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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.

In this issue:

1. [Lawmakers Push To Restart Health IT Legislation](#)
2. [Voluntary Physician Quality Reporting System Created Under Medicare](#)
3. [Secretary Leavitt Accepts HITSP Standards](#)
4. [National Patient Safety Initiative Launched To Provide Free e-Prescribing](#)
5. [Bicameral, Bipartisan Healthy Partnership Act Introduced](#)
6. [HHS Advisory Council Makes Recommendations for Personal Health Records](#)
7. [NIH Launches the Largest Individualized Treatment Trial for Breast Cancer](#)
8. [HHS Awards Medicaid Transformation Grants](#)
9. [Certification Body Has Approved 25% of Ambulatory EHR Products](#)
10. [Government Study Finds that Prevention Remains Missed Opportunity](#)
11. [CMS to Post Comparison of Hospitals' Heart Attack and Heart Failure Mortality Rates](#)
12. [Federal Database Shows Large Geographical Variation in Health Insurance Costs](#)
13. [HHS Secretary Recognizes First "Community Leader" in National Network](#)
14. [Researchers Find that Simple Steps Can Reduce Blood Infections in ICUs](#)
15. [Study Finds Only Slight Increase in Physician Payments Based on Quality](#)
16. [IHI Promising Practice of the Month: Early Warning Scorecards](#)

Lawmakers Push To Restart Health IT Legislation

From iHealthBeat (1/30/07)

Health IT measures are being added to larger legislative initiatives aimed at reducing the price of health coverage for the poor and uninsured, according to health IT analysts, *Technology Daily* reports.

Two revised health IT bills by Rep. Patrick Kennedy (D-R.I.) could initiate the health IT agenda, according to Ticia Gerber, vice president of public policy and international programs at the eHealth Initiative. Kennedy in February plans to reintroduce a bill that would provide physicians with [financial incentives to build personal health records](#). Kennedy in collaboration with Rep. Tim Murphy (R-Pa.) also will reintroduce legislation to help [develop secure, confidential health data networks and help physicians modernize their practices](#), *Technology Daily* reports.

Senate Health, Education, Labor and Pensions Committee Chair Ted Kennedy (D-Mass.) will continue to push for health IT, including legislation that would allow states to grant low-interest loans to physicians to purchase new computer systems, software and other technology. Sen. Michael Enzi (R-Wyo.), the ranking Republican on the Senate HELP committee, said he will work with Ted Kennedy and Sen. Hillary Rodham Clinton (D-N.Y.) to update 2006's comprehensive health IT bill, which was passed unanimously in the Senate.

House Ways and Means Health Subcommittee Chair Pete Stark (D-Calif.) "will be influential in setting the health IT agenda," according to *Technology Daily*. Stark this year will not support the proposed exception to anti-kickback laws that would permit hospitals to donate IT to physicians, a Stark staffer said (Sternstein, *Technology Daily*, 1/29).

Voluntary Physician Quality Reporting System Created Under Medicare

On Dec. 20, 2006, the Tax Relief and Health Care Act of 2006 became law as Public Law 109-432. Section 101 of Division B of the law provides for a one-year increase in the Medicare physician payment rate. The bill also implements a system for the reporting of consensus-based physician quality measures under the [Physician Voluntary Reporting Program](#) beginning July 1, 2007 through December 31, 2007. For 2008, updated quality measures are to be created by the Secretary of Health and Human Services not later than November 15, 2007. A transitional bonus incentive payment of 1.5% shall be paid for quality measure reporting in 2007. This section also establishes a Physician Assistance and Quality Initiative Fund for physician payment and quality improvement initiatives. \$1.35 billion shall be provided for this new fund from the Federal Supplementary Medical Insurance Trust Fund; \$60 million for each year of 2007, 2008, and 2009 will be provided to the Centers for Medicare and Medicaid Services to implement this program.

