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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.

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AQA Alliance Identifies Additional Standard Quality Measures

At its recent fall meeting, the [AQA Alliance identified 31 performance measures](#) for practitioners in 25 surgical and medical specialties that it recommends stakeholders use in private health insurance plan contracts and with government purchasers, thus bringing to 80 the total number of quality measures selected by AQA to date. These measures were proposed by and approved for use among rheumatologists, clinical endocrinologists, dermatologists, ophthalmologists, neurologists, radiologists, and the 20 surgical specialties and subspecialties that are members of the Surgical Quality Alliance. In addition, a survey of patient satisfaction with individual physicians and groups was identified.

AQA is a national coalition of 150 organizations working together on a strategy to measure, report on, and improve physician practice. AQA's role is to reach consensus on

and to facilitate the widespread implementation of standard measures that have been endorsed by the National Quality Forum (NQF) or will be referred for endorsement by the NQF. These are measures that are developed by organizations such as the AMA-convened Physician Consortium for Performance Improvement and the National Committee for Quality Assurance. A complete list of AQA-identified measures and their specifications can be found at <http://www.aqaalliance.org>.

Over Half of HMOs Use Pay-for-Performance

A recent study published in the *New England Journal of Medicine* examines the penetration of pay-for-performance (P4P) programs in United States health maintenance organizations (HMOs) and finds that [P4P initiative are now commonly used by HMOs](#). P4P arrangements are an increasingly popular way for payers to reward physicians and hospitals for adhering to evidence-based standards of clinical care. Researchers from the Harvard School of Public Health and Harvard Medical School surveyed a sample of 252 health plans in 41 metropolitan areas with at least 100,000 HMO enrollees (91 percent of U.S. HMO enrollees) and found that more than half of the responding HMOs (52 percent) used P4P in their provider contracts in 2005. Of the 126 health plans with P4P programs, nearly 90 percent had programs directed at physicians and 38 percent had programs for hospitals. The researchers concluded that as the Centers for Medicare and Medicaid Services begin to design a P4P program for Medicare, it should leverage the early experience of P4P in the commercial market.

New CMS Payment Rates Encourage Increased Physician-Patient Communication

Earlier this month, the Centers for Medicare and Medicaid Services (CMS) released the [Medicare Physician Fee Schedule final rule](#), which becomes effective January 1, 2007. CMS projects that it will pay approximately \$61.5 billion to over 900,000 physicians and other healthcare professionals in 2007 as a result of the new payment rates and policies adopted in this rule. This spending figure reflects current law requirements to reduce payment by 5 percent overall to account for the combined growth in volume and intensity of physician services. A critical component of this new rule is a stronger emphasis on the physician-patient relationship, as it significantly increases the payment for face-to-face visits during which the physician and patient discuss the patient's health status and steps to maintain or improve the patient's health. In addition, the rule lays out a broader range of preventive services to be covered by Medicare.

MedPAC Hears Proposal to Base Payments on "Extended Hospital Medical Staffs"

At a recent meeting, the Medicare Payment Advisory Commission (MedPAC) discussed [an approach to revise Medicare payment to address the variation in quality and spending across communities](#). Dartmouth professor Elliott Fisher presented the approach, which hinges on the creation of "extended hospital medical staffs" (EHMS) that would be held accountable for the services provided to Medicare beneficiaries. Physicians would be assigned to hospitals based on their usual practice patterns, allowing Medicare to monitor

efficiency of service use at the aggregate EHMS level rather than by individual physician. MedPAC commissioners expressed interest in the approach, but noted that many details would need to be explored in the methodology and organizational mechanics before it could be put into practice.

United States Primary Care Fares Poorly in International Comparisons

[Recent survey results, published on *Health Affairs*'s website](#) indicate that primary care physicians in the United States do not have the tools or support to provide the best care possible to patients. Commonwealth Fund researchers surveyed 6,000 primary care physicians in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States. The survey focused on information technology and clinical record systems, care coordination, use of teams, participation in quality initiatives, and financial incentives.

Although the United States outspends the other countries surveyed (by as much as 3 times per capita), its primary care system trails other countries in several areas. About a quarter of primary care doctors in the U.S. (28 percent) and Canada (23 percent) use electronic medical records, compared to an overwhelming majority of doctors in the Netherlands (98 percent), New Zealand (92 percent), the UK (89 percent) and Australia (79 percent). Less than a quarter of U.S. doctors (23 percent) receive computerized alerts for potential harmful drug doses or interactions, compared to the Netherlands (93 percent), the UK (91 percent), New Zealand (87 percent), Australia (80 percent), and Germany (40 percent). Only 40 percent of US primary care doctors can offer patients access to care after hours, compared to 95 percent in the Netherlands, and 87 percent in the UK. Additionally, despite growing interest in the U.S. in providing financial incentives and support to improve performance, U.S. primary care doctors are the least likely to receive incentives targeting quality (30 percent compared to 58 percent in the Netherlands, 72 percent in Australia, 79 percent in New Zealand, and 95 percent in the UK).

