

CSC Healthcare Industry News Summary

January 2012

This News Summary contains synopses of, and commentary on, health-related articles that have been published in the industry and popular press. The Summary is posted by CSC's Global Institute for Emerging Healthcare Practices to this Web site monthly to help you stay abreast of industry issues and trends. The Summary is not intended to be a comprehensive review of these publications, but it will highlight innovations, advances in the state of the art or practice, interesting facts, and "scuttlebutt" about the industry that will help you keep up with what is happening. The information has been sorted into categories to assist you in identifying information that is relevant to your interests.

Touch on any of the links listed in the table below to jump to news in that category. Hyperlinks are included for sites that maintain access so you can read articles in their entirety. (However, some of these sites charge access fees for non-subscribers.) For articles not available on the Web, please contact the publisher. Please note, we offer News Summary as an educational service.

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Macro Trends

You have heard of the 80/20 rule, but in healthcare it is the 50/5 rule. **In 2009, 5 percent of the population represented 50 percent of all healthcare costs** and 1 percent represented 22 percent of costs. The 50 percent of people who spent the least only accounted for 3 percent of healthcare costs. (Cohen, S. and Yu, W. [Statistical Brief #354: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009](#), Agency for Healthcare Research and Quality, Rockville, MD, January 2012)

According to an estimate by the Battelle Memorial Institute, **genetic and genomic clinical laboratory testing generates 116,000 U.S. jobs and contributes \$16.5 billion annually to the U.S. economy**. The report said that the industry's genetic testing services and products support about 44,000 direct jobs and generate about another 73,000 jobs in supplier industries, such as real estate, food services, and wholesale trade businesses. The genetic and genomic laboratory testing sector generated \$657 million in estimated state and local tax revenue and nearly \$1.2 billion in federal taxes in 2009. The report was sponsored by the American Clinical Laboratory Association (ACLA). ([Genetic Lab Testing Creates 116,000 U.S. Jobs, \\$16.5B in Economic Output](#), *Healthcare Finance News*, January 20, 2012)

More than one-in-five Americans was in a family that had problems paying medical bills in 2010. Many of those Americans also experienced severe financial consequences from their medical debt: about two-thirds reported problems paying for other necessities and a quarter considered declaring bankruptcy. ([1 in 5 Americans in Families with Problems Paying Medical Bills in 2010](#), *Center for Studying Health System Change*, December 23, 2011)

The problem of binge drinking is larger than previously thought, according to new numbers released by the CDC. More than 38 million U.S. adults binge drink an average of four times a month. The most drinks they consume, on average, is eight. While binge drinking is more common among young adults ages 18 to 34, older binge drinkers (65+) actually do so more often: an average of five to six times a month. ([Binge Drinking Is Bigger Problem Than Previously Thought, CDC](#), January 10, 2012)

The American Board of Internal Medicine (ABIM) Foundation, in partnership with *Consumer Reports* and nine medical societies, has launched a **new campaign called “Choosing Wisely” which seeks to get patients and doctors to think about overuse of healthcare resources.** Over the next few years, each participating society will target five common tests or procedures that each designates needs discussion or should be questioned. The parameters used to narrow the options include limiting the five to the specialty’s purview and control; frequency and/or cost of the procedures; and having evidence supporting each recommended target. The societies will announce their self-developed lists in April of next year. The campaign comes at a time when the cost of medically unnecessary care is estimated to be in the billions of dollars. ([Choosing Wisely, ABIM](#), December 2011)

“Where Are the Health Care Cost Savings?” is a question that is frequently asked and where many opinions are offered. A recent article provides one answer and debunks several myths. The author counts as “real savings” proposals that cut costs by 1 percent or \$26 billion annually and that fundamentally improve quality and satisfaction with care. Malpractice costs are a common target but proposals to cap award amounts or limit the time lapse before a suit is filed would only save about 10 percent in malpractice insurance costs (or \$3.5 billion), and accompanying reductions in defensive medicine are estimated to reduce costs by \$7 billion. Insurance company profits are another target. However, the total combined profits of the five largest insurers total only \$11.7 billion. Substituting generic for a brand name drug has been a tactic that has already been implemented. Between 2004 and 2009, use of generics increased from 57 percent to 75 percent -- but costs of both brand name and generic drugs have increased by 25 percent. Increasing to 100 percent generics (an unachievable goal) would only save Medicare \$900 million. How about “million dollar babies” – the term that refers to patients whose annual costs exceed \$1 million? Since there are only a few hundred such patients, their total costs only account for 0.5 percent of health care costs. Even if the high-cost patients could be identified in advance, it would not be ethically possible to not treat them. **The only viable way to generate large cost savings is to improve care for chronic conditions.** Among the 10 percent of patients who consume 64 percent of health care dollars, 75 percent have a least one chronic condition, and 22 percent of all health care costs are estimated to be spent treating avoidable complications. The author suggest that improving care for chronic conditions will require: use of electronic health records (EHRs) to store and share patient data, using the data from EHRs to monitor patients and coordinate care, reducing the use of specialists, and covering services such as email and preventive lifestyle interventions. (Ezekiel J Emmanuel, MD; [Where Are the Health Care Cost Savings, Journal of the American Medical Association](#), January 22, 2012 – available without a subscription, registration required)

Findings from a recent survey by the Center for Studying Health System Change show that consumers’ interest in locating health information has declined in the past year. While the proportion of consumers who reported seeking health information increased steadily between 2001 and 2007 (from 38.8 percent to 55.5 percent), the number dropped in 2010 (to 50 percent). The finding parallels a separate finding indicating that patient visits to see their physicians declined between 2007 and 2010 by 4 percent. Center researchers propose several working hypotheses to explain the survey results. Researchers suggest that when there is less demand for physician visits, patients may be able to spend more time with their provider and obtain ample information during encounters to satisfy their needs – thus negating the need to seek additional information from elsewhere. Alternatively, they posit that the findings could indicate that patients are less likely to be engaged when they are less able to see a physician. Lastly, they suggest that the abundance of health information that is available through various media outlets – not least of

which is the Internet – may overwhelm patients and drive them to stop researching their health. ([Why Patients Are Turning Less to Media and Friends for Health Information](#), [amednews.com](#), December 26, 2011)

Consumers

The Department of Veterans Affairs (VA) recently announced that it has established Facebook pages for each of its medical centers across the country. The goal behind the undertaking is to better engage with returning veterans on a local level. According to Secretary of Veterans Affairs Eric K. Shinseki, "This event marks an important milestone in the overall effort to transform how VA communicates with veterans and provides them the healthcare and benefits they have earned." The VA first delved into the social media realm in 2008 when it established a single Facebook page; it now counts more than 150 Facebook pages, 64 Twitter feeds, a Flickr page, YouTube channel, and a "Vantage Point" blog. ([VA Launches Facebook Pages for all 152 Medical Centers](#), *Healthcare IT News*, December 22, 2011)

According to [Healthcare Finance News](#) and MSNBC, **uninsured patients are turning to popular coupon sites like Groupon and LivingSocial to find healthcare services.** Teeth cleanings, eye exams, and chiropractic care are just a few of the offers that have been offered. Some sites are even beginning to look to deals on elective procedures not typically covered by health insurers. Generally, patients purchase the coupons and pay upfront and are then responsible for booking an appointment and redeeming the coupon before it expires. The concept has become popular in recent years. Merchants like it for the exposure to new customers. According to data collected by DealRadar.com, about one in every 11 deals offered on coupon sites is for a healthcare service. A full medical checkup in New York, as seen on Groupon, recently sold for \$69 – significantly less than the regular price of \$200. On AmazonLocal, flu shots were offered for \$17, less than half of their going rate. ([Patients Look to Groupon, LivingSocial to Fill Gaps in Coverage](#), *Healthcare Finance News*, January 6, 2012)

According to the Consumers Health Forum (CHF), **the Patient-Controlled Electronic Health Record (PCEHR) being rolled out in Australia is likely to be a "flop"** because it will offer few benefits initially, and it will deny patients control over who has access to their records. Consumers are likely to withdraw their participation, refuse to grant access, or simply withhold information, according to CHF. The consumer group also calls for the personal electronic health records system to be "opt-out" by default rather than "opt-in", which it says will lead to a lack of critical mass for the system. The drawback to an opt-out model, CHF said, is that patients will rely on their GP for registration, and thus may not feel personally involved or engaged with the new system. (['Limited' PCEHR Set to Flop, Consumer Group Warns, 6 minutes](#), January 19, 2012)

Four companies – including giants **Ford and Microsoft** – have announced that they will collaborate to develop **a new app and supporting technology to allow drivers to monitor their health and wellness while in their automobiles.** The alliance – which will also include companies Healthrageous and BlueMetal Architects – was unveiled in a keynote "Doctor in Your Car" at the Digital Health Summit at the International Consumer Electronic Show in Las Vegas. The idea is that since people spend so much of their time in the car – and since mobile communications devices are ubiquitous – there is value to be gained from offering health and wellness-related services while driving. A spokesperson said he envisions Ford developing a "car that cares." Allegedly there are several reasons why the automobile is an ideal platform for research and development in this area:

- It is convenient and private;
- It facilitates personalized access to the information, products and services people need;
- It is a logical place for them to manage their health while they are more often stuck in traffic.

The goal, officials say, is to figure out how to extend health management into the personal vehicle in a nonintrusive fashion. Microsoft's contribution is to translate robotic sensory information provided by the vehicle into an application that also provides a voice-and-touchscreen interface while integrating biometrical data that comes from a wearable device. The Ford SYNC system will

allow this to be done hands-free. The data received from the driver are then uploaded into the HealthVault cloud. (Ford, Microsoft to Develop 'Doctor in Your Car', *Healthcare IT News*, January 12, 2012)

Active engagement is a key success factor for corporate wellness programs, and sponsors use a variety of incentive techniques to promote participation. **A new study in the *American Journal of Health Promotion* suggests that group lotteries may be more effective than simple financial incentives in promoting participation in one component of wellness programs: filling out health risk assessment (HRA) questionnaires.** (Health risk assessments are screening questionnaires that ask about a patient's health risk factors, such as smoking, weight, exercise, and other health behaviors. They are generally the first step in implementing a wellness program.) Researchers investigating the use of incentives enrolled nearly 1300 employees from a large healthcare management company in the study and investigated the effectiveness of three different incentive approaches. The first approach offered \$25 cash to any employee completing an HRA. The second approach offered \$25 cash plus a \$25 grocery gift card upon completion of an HRA. The third approach assigned employees to lottery teams of four to eight people. Each week, one team would be selected and each team member who had filled out an HRA would win \$100. As an additional incentive, if at least 80 percent of the team members had filled out an HRA, the prize increased to \$125. The cumulative cost of the lottery was designed to be equivalent to the gift card offering. About 65 percent of the employees in the lottery groups completed HRAs, compared to 42 percent in the cash-plus-gift-card group, and 40 percent in the cash-only group. (Team Lotteries Motivate Employees to Participate in Wellness Programs, *Health Behavior News Service*, January 2012)

Philips Healthcare Benelux and Catharina Hospital in the Netherlands recently launched a new month-long social media initiative to better educate the public about the value of healthcare and medical innovations. Individuals can tune in to Twitter to receive before and after updates from Ad Langendonk (@hartpatientAd), a patient from Eindhoven, and his cardiologist, Dr. Lukas Dekker (@cardioloogLukas) as Ad undergoes various medical procedures. On January 28, Ad is scheduled to receive a catheter ablation, a minimally-invasive procedure. In addition to updates on Twitter, individuals will also be able to track the procedure live online <http://www.dialoog.skipt.nl/evolutieindezorg/>. "Discussions about healthcare innovation are often complex and abstract, but ultimately healthcare is all about people," said Will Ickenroth of Philips Healthcare Benelux. "The value of healthcare and the importance of innovation to people and to society as a whole becomes much clearer when you visit a hospital or have a conversation with physicians and patients. Together with Catharina Hospital and Ad Langendonk, we are launching this unique initiative to show this from a patient's personal perspective," he said. Individuals can follow the parties on Twitter until February 10. Note: The Tweets are in Dutch. (Catharina Hospital and Philips Launch Unique Dutch Social Media Initiative Focusing on the Experience of a Heart Patient, Philips, January 10, 2012)

