

In 2009, health care reform is not a luxury. It's a necessity we cannot defer. Soaring health care costs make our current course unsustainable ... the status quo is broken."

— President Barack Obama¹

"There's no way to transform the health care system without information technology."

— Dr. David Blumenthal,
National Coordinator for
Health Information
Technology²

Introduction

Major social and economic forces collided in late 2008 and early 2009, setting the stage for what promises to be a time of transformation in U.S. health care. The combination of a major and ongoing economic downturn, rising unemployment, the widespread collapse of significant financial institutions, and a new administration and Congress with ambitious policy goals are providing the impetus for major reforms across all sectors of the economy. Under these circumstances, longstanding health care industry dilemmas are getting new scrutiny and attention. For the first time in recent social history, there is widespread popular consensus that U. S. health care is too costly, that the system fails to deliver high-quality, safe, and effective health care to enough people and that these failings must be fixed.

The U.S. health care landscape is a complex of disparate stakeholders and institutions with overlapping and often conflicting expectations, roles, and responsibilities for purchasing, delivering, and consuming health care and for ensuring that it is safe and effective. This complexity makes systematic discussion of the cross-industry challenges difficult at the best of times — because there are so many apparently unconnected moving parts. The added pressure created by failures in the surrounding economy and business environment, and the mandate for change that is coming from so many stakeholders, makes it even more important to have a clear understanding of these longstanding problems and opportunities.

The federal government is poised to implement the HITECH Act, a multi-year nation-wide program to promote the adoption of clinical information systems in hospitals and physician practices, and simultaneously enact major health care payment and coverage reform to the systems of financing health care and providing health care coverage to more Americans. These new variables make it more important than ever to have a clear understanding of the cross-industry issues, the impact that health care payment and coverage reform and the HITECH Act are likely to have, and the opportunities that this time of transformation will create.

Navigating Through the Confusion

The U.S. health care industry is confusing at the best of times. The first step in developing a clear picture is to frame the discussion about the longstanding issues using the following five dimensions:

- **Health care costs** in the U.S. consume too much of the gross national product at roughly 17 percent and growing. These costs threaten the viability of Medicare and Medicaid, make health care unaffordable for individuals not covered by employer-sponsored programs, and are driving many employers to discontinue providing health care coverage for employees because they can no longer afford the premiums.

- **Coverage** through private insurance or public programs is the key to health care access in the U.S. system. U.S. Census figures estimate that more than 45 million Americans lack any form of coverage³ and are thus effectively excluded from the health care system for anything except emergency interventions. The economic and social costs of the coverage gap are a major contributor to the overall health care cost crisis.
- Significant **capacity constraints** are emerging in the U.S. health care market. Demand is growing as health care demographics change with the aging of the baby boom generation. Clinical and pharmacological innovation and technology change drive demand as well. At the same time, there are critical shortages of required providers to care for this aging population and to use these new treatment modalities.
- Stakeholder **expectations** about health care are changing. Patient safety and health care quality expectations, combined with cost pressure, are driving a new “value based” orientation to health care that focuses on information transparency and outcomes that deliver value. The emergence of consumers, individuals, and purchasers as active participants in care delivery is another feature of this transformation.
- **Health care information technology** is the critical enabler to the effective organization and delivery of high-quality, effective and safe patient care in an increasingly complex clinical environment. Adoption of technology and effective implementation of electronic health record (EHR) and other clinical information systems has been slow and faces significant organizational, institutional and economic barriers.

The new variables introduced by health care coverage and payment reform and the HITECH Act will have different implications in each of these dimensions — and those impacts will change over time. Even though the exact details are not yet final, there is enough information to make some predictions.

- **Major business reforms to the insurance coverage market**, including mandatory coverage levels, community rating, guaranteed issue and renewal, and elimination of pre-existing condition exclusions, will standardize products, make them more understandable for purchasers, make insurance coverage more broadly available, and provide more affordable coverage options for individuals and small employers who are currently “priced out” of the market.
- **Payment reforms linking compensation to improvements in care coordination, health care quality, and outcomes**, including value-based purchasing (VBP) initiatives, comparative effectiveness criteria, expanded pay-for-performance (P4P) programs, accountable care organizations (ACOs), and patient-centered medical homes (PCMHs) will move beyond traditional fee-for-service mechanisms that reimburse providers based on the services they provide. Moving beyond fee-for-service to a new basis for provider compensation will test the limits of traditional health care provider organizations, require new understandings of provider and hospital roles and responsibilities, and drive innovation in clinical processes and care coordination.
- **HITECH Act provisions will accelerate and increase clinical information system implementation efforts** by hospitals and physician practices both to obtain short-term bonus payments and avoid subsequent payment reductions.

The remainder of this paper examines the current state of each of the dimensions of the framework, makes some predictions for the future, including those presented by health care payment and coverage reform and the HITECH Act, and discusses some of the implications as well as the opportunities that they present.