Secretary Leavitt Accepts HITSP Standards

U.S. Department of Health and Human Services Secretary Michael O. Leavitt accepted the Health Information Technology and Standards Panel (HITSP) Interoperability Specifications during the January 23rd meeting of the American Health Information Community (AHIC). In a letter to the AHIC members, dated January 22, 2007, Secretary Leavitt indicated that by accepting the HITSP Interoperability specifications for version 1.2, he envisions a one-year implementation and testing process for software systems that will likely result in refinement of the implementation guidance. The Secretary will then recognize version 2.0 in December 2007, leading the way for federal agency compliance with Executive Order 13410 as of January 2008. The acceptance of these standards is intended to provide impetus for the health care industry to move quickly towards secure, accessible, nationwide health information exchange which will ultimately benefit the delivery of patient care.

National Patient Safety Initiative Launched To Provide Free e-Prescribing

A coalition of prominent technology companies and leading health care organizations announced on January 16 a [national initiative to provide free electronic prescribing](#) for

every physician in America. The [National ePrescribing Patient Safety Initiative](#) (NEPSI) will make available to physicians a free web-based e-prescribing tool. Preventable medication errors injure at least 1.5 million Americans and claim more than 7,000 lives each year, according to a July 2006 study by the Institute of Medicine (IOM) of the National Academy of Sciences. In an effort to reduce these errors, the IOM has called on all of the nation's physicians to adopt electronic prescribing by 2010.

Bicameral, Bipartisan Healthy Partnership Act Introduced

This month, Senators Jeff Bingaman (D-NM) and George Voinovich (R-OH) and Representatives Tammy Baldwin (D-WI), John Tierney (D-MA), and Tom Price (R-GA) introduced the [Health Partnership Through Creative Federalism Act](#) (S. 325/H.R. 506), which provides for innovation in health care through State initiatives to expand coverage and access and improve quality and efficiency in the health care system. The Health Partnership Act creates partnerships between the Federal government, State and local governments, tribes and tribal organizations, private payers, and health care providers to seek innovation in the health care systems. Under this Act, States, local governments, and tribes and tribal governments would be invited to submit applications to the Federal Government for funding to implement expansion and improvements to current health programs for review by a bipartisan "State Health Innovation Commission." Based on funding available through the Federal budget process, the Commission would approve a variety of reform options and innovative approaches.

HHS Advisory Council Makes Recommendations for Personal Health Records

The [Consumer Empowerment Workgroup of the American Health Information Community \(AHIC\)](#) made recommendations this month to Secretary Leavitt on strategies for promoting the use of consumer-controlled personal health records. The workgroup made a number of recommendations, with patient privacy a recurring theme. It stated that "Consumers should be able to control access to and secondary use of personal health information in PHRs." The workgroup noted, however, that many PHR service providers are not covered entities under HIPAA, leaving consumers without the privacy protections of that law and leaving PHRs without consistent, enforceable policies in this realm. The report also recognized a need for incentives to encourage adoption of PHRs by providers and consumers and recommended that the Certification Commission for Health Information Technology begin moving towards developing a certification process for PHRs.

NIH Launches the Largest Individualized Treatment Trial for Breast Cancer

The National Cancer Institute has launched a [new clinical trial](#) to examine whether genes that are frequently associated with risk of recurrence for women with early-stage breast cancer can be used to assign patients to the most appropriate and effective treatment. In this trial, doctors will use a test that measures the activity of a set of genes in breast tumor tissue to determine which women will receive adjuvant chemotherapy in addition to hormone therapy.

Breast cancer is the most frequently diagnosed cancer in women, with an estimated 212,920 new cases of invasive breast cancer expected in the United States in 2006.

Chemotherapy is recommended for most women in addition to surgical excision, radiation, and hormone therapy, but the proportion of women who actually benefit substantially from chemotherapy is fairly small.

HHS Awards Medicaid Transformation Grants

HHS Secretary Mike Leavitt has awarded [\\$103 million to assist states in improving Medicaid efficiency, economy and health care quality](#). The “Medicaid transformation grants” are a \$150 million program included in the Deficit Reduction Act of 2005 at the urging of Caucus Co-Chairman Tim Murphy (R-PA), to be distributed during fiscal years 2007 and 2008. Twenty-seven states received this first round of grants. The remaining \$47 million will be awarded later this year, and states will receive the funds over the next two years.

HHS has permitted states to use the grants to reduce the rate of errors through the implementation of electronic health records, clinical decision support tools, or electronic prescription programs. The funds also can be used for other Medicaid improvement programs, including efforts aimed at reducing Medicaid waste, fraud and abuse.