New research from Surescripts indicates that **patients whose physicians issue a prescription electronically are more likely to pick up their medications from pharmacies than patients whose physicians use traditional prescribing methods.** Surescripts worked with pharmacies and pharmacy benefit managers to consider patient's behaviors in filling "first fill" prescriptions (new prescriptions, not refills of previously prescribed medications) and examined 40 million prescription requests issued between 2008 and 2010. Findings indicate that more patients picked up e-prescriptions than paper prescriptions or those issued by phone or fax (76.5% vs. 69.5%). Convenience may be an influential factor. "E-prescriptions are beamed via a secured Internet network directly to pharmacies from computers or hand-held devices. The instantaneous transmission means patients do not have to tote a prescription with them, making it a faster, seamless process." Surescripts' data will be included in a forthcoming report, set to be released in December or early next year. (Surescripts: Electronic Prescribing Improves Medication Pick-Up Rates, *Wall Street Journal*, December 16, 2011)

GymPact puts a new twist on providing financial incentives to motivate exercise: the new iPhone app charges the user a penalty for every missed exercise commitment. Users provide a credit card, commit to a certain number of gym visits per week – and select the financial penalty they will be charged per missed visit. At the end of the week the app charges the users who did not meet their goals, subtracts a service fee, and distributes the remainder to network participants who kept their gym visit commitments. Penalties range from \$5 to \$50 per missed gym visit; service fees are about 30 percent of total collections. Winnings range from 50 cents to \$1 per visit which suggests that most users are keeping to their commitments and avoiding the penalties. ([New App Adds Incentives to Go to the Gym](#), *Reuters*, January 16, 2012)

Kaiser Permanente just announced that its members can now securely access their health information electronically through a mobile app. A free app is available to Android users which allows individuals to connect to their records from Kaiser's system and accomplish various tasks, including accessing their diagnostic and laboratory information, exchanging emails with providers, and submitting prescription refill requests. An iPhone app is also being developed which will be released in coming months. Individuals who use other smartphones will also be able to access their information through a "mobile-optimized version" of Kaiser's Web site. ([Nearly 9 Million Kaiser Permanente Health Records Securely Available on Mobile Devices](#), *MarketWatch*, January 24, 2012)

Writing on the blog of the [Harvard Business Review](#), two consultants offer some thoughts on **the trouble with treating patients as consumers**. According to them, treating patients as typical proactive, well-informed consumers who are in control of their consumer decisions can backfire. Consumers are being asked to take on increasingly complex decisions and digest ever-larger amounts of information. According to the authors, there are three problems.

- 1) Patients don't want to be there. Patients want their problem solved and then they want to get back to normal. When patients are required to be proactive decision-makers, the healthcare system is often casting a very reluctant hero into the role.
- 2) Many patients aren't equipped to be decision makers. They may not have the tools. At a time of unusual stress, the system asks them to absorb technical information and make difficult decisions that require specialized expertise.
- 3) Patients are part of a complex system and aren't often independent decision-makers. Decisions are shaped by other stakeholders: friends and family who support the patient, the insurance company who foots the bill, practitioners who provide care and expert advice, the hospital administrators who inform system-level protocol, and so on.

Treatment, the authors write, should be doable, rather than ideal. "As healthcare delivery undergoes a profound transformation, the reflex to put patients in the driver's seat can result in poorly designed delivery systems that don't necessarily improve care or reduce costs." The bottom line: don't undermine the quality of care by demanding more of patients than they should be expected to deliver. ([The Trouble with Treating Patients as Consumers](#), *Harvard Business Review Blog*, January 9, 2012)

A new study published in the [Annals of Internal Medicine](#) indicates that **patients who use a personal health record (PHR) are interested in sharing their information with parties outside of their health system**. The study surveyed 18,471 users of My HealthVet Web site – the U.S. Department of Veterans Affairs (VA) PHR system – between July 7, 2010, and October 4, 2010 (response rate 40.8%). The majority of respondents (79%) expressed interest in granting access to their PHR to someone outside of the VA, such as a spouse (62%), child (23%), other family members (15%), or non-VA providers (25%). The authors conclude that "existing and evolving PHR systems should explore secure mechanisms for shared PHR access to improve information exchange among patients and the multiple persons involved in their care." ([Patient Interest in Sharing Personal Health Record Information](#), *Annals of Internal Medicine*, Vol. 155, No. 12. p. 805-810, December 20, 2011)

Health Plans

Private sector health plans are gearing up for health reform inspired payment and incentive reforms, but their underlying transaction systems are not ready to meet the requirements, according to a recent survey of 106 payer organizations 54.4 percent of payers surveyed plan to support accountable care organizations;

- 50.5 percent plan to support pay-for-performance;
- 51.5 percent plan to support “new payment approaches;” and
- 64.1 percent plan to support “other healthcare reform initiatives.”

Only 37.1 percent of plans have technology that will allow them to support accountable care organizations, and about half can support pay-for-performance programs. **Health plans are generally lagging in their ability to meet the 2013 deadline for ICD-10 implementation as well.** Only 22 percent rated themselves as “completely prepared” and 36 percent rated themselves as “somewhat prepared” for ICD-10 deadlines. More than one-third (37 percent) said their organizations were “only starting to prepare.” ([HealthEdge Survey Shows Payers Planning to Support New Healthcare Models](#), *Healthcare Finance News*, December 27, 2011)

Large insurers are the latest group to leverage the convenience of mobile health applications. Several insurers have begun investing in wellness apps designed to help engage patients. For instance, Aetna recently purchased iTriage, a popular mhealth application that assists patients in locating health information and medical services on the go. In addition, Wellpoint – in collaboration with Verizon Wireless – has launched a pilot program that seeks to connect patients with health coaches through smartphones. Lastly, UnitedHealth Group is partnering with various mobile technology companies on a variety of initiatives, including FitNow, Inc., which makes a popular weight loss app (Lose It!). Insurers insist that they are not trying to substitute mobile health applications for physician care. Rather, their goal is to assist patients in understanding when physician care is necessary and help connect them with care (when necessary) through the use of mobile technology. “The revolution in mobile health is not about replacing physicians but rather in extending their reach and better targeting their time and talent – precious resources in the era of a graying population,” said West Wireless Health (a mobile health research organization) CEO Joseph Smith. ([Large Insurers Invest in Mobile Health Apps to Boost Patient Wellness](#), *iHealthBeat*, January 23, 2012)

CMS used flawed methodology to calculate risk-adjusted payment rates to Medicare Advantage plans resulting in overpayments of as much as \$3.1 billion in 2010, according to a recent review by the Governmental Accountability Office (GAO). Risk adjustments are used by CMS in paying Medicare Advantage plans to cover Medicare beneficiaries and provide additional reimbursement that reflects the severity of illness in the enrolled population. The current methodology compares the cost of providing care to Medicare Advantage beneficiaries with the cost of providing care to beneficiaries in the traditional Medicare program by comparing the claims paid and encounters submitted for the populations. Historically, the coding practices in the Medicare Advantage encounters have been “higher” than in the traditional population which has accounted for some of the variation in apparent costs. CMS adjusts for these coding behavior variations when it analyzes the comparisons, but the GAO study concludes that the level of adjustment is inadequate to account for the cumulative effect of inflationary coding practices in the Medicare Advantage encounter database. CMS estimates that the effect of coding practice inflation accounted for a 3.4 percent of the variation in 2010 and used the same factor for 2011 and 2012 rates. GAO estimates that the actual factor was at least 4.8 percent, and could have been as high as 7.1 percent, and that the variation increases over time so 2011 and 2012 adjustments were understated if 2010 factors were used. Going forward GAO recommends annual updates, the use of more current data, and broadening the set of beneficiary characteristics that are used to calculate morbidity. ([CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices](#), *GAO*, January 12, 2012)

Wellpoint and Aetna are betting that paying more for primary care will reduce overall healthcare expenditures by launching innovative payment practices focused on primary care physicians. The Wellpoint program offers primary care physicians a fee increase of about 10 percent with incentive payments that could reach 50 percent if targets are met. Wellpoint, which covers 34 million lives, expects that the pay increase will result in \$1 billion of increase to primary care physicians. In addition to its fee increase for visits, which will vary by market, WellPoint will offer primary care doctors payments for services such as developing treatment plans for patients with chronic diseases. It says physicians will get a chance to make even more if they help pare the overall cost of a patient's care: a bonus amounting to as much as 20 percent to 30 percent of any savings they achieve. The payoff, according to their actuarial models, will be a reduction in emergency room visits and inpatient hospital stays. Wellpoint is also offering data and information to primary care providers to assist them in meeting the patient care goals that are tied to the additional reimbursement. The Wellpoint program will reach more than 100,000 physicians. In a similar move, Aetna is launching new payment programs aimed at the 55,000 primary care physicians in its network. The Aetna program is expected to result in the creation and support of significant levels of "patient-centered medical home" practice models across their provider networks. Primary care providers will earn bonus fees of \$2 to \$3 per patient per month for achieving certification standards for access and coordination of care. ([An Rx? Pay More to Family Doctors](#), *WSJ*, January 27, 2012)

Aetna is moving beyond its own membership for market share and leveraging a partnership with Best Buy. Aetna will combine its wellness and health promotion programs with devices like pedometers and blood pressure cuffs that are available in the "health technology" departments of some large Chicago-area Best Buy stores. The program is called "My Resources for Living Well" and includes on-line modules focused on fitness, weight management, smoking cessation, and stress management. Each of the on-line programs sells for \$19.99 and includes a combination of coaching session, motivational materials, and online tracking of self-reported progress. Best Buy staff onsite receive training about the on-line component and the supporting health technology devices that can be associated with it. ([Aetna Brings Well-Being to Best Buy](#), *MarketWatch*, January 5, 2012)

Ohio's Medicaid program is the first one in the country to implement value-based purchasing (VB) in contracts with managed care plans – which will be effective in 2013. VBP – a health reform payment initiative that aligns payment for healthcare services with outcomes and effectiveness rather than volume – is a cornerstone of the Medicare program payment reforms but has had little traction in state Medicaid plans until recently. Ohio's effort will require that managed care plans shift some of their provider reimbursements to incentives for healthcare providers to improve enrollees' health. The new contracts will be based on language developed by Catalyst for Payment Reform – a San Francisco-based nonprofit that uses the collective purchasing power of large employers and groups such as General Electric Co., Walmart Corp. and California Public Employees' Retirement System – to push for greater value in healthcare. Using the Catalyst approach with its roots in VBP programs from large private sector employers, sponsors of health coverage may simplify the landscape for physicians and hospitals who are challenged to respond to different reforms in the public and private sectors. ([Ohio Begins Value-Based Measure for Medicaid](#), *Dayton Daily News*, January 9, 2012)

Product design variations in the Medicare Advantage market may attract healthier beneficiaries to enroll, reducing coverage costs and improving health plan financial performance, according to a recent study in the *New England Journal of Medicine*. The study compared seniors in Medicare Advantage plans with gym memberships to seniors in other plans without the gym benefits and to the plans' old membership before it started paying gym fees. Based on information from beneficiary self-assessments, it seems that healthier seniors enroll in plans with a free gym membership. Specifically, 35 percent of seniors enrolled in Medicare Advantage plans with fitness benefits reported being in "excellent" or "very good" health while only 29 percent of seniors in plans without the benefit believed they were in such good health.

