Reform to Target Persistent Health Disparities

BY MARY ELLEN SCHNEIDER

The quality of health care in the United States is improving slowly, with the slowest progress occurring in prevention and chronic disease management, according to the latest government data.

The nation also continues to struggle with health care disparities. Despite efforts to improve access and quality of care for minorities, new national data show that, overall, minorities and low-income individuals receive the worst health care.

The findings were detailed in two reports released by the Health and Human Service department.

The 2009 National Healthcare Quality Report provides a snapshot of how the nation is performing on 169 quality measures; the National Healthcare Disparities Report provides a summary of health care quality and access among various racial and ethnic groups and across income groups.

Although the two reports show significant gaps in care, HHS Secretary Kathleen Sebelius said that she expects to see improvement with the implementation of the new health care reform laws—the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act.

"While the Affordable Care Act isn't a cure, we think it's one of the most effective treatments we've had for these problems in a long time," Ms. Sebelius said during a news conference to release the reports.

Specifically, the health care reform laws will expand data collection and research efforts on health care disparities, increase the size and diversity of the health care workforce, and establish a new national institute on minority health and health disparities at the National Institutes of Health. But most importantly, the laws will expand coverage for millions of Americans who are currently uninsured, Ms. Sebelius said.

"In almost every case, populations who are currently underserved get relief [under the new laws], whether it's minority Americans, women, early retirees, rural Americans, or Americans with disabilities," she said.

The 2009 quality report showed that overall quality is improving at a rate of about 2.3% annually.

However, the speed of improvement varied across settings of care: Hospitals are improving more rapidly, at a median rate of change of about 5.8%, whereas outpatient settings improved at a median rate of change about 1.4%, according to the report.

As a result, improvements in prevention and chronic disease management are lagging behind improvements in acute care. For example, of the nine process measures tracked in the report that worsened, eight related to either preventive services or chronic disease management, including mammography, Pap testing, and fecal occult blood testing.

"Although the trend is going in the right direction, which is good, the pace is unacceptably slow," said Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality, which produced the reports.

On the disparities side, the report showed that many disparities have not decreased over time. For example, from 2000 to 2005, disparities in colorectal cancer screening have grown between American Indians and Alaska Natives vs. whites, increasing at a rate of 7.7% per year. Additionally, blacks and Hispanics had worsening disparities in colorectal cancer mortality from 2000 to 2006. ■

The two reports are available online at www.ahrq.gov/qual/qrdr09.htm.

Federal Committee Considers Effect of IT on Patient Safety

BY MARY ELLEN SCHNEIDER

As physicians and hospitals begin to implement electronic health record systems in the hopes of earning financial incentives from the federal government, experts are considering how to ensure patient safety when working with health information technology.

The federal Health IT Policy Committee, which makes recommendations to the National Coordinator for Health Information Technology, met this spring to discuss some of the areas where potential patient safety hazards exist.

Topping the list were technology issues, such as software bugs, interoperability problems, and implementation and training deficiencies. Another major area of concern was the interaction of people and technology.

According to Paul Egerman, who cochairs the Certification/Adoption Workgroup of the Health IT Policy Committee, straightforward problems with technology are actually in the minority when it comes to safety issues. While these problems can be difficult to uncover, once they are discovered, they can usually be easily and rapidly fixed.

The majority of safety issues surrounding health IT involve multiple factors. That complicates things, Mr. Egerman said, because that means that even if the technology worked perfectly, there could still be problems. "There are tons of issues that are completely independent of technology," said Mr. Egerman, who is CEO of eScription, a computer-aided medical transcription company.

Also of concern is that many of the health IT-related safety issues are local. Marc Probst, who cochairs the Certification/Adoption Workgroup, said that each health care organization is unique, and relies on very different operating systems and security and privacy protocols, as well different types of monitoring. That puts the onus on individual organizations to stay on top of safety issues raised by their health IT systems, he said.

"Every organization is going to be unique, so there is a local responsibility to HIT safety that our vendors simply aren't going to be able to keep up with," said Mr. Probst, who is the chief information officer at Intermountain Healthcare in Salt Lake City.

The Certification/Adoption Workgroup previewed some of its ideas for gathering more data on the HIT-related safety issues and the need for more training. The work group released a set of preliminary recommendations that call for patients to play a greater role in identifying errors.

In the physician's office, for example, patients should ideally be able to observe as physicians enter information into an electronic record so they can call attention to mistakes. On the inpatient side, patients and family members should be encouraged to look at medication lists.

To gain more data on the scope of safety issues, the work group also called for establishing a national database and reporting system that would allow patients and health care providers to make confidential reports about incidents and potential hazards. This could be used for evaluation and analysis, but also for dissemination of potential problems, Mr. Egerman said. ■

Personal Health Record Use on the Upswing, but Still Low, Survey Finds

While the use of personal health records is gaining popularity, still only 1 in 14 Americans report having used one, according to a survey of 1,849 patients.

About 7% of respondents to the survey sponsored by the California HealthCare Foundation (CHCF) said they used a personal health record (PHR). That's more than double the 2.7% who reported using PHRs in a 2008 study conducted by the Markle Foundation.

Among the reasons cited by those who do not use a PHR were concern over data privacy, the perception that they don't need such a tool, and fears that PHRs might cost too much or take up too much time, said Sam Karp, vice president of programs for CHCF.

Of those who reported PHR use, 26% reported using one sponsored by their health care provider while 51% reported using one provided by their health insurer. While PHR users tend to be young, highly educated white men with relatively high incomes, patients with chronic illnesses and those with lower-than-average income and educations were more likely to report benefiting from using a PHR, according to the survey results.

For example, 55% of respondents without a college degree reported that after using a PHR, they asked their provider questions they otherwise would not have asked. Also, 58% of users with incomes of less than $50,000 said that they felt more connected to their doctors as a result of using a PHR.

In addition to assisting patients in managing their health, PHRs can also serve as safety tools, said Dr. Kate Christensen, medical director, Internet services group for Kaiser Permanente. Kaiser, which runs a PHR serving 3 million patients, has found that patients use it to check their medical data and e-mail providers to report errors.

—Anne C. Zieger

DATA WATCH

HITECH Act Reimbursement Plan to Achieve Meaningful EHR Use

	Adopt EHR in 2011	Adopt EHR in 2012	Adopt EHR in 2013	Adopt EHR in 2014
2011	$18,000	—	—	—
2012	$12,000	$18,000	—	—
2013	$8,000	$12,000	$15,000	—
2014	$4,000	$8,000	$12,000	$15,000
2015	$2,000	$4,000	$8,000	$12,000
2016	—	$2,000	$4,000	$8,000
Total	$44,000	$44,000	$39,000	$35,000

Notes: Chart shows potential reimbursements from the CMS to physicians who adopt an electronic health record between 2011 and 2014. This reimbursement is part of the Health Information Technology for Economic and Clinical Health Act.
Source: Presented by Dr. Brian Nussenbaum of Washington University, St. Louis, at the Triological Society's Combined Sections Meeting in Orlando.
For more information about the EMR reimbursement and the criteria for "meaningful use," visit www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3563.