HEALTHCARE COST INFLATION

Cost Inflation

Coverage Expansion

Capacity Constraints

Evolving Expectations

Information Technology

Health care cost inflation has outpaced the overall U.S. economy at record levels for more than twenty years. Health care costs accounted for 17 percent of U.S. GDP in 2008 and, on the current trajectory, are expected to account for more than 20 percent by 2018.⁴

- As health care inflation grows faster than wages, individuals spend more of their personal income on health care directly and indirectly, as health care coverage accounts for an ever larger percentage of their total compensation.⁵
- Comprehensive employer-sponsored health care coverage — traditionally a mainstay of U.S. labor and health care practices — is decreasing as employers find themselves unable to sustain the escalating costs.⁶
- In the increasingly competitive global economy, U.S. companies that provide health care coverage for employees struggle to match the cost structures of competitors in countries that spend far less on health care.⁷

This might be tolerable if the value of these expenditures on health care was higher. However, comparisons between the United States and similar economies suggest otherwise. While U.S. expenditures on health care, per capita, exceed those of other industrialized nations by at least 30 percent,⁸ U.S. performance on basic public health measures is among the lowest.⁹ So, despite this level of incredible spending, there is no evidence that the U.S. population is healthier than in places where expenditures are lower.

This is not news. What is news is the widespread consensus that current costs are breaking the health care system and that continued inflation at these levels will break the general economy.¹⁰

Getting control of health care costs is a formidable undertaking. The sources of administrative inefficiency are relatively easy to identify, and tactics to reduce operating costs and improve administrative efficiencies are easy to design and implement using techniques that are mature and well understood. The problem is that administrative and overhead costs are the smaller component of total health care cost. What is more difficult is to address the costs and cost inflation of the underlying medical care itself. When it comes to inflation in the cost of medical care itself, the root causes are not well understood, and effective interventions that really address the underlying problem are difficult to design and implement. The health care industry has only been successful in controlling costs through pricing and reimbursement; efforts to impact the utilization and intensity of care and to address underlying inflationary practices have been spectacularly unsuccessful.

2015 Predictions

Despite incremental improvements, health care cost and inflation will be as big a problem in 2015 as it is today. The reason for this is simple: there are complex problems driving health care cost inflation and the next five years will be a period of innovation, adjustment, and experimentation as various cost controls are introduced.

Cost Inflation

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- **Traditional cost-reduction efforts will produce familiar, incremental results.** The industry will continue to rely on negotiating price concessions from providers and implementing tactics to eliminate waste, duplication, and fraud. These tactics are well understood and, within their limits, effective tools.
- **The introduction of provider reimbursement reforms that align income incentives with health care outcomes will accelerate but will produce inconclusive results in the near term.** The Centers for Medicare & Medicaid Services (CMS) will continue to lead the way in these efforts, beginning with value-based purchasing initiatives for Medicare in 2009. Comparative effectiveness research and studies may eventually yield information for reimbursement reforms as well. Commercial payer adoption will be rapid and new innovation will accelerate as widespread implementation of reimbursement innovations takes place.
- **Payment reforms that integrate new provider organization models, like accountable care organizations and patient-centered medical homes, in order to coordinate and deliver high-quality, low-cost care will be introduced and tested — likely in carefully defined regional markets.** Physicians and hospitals that can meet the organizational and clinical process integration challenges required by these experiments will be the most successful.
- **Administrative simplification efforts to reduce hidden overhead costs will accelerate but will prove minimally successful in the near term.** A recent study suggests that hidden overhead costs in physician practices account for 6.9 percent of total provider reimbursements annually.¹¹ As reimbursement reforms are introduced, their success will be measured in direct and indirect cost impacts. Reimbursement reforms that lower direct costs while increasing indirect or overhead costs cannot be considered successful or suitable for widespread implementation.
- **Tort reforms designed to reduce the financial risk of liability claims and malpractice settlements will not be a significant element in cost reduction tactics in the near term.** Some sectors of the health care industry traditionally argue that tort reform is required to limit the financial risk of liability claims and malpractice settlements which, they argue, are a major contributor to health care inefficiencies and thus to health care cost inflation. The current debate about health care reform with its focus on payment and coverage changes has diluted support for tort reform efforts.

Coverage reform efforts that expand coverage to the uninsured will create new cost pressures. More people will be getting more routine and required care in 2015 than are getting it today. Delivering more care will increase direct costs of health care. In the long run, improving access and affordability to routine care will reduce indirect health care and other social costs — in 2015 it will simply look like health care is costing more.

Cost shifting to consumers will continue as employer and government purchasers seek ways to reduce and control health care expenditures. The standardization of benefit packages and pricing requirements that will be part of coverage reform will establish the framework for these shifts, creating a “floor” against which all other market offerings can be measured. Additional benefits and services will continue to be available, as will benefit plans that cover them — but they will come at a higher price, which individuals and employees will be expected to cover.

Implications

Acceleration of cost cutting and reimbursement reform efforts will place continuing pressure on health care delivery organizations to reduce waste, eliminate fraud and reform billing and recovery practices. As reimbursement reforms and innovations are implemented, health care delivery organizations and providers will be forced to respond to and accommodate new documentation, reporting, and invoicing requirements. If the experience gained from the implementation of core measures and Hospital Acquired Condition (HAC)

Cost Inflation

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requirements is a predictor of the future, many of these reforms and innovations will reach deep into care delivery — addressing care delivery practices, reengineering, and workflow redesign to ensure that required evaluations and documentation are completed.

Health plans and payers can expect continuing pressure to reduce and control administrative overhead and to produce operational efficiencies, particularly operational efficiencies that result in administrative simplification and promote overhead reductions for providers and health care delivery organizations. Rapid innovation in outcomes-based reimbursement will eventually impact the underlying accelerators of health care cost, but will require the immediate development of supporting capabilities and systems.

