

Health Information Technology: An Introduction

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January 17, 2006
Minnesota Legislative Committee Meeting

Overview

- Focusing on HIT for improving health care
- What do hospitals and clinics have available?
- How can HIT help?
- Barriers to effective use of HIT
- Health information exchange and interoperability (HIEI) – The National Agenda
- HIEI in MN – one example

Health Domains for HIT Use

Health Care space	Clinical Research	Biomedical Science
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- Individuals (patients) ← *This talk's focus*
- Populations (public health)

HIT in Support of Patient Care

- On the front line
 - Electronic medical records (EMR, EHR) systems
 - Practice management systems
- Clinical information support systems
 - Laboratory
 - Pharmacy
 - Imaging (PACS)
 - ... and many more
- Administrative support systems
 - Scheduling
 - Patient directories
 - Revenue cycle systems
 - ... and many more

What are frontline systems used for?

- Schedule, check in, & room patients
- Facilitate workflow by status communication
- Retrieve prior health information
- Record today's problems & observations
- Record today's assessment & plan
- Communicate orders
- Remind & alert of exceptional conditions
- Collect & communicate billing information
- Analyze & improve clinical practice

How Can the EHR Improve Clinical Practice?

- Easy access to patient data
- Improve ordering process
 - Ensure completeness, correctness
 - Perform drug interaction checks
 - Calculate and adjust doses based upon age, weight, renal function
- Reminders & alerts
 - Drug – allergy alerts
 - Redundant test reminders
 - Preventive services reminders
- Improved clinical messaging & workflow
- Decrease office overhead cost
 - Reduced transcription costs
 - Reduced chart pulls
- Improved communication
 - Patients
 - Labs & pharmacies
 - Improved referral coordination
- Improved charge capture and accounts receivable
- Facilitate practice improvement
- Ease HIPAA compliance
- Decrease malpractice exposure

Health care is not a computer-friendly environment

- Complex "product"; each patient is unique
- Very broad and uncontrolled vocabulary
- Many work decisions are values-laden; values are personal
- Complex processes; many roles, much individualization, freedom of choice
- Activity is fragmented, distributed & sometimes urgent
- Must facilitate workflow, not just data storage
- Many interacting systems; communication standards are more like suggestions than rules
- Life science knowledge is incomplete, sometimes wrong, always evolving, and slowly communicated

Health Info. Technology (HIT): a panacea for healthcare?

- AS many as 98,000 people per year die from medical errors that occur in hospitals
- HIT may be key to improving patient safety
 - IOM Crossing the Chasm challenge – effective clinical use of HIT
 - The Leapfrog Group focused on CPOE & alerts
 - HIT Leadership Panel – "Widespread adoption of interoperable health IT should be a top priority for the US health care system" (5/11/05)
 - Bipartisan! congressional support (12/05)

To Err is Human: Building a Safer Health System, 2000, NAP
Crossing the Quality Chasm: A New Health System for the 21st Century, 2001, NAP

The National HIT Picture



- 4/27/04 - Federal executive order established the Office of the National Coordinator for HIT (ONC)
- 7/21/04 – Framework for Strategic Action
- 10/6/05 Contracts for standards harmonization, EHR certification, and privacy/security awarded
- 10/7/05 - 1st meeting of the American Health Information Community (AHIC)
- 11/10/05 – Nationwide Health Information Network prototype awards

Available at www.os.hhs.gov/healthit/

The need for health information exchange

- Medical error, patient safety, and quality issues
- Providers have incomplete knowledge of their patients
- Patients are portable; their health records aren't
- A fractured healthcare delivery system
- An 'unwired' system

What is interoperability?

- Definition: Interoperability is the ability of two or more systems to **exchange information** and to **use the information** that has been exchanged.

Why is interoperability so important?



- Patients can more easily move among clinicians
- Care can be better coordinated
- Without it, EMR adoption will strengthen existing information silos
- HIEI may save the US healthcare system's money
 - \$337B over a 10-year implementation period
 - \$78B a year thereafter

DJ Brailer. *Health Affairs*, January 2005.
J Walker et. al. *Health Affairs*, January 2005.

Some big barriers to deploying EHRs

- Their cost is significant
 - Providers pay for EMRs; Payers reap most of the savings
 - Market incentives not well-aligned to improved quality & efficiency
- Adoption gap
 - Large practices - >50% likelihood of MD use
 - Small practices (<10 MDs in group) - < 10% use
- Shortage of know-how
 - Culture, practice, and communication paths are changed
 - Change management & re-engineering know-how is rare
- Today's EHRs cannot communicate with each other
 - Vocabulary is not standardized
 - Security regulations and practices are not harmonized
 - info is power and may not be willingly shared

A Community-shared Clinical Abstract to Improve Care

A Planning Grant Submitted to Agency for Healthcare Research & Quality (AHRQ)