Medicare Advantage plans are highly regulated and are specifically prohibited from denying coverage based on illness or pre-existing conditions or from using strategies to attract healthier patients. ([Fitness Memberships and Favorable Selection in Medicare Advantage Plans](#), *New England Journal of Medicine*, 2012; 366:150-157, January 12, 2012 – subscription or purchase required)

An insurance company in Australia wants the Federal Government to provide anonymous patient data from the Personally-Controlled E-Health Records (PCEHR) system so that it and other companies can do research on Australian health. Under legislation currently before parliament, only consumers have control over access to information in their own e-health record, and only they can decide which health practitioners are able to see what information contained in their e-health record. However, insurance company Bupa believes that this is too limited and that – in the interests of research – all data should be anonymized and made available for research. Bupa argues that health and wellness organizations are uniquely positioned to develop and implement sophisticated data-mining tools, which can lead to better programs to improve health. For example, companies could determine what percentage of diabetes patients do not have their annual eye exam or the percentage of people with heart disease who do not take statin medication. Meanwhile, other groups have raised concerns about privacy. The Australian Privacy Foundation expressed skepticism and said that the legislation needs to better define the term "health provider" – those who will be able to access the PCEHR system. ([Insurance Firm Wants to Mine e-health Data](#), *ZDNet*, January 12, 2012)

Health Delivery

A new policy analysis piece from the National Institute for Health Care Reform (NIHCR) proposes two new ideas in order to expand the supply of primary care providers and address the workforce shortage. While ongoing efforts to boost the supply of primary care providers such as educational loan forgiveness, scholarships, and higher payment rates are expected to boost the number of doctors entering primary care, these efforts are not expected to fully take hold for a number of years. Instead, the authors suggest:

- **Expanding the scope of practice:** The analysis suggests broadening scope-of-practice laws for APNs as a possible method to expand primary care capacity more rapidly. Current state scope-of-practice laws, which determine the tasks non-physician health professionals can perform and the extent to which they may work independently, vary widely. (Currently, 22 states and the District of Columbia allow APNs to practice independently. Other states require some form of physician oversight for APNs.) On patient satisfaction and short-term mortality, APN performance is equal to that of physicians.
- **Payment Policies for Team-Based Care:** Changing the way practitioners are paid can have an immediate effect on the amount and type of care they deliver. Methods such as capitated payments that put providers at risk for the cost of care or case management models that provide additional payments for care management may provide incentives and encourage the development of teams that share care responsibilities. These teams potentially could deliver more primary care to a greater number of patients than a physician working alone could provide.

([Expanding Scope of Practice May Be Solution to Primary Care Workforce Shortage](#), *Healthcare Finance News*, December 28, 2011)

Does the healthcare industry have a random jargon generator at work? Most years it seems like it and according to industry observers 2012 will be a banner year, as the Top 12 Healthcare Buzzwords for 2012 grapple with the multiple interlocking paradoxes of health reform.

- **No. 1 – Palliative Intensive Care** – an emerging approach to ICU and CCU care that integrates the traditional interventions with the practices of palliative care providers (in recognition that 30 percent or more of inpatient mortality occurs in the ICU and CCU.)
- **No.2 – Cultural DNA** – an expression increasingly used by healthcare quality leaders to describe the positive impact and effect on safety and quality when organizational leaders “walk-the-walk and talk-the-talk.” The notion is that even though DNA is not subject to change (and some would argue that culture is not either) – the consistent practice of new behaviors can lead to transformation.
- **No. 3 – Change fatigue** – a new kind of fatigue that comes from too much change, too much innovation, too many new requirements and practices that are implemented too fast. It is a sharp contrast to the fatigue that comes from being stuck in boring old routines.
- **No. 4 – Accountable care skimping** – describes the possibility that providers who are accountable for the cost and efficacy of the care they provide may make decisions that “skimp on care.” Note that the word “skimp” appears four times in the final ACO MSSP rule.
- **No. 5 – Positive deviance or disruptive innovation** – in a time of significant change and industry transformation those who practice differently (deviating from norms or innovating) may be producing excellent results anyway, or creating new methods for producing better results. Different isn’t necessarily bad.....
- **No. 6 – Essential benefits** – defined in the Affordable Care Act; there are ten essential benefits – ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness

services and chronic disease management, and pediatric services. However, recent guidance from HHS leaves the details up to the states allowing some benefits to be essential in one state, but not in another.....

- **No. 7 – Day 31** – New CMS penalties for preventable readmissions within 30 days of discharge raise questions about practices that emerge to delay admissions to the thirty-first day.
- **No. 8 – Getting to genba (or gemba)** – a term from LEAN process improvement methodology for the idea that by going to where the work actually happens, costs may be reduced, care could be streamlined, and patient care might very well improve.
- **No. 9 – Gamification** – the use of techniques like game-like interfaces and qualities as a way to get patients, caregivers and others to learn about their health and use their healthcare data to improve it.
- **No. 10 – Engagement** – not a new word, but relatively new in healthcare settings; it is a term to describe the process of ensuring that all the concerns of the stakeholders are reflected and addressed in the solution and then that they are all committed to its success.
- **No. 11 – Getting to zero** – the increasingly controversial implicit goal – embedded in many quality improvement and incentive programs – to completely eliminate adverse events, surgical errors, hospital-acquired infections, ventilator-associated pneumonia, and anything else bad that happens to patients in healthcare settings.
- **No. 12 – Service recovery mode** – practice from retail and service industries that is gaining traction in healthcare, describes proactive steps taken when errors or failure in service occur. Examples include apologies and financial compensation, even visits from the CEO, when mishaps occur, even before fault is clearly assigned and long before litigation begins.

([Top 12 Healthcare Buzzwords for 2012](#), *HealthLeaders Media*, December 27, 2011)

Conventional wisdom supports the phased approach to implementing electronic health records (EHRs), but one author writing for *Health Data Management* offers some points to consider on **why the “big-bang” approach to implementation might be better**. A few of her points:

- “First off, there are those American Recovery and Reinvestment Act deadlines. With the pressure to not only implement but to prove the meaningful use of electronic records technology only months away, there is simply no time for the long, drawn-out, phased-in implementation.”
- But regardless of meaningful use, she writes, she still advocates strongly for big-bang implementations over phased-in approaches. She says that a staged approach sends the wrong message. “If leaders are trying to sell staff members on the importance of using an EHR, how can they say that it is OK for half of the hospital’s users to keep using paper for months – even years – while others are using electronic records? It is a mixed message that will cause staff to disregard the importance of electronic systems.”
- A phased-in approach is also “extremely inefficient” according to the author. The end result is that “the hospital limps along carrying the weight of all these siloed technology builds on its shoulders.” Moreover, during implementation, “processes are broken and then fixed during each stage.” Leaders then spend time trying to fix what was just broken, as opposed to simply implementing the whole system at once, and fixing the broken process in one fell swoop.

([Big-Bang EHR: The Right Choice](#), *Health Data Management*, March 2, 2011)

Eighty-eight percent of *Most Wired* hospitals download blood glucose data directly into the electronic health record (EHR). The data show that *Most Wired* hospitals have made progress with downloading data from patient monitoring equipment directly into electronic records systems. Other results from the 2011 *Most Wired* survey are cited for the following types of data:

- ECG – 80 percent
- Bedside blood pressure – 71 percent
- Bedside pulse oximetry – 70 percent

- Bedside lab tests – 65 percent
([Integrating Patient Data into the EHR](#), *Hospitals & Health Networks*, January 2012)

A new study published in the *Archives of Internal Medicine* finds that the use of electronic health records (EHRs) may help reduce healthcare disparities. Researchers analyzed the 2007-2008 National Ambulatory Medical Care Survey data on primary care visits in which physicians recorded the patient's blood pressure. The findings show that 75 percent of white patients had acceptable blood pressure levels versus 69 percent of black patients in offices that used paper-based medical records. In contrast, 78 percent of white patients had acceptable blood pressure levels versus 75 percent of black patients in offices with EHRs. Lead author Lipika Samal cautions that the findings only show an association and do not demonstrate that EHRs reduce health disparities on their own. She says that more research is needed on the topic but added that "if we really do find the tools help to reduce disparity, then, as a society, we should incentivize people to use these tools." ([EHRs Can Help Address Health Care Disparities, Study Finds](#), *iHealthBeat*, January 10, 2012)

A new report offers guidance to healthcare organizations on how to address the risks involved in the use of social media in healthcare. According to the report, a number of healthcare organizations in the U.S. are already using social media in a variety of interesting ways – groups use social media to distribute news and educational information, promote community events, share success stories, and engage patients. The authors assert that the use of social media in healthcare has the potential to provide various benefits, including improved outreach and communication to and with patients. However, the use of social media in healthcare lags behind other sectors. Many in the healthcare sector remain wary of the risks involved in using social media. For instance, social media could expose organizations to patient privacy breaches and HIPAA violations if clinicians or staff inappropriately share patient information on social media channels. To guard against this and other risks, while also ensuring that social media resources are used effectively, the report recommends that organizations establish and enforce policies regarding its social media use. In particular, the report states that, to be effective, these plans must "define how engaged the organization will be, who its audience will be, and who will be responsible for managing social media outlets as well as establishing policies and procedures for managing risks related to privacy, reputation management, and employment issues." ([Social Media in Healthcare](#), *ECRI Institute*, January 2012 – registration required)

A new report finds that retail health clinics are poised for growth in 2012 and beyond. Retail health clinics saw significant growth between 2006 and 2008, but the growth rate slowed in 2009 and 2010. Some had speculated that the boom was tapering off. However, in 2011 the growth rate jumped again by 11.2 percent. Merchant Medicine Chief Executive Thomas Charland predicts that the growth will continue in 2012 and in future years. The implementation of the federal health reform is expected to be a boon for retail clinics. One major retail health clinic provider is already planning to expand their operations to meet the demand of newly-insured patients. Larry J. Merlo of CVS Caremark, which operates 650 MinuteClinics in their retail locations, says plans are underway to nearly double the number of clinics in coming years. "We announced plans to open 500 clinics over the next five years," he said. "We believe our plans to double our clinic count over the next several years will position us well to play an important role in providing care to the 32 million newly insured beginning in 2014." ([Retail Health Clinics to Resurge in 2012](#), *Fierce Healthcare*, January 10, 2012)

"Growing demands for quality, safety, effectiveness and economy require hospital strategies with ever more moving parts. Making sure they all work smoothly together is the chief operating officer's main task." According to *Hospitals & Health Networks*, this had made today's chief operating officer into a "**chief integration officer**." Succeeding in this new, challenging role requires a broad range of experiences and competencies. One COO cites relying on her prior experience as a system corporate counsel to drill down to the important issues in complex situations and to work through issues in negotiating with physicians. From outpatient operations, she gained experience with matrix reporting and collaboration. Others report that the role has

changed less than the scope of the operating units to be managed and that the job now encompasses IT and clinical process improvement because “clinical quality and patient satisfaction are directly related to financial performance and even bond ratings.” Another change is that a COO must “transition from a tactical role of managing day to day to that of a more strategic thinker.” One executives sums this up as, “doing things right *and* doing the right things.” ([Focus on the C-Suite: Integrator-in-Chief, *Hospitals & Health Networks*, January 2012](#))