National coverage reform efforts designed to reduce the cost of health care coverage may provide some relief for small and micro-employers that are at risk of being “priced out” of the market for health care benefits, but for most employer and group purchasers, cost and inflation will continue to be major financial burdens to their organizations. Purchaser organizations must continue to promote reimbursement reforms that reward quality and clinical outcomes as well as care delivery and administrative practices that result in operational and other efficiencies and cost reductions. Those purchasers who have not done so need to consider direct intervention in the health and wellness of their populations — in an effort to promote wellness, improve productivity and lay the groundwork for longer term improvements in health status that will result in lower future health care costs.

Coverage reform efforts designed to make health care coverage more affordable may provide some cost relief to consumers, as they do for small and micro-employers. However, for many consumers, particularly those who have historically enjoyed high levels of coverage through their employers, there will be an increase in their personal financial responsibility for health care costs as purchasers and plan sponsors continue to shift costs to consumers.

- In the near term, more consumers are likely to have higher out-of-pocket costs that result from benefit redesign and continued cost shifting from payers and coverage sponsors.
- Along with more personal financial risk, consumers will be required to develop and demonstrate the proactive cost management skills and behaviors that have been attributed to purchasers of consumer-directed and high-deductible plans.
- Purchaser and payer efforts to align consumer financial incentives with healthy behaviors and lifestyle choices will drive changes as consumers prepare to adhere to new expectations, or to take financial responsibility for the health care cost implications of their choices.

The Bottom Line

Learning to do more with less will be the key to success for at least the next five years — for payers and providers of healthcare.

Operating efficiently (e.g., eliminating waste, duplication and redundancy) will be critical for providers and payers alike as the entire industry copes with continued cost pressure.

Solving the underlying causes of healthcare cost inflation will require moving beyond payment systems that rely on fee-for-service reimbursement. Health delivery organizations that make the organizational and clinical process changes that new payment reforms will require, and that can successfully form accountable care organizations to support effective care coordination and clinical collaboration, as well as innovations like the patient-centered medical home, will be positioned for long-term success.

COVERAGE EXPANSION

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Many factors influence the availability, continuity and quality of health care that patients receive, but in the United States the single best predictor is whether or not one has health insurance coverage. Those with high levels of coverage have access to a wide variety of services, providers and sources of health care. They receive high levels of care and continuity of care with little financial risk. Conversely, those with low levels of coverage have limited access to health care services and providers. They receive correspondingly lower levels of care, experience disruptions in continuity, and face significant financial risk whenever they need health care services.

Today, there are more than 45 million Americans without health care coverage in the United States.¹² Runaway inflation in health insurance premiums¹³ is causing employers to drop health care benefits for employees, and the almost insurmountable cost and availability barriers that individuals who try to purchase health care coverage face are leading to projections that without reform, the total uninsured population will reach 61 million¹⁴ by 2020.

2015 Predictions

Health care coverage reforms will preserve current coverage and extend more affordable coverage to individuals and small employers who are currently “priced out” of the market. This will include:

- Expansion of public assistance programs to support health care coverage for the “working poor” for families and for children,
- Preservation of existing health benefits, including employer-sponsored benefits, fulfilling the bipartisan commitment — “those who are happy with their current coverage will be able to keep it,”¹⁶ and
- Individuals will be required to obtain coverage either through their employer, some form of a public plan, or in the newly regulated and reformed individual and small group market where coverage will meet the affordability requirement.

It is too early to make a prediction about the “public” plan, but a few things are already clear. Providers, hospitals, employer sponsors, and commercial health plans expect to experience various levels of operating declines, competition, and cost shifting if a public plan is implemented that achieves significant market share and relies on Medicare reimbursement rates and billing rules. At the other end of the spectrum, a public option in which the federal government contracts with commercial payers and plans to administer a pre-defined benefit plan opens new opportunities for business growth and for the development of competitive provider networks. Whatever the final version looks like, there will be significant implications for all stakeholders, some negative and some positive, which will vary based on the design of whatever public plan is adopted.

Health care coverage reforms will establish standards for benefits and pricing that in the long run will standardize and “commoditize” marketplace offerings across the spectrum of coverage options and sources. Ensuring the availability of affordable, effective coverage for individuals and small employers will require the definition of coverage and pricing standards, and establishing mechanisms that allow purchasers to effectively compare and contrast offerings to make purchase decisions.¹⁷ Enforcing standards and simplifying comparisons will provide a level of transparency that is missing from current markets — and will create a de facto standard against which employer sponsored benefits and entitlement program benefits can be measured. This will have profound impact

on the health care benefit market — particularly in reducing the variation in benefit and service options, and will transform the basis on which health plans and commercial carriers compete for business.

Expanding coverage will exacerbate current health care cost and capacity issues and accelerate the “flight” of some providers and consumers from the mainstream health care system. Providing coverage and effective health care continuity to an additional 45 million people will strain the system. The resulting capacity constraints will feel like rationing to those accustomed to high levels of care and service — both as providers and as recipients of care. Providers and consumers with the desire and the means to do so will find opportunities to exit the system, establishing and reinforcing a second, and even third, tier of health care for those who can afford to pay.

Health Insurance Exchanges modeled on the Massachusetts Connector will be a critical enabling technology for any version of health care reform. All of the reform proposals under consideration require the creation of an electronic marketplace where individuals and groups can compare benefit plans, health plans, and pricing and then make their purchases. These exchanges must be built, tested, and delivered to the industry in a rapid time frame, and then they must be populated with all the information that is required to make them run. Whether the exchanges, or multiple exchanges, are a public, private, or shared resource and responsibility, it is clear that significant technical and industry expertise will be required to develop, deploy and maintain them.

