21).

The report states, "If we closed just those gaps that are described in the Scorecard, we could save at least \$50 billion to \$100 billion per year in health care spending and prevent 100,000 to 150,000 deaths," adding, "Moreover, the nation would gain from improved productivity" (Fox, *Reuters*, 9/20). Cathy Schoen, senior vice president for research at the Commonwealth Fund, said, "We have lives at stake. We should expect higher value in return" for health care spending (*Bloomberg/Miami Herald*, 9/21). An abstract of the report is available [online](#).

AHIC Meeting Focuses on State Health Information Exchange Efforts

The [American Health Information Community](#) met on September 12 with presentations on several important HIT topics including state health information exchanges (HIE), HIT adoption as well as personalized medicine and application. Kelly Cronin, director of Programs and Coordination Programs, Office of the National Coordinator for Health Information Technology, stated her office is funding additional work to:

- Identify barriers with federal solutions,
- Recommend HIE cost models that have generated revenue,
- Determine the involvement of state Medicaid programs,
- Examine the flexibility of state Medicaid programs to facilitate HIE,
- Explore how and when to engage CMS and other public payers,
- Examine the role of the VA, DoD, and the federal employees health benefit program, and
- Create explicit links and coordination mechanisms between the work of AHIC and ONC and State-level HIE.

ONC is also supporting the formation of a new state collaborative, mirroring the role of AHIC at the state level. Other HIE panelists included Linda Kloss, American Health Information Management Association; Laura L. Adams, Rhode Island Quality Institute; Ray Campbell, Massachusetts Health Data Consortium; Lynn Dierker, Colorado Health Institute; and Kala Ladenheim, Forum for State Health Policy Leadership.

GAO Report Finds Outsourcing and Privacy Breaches in Health Information

The GAO recently released a report, [Domestic and Offshore Outsourcing of Personal Information in Medicare, Medicaid, and TRICARE](#), which found that federal contractors and state Medicaid agencies widely reported domestic outsourcing of services involving the use of personal health information but little direct offshore outsourcing. The extent of offshore outsourcing by vendors may be understated because many federal contractors and agencies did not know whether their domestic vendors transferred personal health information to other locations or vendors. In responding to the survey, over 40 percent of the federal contractors and state Medicaid agencies reported that they experienced a recent privacy breach involving personal health information.

GAO recommended that CMS require state Medicaid agencies and all Medicare contractors responsible for safeguarding personal health information to notify CMS of privacy breaches. Similar requirements already apply to TRICARE and Medicare FFS contractors. In their comments, CMS and DOD concurred.

HHS Released Report on QIO Program

On September 1, Secretary of Health and Human Services Michael O. Leavitt released a [report](#) to Congress outlining his response to a March 9 study from the Institute of Medicine, which called for maximizing the potential of the Quality Improvement Organization (QIO) program.

The Secretary's report to Congress characterized the QIO program as "a cornerstone [of CMS] efforts to improve quality and efficiency of care for Medicare beneficiaries," saying that "The Program has been instrumental in advancing national efforts to measure and improve quality, and it presents unique opportunities to support improvements in care in the future." In response to criticisms by the IOM, however, the report stated that HHS would evaluate the impact QIOs have on improving Medicare quality, increase oversight and governance to assure that contract funds are used appropriately, increase competition for QIO contracts, and strengthen opportunities for QIO to improve care at the local level.

The QIO program is a national network of independent contractors providing hands-on assistance to providers in every state and territory to improve the quality, safety and efficiency of care for Medicare beneficiaries. The program was created by Congress and is administered by CMS.

Health I.T., Physicians' Medicare Payments in Congressional Endgame

As the November 7th election approaches, the 109th U.S. Congress is winding down. One major health care priority for both the House and Senate is a legislative remedy to prevent scheduled reductions in Medicare physician payments. If Congress does not act before the end of the calendar year, physicians will take a 5 percent cut in Medicare payments beginning January 1, 2007. A House Ways and Means proposal providing a one-year freeze on all physician payments, with physicians who participate in a voluntary quality reporting program beginning in the middle of 2007 receiving a 2.8% update was floated. This proposal would not move the baseline of physician reductions, thus the scheduled 2008 5% physician reduction would be on top of the projected 2007 5.1% reduction, even if the 2007 reduction were not enacted. By not resetting the baseline, the proposal carries a price tag of only \$3 billion. An alternative Energy and Commerce proposal would implement a 0.5% increase for each of 2007-2009 with voluntary quality reporting to begin in 2008 and 2009 and an additional 0.25% update for participating physicians. Participating physicians may report to QIOs, state medical societies or CMS. The proposal would cost \$30 billion over three years. A hearing has been scheduled before the U.S. House Energy and Commerce Health Committee on Thursday, September 28, 2006 entitled Medicare Physician Payments: 2007 and Beyond.