A “silver stampede” is about to hit hospitals as the baby boomer generation starts to fill hospital beds, and some hospitals are doing more than just educating clinicians in **geriatric care** to respond. For example, at Abington Memorial (PA), every patient is screened for falls, pressure ulcers, and delirium. A therapeutic walker program includes a get-out-of-bed protocol that authorizes nurses trained by physical therapy to determine when patients can get out of bed. Trained volunteers visit with older patients daily, helping them with meals, bedside exercises or walking, and hearing and vision equipment. A geriatric team is available for consultation and routinely rounds on trauma patients. Throughout the hospital are 75 nurses with geriatric nursing certification. Some hospitals have Acute Care of the Elderly (ACE) units to manage patients at high risk of losing their ability to live independently due to hospitalization. At Wake Forest Baptist Health (NC), an ACE Transitional Program, a geriatric fellow, medical resident, and medical student visit older people in their homes or nursing homes during the first ten days after discharge to check on status and social supports, as well as link with home health nurses. ([Is Your Hospital Ready? The Silver Stampede, *Hospitals & Health Networks*, December 2011](#))

Patient Safety/Quality

Verbal and telephone orders in the hospital are widely recognized as a potential source of “miscommunication or misunderstanding because of a variety of human and environmental factors, including receiver or sender fatigue, workload, sound-alike medications, background noise, accents, dialects, and different pronunciations.” In its accreditation standards, the [Joint Commission](#) requires that hospitals minimize the use of verbally-communicated orders and adopt other practices to reduce risks. A recently published review of source documents from 40 hospitals (of all sizes and types) provides a current picture of the policies and procedures hospitals are using to address this issue. Key findings include:

- “As expected, physicians were the most frequently identified healthcare provider authorized to give verbal orders, regardless of hospital category. PAs and nurse practitioners represented the next most common types, followed by podiatrists. In several hospitals throughout all categories, the undifferentiated group, ‘Licensed Independent Practitioners,’ was also authorized to give verbal orders.”
- RNs, LPNs, and pharmacists were authorized to take verbal orders in 37, 31, and 38 of the 40 hospitals, respectively.
- “Required documentation elements related to verbal orders were highly consistent in terms of documenting the following in addition to the order details: who gave and who received the verbal order, the date and time the verbal order was given, and that the order needed to be cosigned by the individual giving the verbal order.”
- *Conflicting* timeframes for cosigning verbal orders (i.e., within 12 hours) were found within 38-67 percent of hospitals depending upon category (i.e., urban, rural).
- Sixty-four percent of the academic medical centers required authenticating the individual giving telephone verbal orders but very few of the other hospitals.
- Every hospital required that the individual taking the verbal order read it back to the orderer.

Despite finding common practices for areas required by the [Joint Commission](#) (documentation, read back in particular), the authors noted concerns about other areas of policy and procedure in which there appears to be great variability. They recommend further research in areas such as compliance with existing policies and procedures and the extent to which verbal orders contribute to adverse events. ([A Review of Verbal Order Policies in Acute Care Hospitals](#), [Joint Commission Journal on Quality and Patient Safety](#), Volume 38, Number 1, p. 24-33(10), January 2012 – subscription or purchase required)

Although interruptions have always been a fact of life for physicians, the increasing presence of computers and mobile devices such as smart phones has led to a new term – **distracted doctoring** – to describe the potential risk to patient safety. *The New York Times* cites one peer-reviewed article published in the journal *Perfusion* (about cardio-pulmonary bypass surgery) that reported 55 percent of technicians who monitor bypass machines had talked on cell phones during heart surgery, and one-half had also texted while in surgery. They also report one malpractice case resulting from neurosurgery during which the surgeon made personal calls on a cell phone by using a wireless headset. “Medical professionals say young doctors can be particularly susceptible to distraction because they have grown up being constantly connected.” ([Concerns Grow over 'Distracted Doctoring'](#), [UPI.com](#), December 15, 2011)

The AMA has released two trend reports on **medical malpractice** (full reports are available to AMA members only). Some of the findings (all based on data from 2010):

- Sixty-four percent of malpractice claims were closed without payment (because they were withdrawn, dropped, or dismissed). However, these claims cost an average of \$26,851 to defend before they were closed and represent one-third of the total cost of defending malpractice suits.

- Overall, the average cost of defending a malpractice claim was \$ 47,158 – a 63 percent increase from 2001.
- The average settlement was \$331,947 (a 12 percent increase from 2001).
- Forty-one percent of physicians have malpractice insurance limits over \$1 million, up from 28 percent in 2001.

([AMA Reports Show High Cost of Malpractice Suits](#), *Healthcare Finance News*, December 27, 2011)

A report from the inspector general of HHS concludes that **only 14 percent of adverse events in hospitalized Medicare patients are reported to the hospital administration**, less than 10 percent are investigated by the hospital, and less than 2 percent result in changes in hospital policy or process. Adverse events were defined as events that caused “significant harm” and included medication errors, bedsores, infections, overuse of painkillers, and excessive bleeding. Under the conditions of Medicare payment these events must be tracked and analyzed to improve care. The cases were identified by an independent review of patient records. The report estimates that 130,000 adverse events are experienced by Medicare patients each month. Almost all hospitals had systems for reporting adverse events. Reasons why the events were not reported included that that staff did not understand that it was a reportable event and that they assumed someone else was reporting it. The CMS plans to issue more specific guidance on what constitutes a reportable event. ([Report Finds Most Errors at Hospitals Go Unreported](#), *New York Times*, January 6, 2012)

A new program at Spectrum Health is reducing ED visits after only six weeks. The program targets patients who frequently use emergency rooms. In December, staff identified and reached out to 190 patients who had visited emergency rooms at two participating hospitals over ten times in the past year and invited them to participate in a new coordinated care treatment regimen. Patients who opted to participate (n=140) were assigned to a multi-specialist intervention team, consisting of nurse case managers, social workers, psychologists, and addiction specialists, which works with them to address the issues – such as addiction and pain – that would have prompted them to visit the ED in the past. More than a third of the patients visiting the center suffer from a neurobiological addiction to a substance. Early findings indicate positive results. Thus far, it has already diverted the majority of these patients away from the ED and produced a net savings of \$300,000. “It’s going really well – better than we had hoped,” says Spectrum Health Medical Group Center for Integrative Medicine Director R. Corey Waller, MD. “We are focusing on getting the patients better and not decreasing ED visits because if we do one the other will follow.” ([Spectrum Health Targets ED Frequent Fliers for Primary Care](#)”, *HealthLeaders Media*, January 17, 2012)

A new study in the *Journal of Health Communications* examines the efficacy of providing educational materials online versus via a paper-based format. Older women patients of the Fox Chase Cancer Center who were found to be at-risk for colorectal cancer and agreed to participate in the study were randomized to one of two intervention groups or a control group. Intervention group participants either received access to a password-protected Web site (created for the study) that provided educational information about colorectal cancer and screening options or were given the same information in a paper-based format. The study indicates that more patients used the paper-based educational materials than the Web site. Web site tracking revealed that of 130 patients who were given access to the Web site, only 24.6 percent actually logged onto the site with the majority logging on once and spending between 1-22 minutes on the site. In contrast, of 171 patients who were provided with identical educational information in a paper-based format, 42 percent reported reviewing the information at least once (with 30 percent of patients reporting that they did so twice). The authors were surprised by the low usage of the Web site and assert that their findings question existing assumptions about the efficacy of Web-based health resources. “Easy access to the highly interactive, multimedia driven Web has created a perception that if we build inviting Web sites the public will come,” they write, adding that “It is not clear that when new interventions are built [that] target audiences will come.” ([Build It, and Will They Come? Unexpected Findings from a Study on a Web-Based Intervention to](#)

Improve Colorectal Cancer Screening, *Journal of Health Communications*, January 2012; 17(1):41-53, Epub June 22, 2011)

Venous thromboembolism (VTE) is not only a significant cause of morbidity and mortality but also an increasing quality improvement target in hospital care accompanied by quality measures around well-accepted interventions to prevent them in hospitalized patients (in HITECH Stage 1 for hospitals and slated for inclusion in Medicare Value-Based Purchasing). Hence, an article concerning **one hospital's work to ensure appropriate prevention measures for every patient** in the February issue of *The Joint Commission Journal on Quality and Patient Safety* is of interest.

- The program at Saint Francis Hospital (OK) included a core requirement that care be standardized – risk assessment and interventions – across all medical and surgical units, and a multi-disciplinary team was assembled to accomplish this. Following a broad educational campaign (incorporating eLearning modules among the venues), VTE prophylaxis order sets were implemented on paper or within CPOE (on units where it was being used) and added as a section to all existing admission order sets. For any patient for which VTE had not been addressed (via order or documented exception) within 8 hours of admission, an electronic trigger placed an action item on a work list of the patient's nurse with instructions to contact the physician. Physician compliance was also tracked and reported monthly to department chairs and the CMO.
- The authors report that the VTE rate declined by 31.6 percent over a two-year period and attribute the program success to the multi-disciplinary approach taken, the role of physician champions, the multi-pronged approach to clinician education, and providing evidence from efforts at other hospitals to support design of the interventions used at Saint Francis. "The staff and physician education implemented during the project has continued through an annual wall display in a public area, a nursing quiz and prizes, presentations in nursing orientation and medical department meetings, review of failed cases in medical peer review, and presentations by physicians on the topic."

(Improving Venous Thromboembolism Prevention Processes and Outcomes at a Community Hospital, *Joint Commission Journal on Quality and Patient Safety*, Volume 38, Number 2, February 2012, p. 61-66(6) – subscription or purchase required)

Pharmaceutical/Life Sciences

Some pharmacy managers are saying that **dealing with shortages has become the “new normal.”** Meanwhile, providers are feeling the financial impact of the higher-priced alternatives and the personnel hours required to deal with the escalating shortages. One coordinator of pharmacy automation and technology at a facility in Florida says she is now buying common drugs through a third-party vendor at high markups because the drugs are not available through the normal direct channels. She says she used to buy morphine for 99 cents per dose and is now spending \$4.75 for the same amount. Fentanyl, a popular pain medication, has shot up in price from 31 cents per vial to \$4.65. And there is little leverage for negotiation. Instead, they spend time constantly comparing alternatives, like switching from injectables to syrups or vice versa. ([Drug Shortages Become the 'New Normal' for Pharmacy Managers](#), *Healthcare Finance News*, December 28, 2011)

The use of social media is increasing in the pharmaceutical industry but that activities vary widely between companies. The report ranks pharmaceutical companies' in terms of their spending on traditional media and their use of social media (Facebook and Twitter). The report shows that Pfizer is a leader in both realms. The company placed first in traditional promotional spending, first in the number of Twitter followers, and third in the number of Facebook “likes.” Interestingly, while some companies are performing well in both realms, some companies that rank high in traditional promotional spending rank significantly lower in terms of their social media presence and vice versa. Novartis ranked second in promotional spending but 17th in terms of Facebook “likes.” In contrast, Johnson & Johnson ranked second in both the number of Facebook “likes” and Twitter followers but placed 11th in promotional spending.” ([Cegedim Strategic Data \(CSD\) Ranks Pharmaceutical Companies' Social Media Presence](#), *FierceBiotech*, December 2011)