Implications

In the near term, coverage reform that results in extending affordable coverage to the uninsured will be a mixed blessing for health care industry stakeholders.

Health delivery organizations and providers will have to quickly adopt care delivery models and practices that allow their already overextended organizations to respond effectively to the demand that will be generated by up to 45 million new patients — many of whom will have access to routine care for the first time. The cost pressures from extending coverage to these new populations will further erode reimbursement levels — creating added financial pressure for providers.

On a positive note, providers and hospitals may find it simpler to meet payer administrative requirements once coverage reforms are in place. Coverage reforms will simplify and standardize many products, benefits, and administrative requirements for a major segment of the market. Standardization will promote administrative simplification, streamlined operations, and overhead cost reductions across health care delivery organizations.

Enormous changes and opportunities in the payer segment will result from implementation of coverage reforms under almost any possible scenario. Operational efficiencies that result from the standardization of products and pricing will be offset by the administrative and logistical burden of rapid and large scale expansion of individual and small group customer bases.

- Plans that demonstrate best practice competencies in enrollment, eligibility, and premium billing will quickly rise to the top in these new markets, as coverage is extended to as many as 45 million new enrollees, many of whom will be enrolled in benefit packages with innovative and complex enrollment, funding, and billing arrangements that combine features of individual products, government programs, and group-sponsored plans.
- Traditional rating, underwriting, and renewal practices will have to be redesigned and re-implemented to meet the requirements of new coverage reforms — and risk models developed to adequately describe and predict the likely business impact of these new segments of business.
- The cost and demand pressures that this new population places on provider and health care delivery organizations will require new provider network management strategies and support tactics.

- Payer organizations will need to significantly reengineer existing customer service approaches, staffing, and automation to accommodate the volume and needs of these new customers.

The major near term impact for employers and employer-sponsored health benefits will be for employers who do not currently provide coverage for employees.

- Coverage reforms like community rating, the limitation on pre-existing condition exclusions, guaranteed issue, and guaranteed renewal are likely to reduce the cost of available plans for small groups and micro groups, which will make these plans more accessible to these potential markets.
- If the final reform legislation requires employers to “pay or play,” it will remove the cost-free option currently enjoyed by those who do not provide employee health benefits.

In the longer term, the market reforms and product and pricing standardization that are implemented with coverage reform will have far-reaching implications for all stakeholders. Initially, existing employer-sponsored benefits will be richer than the coverage options available through the new programs. As these new benefit plans mature, they will set the standard by which all health care options are measured. Benefit packages that are richer will increasingly be viewed as possible targets for taxation, for cost shifting to consumers who desire them, and as luxury goods that are only available to those with the means to purchase them.

- Group purchasers will experience long-term cost reductions and the opportunity to use enriched benefits as a recruitment and retention tool.
- Consumers can expect to pay more out of pocket for enhanced benefits and for services that no longer fall within the “standard.”
- Providers can expect further administrative simplification and reduced administrative costs as variation in administrative requirements decreases, but this will be offset by financial pressure from payers and consumers to justify the use of “non-standard” services and treatment modalities.
- Payers and health plans can also expect reductions in administrative overhead that result from standardization and “commoditization” of basic health care benefits. Organizations that operate efficiently will continue to have a significant marketplace advantage.

At the same time, payers and health plans can expect to see growth in products and services that augment the basic benefit package, which will require creative enrollment, pricing, and billing practices to support it.

The Bottom Line

In the short-term, the success of health care coverage reform efforts will present volume and access issues for payer and provider organizations. Under continuing cost pressure, organizations that operate efficiently by eliminating duplication, administrative overhead, and other “waste” will have a significant advantage in coping with this challenge.

Payer organizations with operational capabilities to master the new complexities of enrollment, eligibility verification, premium calculations, funding, and subsidies required for expansion of Medicare, Medicaid and by new coverage offerings will be positioned for long-term success in the new markets.

In the longer-term, as coverage reforms result in the standardization and “commoditization” of benefit plans, successful payer organizations will be the ones that provide high volume/low-cost solutions for standard plans and packages.

Payer organizations that are prepared to provide innovative value-added services and market offerings outside the scope of the new standards will be positioned for growth after 2015.

CAPACITY CONSTRAINTS

Cost Inflation
 Coverage Expansion
Capacity Constraints
 Evolving Expectations
 Information Technology

One of the core challenges the U.S. health care industry must face during the next five (and following) years is matching a growing demand for care with a care delivery capacity that, as currently structured, is already showing signs of being inadequate and is projected to fall farther behind. It is also a trend health care reform will exacerbate by providing care-enabling coverage to the currently uninsured.

Increasing demand is coming from changing expectations as well as needs across the U.S. population. Examples of current and pending sources include:

- **An aging population:** By 2015, the over 65 population will increase by almost 7 million (or almost 18 percent),¹⁸ and people 65 and older use twice as many physician resources as those younger than 65.¹⁹
- **A sicker population:** By 2015 U.S. residents (and not just the elderly) with one or more chronic conditions will increase by more than 8 million (more than 5 percent), and people with chronic conditions account for more than 70 percent of physician visits.²⁰
- **A population with greater active lifestyle maintenance and other care demands:** For example, it is predicted that by 2030, Americans will receive eight times as many knee replacements as they are getting today.²¹
- **Health care reform:** One year after Massachusetts (whose coverage policy is often cited as a model for federal reform) mandated health insurance for all state residents, the number of adults reporting they could not find a primary care provider rose by 75 percent,²² and long waits for referral appointments (50 plus days for some specialties) are now being reported.²³

Compounding the problem, the supply of caregivers was not projected to grow fast enough to keep up with demand even without increases in insurance coverage. The number of physicians in the U.S., for example, although not expected to decline, is not increasing as fast as the demand, and the availability of nurses is actually expected to decline. In addition, the distribution of physicians by specialty is shifting from primary care to other specialties at an alarming rate (a 50 percent decline in the ratio of medical school graduates who selected primary care during the past decade). There are multiple reasons for overall shortages (including medical school capacity, which medical colleges are taking steps to address), but two of the big reasons for shifts away from primary care are money — “... the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties,”²⁴ — and perceived lower prestige associated with primary care as opposed to other specialties, particularly among physicians.

