Federal Health Matters

New Command Structure for Army Reserve Medical Units

On October 16, the new Army Reserve Medical Command (AR-MEDCOM) was activated during a ceremony at its headquarters at the C.W. Bill Young Armed Forces Reserve Center in Pinellas Park, FL. Part of an army-wide effort to increase the readiness and mobilization capacity of the reserve forces, the AR-MEDCOM constitutes the largest functional command within the U.S. Army Reserve.

Headed by Major General Kenneth D. Herbst, a former deputy surgeon general of the army for mobilization, readiness, and reserve affairs and a current professor of medicine at the University of California, San Diego, the AR-MEDCOM is charged with a threefold mission: to consolidate and centrally manage all army reserve medical units and soldiers (over 258 units and 28,000 personnel stationed across the United States and Puerto Rico); to improve soldier readiness, medical support, and medical training, while streamlining mobilization timelines; and to synchronize and align army reserve medical units with the U.S. Army Medical Command and the U.S. Army Office of the Surgeon General.

According to Herbst, the AR-MEDCOM represents a new focus on managing military forces by function, rather than simply geography. By consolidating the medical expertise into one command, the DoD aims to cut the time needed to activate medical reservists and reduce the bureaucracy involved in locating those with special skills. At the same time, the command will focus on training medical reservists as teams—rather than individuals—and emphasize "soldier skills" as well as medical techniques so that the reservists will be better prepared to carry out missions when deployed. Lieutenant General James R. Helmley, commander general of the U.S. Army Reserve Command, describes the AR-MEDCOM as one way in which the DoD is working to transform the army reserve from "a technically focused force in reserve" to a "learning organization that provides trained, ready, inactive duty soldiers, poised and available for active service."

Gaps Remain in VA Musculoskeletal Disability Exams

An October 14 report by the Government Accountability Office (GAO) found that about one in five VA compensation and pension examinations for joint and spine disabilities doesn't consider some necessary medical factors. This report was the culmination of a study commissioned by Representative Lane Evans (IL), ranking democrat on the House VA Committee, in order to measure the VA's progress in incorporating criteria established in a 1995 U.S. Court of Appeals for Veterans Claims case, *DeLuca v. Brown*. The court ruled that, when assessing disability due to joint and spine injuries, the VA must factor in pain and fatigue that occur after repetitive use or during a flare-up of the condition. Without this information, the severity rating assigned for the disability—which affects both disability payments and health benefits—may be inappropriate.

In 2002, 61% of the reports from VA joint and spine disability exams were still missing the information mandated by *DeLuca v. Brown*. Since then, this percentage has dropped to 22%—an improvement the GAO attributes primarily to the establishment in 2004 of formal performance measures for the quality of VA disability exam reports. The VA also has distributed musculoskeletal exam training videos and resource materials, sponsored national training conferences and satellite broadcasts on the *DeLuca v. Brown* criteria, published VISN-specific monthly performance statistics on compliance with the criteria (since October 2003), and developed and distributed automated electronic templates for conducting and reporting on disability exams.

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Despite this progress, the GAO points out that the 22% rate of incomplete exam reports is of concern. Furthermore, its investigation revealed wide variation in rates of compliance with the criteria among the VA's 21 VISNs: from 57% in VISN 1 (the VA

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New England Healthcare System) to 92% in VISNs 6 and 16 (the VA Mid-Atlantic Health Care Network and the South Central VA Health Care Network, respectively). The GAO report recommends that the VA devise new strategies to address and correct these inconsistencies.

The report also identifies problems with the disability exam requests that are generated by VA regional offices. Data from the VA's Compensation and Pension Examination Program (CPEP) Office indicate, for example, that 32% of spine exam requests made in the second quarter of fiscal year 2005 had at least one error, such as not identifying the pertinent condition or not requesting the appropriate exam. The GAO has advised the VA to establish a performance measure for the quality of exam requests—as it did for the exam reports. This measure could be implemented, the GAO suggests, once the CPEP Office distributes the new software it has developed to make case-specific exam request error information available to regional offices through the VA's intranet.

The VA has indicated that it concurs with the assessments in the GAO's report—though it disputes the notion that new strategies are immediately necessary to correct the inconsistencies in report compliance. It would prefer to continue collecting data and monitoring progress in order to gain a better understanding of the need for intervention or new strategic approaches.

HHS Takes Action to Facilitate Advances in HIT

In April 2004, President Bush called for the widespread use of electronic health records (EHRs) within the next 10 years, in order to improve the quality and efficiency of health care and to make it more consumer-centric. Recently, the HHS has taken a number of steps toward achieving that health information technology (HIT) goal.

On October 7, HHS Secretary Mike Leavitt held the first meeting of the American Health Information Community, a federally chartered commission charged with advising the HHS on how best to make health records digital and interoperable—that is, accessible to and usable by multiple providers—while protecting patient privacy and security. The community is composed of 17 members from both the public and private sector, including VA Under Secretary for Health Jonathan B. Perlin, MD and Assistant Secretary of Defense for Health Affairs William Winkenwerder, Jr. The community, said Leavitt, would aim to meet every four to six weeks, formulating an agenda, assigning particular tasks and problems to working groups chaired by community members, building consensus based on the findings of the working groups, and recommending action.

The HHS Office of the National Coordinator for Health Information Technology also will collaborate with George Washington University in Washington, DC and Massachusetts General Hospital/Harvard Institute for Health Policy in Boston on the new Health Information Technology Adoption Initiative, which aims to characterize and measure the state of EHR adoption and determine the effectiveness of policies aimed at accelerating adoption. Although several studies have attempted to measure adoption rates of HIT and EHRs, no single approach for doing so has been established. This initiative will provide a baseline measurement of EHR adoption rates and develop a quantifiable method for measuring the increased uptake.

Other recent actions include new regulations proposed by the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of Inspector General (OIG). The new CMS rule would make it easier for hospitals and certain health care organizations to furnish hardware, software, and related training services to physicians for electronic prescribing and EHRs—particularly when the support involves systems that are interoperable. In order to do so, the proposal creates an exception to the "physician self-referral" law, which states that physicians participating in Medicare are prohibited from referring Medicare patients for certain health services to health care entities with which the physician has a financial relationship. Similarly, the OIG has proposed safe harbors for arrangements involving the donation of EHR and electronic prescribing technology. These exceptions and safe harbors would be narrow in scope until the establishment of nationwide HIT product certification criteria. ●