According to a collection of studies published in the *British Medical Journal*, some researchers are not complying with a federal requirement to post results of clinical trials on the NIH Web site. The FDA issued rules in 2007 requiring that the summary results for certain trials be posted on [ClinicalTrials.gov](#) within a year of the completion of the study. Study findings indicate that results from many studies have not been published. One study examining 2009 data found that less than a quarter (22 percent) of eligible trials were posted within the required timeframe. A separate study found that less than half (46 percent) of the results of NIH-funded trials were published in a peer-reviewed journal after 30 months and that nearly a third (32 percent) of trials were still unpublished after 51 months. The absence of this data could have serious implications as evidenced by a third study, wherein researchers found that when the unpublished data is included in meta-analyses of drug trials, they often produce different results. According to the authors, the “addition of unpublished FDA trial data caused 46 percent (19/41) of the summary estimates from the meta-analyses to show lower efficacy of the drug, 7 percent (3/41) to show identical efficacy, and 46 percent (19/41) to show greater efficacy.” Richard Lehman, a consulting psychiatrist at the University of Oxford and Elizabeth Loder, a *BMJ* contributing editor urged that stronger enforcement of the requirement in an editorial that accompanied the studies. “Concealment of data should be regarded as the serious ethical breach that it is, and clinical researchers who fail to disclose data should be subject to disciplinary action by professional organizations,” they wrote. ([Studies: Researchers Fail to Report Clinical Trial Data to Federal Website](#), *iHealthBeat*, January 5, 2012)

The FDA recently released draft guidance outlining recommendations on how pharmaceutical companies and medical device manufacturers may respond to requests for unapproved or off-label information made on social media channels and other forums. Among other things, the guidelines establish that firms may respond to such requests if they specifically pertain to their products. However, firms should limit their response in a public forum,

such as on a social media site, to stating that the question deals with an off-label use of the product and directing the individual to contact the company (while also providing detailed contact information) to obtain further information. In addition, firm representatives posting such information should clearly disclose their involvement with the firm and provide a link to the product's FDA-required labeling that is not promotional in nature. According to the guidelines, detailed responses to such questions should not be provided in public forums as such actions could serve to communicate unapproved information to a broader audience of viewers who have not requested the information. According to the FDA, "in this circumstance, communication to persons who have not requested information may promote a product for a use or condition for which FDA has not approved or cleared." If the individual then privately contacts the firm seeking such information, the FDA grants that firms should provide "truthful, non-misleading, accurate, and balanced" information that is "scientific in nature" and addresses only the posed question. The information should be provided by scientific or medical staff who are not employed in marketing or sale departments and directed to the individual who initiated the request via, "private, one-on-one communication." The guidance also outlines a list of enclosures that should accompany the response and what steps the firm should take to maintain a record of the information exchange. The FDA asserts that responses to unsolicited requests for information conducted in this manner will not be used as "evidence of the firm's intent that its product be used for an unapproved or uncleared use." Comments on the proposed guidance will be accepted until March 26, 2012. The release of the guidance has been highly anticipated since the FDA held a hearing on the promotion of FDA-regulated products via social media and other Internet channels in November 2009. While the guidance is extremely narrow in scope, dealing with only one use of social media, officials say that additional guidance is being developed. According to FDA spokesperson Karen Mahoney, the draft guidance represents "the first of multiple planned guidances that respond to testimony and comments." ([Guidance for Industry Responding to Unsolicited Requests for Off-Label Information about Prescription Drugs and Medical Devices, FDA, December 2011 – PDF format](#))

Two biotechnology firms recently announced that they will soon unveil machines that can sequence a human genome in just a day at a price that is under \$1,000. A development such as this has been highly anticipated by researchers for some time. Some say it could mean big things for medicine. For instance, the price drop would make it more affordable for doctors to study patients' genomes in making diagnoses and provide "personalized medicine." In addition, the lower cost would also aid researchers in studying which genes cause certain traits and why. According to Dr. Topol, Chief Academic Officer at Scripps Health in California, until recently, sequencing a genome has taken an entire week and cost around \$4,000. "This opens up all kinds of opportunities in genomic medicine," he said. However, he anticipates that not everyone may be eager to take advantage of this new capability. "People are still uncomfortable contemplating their own genes, he added – and many doctors remain uncomfortable with genetic information too." ([What a \\$1,000 Genome Could Mean for Medicine, LA Times, January 10, 2012](#))

A scarcity of investment financing for biomedical research and development projects may delay a long-term recovery in the biomedical industry according to a new survey of CEOs at 100 biomedical companies in California. Seventy-five percent of those surveyed had experienced delays in research or development in 2011 (up from 69 percent in 2010). Survey respondents identified the lack of available financing for delays in research and development agendas. The lack of financing from traditional sources has accelerated the effort to seek other sources of funding and in 2011.

- Forty-four percent of respondents plan to seek licensing agreements and corporate partnerships (compared with 22 percent in 2010).
- Thirty percent plan to seek corporate venture financing (an increase from the 10 percent who planned to in 2010).
- Eleven percent are considering non-governmental organizations like patient advocacy groups (up from 4 percent in 2010).

([Survey Finds Biomedical Firms Delaying Research, Seeking Funding Options, California Healthline, January 11, 2012](#))

According to an author writing at PharmaExec.com, the **pharma world is embracing the iPad** as a new sales tool *and* as a new way to communicate with and educate patients. Far from being a device to replace the sales rep, pharma companies are finding that the iPad serves to augment the relationship between representatives and physicians. Using a tool that offers better and more dynamic content, reps can be more efficient in the relationship. There are also companies succeeding at interactive apps for doctors. Johnson & Johnson's psoriasis iPad app for dermatologists and patients allows a quick and simple evaluation of the severity of their condition. The app has been averaging almost 60 downloads a day for well over a year. The reason for its success, explains one analyst, is that it is "pick-up-and-play, and immediately rewarding." ([iPad Apps: Are You Content with Your Content? PharmaExec.com](http://PharmaExec.com), January 1, 2012)

A new Web site unveiled by St. Jude Children's Research Hospital in Tennessee showcases findings from the Pediatric Cancer Genome Project (PCGP). St. Jude Children's Research Hospital in collaboration with Washington University School of Medicine launched the project in 2010, which sought to sequence entire genomes of both cancer and normal cells taken from 600 pediatric cancer patients. Prior to this time, no one had sequenced complete pediatric cancer genomes. Since the effort began, over 250 sets have been sequenced. The new Web site, "Explore," provides access to genomic data and published results from the project, in addition to other information, and seeks to increase learning and hypothesis testing. "Explore allows researchers to access the genome project's unique, published data specific to pediatric cancers and to make discoveries on their own," said St. Jude Deputy Director and Scientific Director James Downing, MD. "We want to be a catalyst for the field and accelerate progress with the research gleaned from the genome project." (Pediatric Cancer Genome Project – accessed January 23, 2012)

The market for stem cell technologies is projected to rise to over \$700 million this year, according to market research firm Kalorama. Further, if some yet-to-be-determined trends turn positive, the market could potentially reach over \$1 billion soon. Newly permitted U.S. usage is one trend accounting for the growth. According to one author of the report, "A likely scenario is that developers will continue to expand the utilization of ethically acceptable adult stem cells and that patents and royalty payments will not seriously inhibit financial incentives. We also anticipate that at least a portion of current technologies under development will provide safe, clear regulations and show substantial benefits over current therapies." Cell therapies are now largely confined to a few conditions, especially oncological conditions such as leukemia, multiple myeloma, and non-Hodgkins lymphoma. (Stem Cells: Worldwide Markets for Transplantation, Cord Blood Banking and Drug Development, Kalorama, January 2012)

Large pharmaceutical companies are increasingly eyeing manufacturing outsourcing as a strategic move that would allow them to direct more attention on other areas, such as in increasing research and development. It is expected that the patent expiry for various drugs and biologics will reduce capacity utilization rates at manufacturing facilities which could make outsourcing a more viable option for pharmaceutical and biotech companies. "As pharmaceutical and biotech companies strive to enhance their internal core competencies, outsourcing is likely to become increasingly entrenched as a strategic manufacturing option," said Frost & Sullivan Research Analyst Aiswariya Chidambaram. "The impact of the economic crisis, coupled with the poor performance of the venture capital industry in Europe, has underlined the popularity of contract manufacturing as it has become synonymous with cost cutting and the timely entry of products into the market," she said. This stands to create a great deal of growth potential for contract manufacturing organizations, especially in Europe. According to Frost & Sullivan, the European pharmaceutical contract manufacturing market grossed revenues of \$10.2 billion last year alone; analysts predict that the market could earn revenues of up to \$20.75 billion in 2018. (Rising Interest of Big Pharma Creates Immense Growth Potential for Contract Manufacturing Organisations, Frost & Sullivan, January 23, 2012)

Regulatory/Legal

For many healthcare organizations 2012 should be “the” year for ICD-10 remediation as efforts to meet the 2013 implementation deadline accelerate. Industry observers at ICD-10 Watch explain how five HIT trends will influence the trajectory of those efforts:

- **ICD-10 readiness will emerge as a major economic stimulus for healthcare**
 - Application and system vendors accelerate delivery of compliant upgrades and new products – at the same time they will create demand for upgrades to documentation, medical coding, and other diagnosis-dependent workflow activities to optimize the use of ICD-10.
 - Demand for ICD-10 capable medical coding professionals will continue to escalate, driving demand for training and certification programs as well as new entrants to the profession.
- **Post-mortem analysis of the HIPAA 5010 implementation (due in Q1 of 2012) will provide insights for ICD-10 implementation**
 - The industry will also look more closely at the Canadian implementation experience for clues and “teachable moments.”
 - Canadian experience and HIPAA 5010 experience may provide enough critical insights to support a delay in the October 2013 deadline for ICD-10....
- **Industry opposition and leadership changes at CMS will fragment focus and create some uncertainty about the “real” implementation deadline**
 - The AMA and MGMA are strong voices for delay at a minimum and tabling the effort entirely.
 - CMS leadership post-Berwick has not been confirmed by the U.S. Senate.
 - ICD-10 is probably too technical and too “wonky” for opponents to successfully make it a major campaign issue unless it gets combined with an overhaul of the Affordable Care Act or becomes a factor in the negotiations to confirm Marilyn Tavenner as the new head of CMS.
- **Breakthroughs in natural language processing (NLP) in the smartphone market will accelerate demand for an NLP “app” approach to ICD-10 coding**
 - The Siri feature in iPhone 4S is spurring competitors to deploy similar solutions for Google and Android next year.
 - Clinician adoption of smartphone technology will accelerate demand for similar features in the electronic health record (EHR) world.
- **HIT vendors will begin to realize that disruptive innovation is a way of life for healthcare too**
 - The easy, inexpensive availability of complex user-friendly functionality via smartphones and other mobile devices will create new demands from users who have traditionally been slow to adopt new tools and technology.
 - Traditional HIT development and delivery models will not be able to keep up and vendors who fail to adapt to the disruptive model will be at risk for losing market share to new entrants.

([Five Trends That Will Shape ICD-10 Implementation in 2012](#), [ICD10Watch.com](#), December 28, 2011)

An article in the *Wall Street Journal* asks, **should every patient have a unique ID number for all medical records?** Proponents say that the idea of a universal patient identifier (UPI) deserves consideration because it is the efficient way to connect patients to their medical data. They say that the use of UPIs would facilitate information sharing among doctors and guard against needless medical errors. They would guard against misidentification. (A RAND study found that patients are misidentified at a rate of about 7 to 10 percent during record searches.) Proponents point out another potential privacy-related benefit: health records would never again

need to be stored alongside financial data like Social Security numbers. Privacy activists, however, oppose the idea. They say that information from medical records already is routinely collected and sold for commercial gain without patient consent and that a healthcare ID system would only encourage more of the same. UPIs could be co-opted just as SSNs have been. They believe that records can be digitized without imposing a new system and issuing universal health IDs to everyone. The author of the article ultimately comes down on the side of UPIs. He recommends that Congress should “lift the ban on federal funding for UPI research” and that the medical community should “inform patients about the benefits of UPIs.” ([Should Every Patient Have a Unique ID Number for All Medical Records? WSJ](#), January 23, 2012)

In Australia, the patient privacy associated with the government’s new personally controlled e-health record (PCEHR) is now a topic of public discussion. Recently, a law firm released a report that examined the implications of PCEHR on privacy, and, in turn, Australia’s Department of Health and Ageing provided a set of responses in which it accepted or supported most of them. Some of the interesting provisions that the Department accepted include the following:

- 4.4 – That the PCEHR Bill prohibit consumers being placed at a disadvantage (financially or in relation to access to healthcare) for declining to provide permission for a healthcare provider to access their PCEHR.
- 4.14 – That the arrangements with Authorised Registration Agents ensure that there are physical privacy protections for consumers using their shop fronts, such as timed log-outs and privacy screens on public-facing computers.
- 4.29 – That consumers have available to them a 'preview' function, which allows the consumer to see how their record will appear to other types of users depending on the access controls they set.
- 4.30 – That the design of the system include some prompt every few years (such as a screen prompt on next log-in) to consumers with Nominated Representatives to review their choices and check the accuracy of their information.