Meanwhile, aides in both chambers say that some progress has occurred in reconciling H.R. 4157 and S. 1418 which encourages the use of information technology in the health industry. Major differences between the House and Senate are over whether to lift some anti-kickback regulations and the amount of grant money that will be made available to providers. Prospects for action before Congress recesses for elections remain uncertain.

House Subcommittee Approves Federal Employee Health I.T. Bill

The U.S. House Government Reform Committee's Federal Workforce and Agency Organization [Subcommittee passed H.R. 4589 to create personal health records for federal beneficiaries](#). The bill requires each FEHPB health plan to make a plan-based electronic health record, fed with claims data, available to each FEHBP member upon request beginning no later than the fourth contract year after enactment. The information must be made available to other FEHBP carriers when a beneficiary switches plans. Within a year of the implementation of the plan-based health record, each FEHBP carrier must have capacity to offer each member a second personal electronic health record that would be controlled by the individual and would contain personal health information the individual chooses to include, such as personal and family health histories, symptoms, over-the-counter medication use, diet, exercise, and other relevant health information and activities. Senators Tom Carper (D-DE) and George Voinovich (R-OH) recently introduced a [similar bill](#) in the Senate. Personal health records promise to provide valuable information by leveraging the claims data, technology, and capabilities of health plans to improve health care decisions by patients and providers.

Study: Nurses Lack I.T. Training

From iHealthBeat (9/7/06)

A new study finds that most nurses receive minimal or no IT training, [eWeek](#) reports.

The survey of 559 nurses, which was conducted by health IT provider CDW Healthcare, finds that one-quarter received no IT training and 56% said they received between one and eight hours of training in the last year. Those in organizations with nursing informatics positions were most likely to receive adequate IT training, according to the survey.

Fifty-five percent of the nurses surveyed indicated that more training would help improve their use of IT in their jobs, [eWeek](#) reports. Nurses cited incompatible systems, unreliable systems and limited access to necessary systems as other complaints regarding their experience with IT. However, 86% said that IT could improve the quality of patient care.

The study also finds that:

- ▶ 44% of nurses use an IT device for three or more hours daily;
- ▶ Seven in 10 nurses use e-mail daily;
- ▶ Six in 10 nurses use electronic health records daily; and

- ▶ About half of nurses surveyed use a computerized physician order entry system to order patient tests or medications (Lawrence, *eWeek*, 9/6).

Transparency Initiative Sparks Funding, Implementation Concerns

From iHealthBeat (9/6/06)

President Bush last month issued an [executive order](#) calling for federal agencies to adopt health IT and publicly report health care price and quality data in a push for greater transparency, *American Medical News* reports. A number of physicians and medical groups support the measure, but funding and implementation concerns remain.

The American Medical Association [supports transparency](#) and already urges physicians, hospitals and others to publicly post their fees. AMA said that Bush's executive order is a step toward health care cost transparency but that full transparency should include health plans' charges.

Dr. Joseph Heyman, a member of the AMA Board of Trustees, said that the cost of health IT can be a deterrent. AMA policy supports health IT initiatives that "provide positive incentives" for physicians to adopt technology.

Dr. Karl Ulrich, president and CEO of the Marshfield Clinic in Wisconsin, said he supports the sentiment of Bush's executive order. "By making costs and quality transparent, that is really creating an accountability that is long overdue," he said. Ulrich noted that the executive order does not include funding for the federal effort.

Karen Ignagni, president of America's Health Insurance Plans, said the executive order "[rewards the delivery of high-quality care](#), fosters an interoperable health care system and takes steps to ensure that consumers are equipped with the best available information they need to make health care decisions."

The American College of Physicians' [response to the executive order](#) is "generally positive," said Dr. Lynne Kirk, the college's president. However, "[j]ust posting the fee can be misleading," Kirk said. "It's only part of the information that people need."