Certification Body Has Approved 25% of Ambulatory EHR Products

from iHealthBeat (1/30/07)

The Certification Commission for Healthcare IT announced that it has certified 18 additional ambulatory electronic health record products for meeting specific criteria in functionality, interoperability, security and reliability, [Health Data Management](#) reports. CCHIT has certified a total of 55 [ambulatory EHR products](#) in nine months, which it estimates accounts for 25% of the market.

Some vendors already had received certification for other EHR products, while some vendors received their first certification. Also, some of the new certifications were for newer versions of existing EHRs that previously were certified.

CCHIT on Monday began its final application period for ambulatory EHR certification under 2006 criteria, and it will accept applications through Feb. 14. The commission between Feb. 14 and Feb. 28 will accept comments on final 2007 ambulatory EHR criteria and test scripts, and it expects to publish on March 16 the final version of the criteria.

The commission also is working on other EHR certification programs, including inpatient EHRs, and soon will publish a draft report of a survey and proposed plan. The commission will accept comments on the draft report between Feb. 2 and March 2, and at its March meeting, the commission plans to finalize its next steps ([Health Data Management](#), 1/29).

Government Study Finds that Prevention Remains Missed Opportunity

The overall quality of the U.S. health care system is improving, but [providers are missing important chances to help Americans avoid disease or serious complications](#), according to annual reports issued on January 11, 2007 by the Department of Health & Human

Services' (HHS) Agency for Health care Research and Quality (AHRQ). The 2006 [National Health care Quality Report](#) and [National Health care Disparities Report](#) both found that the use of proven prevention strategies lags significantly behind other gains in health care. For example, only about 52 percent of adults reported receiving recommended colorectal cancer screenings even though about 56,000 Americans die from colorectal cancer, and 150,000 new cases are diagnosed each year. Missed prevention opportunities were also found for obese adults and for individuals with asthma and diabetes.

Overall, the review of 40 core quality measures found a 3.1 percent increase in the quality of care—the same rate of improvement as the previous 2 years. The greatest quality gains occurred in U.S. hospitals, where quality improved 7.8 percent. Ambulatory care—health services provided at doctors' offices, clinics or other settings without an overnight stay—improved by 3.2 percent. Nursing home and home health care improved by 1 percent. In addition, as in previous years, the federal disparities report found access to care varied widely between racial, ethnic, and economic groups. Blacks received poorer quality care than whites for 73 percent of the core measures included in the disparities report. Hispanics received poorer quality of care than non-Hispanic whites for 77 percent of the measures. Poor people received lower quality of care than high-income people for 71 percent of the measures.

CMS to Post Comparison of Hospitals' Heart Attack and Heart Failure Mortality Rates

Starting in June 2007, [consumers will be able to access information on how the 30-day mortality rates for nearly 4000 hospitals across the nation](#) compare with the national Medicare mortality rates of 17.8 percent for heart attacks and 11.6 percent for heart failure. This information will be posted on the Medicare website called [Hospital Compare](#)—and rather than directly posting hospitals' mortality rates, the site will simply report whether a hospital performs better, worse, or on par with the national average. Hospital Compare currently reports on hospital performance in providing care for patients with heart disease and certain other medical conditions; however, it does not reveal how patients do after they leave the hospital. This new information is expected to begin to address that gap by offering consumers a more reliable index of a hospital's performance than inpatient deaths and by also not rewarding hospitals that transfer or discharge their patients before death.

Federal Database Shows Large Geographical Variation in Health Insurance Costs

A new [federal database](#) for the first time allows companies, consumers, health care analysts, and others to compare health insurance costs among the nation's largest cities and other geographical areas. This new metropolitan area data table developed by the Department of Health & Human Services' (HHS) Agency for Health care Research and Quality (AHRQ) provides comparable statistics on average annual costs for companies and workers contributing to private-sector health insurance. The estimates, which are from AHRQ's Medical Expenditure Panel Survey for 2004—the most current data—show large geographical variations in how much Americans pay for family coverage and

individual coverage, as well as how much employers contribute to workers' health insurance premiums. For example, for family health insurance plans, Seattle workers contributed the most (an average \$3,299 per year), while New York City-area workers contributed the least (\$1,851). The data include statistical averages from the following cities and surrounding areas: New York, Los Angeles, Chicago, Philadelphia, Dallas-Fort Worth, Miami, Houston, Washington, DC, Atlanta, Detroit, Boston, San Francisco, Riverside, Phoenix, Seattle, Minneapolis, San Diego, St. Louis, Baltimore and Tampa—and also provides comparisons within states.