([E-health Privacy under the Microscope, ZDnet](#), January 3, 2012)

The NHS Future Forum, a group of physicians that advises the Government concerning healthcare reform, has recommended that **National Health Service patients be able to see their medical records online by 2015.** “According to its proposals, the Forum’s idea is that people essentially “own” their medical records and should be able to see their medical history, download their case notes, and even see the comments made by GPs and medical staff (providing they can read the writing) about their particular case or ailment. Patients will also be able to order their repeat prescriptions and make appointments online, free-of-charge.” ([Push to Allow NHS Patients to See Medical Records Online, TechWeekEurope](#), December 30, 2011)

A survey of 418 provider organizations finds that **for two-thirds of respondents, the responsibility for handling audits under the Medicare Recovery Audit Contractor program falls to the compliance department.** The figures were relatively consistent across organizations of all sizes, with the exception of organizations with 250 or fewer employees, which have the compliance department handling RACs nearly 75 percent of the time. Other findings:

- Fifty-seven percent of respondents with 250 or fewer employees dedicate one FTE to handling RAC audits and responses.
- Fifty-six percent of those with 1,000 to 5,000 employees dedicate one FTE to RAC.
- Sixty-four percent of organizations with at least 5,000 employees dedicate up to three FTEs to RAC.
- Seventy-seven percent of the smallest organizations had not used consultants to help deal with RACs, while just 40 percent of the largest refrained from contracting for consulting services.
- Fifty percent of all respondents indicated that compliance budgets have not increased during the current fiscal year despite the RAC program ramping up. (About a third saw

the budget increase somewhat, with 10 percent having a significant increase, and about 5 percent reporting a decreased budget.)

The survey was conducted by the Health Care Compliance Association. ([RAC Survey Data, Health Care Compliance Association](#), January 2012 – registration required)

The National Coordinator for Health Information Technology's Office of the Chief Privacy Officer has launched a new project to improve privacy and security for mobile devices. The goal of the project is to develop "an effective and practical way to bring awareness and understanding to those in the clinical sector to help them better secure and protect health information while using mobile devices (e.g., laptops, tablets and smartphones)." The project will build upon existing HIPAA guidelines by identifying **best practices for privacy and security for mobile devices**. The best practices will then be disseminated to healthcare providers in the field. HHS officials plan to convene a public roundtable this spring. Another recently-launched project features the HHS teaming up with the American Association of Diabetes Educators, AT&T, and Baylor University to study the use of secure video streaming on smartphones to push out directed diabetes self-management education courses. ([ONC Seeks Good Practices for Mobile Device Privacy and Security, mHIMSS](#), January 25, 2012)

Physician Practice

A new study indicates that physician owners are more likely to perceive difficulties in electronic health record (EHR) implementation than physician employees. A study in the [Journal of the American Medical Informatics Association](#) presents data from pre- and post-implementation surveys of 163 physicians who installed an EHR system in their practices as part of a Massachusetts eHealth Collaborative pilot program. Findings indicate that most respondents (54 percent) found EHR implementation to be “somewhat difficult” with a third of respondents (35 percent) finding implementation to be “very difficult.” Comparing responses between physician owners (who own their medical practices partially or fully) and physician employees, the authors found that physician owners were more likely to report the EMR implementation as “very difficult” than were physician employees. The authors posit that the financial risk involved in owning and operating a medical practice may make physician owners more inclined to perceive challenges involved in EHR adoption. They suggest that “physicians who own their practice may need more external support for EHR implementation than those who do not.” ([Factors Associated with Difficult Electronic Health Record Implementation in Office Practice, Journal of the American Medical Informatics Association](#), doi:10.113, January 16, 2012)

Tablet computers may soon be a common feature in doctor’s offices, predicts research firm NPD Group. The firm surveyed small and mid-sized medical practices and found that nearly three-quarters of respondents (73 percent) had plans to purchase tablets in the coming year. Practices expect to spend a cumulative total of \$6,800 on their purchases. Smaller practices tend to invest in tablets more than larger practices. According to NPD Vice-President Stephen Baker, their smaller size works to their advantage in implementation. “You tend to see small businesses looking at those products and [getting] excited with the potential because you can implement things a little faster when you’re an under-50-person company.” ([Doctors’ Offices to Emerge as Heavy Tablet Buyers in 2012: NPD Group, eWeek](#), January 6, 2012)

Imaging usage by Medicare clinicians increased 85 percent from 2000 to 2009, according to data from the Medicare Payment Advisory Commission that was reported in [Modern Healthcare’s](#) special issue “By the Numbers.” ([Medicare/Medicaid, Modern Healthcare](#), p. 32, December 2011 – subscription or purchase required)

The American Medical Association (AMA) **has added a set of video tutorials to its Web site in an effort to help physicians adopt health information technology.** The “Pre-Visit Planning” tutorial addresses how to establish an infrastructure to provide patient information to a physician before the patient arrives. The Point-of-Care Documentation tutorial covers the types of computing devices used during an office visit. The ePrescribing tutorial explains the value of electronic prescribing and other opportunities for improving medication management. ([New Health I.T. Tutorials from the AMA, Health Data Management](#), January 2012)

According to an article in the [Archives of Dermatology](#), **“Telemedicine serves as a valuable tool in the diagnosis and management of skin diseases** because cutaneous conditions can be readily examined via digital still or video images. The increasing use of teledermatology to serve geographically distant communities, medically underserved communities, and veterans attests to the continued growth of teledermatology applications in the United States as well as other countries.” Live-interactive teledermatology allows for real-time interaction among the referring physician, patient, and consulting dermatologist, aided by videoconferencing. A recently published study evaluated the impact of this type of program on patient diagnosis, disease management, and clinical outcomes at a major academic medical center with an established teledermatology program since 1996 (UC Davis, with patients referred from 31 facilities throughout California). Nearly 70 percent of the patients experienced a change in diagnosis from the initial diagnosis by the referring physician, and more than 97 percent experienced changes in

disease management (changes in medication or dosage or vehicle, procedural interventions, or laboratory or pathology testing) as a result of the teledermatologist evaluation. Furthermore, 68.7 percent of patients with at least two teledermatology visits within one year were judged to have experienced clinical improvement. Multivariate analysis showed that changes in diagnosis, changes in treatment plan, and the number of teledermatology visits were significantly associated with improved clinical outcomes. (The authors note that the program cares for an underserved population in California, including a sizable prison population, and thus may not reflect the demographic distribution of the overall U.S. population.) ([Impact of Live Interactive Teledermatology on Diagnosis, Disease Management, and Clinical Outcomes, Archives of Dermatology](#), Vol. 148, No. 1, p. 61-65, 2012 – subscription or purchase required)

Negative patient comments posted on social media sites and consumer review sites can be damaging to reputations, as many doctors are finding out. Some doctors feel that comments and complaints posted by patients are unfair and inaccurate but feel powerless to respond publicly given constraints of patient privacy protections. “It is really a problem, to be quite honest,” says Dr. Benjamin Schlechter, a plastic surgeon based near Reading, PA. Physicians are beginning to take steps to protect their reputations. Some encourage satisfied patients to post positive reviews online. Others are seeking professional help. The rise of social media and consumer review sites has given rise to a new industry that assists providers and other individuals in improving their online reputations. According to Eric Benton of Reputation Management Consultants in Irvine, CA, business growth has been “logarithmic” in the past few years. Benton and his colleagues work to solicit positive reviews of their clients in order to balance out negative reviews. In addition, they are also able to manipulate the order of Internet research results to detract attention from review sites. Benton says that clients pay him between \$900 and \$5,000 monthly to repair their reputations; many come to him after they have seen their business decline by 10 to 20 percent. ([Doctors Feel Helpless over Patients' Online Slams, Philly.com](#), January 6, 2012)

As electronic health record (EHR) implementers struggle to make **electronic clinical documentation** less labor-intensive for physicians, one possible approach is to employ scribes to perform this task. According to a team from the Children’s Hospitals and Clinics of Minnesota, **using scribes during inpatient rounding** can improve the timeliness of documentation and improve patient and provider satisfaction, though it failed to meet the objective of increasing the number of discharges by noon. The article provides many details concerning the program, including:

- Initially, scribe program costs were less than the cost of transcribing progress notes dictated by hospitalists. The introduction of “background speech recognition technology,” however, increased productivity and brought transcription costs down enough that the scribe program ended up costing more.
- A local, physician-owned scribe service set up the program. Recruitment focused on pre-medical students with a BA/BS, good grades, and prior related coursework; good performance on a transcription test; and willingness to work on their feet for 4-5 hours at a time without breaks.
- The scribing process was designed to include tasks for every member of the rounding team with the goal of a completed note by the time the team leaves the patient’s room. Scribes prefilled templates with available patient information in advance. Physicians review and sign all notes before the scribe leaves for the day.

Among the challenges encountered were the reluctance of some physicians to verbalize the review of systems, physical exam, and plan in the presence of patients and family; insufficient battery life of the computers on wheels used by the scribes; and efforts required to ensure that documentation by scribes fully meets the expectations of the Joint Commission. Apparently the parent response was “overwhelmingly positive.” The article implies but does not state explicitly that the scribe program is continuing. ([Rounding with Scribes, AHIMA](#), January 2012)

Are declining reimbursement rates and uncertainty about the future of the program driving physicians out of the Medicare program? The HHS Office of the Inspector General has

concluded that it is impossible to know, based on the information that is currently available. In a study commissioned in early 2011 to study the impact and effects of physician attrition on the Medicare program, HHS OIG has found that no one collects and maintains sufficient data regarding the characteristics of physicians who opt out of Medicare. Although CMS provided guidelines for the collection and maintenance of such data following program changes in 2009, there is no reliable comparable data for the period of 1998 to 2008. The lack of data made it impossible to complete the study. HHS OIG concludes the report with a recommendation that CMS provide guidance for the collection and maintenance of this comparative data. ([Memorandum Report: Lack of Data Regarding Physicians Opting Out of Medicare, HHS OIG, January 26, 2012](#))

Younger doctors are receiving greater interest from recruiters than older doctors, according to a survey by Medicus, a physician recruiting company. In the survey of 1,072 physicians of varying backgrounds, specialties, and experience levels, researchers found that physician candidates who were 15 years or more out of training received less interest from recruiters and potential employers as did those within 15 years of their training. Doctors who were 16 or more years out of training applied to approximately 7.95 opportunities in the past two years and received an average of 2.12 offers while those within 15 years of their training applied to approximately 8.25 positions in the same time period and received an average of 7.88 offers. Sixty-five percent of doctors within 15 years of training reported an average response time of one week or less from the time of their application, but only 51 percent of doctors 16 years or more from training reported the same response time as their younger peers. ([Potential Employers More Interested in Hiring Younger Doctors, Healthcare Finance News, December 29, 2011](#))