Current Shortage Predictions		
	2015	2025
Total Physicians: ²⁵	5.2 percent	14.5 percent
Primary Care Physicians: ²⁶	4.0 percent	14.3 percent
Nurses: ²⁷	26.5 percent	>35 percent

2015 Predictions

Despite efforts by educational and government groups to increase medical and nursing school enrollment, supply constraints will persist into 2015 and beyond.

The declining ratio of primary care physicians will continue unless immediate changes are made to make primary care more appealing.²⁸

Supply constraints will inevitably result in more and longer appointment and other care delays, which will feel like rationing to patients and providers. Providers and payers will face public pressure to respond to resulting dissatisfaction.

Implications

Health care providers facing caregiver shortages must explore and implement alternative care delivery options that leverage capacity in ways that enable their caregivers to deliver more care to more patients and payers must reimburse for these alternatives. Examples include e-visits that providers can electronically queue and often quickly resolve with instructions and/or quick orders, group visits that multiplex physician access to several patients at once, and mid-level [nurse practitioner (NP) and physician assistant (PA)] visits for delegating straightforward care and care administration. Moderate success with these alternatives is already being reported. For example, Harvard Vanguard Medical Associates in Brookline, Massachusetts has been experimenting with group visits for more than 12 months and reports providers seeing as many as three times as many patients per time slot as well as high patient satisfaction.²⁹

Providers will have to take the lead on implementing alternative care modes, but they need help. That help includes more and better reimbursement mechanisms for alternative care events from public and commercial payers, and expanded HIT support that includes patient portals or tethered PHRs (personal health records) for secure patient-provider messaging. In addition, taking full advantage of NP and PA visits requires that more if not all states extend provider licensure to NPs and PAs, and that commercial and public payers expand provider networks to include PAs and NPs as primary care providers.

All segments of the industry have to work together to make primary care more attractive and entice more physicians, NPs and PAs to select these specialties. One of the big challenges is increasing primary care reimbursement for physicians. The average medical school graduate begins his or her career strapped with \$140,000 in educational debts,³⁰ and primary care salaries, which average 55 percent of what other specialists can expect,³¹ make that practice a difficult choice. Managing primary care physician capacity is critical to several health care reform efforts including key roles for these physicians in reducing costly inefficiencies and improving care quality and safety. Unless reimbursement rates are increased to match or at least approach what specialists have the opportunity to receive, convincing more medical school graduates to enter primary care practices will be difficult if not impossible.

The Bottom Line

Health care capacity constraints are here to stay for the foreseeable future. Successful payers and providers will be the ones that take steps now to leverage scarce provider resources.

Provider organizations must implement care models and organizational structures that leverage scarce clinical resources, and make investments in the implementation of technology and tools to support them.

Payer organizations must adapt traditional provider network requirements to acknowledge and embrace these new care models and organizations, and must make changes to payment mechanisms to reflect these new structures and processes.

Managing demand will require payers to look beyond traditional health care settings and traditional providers — to engage directly with purchasers and individuals to mobilize patient self-care and wellness management programs and technologies.

HEALTHCARE EVOLVING EXPECTATIONS FOR PATIENT CARE SAFETY, QUALITY AND VALUE

Cost Inflation
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Over the past ten years, heightened expectations about patient safety and clinical quality have combined with rising concerns about health care cost inflation to create demand for care that is safe and effective for the patient and provides tangible value for the purchaser. The changes in expectations about how health care should be delivered, what the patient experience should be, and whether it is worth paying for have led to significant interventions and innovations by payers, purchasers, providers, and regulators in the form of quality and safety improvement initiatives, increased performance transparency and accountability, and the alignment of financial incentives with outcomes. The pressures and concerns of all stakeholders around performance and value continue, and are positioned to drive profound changes in accountability and roles across every sector of the industry, including patients, providers, employer and government purchasers, and health plans and other payers.

2015 Predictions

Reporting requirements that make performance transparent and reimbursement reforms that combine quality, safety, and cost objectives will continue expanding, but real changes in quality will be slow to materialize.

- Implementation of clinical quality and safety innovations and improvements remains problematic. Two recent studies find poor compliance with patient care safety and quality measures,³² and it is not entirely clear which quality and safety initiatives produce tangible improvement in outcomes.
- What the industry really needs is information about which clinical interventions and practices work best and which ones are most cost-effective. Unfortunately, comparative effectiveness study results, which have the potential to provide this information and thus change the underlying cost structure of clinical practice, are still limited in scope and may take years to produce results.

Federal health care reform initiatives will force the industry to address current weaknesses in coordination of care quality and efficacy across care boundaries (e.g., acute hospital, primary, and specialty care).³³ Provider organizations that are currently best positioned are integrated networks such as Geisinger Health System, HealthPartners, and Kaiser Permanente. Other organizations must pursue the cultural and organizational changes to integrate clinicians and care facilities and create organizations that can manage care and payment across settings, such as the patient-centered medical home (PCMH) and accountable care organizations (ACOs).