Michele Johnson, senior government relations representative for the Medical Group Management Association, said Bush's executive order calls for interoperable electronic health records without funding or mandates to support it. "I'm not sure whether the order itself will have any impact on physicians," Johnson said (Wilson, *American Medical News*, 9/11).

Study: Medical Technology Extends Life Expectancy

From iHealthBeat (9/5/06)

A study published in the current issue of the *New England Journal of Medicine* finds that investments in medical technologies, including health IT, over the last 40 years have

extended the life expectancy of U.S. residents by nearly seven years, *Healthcare IT News* reports.

Each additional year costs an average of nearly \$20,000 and extending life for the elderly costs about \$145,000 per additional year, *Healthcare IT News* reports.

Steven Ubl, president and CEO of AdvaMed, said several types of technology -- such as health IT, implantable devices, diagnostic laboratory tests and new imaging techniques -- have improved the life expectancy of U.S. residents during the study's time frame, *Healthcare IT News* reports.

Scott Wallace, president and CEO of the National Alliance for Health IT, said he hoped this study would help influence the debate over health care expenditures, noting that critics of current health IT legislation in Congress have focused mainly on health care costs. "Information technology can eliminate spending on waste and other useless expenditures," he said (Beaudoin, *Healthcare IT News*, 9/1).

Aetna Expands Access to Physician Cost and Quality Information

[Aetna announced](#) a major expansion of its program to make physician cost and quality information public. Effective January 2007, price, clinical quality and efficiency information will be available in a total of 26 markets.

The insurer will make available data on physicians' clinical performance and efficiency in their use of health care resources, focusing on 12 specialties: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, vascular surgery and urology. The information is designed to help consumers, particularly those participating in consumer-directed health plans, to make informed decisions about their healthcare, an Aetna spokesman said. Aetna is one of the nation's largest health plans, serving an estimated 29.9 million people nationally.

CMS Launches New Hospital-Physician "Gainsharing" Pilot

The Centers for Medicare & Medicaid Services (CMS) [announced a three-year demonstration program](#) to examine whether allowing hospitals to provide financial incentives for physicians to support better care can improve patient outcomes without increasing costs.

In the demonstration program, the hospital would be paid its usual inpatient rate for the patient's care, but would pay to the physician a portion of the savings resulting from quality improvement and efficiency initiatives taken by the physician. Such incentive payments would only be allowed for documented, significant improvements in quality of care and savings in the overall costs of care. The program is known as the Physician-Hospital Collaboration Demonstration (PHCD).

The program is intended to focus on the entire scope of health care for a surgical episode or other episode of illness involving hospital care. It will encompass physician groups and up to 72 hospitals in a limited number of geographic areas across the country, and will test whether financial incentives from hospital payments to their physicians for quality and efficiency improvement can increase quality while reducing hospitals' and Medicare's costs.

Proliferation of Hospital Quality-Reporting Programs Limits Benefits for Patients

While reporting programs have raised the profile of hospital quality measurement and improvement, lack of coordination and inadequate resources hinder efforts to improve patient care, according to a [study by Center for Studying Health System Change \(HSC\)](#) researchers in the September/October edition of *Health Affairs*.

In the 12 communities studied, hospitals identified 38 unique reporting programs. The programs varied not only in clinical focus and reporting requirements but also in sponsorship, incentives, mandatory versus voluntary nature, inclusion of outcome measures, and provision of concrete quality improvement support, according to the study. Hospitals have devoted additional resources and staff to quality measurement and improvement, but inadequate information technology (IT) systems have added to the staffing burden of reporting, the study found.

"All reporting programs could benefit from more deliberate coordination to decrease reporting burden. Coordination could foster more consistent or complementary sets of target conditions across programs and standardized technical reporting formats. Although JCAHO and CMS initiatives were tightly coordinated in design, this cooperation has not extended to most other programs, particularly private programs," the article states.

IHI Promising Practice of the Month: Simulation for Perinatal Care

Simulated emergencies offer critical learning opportunities and can reduce medical trauma. A growing number of hospitals are turning to simulation to improve outcomes for pregnant women and newborns during labor and delivery; better communication is central to the effort. For more information, click [here](#).

The House 21st 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. (Items 5-9)

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. (Item 16)

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 and www.NQFExecutiveInstitute.org. (Items 12-15)