Technology

Two high school seniors put their Xbox 360 gaming skills to work to design a tool that analyzes human gait patterns. The effort won them a \$100,000 college scholarship in the Siemens Foundation 2011 Innovation competition. In their research, Ziyuan Liu and Cassee Cain combined the use of the Kinect for Xbox 360, a device with a camera and a depth sensor, and a robotic leg to analyze leg motions while walking. The team's project may help with the development of an accurate, affordable device to detect abnormal gait patterns, which, according to the competition judges, could bring personalized rehabilitation to the home, reducing medical costs, and allow clinicians to monitor a patient's progress from a remote site. ([Siemens Foundation Winners for 2011](#), [Siemens](#), December 2011)

Social media postings, like those on Twitter and Facebook, can be used to identify and track outbreaks of disease, and in the future, they may be useful for managing and controlling epidemics, according to new research in [The American Journal of Tropical Medicine and Hygiene](#). Researchers from Harvard Medical School and Massachusetts General Hospital created a timeline by searching for the term cholera and the #cholera hashtag on Twitter from October 20 to November 3, 2010. In the two weeks before health officials reported the outbreak, 65,728 tweets with the word "cholera" were posted on Twitter. The authors also used free information from [HealthMap](#), a Web site that monitors news of outbreaks around the world. From HealthMap, they compiled 188,819 tweets in the first 100 days after the initial upsurge. According to researchers, the findings from the Twitter analysis correlated with those from official case data, but were **available up to two weeks earlier**. Still, it is wise to remember the limitations of social media sources. In 2009, Twitter postings about swine flu created online panic only while the incidence was low – as real-life outbreaks increased, the volume of Tweets declined precipitously. ([The 'First' Case of Cholera in Haiti: Lessons for Global Health](#), [American Journal of Tropical Medicine and Hygiene](#), Vol. 86, No. 1, p. 36-38, 2012. – subscription or purchase required)

Vioguard ,a new venture founded by former Microsoft employees has produced a keyboard that looks and operates like a standard notebook keyboard except that is *self-sanitizing*. The [new keyboard has received FDA approval as a patented, self-sanitizing computer keyboard for use in hospitals and clinics](#). Conventional keyboards have been cited as a key vector for the transmission for viruses and bacteria. At the work station, the keyboard is installed with a clean, light-tight enclosure. On a scheduled, or manual basis, the keyboard retracts into the enclosure and is flooded with high-power germicidal UV light. The keyboard is reactivated for use by a motion-sensor at the work station. The sanitizing process is controlled by a microprocessor, and the Ultraviolet "Class C" light used by the keyboard device is a well-known germicide. Vioguard was awarded a patent in December, and the keyboard went through a clinical trial. The results were recently published in the [American Journal of Infection](#). ([Sharing a Computer? FDA Approves Germ-Killing Keyboard](#), [Bizjournals](#), January 3, 2012)

A new white paper describes the implications are of the new HTML5 markup language making its way to more mobile devices and tablets. **Devices that have HTML5-enabled browsers, according to the report, will provide an alternative to native applications.** They predict that half of all apps that would be written in platform-specific native languages today will be written exclusively in HTML5 by 2015. Gartner has projected that the emergence of media tablets and the more than 5 billion mobile phones in use worldwide in 2010 will grow to more than 6.7 billion connections by 2015. In designing for these devices, choice of technology is important, as it needs to enable a cohesive design canvas, make deployment simple, and offer sufficient device API access. Naturally, the white paper pushes for the Kony solution (a platform that "provides direct integration to each channel emulator," etc.), but it also includes two useful diagrams

depicting the evolution of mobile browser technologies. ([The Power of Choice, Health Data Management](#), January 13, 2012 – registration required)

The mobile health (“mHealth”) **market earned revenues of \$230 million in 2010 and is estimated to reach \$392 million in 2015**, according to a new report. According to the researchers, the mobile health app market continues to see substantial growth. Growth is expected to continue as business models and significant value offerings evolve. The mHealth industry has outpaced its forecasted growth and revenue every year since 2008. Increasingly sophisticated mobile technologies and relationship-management tools will disrupt the market, said the report. Consumers will continue to purchase and use more mHealth apps, thus driving up app revenue. An increase in FDA regulation and oversight may dampen innovation, but the precise impact is yet to be seen. ([Mobile Health App Market to Reach \\$392M in 2015, Healthcare Finance News](#), January 10, 2012)

Telehealth initiatives have a positive effect on rural patients and patients that are elderly or homebound. However, according to one author, telehealth projects will not survive unless five key elements are present. They are:

- **Establish an incentive-based program.** Sustainable funding is vital to the successful, widespread adoption of telehealth. This is necessary to overcome the start-up costs associated with implementing such initiatives.
- **Establish an infrastructure.** Infrastructure is the heart of telehealth. This includes equipment such as fiber optics, broadband/wireless coverage, video, computer, voice, and imaging.
- **Improve telehealth reimbursements.** There is no universal reimbursement policy among public and private sectors governing the reimbursement of telehealth services. Payment is limited for interactive consultations and chronic-care patients. The Centers for Medicare and Medicaid Services and the American Medical Association are working together to formalize a payment model for telehealth services, but it is not known when this will be ready.
- **Foster user acceptance and confidence in telehealth.** Increase user acceptance of technology for clinicians and patients who are not tech savvy. Successful telehealth programs must be able to easily integrate the telehealth process into healthcare and patient environments seamlessly.
- **Ensure adequate resources and time.** Successful telehealth programs must have the proper allocated resources and time necessary to ensure widespread adoption. “People and processes are the key components to effective telehealth utilization.

(McKnickle, M. [Telehealth Success Depends on a Solid Foundation, mHIMSS](#), January 17, 2012)

The popularity of mHealth applications continues to rise. **In considering what lies ahead for mhealth, Brian Edwards, iMedicalApps mhealth feature editor, forecasted five trends.** In particular, he predicts that the following will gain prominence in the months and years ahead:

1. **Binary network apps.** Applications that connect to and track peripheral devices, such as wearable sensors, could be one of the next big things in 2012 and beyond. “It is the ability to take the iPhone and a patient with a T-shirt with a built-in sensor and keep track of their vitals all day,” he said.
2. **Apps that track patient activity.** Applications that assist individuals in monitoring their health data on their phones will continue to offer benefits in the years ahead. Such apps are convenient to use on the go, compile patient information, and can potentially alert patients and providers about potential complications. “Especially with chronic conditions like diabetes’ when there’s a flare-up, it is integral to know when... it is like a check-engine light for the body,” he said.
3. **Health-Focused Games.** New games are beginning to emerge that seek to educate patients and prompt individuals to take steps to improve their health and wellness have recently been released; Edwards says to expect more. “Everyone’s trying to game-ify everything,” he says.

4. **Apps that diagnose and treat patients.** According to Edwards, a number of companies are working to develop innovative new body area network technologies to assist in diagnosing and monitoring patients.
5. **Apps that empower patients.** Applications that assist healthcare consumers in accessing health information and making health decisions will continue to grow in popularity in 2012 and beyond.

(5 Mobile Trends for 2012, [Healthcare IT News](#), December 2011)

[AHIMA](#) has prepared a practice brief encouraging the use of **an institutional data dictionary to ensure data consistency and accuracy**. “In many organizations data are stored in different databases and may be of inconsistent quality. Issues such as variable naming conventions, definitions, field length, and element values can all lead to misuse or misinterpretation of data in reporting.” The practice brief outlines best practices that can help organizations maintain their data dictionaries and data integrity. Their list:

- Know the data;
- Map the data across all systems;
- Develop a data quality management process that includes ongoing maintenance and review of the data dictionary;
- Comply with regulations and standards;
- Ensure accuracy of data collection and reporting;
- Establish change management policies and procedures; and
- Develop active and ongoing user education and training.

It also defines the role of the data administrator and argues that it should be a HIM professional and included as a part of an overarching structure for data governance. ([Managing a Data Dictionary](#), [AHIMA](#), January 2012)

Weight loss and weight management rely on balancing the intake of calories and the output of energy required for daily living. Measuring caloric intake is relatively straightforward, and many resources are available to the health-conscious consumer trying to keep track of them. Monitoring the use of calories and calibrating exercise to optimize it is much trickier. A new personal health tool aims to fix that problem. **A new device provides a physiological measurement of calories burned, measuring them “just like a heartbeat.”** The monitor is worn on the upper arm and uses technology from metabolic research to measure the four kinds of heat generated by the body – radiant, conductive, evaporative, and convective. The arm band wirelessly transmits caloric information to a readout. Users can establish goals, and the unit is able to provide alerts and current status of calories burned. The data can also be downloaded to a computer to monitor progress, and the information can be accessed from any computer. The Class II exempt device will undergo some trials in beta testing in the first quarter of the year and expected to be launched in the second half of the year. ([Startup’s Calorie Monitor to Tackle Obesity with No Guesswork Involved](#), [MedCityNews](#), January 1, 2012)

Medical students can now wear 3D glasses to learn about the anatomy of the human body.

At the New York University School of Medicine, students can navigate through a virtual body using a computer and 3D glasses. They can dissect the virtual body, which is projected on a screen. The system was developed by BioDigital Systems, a medical visualization company from New York. Their goal is to provide a searchable, customizable map of the human body – something like Google Maps for the human body. ([Medical Students to Wear 3D Glasses for Anatomy Class?](#) [medGadget](#), January 13, 2012)

Taking a bit of a contrarian view, the Web site [searchhealthIT.com](#) has posted a list of **five health IT trends NOT to watch in 2012**. They are:

- **Electronic medical records (EMRs):** The Office of the National Coordinator for Health IT (ONC) has noted that while an EMR does let a physician track patient data and improve his or her care quality, it is the electronic health record (EHR) that can be shared among caregivers and accessed by patients. EHRs will see emphasis. EMRs will not.

- **Personal health records (PHRs):** PHR services will not go extinct in 2012, but they will not be one of the major health IT trends of the new year, either. With Google Health shelved and Microsoft HealthVault facing an uncertain future in the wake of Microsoft's joint venture with General Electric Co., major PHR services appear to be in trouble. PHR privacy remains questionable.
- The **hospital information system (HIS)** or **clinical information system (CIS):** These systems appear destined for the same fate as the EMR, and for the same reason. While HIS and CIS do a good job of collecting data and conducting clinical decision support, they struggle to share that data through health information exchange, in part because many such systems pre-date the use of data interoperability standards.
- **Computerized physician order entry (CPOE).** Yes, CPOE is a meaningful use core measure, and those who have undergone meaningful use attestation are, therefore, using it. However, CPOE adoption remains low, in large part because the "P" in CPOE has often been neglected. Systems have been typically developed for hospitals, and they have been slow to adapt to the tablet PCs and smartphones that physicians have more than happily embraced. Mobile health applications will be the story for wellness and chronic care management in 2012.
- **Regional health information organization (RHIO).** The entities are not defunct, but the term "RHIO" is. It is a shame, too, because having to distinguish between "health information exchange" and "health information exchange organization" is a bit of a pain. ([Five Health IT Trends Not to Watch in 2012](#), [SearchHealthIT.com](#), December 29, 2011)

Healthcare Reform

New research suggests that the investments that providers and payers are making in primary care, accountable care, and patient-centered medical homes can reduce overall mortality. In a study published in the *Annals of Family Medicine*, researchers asked patients to report their access to a usual source of care (USOC) and to rate that USOC on five practice attributes that are commonly associated with a “medical home” approach:

- Care for new health problems;
- Preventive care;
- Referrals to other healthcare professionals;
- Access to providers in the evening and on weekends; and
- Patient “centeredness” (as demonstrated by listening and seeking patient input when selecting treatments).