Providers will be accountable for producing acceptable quality and cost outcomes and avoiding unnecessary or duplicate service.

Purchasers will continue to expand direct interventions in wellness, health promotion, and health management programs, and combine them with benefit design changes and financial incentives for compliance and participation. There is growing recognition that improving health outcomes requires a motivated and compliant patient.

The practice of holding health care consumers accountable at the individual level for the financial consequences of health and lifestyle behaviors will begin to spread, and the practice of using financial incentives and penalties will increase.

Demand for effective, integrated patient self care processes, tools and technology will increase fueled by capacity constraints in traditional care delivery settings, and by increases in personal responsibility for health and health status.

Implications

Heightened expectations about patient safety and clinical quality are already affecting care delivery organizations. They include new checklists employed before and after procedures to help prevent errors, improved preadmission patient examinations to prevent non-payment for pre-existing conditions, and increased pay-for-performance and core measure reporting.

Part of the change will require adopting and optimizing health information technology (HIT) tools, including electronic health record (EHR) clinical decision support, patient documentation, and standalone applications such as e-prescribing, online disease registries, and disease management applications. Likely changes to reimbursement from health care reform may include the need to replace and/or upgrade revenue cycle systems (for which there are currently no federal incentive payments similar to those for EHR system adoption included in the American Recovery and Reinvestment Act of 2009).

A consistent theme from health care reform advocates is that better and more cost-effective care come together most often at venues where inpatient and ambulatory providers, primary care and consulting providers, and providers from multiple practices connect to coordinate care and share information and where payments are aligned with desired outcomes. Providers of all types will be stretched to bridge significant gaps between how they do business today (as “fragmented,” independent units) and more coordinated care expected in the future. Health plans and commercial payers must also carefully consider tactics to meet these new expectations. The pace and extent of that change is expected to be unprecedented.

Pressure on provider organizations for quality, safety, and value improvements continues to build, and the administrative burden associated with meeting the challenges will be intense. Prudent health plans and payers will support increasingly fragile provider networks by carefully considering the implications of their demands on the provider sector, and accelerating administrative simplification efforts to minimize the impact.

Purchaser-sponsored quality improvement initiatives from the public and private sector must be quickly evaluated and implemented, and traditional health plan transaction systems and workflows must be adjusted to account for the innovations. If the level of difficulty that health plans have experienced in the implementation of P4P programs and recent CMS reimbursement reforms are predictors of the future, then it is clear that health plans will be challenged to meet the expectations quickly and efficiently.³⁴

The direct role that purchasers are playing in health and wellness management activities presents opportunities for the traditional health plan as well. Early adopters of these practices have tended to be large self-funded employers with the resources to invest in building and operating these programs, and access to the patient-level clinical information that is required to make them work. The labor productivity ROI for workplace health and wellness programs may be more than 100 percent in some settings,³⁵ which will promote demand for these programs. Smaller purchasers will need a business partner to provide the scale, infrastructure, and access to patient-level data for their programs. Health plans are in a unique market position to aggregate this demand and provide solutions. The payer organization that can leverage traditional analytical, medical management and case management competencies to meet this demand from purchasers will have a significant growth opportunity.

It will be equally challenging for health plans to meet the expectations of health care consumers. Traditional health plans and payer practices are built on the assumption that the purchaser of benefits, usually an employer, is the customer. Increasingly, health care consumers in all market segments are expecting retail-like quality standards, service levels, and value from health care interactions. The health plan that can accelerate current efforts in creating a more “retail” experience for health care consumers in all market segments to meet the demand for transparency, service and satisfaction will have a significant advantage in the future.

The Bottom Line

Payer and provider organizations must take steps now to acknowledge fundamental changes in purchaser and consumer expectations about health care.

Demand for provider quality comparisons and outcomes and cost transparency continues to increase, both from consumers and from payers and regulators. Health care delivery organizations that make investments in workflow redesign and in EHRs and other tools to support these efforts will be positioned to meet these demands and succeed.

Payer organizations that take steps to mobilize their transaction data and systems to provide information on quality and cost and deploy decision support tools that use the information to support purchasers and consumers will be positioned for success.

The activism of purchasers and consumers in promoting self-care, disease management, and wellness is an established and successful trend. Payer and provider organizations that can collaborate effectively with these “new” health care system participants to deliver programs and services that support them will be positioned for growth and expansion in this emerging market niche.

Cost Inflation
 Coverage Expansion
 Capacity Constraints
 Evolving Expectations
Information Technology

“To improve the quality of our health care while lowering its cost, we will make immediate investments necessary to ensure that within five years, all of America’s medical records are computerized.”