The researchers state that the survey findings "underscore the need for new national policies" and that as the U.S. confronts how to redesign incentives to improve access, quality, and efficiency, it should take the opportunity to learn from the diverse approaches taken by other countries that are implementing system-wide initiatives.

HHS Seeks Input on Health IT and Genetic Testing

The Department of Health and Human Services (HHS) has issued a formal [request for information on policy recommendations and best practices to merge healthcare IT and genetic testing](#) to develop an approach toward personalized healthcare. The request coincides with last month's launch by the American Health Information Community (AHIC) of a work group on IT and genetic testing. At an AHIC meeting on October 31, HHS Secretary Mike Leavitt asked the Office of the National Coordinator for Health Information Technology to develop an organizational structure for the work group and a

list of candidates for membership. AHIC is expected to address the recommendation at its next meeting scheduled for December 12.

According to the HHS announcement, the government "requests input from interested parties on plans for developing and using resources involving health IT and genetic and molecular medicine, with specific reference to incorporating these capacities in evidence-based clinical practice, health outcomes evaluations, research, and transformation of healthcare delivery.

"Input is sought on the interest and current planning activities of healthcare systems and related organizations on the needs and applications of these transformative aspects of personalized healthcare," the announcement said. The deadline for responses is January 2, 2007.

AHIC Workgroup Issues Privacy and Security Use Cases

A federal advisory work group on healthcare information privacy and security on November 2 axed a proposal to include risk assessments as a basic element of privacy and security protection among a list of recommendations it is developing to be forwarded to the AHIC. The [AHIC confidentiality, privacy and security work group](#), which was formed in May to advise the federal government on healthcare IT privacy and security policy, went over a draft document containing 10 possible policy recommendations. The AHIC has developed so-called "use cases," specific care episodes, around which various federal contractors and AHIC work groups are developing standards and policies. The use cases currently under discussion involve moving a specific set of data elements from emergency and outpatient care sites to public health agencies for bio-surveillance, populating medication histories and basic demographic information in a personal health record and transferring laboratory test results to an electronic health-record system.

HIT is a Top Priority for New Senate HELP Committee Chairman Kennedy

Incoming Senate HELP Committee Chairman Edward M. Kennedy announced his top priorities for the 110th Congress are to pass health information technology legislation, increase the minimum wage to \$7.25 an hour, and expand federal funding for stem cell research. Kennedy, who laid out his top priorities in a floor speech and briefing, said he believes all three bills could be passed early in the year. As a first step toward his ultimate goal of expanding Medicare to all citizens, Kennedy said he will work to expand the Children's Health Insurance Program to cover all children.

HHS Secretary Asks Employers to Commit to Healthcare Quality and Cost

On November 17, [HHS Secretary Mike Leavitt called on employers](#) to commit to four steps to improve healthcare quality and reduce health costs by improving information in the health care sector in concert with federal efforts. "If we are going to get a handle on healthcare costs -- and we must -- we first need to know what our costs are and what we are getting for our money," Secretary Leavitt said in a press release. "Our nation's private employers are the major source of health insurance for Americans, and they can help us

provide the information consumers need to achieve better value for their health care dollars."

At a meeting of business leaders representing large and small companies nationwide, Secretary Leavitt said commitment to four "cornerstone" goals would lead to improved quality of care and lower costs:

- Standards for connecting health information technology, making it possible to share patient health information securely and seamlessly among health care providers.
- Quality of care reporting, so that healthcare providers as well as the public can learn how well each provider measures up in delivering care.
- Providing costs of health services in advance, so that when patients choose routine and elective care, they can make comparisons on the basis of both quality and how much of the total cost they will have to pay under their health plan.
- Providing incentives for quality care at competitive prices, as in payments to providers based on the quality of their services, or insurance options that reward consumers for choosing on the basis of quality and cost.

NASCIO Issues Report on State Health IT Initiatives

Profiles of Progress: State Health IT Initiatives is a new report by the National Association of State CIO (NASCIO) Health IT Committee that provides a [state-by-state "snapshot"](#) of progress that each state has made in the HIT implementation process. Each individual state profile highlights the steps that states are taking in regards to HIT issues, from Executive Orders and legislative-driven initiatives to public/private or public/non-profit partnerships. The compendium also examines the roles and responsibilities the state CIO has in these efforts.