HHS Secretary Recognizes First “Community Leader” in National Network

On January 3, 2007, HHS Secretary Mike Leavitt issued [formal recognition of the Puget Sound Health Alliance](#) as part of an expanded network of region-based organizations focused on improving the quality of health care while reducing health care cost inflation. The Seattle-based Alliance, which includes health care providers, payers, patient representatives, and others, is the first organization designated by the HHS Secretary as a Community Leader for Value-Driven Health Care. As a "Community Leader" organization, it will support four key national health care goals identified by the Secretary and work to achieve the four goals at the local and regional level. These four "cornerstone" goals are: (1) public reporting of quality of care, (2) public reporting of the cost of health services, (3) interoperable health information technology, and (4) incentives for achieving better value in health care. Recognition of the Alliance represents a new step in building a national network of regional organizations that bring together local stakeholders to improve health care while holding costs down. In addition to the new "Community Leader" category, six regional pilot projects were established last year under the Better Quality Information for Medicare Beneficiaries (BQIMB) project, in Massachusetts, Indiana, Wisconsin, Minnesota, Arizona, and California.

Researchers Find that Simple Steps Can Reduce Blood Infections in ICUs

[A recent study, published in the New England Journal of Medicine](#), finds that hospitals can significantly reduce (up to 66 percent) the number of serious catheter-related blood infections in intensive care units (ICUs) by using simple, low-tech measures. Central-venous catheters are placed in blood vessels that lead to the heart and are used to deliver treatment and monitor patient status. However, the article reports that an estimated 80,000 infections and 28,000 deaths occur each year in the United States as a result of central-venous catheters, with each infection costing the health care system about \$45,000. The researchers reviewed data from 103 Michigan ICUs before, during, and after they implemented a variety of practices intended to reduce the rates of these infections. The practices included training staff in infection control measures; routine handwashing; using sites other than the groin, which is hard to keep sterile, for lines whenever possible; wearing masks, gloves, and gowns when placing lines, and changing them between each procedure; cleaning the patient's skin with chlorhexidine; using special, standardized central-line supply carts controlled for one-time use; and timely removal of unneeded catheters.

Study Finds Only Slight Increase in Physician Payments Based on Quality

According to a [recently released study by the Center for Studying Health System Change](#), physician compensation based on quality measures has increased slightly, while incentives tied to the quantity of care delivered by physicians, called “productivity-based financial incentives in the study, remain the dominant form of reimbursement, consistently affecting 70 percent of physicians in non-solo practice since 1996-97. The study, which based its findings on the group's Community Tracking Study Physician Survey, examined data from 1996 to 2005. According to the findings, the percentage of physicians compensated in part based on quality measures increased from 17.6 percent of physicians in 2000–2001 to 20.2 percent in 2004–2005. The study noted, however, that nearly all of these physicians also face “productivity-based” incentives. The study's authors conclude that until policy makers make changes to complement current pay-for-performance efforts, physicians will continue to be reimbursed by the fee-for-service model, “an incentive that has uncertain implications for quality of care but which likely increases the cost of care by encouraging the provision of more services to patients.”

IHI Promising Practice of the Month: Early Warning Scorecards

Rapid Response Teams have impressed health care leaders as a method for reducing cardiac arrests and other sudden, life-threatening events in patients on general medical floors. Now, some hospitals are taking the concept a step further with potentially an even more accurate assessment tool for identifying deteriorating patients. The hope with what are sometimes called ‘Early Warning Scorecard Systems’ is that front line providers will know more precisely when to call for a Rapid Response Team’s intervention. Click [here](#) to read more.

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 2-5)

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.NOFExecutiveInstitute.org. (Items 10-15)