— President Barack Obama, January 2009⁴⁰

Recent *New England Journal of Medicine* studies report the following installed EHR system penetration in the U.S. in 2008 and 2009:³⁹

	Hospital	Physician Practices
“Basic:”	7.6 percent	13.0 percent
“Fully functional:”	1.5 percent	4.0 percent
Total:	9.1 percent	17.0 percent

The health care information technology (HIT) focal point in the U.S. for the next five years will be accelerating acquisition, implementation, and integration of clinical information systems (CISs). Within the last several years, CISs have been identified as key resources for helping to fix much of what is bringing down the value of health care, including inefficient (costly) care delivery and administration, poor care quality, and care that is often less than safe. As a result, almost every health care reform proposal now includes extensive calls for new and more clinical systems.³⁶ As Dr. David Blumenthal, National Coordinator for Health Information Technology, recently stated, “There’s no way to transform the health-care system without information technology.”³⁷ Goals are:

- Electronic health record (EHR) systems that providers can use to create and review online records for all patients, and which include point-of-care support such as order processing and clinical decision support (CDS);
- Integration of EHR systems with other HIT applications (such as revenue cycle and enrollment systems) to exchange and share data that facilitate activities such as billing and coverage-based care decision making;
- Interoperability among EHR and other CIS systems (and system users) at separate care sites — so that cross-venue care (such as between primary care practices and hospital or primary and specialty care practices) can be tracked and coordinated; and
- Health information exchange (HIE), including regional health information organization (RHIO) and private HIE networks that provide a platform for transmitting data, and development and adoption of standards for transmitting and exchanging patient data.

Commercial and “home-grown” EHR systems have been available for about 30 years. The problem is that adoption in the U.S. has been slow and confined to a minority of hospitals, practices, and integrated delivery networks (IDNs) scattered throughout the nation. According to *New England Journal of Medicine* surveys published in 2008 and 2009, only 9.1 percent of hospitals and 17 percent of physician practices in the U.S. offer even “basic” EHRs. The goal of EHR proponents is momentum to make clinical information system use in the U.S. as much a part of health care as the stethoscope. This is already close to reality for primary care in Europe, where, for example, 97 percent of Dutch general practitioners in the Netherlands, and similar numbers of providers in Denmark and Norway, use EHR systems.³⁸

Incentives and other motivations for using EHRs have emerged from numerous sources within the industry, including payers looking for ways to decrease costs and increase value and public interest groups trying to improve care quality and safety. Examples include employer-initiated pay-for-performance incentives for using EHRs and e-prescribing systems, and increasing demands for pay-for-performance, core measure and other reporting (which proponents rightly argue that only patient record databases can adequately support at high volumes).

In 2009, the motivation was augmented by HITECH Act stimulus provisions that allocate \$36 billion in Medicare and Medicaid claims payment rewards to hospitals and practices that demonstrate EHR utilization. HITECH Act provision incentives will be dramatic; however, qualification criteria are also demanding, and for that and other reasons, they will not displace other motivations, but will help accelerate EHR acquisition and implementation at hospitals and practices that are otherwise positioned and motivated.

There are two current strategies being employed to expand CIS access to health care providers. The first is the aggressive approach: installing and implementing full-featured EHR systems. This approach has been successful at large delivery networks (such as Kaiser Permanente, Cleveland Clinic, and North Shore University Health System) where clinicians share common patient records, and will become increasingly viable at all hospitals and practices as health information exchange (HIE) becomes more widely available. The other strategy is an incremental approach: installing and supporting standalone EHR and CIS modules (that are otherwise bundled as part of EHR systems) that provide quick access to limited features, at lower initial cost, with only incidental interruption in day-to-day care processes, and with the expectation that many providers who find these features beneficial will subsequently convert to full EHR systems. Examples include: HIE provider portals that enable affiliated physicians to view hospital-based patient information such as results and discharge summaries, and in some cases also place and track orders; e-prescribing systems that include medication interaction and duplicate alerting as well as electronic order transmittal; and online disease registries and disease management applications.

2015 Predictions

Health care providers will divide into two EHR adoption camps during the next five years:

- Those that acquire and implement (or upgrade current) EHR systems, with the intention of qualifying for HITECH Act incentive payments; and
- Those that decide to “stay the course,” characterized by less-aggressive implementation schedules and attempts to postpone full EHR implementation. These providers will take advantage of HIE provider portals to share and view data from hospital and other systems, and standalone CIS applications such as e-prescribing and online disease registries.

By 2015, the number of hospitals and practices in the U.S. using and pursuing EHR and other clinical systems will substantially increase. The majority will still not be fully configured and implemented (which will mean the need for continued efforts into the future), but they will have initiated a momentum with the potential to make electronic health records an industry standard.

The greater number of hospitals and practices purchasing and installing EHR and other CISs will create an increased demand for resources to manage and facilitate implementations. This will include more IT technical and implementation support staff, new and faster methodologies for installing and implementing EHR and other systems, more HIEs, and new information system solutions, such as preconfigured, remotely hosted EHR systems, with which organizations can successfully “go live” in a fraction of the time it currently takes.

HIEs will expand and play important roles in EHR and other clinical system expansion. Those roles will include supporting data exchange between distinct EHR systems, provider portals that non-EHR users can use to view patient information from remote systems, and other data exchanges such as e-prescribing system order transmittal and medication history downloads. They will operate both as private hospital HIEs and regional health information organizations (RHIOs), and HIE system vendors will be leading providers of network frameworks and operational support. HIEs play critical roles in accountable care organization, patient-centered medical home and other care coordination programs by facilitating patient information exchange and affiliated provider access to cross-venue services such as hospital order entry.

Patient access to provider HIT networks, via patient portals, tethered PHRs, and other links, will expand. Changes this will promote include:

- Expanded patient self-care: via online appointment booking, online tracking of health maintenance agendas, patient chat rooms, and online access to self-care instructions, results, and related health care information.

Predictions about EHR adoption in five years vary.