GAO Recommends Congress Focus on Establishing Medicare Pay-for-Performance System, Financial Oversight of Medicaid

From Kaiser Network's Daily Health Policy Report (11/28/06):

In a letter sent to congressional leaders on Nov. 17, the [Government Accountability Office](#) made several recommendations for the 110th Congress, including that lawmakers should overhaul entitlement programs, [CQ HealthBeat](#) reports. In the letter, GAO Comptroller General David Walker wrote, "Absent reform, Medicare's and Medicaid's long-term fiscal sustainability for supporting health care for elderly, disabled and low-income Americans is in jeopardy." GAO said Congress should use Medicare reimbursements to reward quality and efficiency. With 42 million beneficiaries and \$330 billion in spending in 2005, the Medicare "program's size and complexity make it vulnerable to improper payments and inefficient payment systems," according to the letter. GAO also recommended that Congress assess [CMS](#)' managerial oversight of Medicare, including efforts to provide information to assist beneficiaries in making choices about the prescription drug benefit. Medicaid, with about 56 million beneficiaries and state and federal spending for 2004 estimated at about \$298 billion, also is a potential

hazard for improper payments, GAO said. The letter suggested that Congress limit Medicaid payments to government facilities to the costs of providing services, which would "curtail states' use of financing schemes to inappropriately obtain federal matching funds." Congress also should ensure that initiatives to restructure Medicaid eligibility and benefits are consistent with the administration's goal of budget neutrality for the federal government, according to the letter (Carey, *CQ HealthBeat*, 11/27).

Health Care Leader: IT Adoption Requires Behavior Change, Privacy Measures

From iHealthBeat (11/20/06):

Health IT improves the quality of care in large health care organizations that devote substantial funds to the IT systems, but adoption rates for some technologies remain low, according to Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality, *Health IT Strategist* reports.

Clancy last week at a Joint Commission on Accreditation of Healthcare Organizations conference in Chicago said that health IT systems such as computerized physician order entry are not always used because the facilities think they operate too slowly and inefficiently.

To change these trends, AHRQ is providing about \$166 million to fund more than 125 health IT projects and demonstrations in 43 states, with a strong emphasis on rural areas, Clancy added.

She also said the implementation of health IT requires behavior change, and more research needs to be completed outside of the four main sources, which are:

- The Department of Veterans Affairs;
- Partners HealthCare, which is affiliated with the Harvard Medical School;
- Intermountain Healthcare in Salt Lake City; and
- The Regenstrief Institute in Indianapolis, which is affiliated with the Indiana University School of Medicine.

"Probably the most important issue here is privacy," she said, adding that patients must be allowed to opt out of data-sharing systems, *Health IT Strategist* reports. The industry also needs standardization and interoperability, she said (Robeznieks, *Health IT Strategist*, 11/17).

Medicaid Spending Falls for First Time

From Kaiser Network's Daily Health Policy Report (11/27/06):

Medicaid spending declined by 1.4% in the first nine months of 2006 compared with the same period last year, marking the first decrease in spending since the program was created in 1965, according to the [Bureau of Economic Analysis](#), *USA Today* reports. After adjusting for the rate of health care inflation, Medicaid spending declined by 5.4% this year, according to the bureau. "Substantial" savings resulted from many small cost-

containment policies adopted by states in recent years, *USA Today* reports. Such policies include shifting elderly beneficiaries from nursing homes into less-costly home health care; tightening restrictions on fraud; refining the management of high-cost beneficiaries, such as those with serious chronic diseases; and reducing some payments to hospitals and doctors. Arizona Medicaid Director Anthony Rodgers said, "States have made really aggressive changes in how care is managed in Medicaid. Every state has taken a different approach, but the success can be seen almost everywhere." In addition, some of the savings are the result of shifting some medication costs to the Medicare prescription drug benefit. Under the benefit, states must partially reimburse the federal government for money saved. According to *USA Today*, the "complicated cost shifting between the two programs makes it impossible to know precisely how much Medicaid cost cutting is simply shifting expenses to the federal program." A *USA Today* analysis found that without the Medicare drug benefit, Medicaid spending would have been about equal to spending in 2005, or down 4% after adjusting for inflation (Cauchon, *USA Today*, 11/27).

IHI Promising Practice of the Month: Systematizing Hand Hygiene

There's no excuse for health care providers to be passing along infectious germs to hospitalized patients, but until recently, efforts to insist upon hand hygiene compliance in the nation's hospitals were just that.. efforts. Now, with growing attention to the sometimes deadly consequences of virulent hospital born infections, federal agencies, hospitals and health care organizations have teamed up to make hand hygiene a 'must' - with encouraging results. 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 5-10)

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 14)

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 1-5)