One point was awarded for each practice attribute. No USOC received a score of 0 and the average score was a 3. Using six years of experience data – adjusted for population morbidity, demographic and economic factors – researchers concluded that higher scores on the “medical home” practice attributes were significantly correlated with lower mortality rates in a given area. (Jerant, et al. *Primary Care Attributes and Mortality: A National Person-Level Study*, *Annals of Family Medicine*, Vol. 10, No. 1, p. 34-41, January/February 2012)

Implementing ICD-10 is a bad idea for healthcare and for patients according to the American Medical Association (AMA). James Madara, M.D. – writing on behalf of the membership of the AMA – has formally requested House Speaker John Boehner to stop the mandated implementation which has a due date of October 2013. Among its arguments, the physician advocacy and lobbying organization states that the cost of ICD-10 remediation and implementation is too high with estimated costs of \$83,290 to \$2.7 million dollars per organization, and the effort to complete ICD-10 competes with scarce resources required to meet meaningful use objectives of electronic health records implementation. Most significant, and perhaps surprising, to industry advocates of ICD-10 coding systems, the AMA argues that the implementation costs will not result in any real benefit to patients or improvements in quality of care. (*Letter from AMA to Speaker Boehner*, *AMA*, January 12, 2012)

As required by the Affordable Care Act, **CMS has issued a final notice concerning an initial set of core measures for Medicaid adult patients for voluntary use by state Medicaid programs.** (The law also requires the development of a standard reporting format by January 1, 2013, and that CMS publish any changes to the measures on a yearly basis.) The final set of 26 measures addresses prevention and health promotion (12 measures), management of acute chronic conditions (three measures), management of chronic conditions (seven measures), family experiences of care (one measure), care coordination (one measure), and availability (two measures) Many of the measures are already in use in other CMS programs including HITECH and the ACO program (other programs cross-referenced in the table final rule). They include claims-based measures (i.e., readmissions) and patient-survey based measures, as well as chart-abstracted ones. (*Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults*, *CMS*, December 2011)

HHS has released the interim final rule detailing the administrative simplification standards for electronic funds transfer (EFT) and electronic remittance advice (ERA). The rule is scheduled for publication in the *Federal Register* on January 10. After a 60-day comment period the rule will be updated and finalized. The deadline for implementation of the standards is January 1, 2014. These are the first two new transactions mandated by the Affordable Care Act, and their deadlines follow closely on the planned completion of ICD-10 implementation efforts. Administrative simplification initiatives from the Affordable Care Act are designed to reduce administrative overhead and the “hassle factor” for providers and payers in the healthcare sector

by automating transactions and replacing paper forms with standardized HIPAA compliant electronic standards. The EFT standard defines the electronic format and data content of the transmission a health plan sends to a bank when paying a provider claim as well as the notification to the provider that the payment has been made. The ERA standard defines the content and data that describes the reason for the payment and includes elements like date and location of services, and patient and service identifiers. ([Administrative Simplification: Adoption of Standards for Health Care Electronic Funds, HHS, January 2012 – PDF format](#))

At the ONC HIT Policy Committee meeting on January 11, the CMS and ONC work groups presented a review of 2011 and plans for 2012. CMS provided updated numbers on meaningful use (MU) payments made through December 31. (The data presented were preliminary; these are based on the final data, posted [online](#)). As of December 31:

- 172,972 eligible professionals (EPs) and 3,077 hospitals have registered for MU payments. Slightly more than 10 percent of those registered during December.
- 1,081 hospitals have received \$1,963,337,000 in payments as of this year (more from Medicare than Medicaid).
- 29,344 EPs received \$570,350,910 in payments – about equally divided between Medicare and Medicaid; 75 percent of Medicaid payments went to physicians and 17 percent to NPs. About 40 percent of Medicare payments went to primary care providers and 60 percent to specialists.
- December was the highest month so far for payments – equaling about 20 percent of total payments.
- As of January 2012, 42 states had approved plans, but only 33 had distributed Medicaid payments.
- Most EPs and hospitals far exceeded thresholds for the measures they selected.
- Patterns of which menu items were avoided (deferred) vs. selected have been consistent over time and similar for providers and hospitals. Providing summaries at transitions in care were deferred by 93%percent of hospitals and 85 percent of providers. Medication reconciliation was deferred by 75 percent of hospitals and 56 percent of providers. Immunizations were the only public health measure selected by more than 20 percent of hospitals and providers. Sending patient reminders was deferred by 77 percent of EPs, and providing educational resources was deferred by 62 percent of hospitals.

The priorities for 2012 include:

- Continued increases in organizations meeting meaningful use.
- Health Information exchange-interoperability.
- Consumer involvement (patient observations, healthy apps).
- IT safety.
- Quality improvement (decision support move more quickly into practice).

The committee considered some recommendations that could have an impact on Stage 2 requirements. One was to allow organizations to report quality measures from non-certified systems as long as the data for the reports were generated from certified systems. This would **not** change the requirement that certified products be able to report quality measures. However, many vendors have “hard wired” the quality reporting capabilities which limits the users flexibility in generating the required data. Also, organizations ahead of the curve developed their own quality reporting systems that they now need to get certified to use. The CMS would develop a set of test data that organizations could use to test the accuracy of non-certified products. In the longer term, the committee would like to see requirements for a reporting platform that could be adapted to report any measure. The agenda for the meeting is posted (and transcripts will be posted on the [Policy Committee Web Site](#)).

The last 20 years of **Medicare demonstration projects in disease management and value-based payment innovations do not exactly support the high hopes that health reformers have for these initiatives to reduce the rate of healthcare spending**, according to the newest findings from the Congressional Budget Office (CBO). In total, ten demonstrations were studied – six in disease management and care coordination and four in value-based payments. Only one

of the studies – a project that bundled payments for heart bypass treatment – demonstrated overall savings to the Medicare program sponsor. According to the CBO, the key factor that affected the results was the nature of the incentives offered to providers – only the bundled payment initiative actually changed the mechanism for paying providers. All the others relied on the payment of bonuses in addition to traditional Medicare reimbursement. **The CBO report speculates that the cost reduction potential of the majority of the demonstration projects was overwhelmed by the inflationary impact of traditional Medicare reimbursement practices.** On a more positive note, the report identified specific approaches from the demonstration projects that warrant wider implementation – because they show promise for savings if applied more broadly – including:

- Gathering timely data on the use of care, especially hospital admissions;
- Focusing on transitions in care settings;
- Using team-based care;
- Targeting interventions toward high-risk enrollees; and
- Limiting the costs of intervention.

([Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment](#), CBO, January 18, 2012)

Comparative effectiveness research, which evaluates different treatment modalities to identify the most effective, is one of the Affordable Care Act cornerstones for achieving the “triple aim” of health reform – outcomes improvement, quality improvement and cost reduction. The Patient-Centered Outcomes Research Institute (PCORI), a 22-member panel of healthcare stakeholders that includes representatives of drug and device makers, insurers, consumers, researchers and government agencies, is responsible for driving the comparative effectiveness research agenda under the Affordable Care Act and has formally begun the work to establish research priorities and an agenda for the future. Unexpectedly, the **PCORI proposals do not specify particular diseases or treatment modalities as focus areas for federally funded comparative effectiveness research**, disappointing some observers who question how the effort will maintain focus. Rather, the proposed priorities and agenda are organized around five areas of improvement which will be inclusive of all diseases and health conditions:

- Assessment of Options for Prevention, Diagnosis, and Treatment
- Improving Health Care Systems;
- Communication and Dissemination Research;
- Addressing Disparities; and
- Accelerating Patient-Centered Outcomes Research and Methodological Research.

With funding of up to \$3 billion over the next ten years, PCORI is poised to become a significant contributor to the healthcare research agenda. The comment period on the proposals closes on March 15, 2012, and the final version is scheduled for release sometime in May. ([Patient-Centered Outcomes Research Institute Seeks Input on National Priorities for Research and Research Agenda](#), PCORI, January 23, 2012; and [Draft National Priorities for Research and Research Agenda V1](#), PCORI, January 23, 2012)

HIEs

The European Commission recently adopted a decision to establish an eHealth Network.

The new network will unite national authorities on a voluntary basis to advance work on common orientations for eHealth. The intent behind the undertaking is to work on attaining interoperability of electronic health systems across the EU and increase the use of eHealth. Speaking of the development, European Commissioner for Health and Consumer Policy John Dalli said “I am confident that the eHealth Network will play a key role in making eHealth a reality across Europe – so that routine medical checks are performed in the comfort of our homes via telemonitoring; so that we take our ePrescription along with our eTicket when we travel, with the confidence that our medical information follows us everywhere in the EU; so that all Europeans can access the best possible healthcare from wherever they are.” ([Driving Forward the Uptake of e-Health with a New Network for European Co-operation](#), *eHealthNews*, December 23, 2011)

Virginia recently launched an online registry that allows residents to complete and store advance life directives documenting their end-of-life wishes. The registry is slated to be connected to a statewide information exchange set to launch in 2013. In the past, logistical issues have sometimes interfered with patients’ end-of-life wishes being met. Patients often receive care in various settings from many different providers. In the past, it has sometimes been difficult for instructions to travel across different care settings. Connecting advance directives to an online information exchange is expected to improve the ease of access to the information, which will further help to ensure that patients’ wishes are honored. ([Handful of States Promise Physicians Online Access to Advance Directives](#), *amednews.com*, January 3, 2012)

Most EHR-fed personal health records in use today do not include encounter notes in the information available for patient viewing. A team from three institutions in Massachusetts (Beth Israel Deaconess), Pennsylvania (Geisinger), and Washington (Harborview Medical Center) – all of which had online personal health records already offering access to lab test results, medications, and other information – recently published results of a survey to assess patient and physician attitudes about **adding physician notes**. The RWJ-funded project, OpenNotes, involved PCPs who volunteered to send their patients electronic invitations to read visit notes online before the next scheduled encounter. Of the PCPs invited to join the demonstration project, 64 percent agreed to participate. Sixty-nine to 81 percent of this group across the three sites thought open visit notes were a good idea, and 74-94 percent anticipated improved communication and patient education. “Overall, PCPs who declined to participate predicted that open visit notes would lead to negative consequences for the way they practiced and would have little positive effect on their patients.” More than 80 percent at every site anticipated more patient questions between visits. Most patients were “overwhelmingly positive” about the prospect of reading visit notes; enthusiasm extended across age, education, and health status; and 22 percent expected to share visit notes with others. Relatively few expressed any fears such as being worried or confused by notes (fewer than 1 in 6 patients) though one-third worried about the effect of open visit notes on privacy. “Whether open visit notes bring doctors and patients closer together, tend to drive them apart, or have little effect on the patient-doctor relationship remains to be seen. One might think of open visit notes as analogous to a new medicine: Its goal is to improve the process and outcome of care for those who use it, but as with every therapy, some may be harmed by it and some may choose not to use it.” We can expect more reports from this project in the future. (Walker, et al. [Inviting Patients to Read Their Doctors’ Notes: Patients and Doctors Look Ahead](#), *Annals of Internal Medicine*, Vol. 155, No. 12, p. 811-819, December 20, 2011)

According to a new study, **nearly 70 percent of CIOs say their organization is currently planning for a Health Information Exchange (HIE)**. The study comes from Beacon Partners. Some findings:

- Sixty-four percent of responding organizations said the CIO is the person responsible for HIE development in their organization.
- CEOs and COOs separately were responsible at less than 10 percent of responding facilities.
- Nearly half of organizations responding said they have not yet designated a department, oversight group, or executive role to a development effort.
- More than half of the respondents were CIOs, and 58 percent of those CIOs are from community hospitals.
- Twenty-five percent of respondents have a net patient service revenue (NPSR) of less than \$50 million.

([Health Information Exchange: Getting Real](#), *Health Data Management*, January 2012)