- As low as 25 percent and as high as 75 percent
— John Glaser, CEO, Partners Healthcare, Boston⁴¹
- 40 percent of Medicare and Medicaid eligible providers
— CMS⁴²
- 47.3 percent of small-practice physicians
— JAMIA study⁴³
- 44 percent of physician practices, and 67 percent of physicians
— Bridges to Excellence⁴⁴

- More cost-effective e-visit and other remote care events: via blood glucose and other device links for downloading results from home, electronic provider-patient messaging, and telemedicine.
- Better leveraging of provider resources: by replacing face-to-face visits with e-visits, e-messaging, and reference to online resources when appropriate.

Implications

CIS implications for hospitals and physician practices will be logistical challenges: everything from funding and financing system purchases and operating costs to convincing IT-challenged physicians to give up their clipboards and pens.

The two most immediate challenges will be cost challenges (the most common reason provider organizations cite for not acquiring systems) and implementation challenges (the second most common). Costs will be partially addressed by numerous award programs, but even the very rich HITECH Act provision bonuses will only cover a portion of costs, and payments will be retrospective — meaning that providers must still fund substantial portions of and arrange financing for all costs. A lesson here for organizations considering acquiring EHRs with the primary intent of realizing HITECH Act incentive payments is “pause and rethink the objectives.” The incentives are clearly a boon to assist and accelerate efforts of organizations already on the way to installing and/or otherwise financially and operationally committed to using EHR systems to improve care outcomes.

The biggest implementation challenge, particularly for organizations just getting started, will be finding faster and easier ways to install and go-live with EHR systems. Current EHR system installations and implementations typically take years, and organizations under the gun to meet time-sensitive HITECH Act meaningful use criteria and realize returns on investment need to move much more quickly. Solutions include starting immediately, better and faster implementation project plans and management, and new system accommodations, including more pre-configuration of options to meet the majority of go-live requirements, and (particularly for small to medium-sized organizations) remotely hosted systems that can minimize up-front costs, implementation efforts and IT staffing challenges. However, quick installs cannot be undertaken at the expense of not training providers and staff, and failing to reengineer workflows that collaborate with the tools for managing patient information and patient flow that EHRs provide.

A key part of managing implementations will be tracking varying demands, such as Meaningful Use (HITECH Act incentive award) criteria and data exchange and other technical standards that are currently being defined by the Office of the National Coordinator of Health Information Technology (ONC) and will evolve over time. Those standards will be important not only as a gauge for measuring incentive award readiness, but also for tracking what the industry as a whole will come to expect from clinical systems and CIS users.

Finally, hospitals and practices that decide to postpone full EHR system implementation must identify interim and long-term strategies. Even without HITECH Act provision incentive success, the conversion of organizations around them is inevitable, and expectations for data exchange and EHR-based reporting of core measures and pay-for-performance data will increase, and HITECH Act provisions (that are likely to be adopted by commercial payers as well) include subsequent payment penalties for non-conformance with EHR meaningful use standards. It certainly will not be possible to respond to demand for accountable care or chronic disease management across settings without ubiquitous EHRs.

The Bottom Line

In order to survive and succeed in 2015 and beyond, health care delivery organizations must effectively implement and integrate EHR systems into day-to-day clinical and administrative operations — to meet reporting requirements, to support care coordination and collaboration strategies, to respond to payment reforms, and most importantly to promote safe, high-quality, and effective health care.

The HITECH Act provides some incentives to promote adoption and implementation of EHRs, but those incentives will not be enough to overcome all the obstacles to implementation. Successful health care delivery organizations will use HITECH Act incentives to promote and enhance long-term HIT plans and strategies, based on the recognition that HIT in general, and the current focus on EHR systems, is a critical enabler for their long-term transformation and success. Those that do not take advantage of the HITECH Act opportunity are at high risk of not being able to respond to the next era of accountable care and finance reforms.

Conclusion

The next five years will be a time of experimentation, innovation and transformation for U.S. health care as the industry takes on the challenges of controlling skyrocketing costs, and extending safe, effective, high-quality healthcare coverage to all. Progress will be slow because the issues are large and the practices that created them are established and institutionalized, and will be hard to change. The solutions that result will be complex and multi-faceted, and the process of developing those solutions will be filled with trial and error because the exact path from the current state to the future is not yet clear.

Despite the uncertainty and the likelihood of rework as reforms are implemented and solutions are designed, there are a handful of things that health care organizations must do to succeed during and after this transition:

Doing more with less will define the healthcare landscape of the immediate future for payers and for providers. Organizations that maintain a relentless focus on cost reduction and operational efficiency will be in the best position to succeed.

The “new” roles of employers and consumers actively engaged in self care, disease management and wellness promotion are here to stay. Traditional participants, like hospitals and physicians, and health plans and payers, must recognize the potential of these new partners, designing and implementing financial, operational and technology strategies to engage and support their efforts.

Moving the reimbursement model from fee-for-service to one based on high-quality, cost-effective clinical outcomes is the clearest available path to long-term control and reduction of health care costs. Health care providers that can organize themselves to provide reliable, high-quality, low-cost, effective, coordinated care will succeed while others will fail.

Coverage reforms that reduce costs and promote access to coverage will result in standardization and “commoditization” of many health care coverage products. Payer organizations that optimize operations to meet this challenge will succeed, but growth may be a challenge. Payers that successfully implement value-added services and products that enhance the new commodity products will realize growth opportunities.

Health care information technology is still the critical enabler for transformation in health care delivery organizations. Hospitals and physician organizations that maintain and accelerate their HIT strategies, leveraging HITECH Act incentives for EHR implementation and supporting physicians and patients with IT capabilities, will be best positioned to succeed in the future. Those that “wait and see” are likely to fail.

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