Healthcare Partners:
 Allina Hospitals & Clinics
 Fairview Health Services
 HealthPartners

Submitted on April 22, 2004

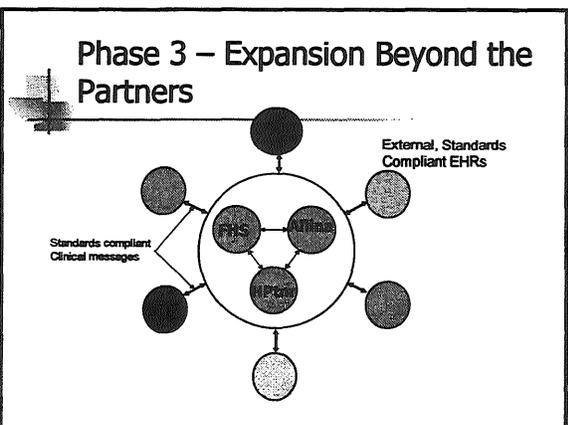
Information Gaps in the ED

- Gaps are frequent - 32% of visits
- Gaps are consequential
 - Very important or essential 48%
 - Somewhat important 32%
 - Prolong the ED stay
 - Increase costs
 - Redundant testing & repeated MD assessments

Stell A et al. CMAJ 2003; 169:1023-8.

Project Vision

At the time patients undergo transitions in care, providers will have ready access (via a shared clinical abstract) to the data needed to make informed clinical decisions, including those associated with medication reconciliation, so as to favorably impact the quality of care and patient safety.



Questions

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Health Information Technology, Quality Improvement, and Data: Necessary but not sufficient

Gary Oftedahl, MD
Medical Director/Interim President
Institute for Clinical Systems
Improvement

ICSI

- A collaboration of 57 medical groups & hospital systems
 - 60 hospitals with 8,341 beds (including 55% of the beds in Minnesota)
 - 56 medical practices with 7,500 physicians (including 75% of those in Minnesota)
- Sponsored by six health plans
- Established in 1993

ICSI Program

- Core commitment cycle
- Scientific groundwork
 - Guideline development & maintenance
 - Technology assessment
- Support for improvement
 - Education & training
 - Coaching
 - Action groups (improvement collaboratives)
 - Knowledge products
- Advocacy for quality

Quality focus--1993-2000

- Guideline development--the science
- Principles of CQI
 - Team based
 - Data driven
 - Customer focused
 - Process orientation, not personal
- Separated from leadership--"project" driven

The Shift begins....

- 1999--Institute of Medicine--"To Err is Human" released
 - 98,000 lives/year lost from medical error
- Second IOM report--Crossing The Quality Chasm
 - Difference between the care we deliver and what our patients deserve is a "chasm" not a gap

Quality Improvement in MN

- ICSI--increasing focus on need for systems, new methods, use of guidelines/evidence based medicine
- Guidelines--good idea, but usually "on the shelf"
- Barriers--lack of data, lack of ability to measure, culture of denial ("cookbook" medicine)

QI and HIT???

- Challenges--"one provider at a time"
- Not about "hardware and software" alone--about quality
- HIT necessary, not sufficient to move quality
- Need to define the goals of the quality movement

Quality Movement Goals

- Better identify components of quality healthcare
- Better ways to deliver quality healthcare
- Perhaps actually SAVE money, as well as lives--quality care is cost effective care

HIT and QI--the challenge

- Present culture of health care
 - Tradition--"we've never done that before"
 - Paper based
 - Craftman's approach vs. systems approach
- Movement to HIT--one part technology and two parts culture and process change
 - Needs to support workflow, not add layers

HIT/QI--the convergence

- Access to patient information when and where it's needed
 - HIT may allow portability of information
 - Presently, virtually nonexistent
 - Will not occur without technology to support efforts

HIT/QI--the convergence

- Better quality means providing information for best treatment choices for patients to providers
 - Need to imbed protocols/guidelines in process, not on the shelf
 - Challenge of developing the technology to support this in many venues

HIT/QI--the convergence

- Better quality means preventing medical errors
 - Presently a culture of "fear", lack of systems to identify and report errors.
 - HIT opportunities
 - Error reporting systems
 - CPOE (Computer Point of Entry) orders
 - Bar coding of medications
 - Can't accomplish the above without HIT support

HIT/QI--the convergence

- Better quality means coordinating the patient's care
 - Similar to information access--information available to all providers involved.....and the patient

HIT/QI--the convergence

- Better measurement key to improvement in healthcare
 - Positive value of feedback on performance to providers--not easy without HIT
 - Ability to move toward public reporting/data transparency--Minnesota Community Measurement
 - Movement to agreement on standards of care

HIT/QI--the convergence

- Assisting healthcare providers in engaging patients in their personal healthcare
 - HIT opportunities to provide information in many ways
 - Access to medical records
 - Access to accurate information on Internet
 - Potential use of email, telemedicine

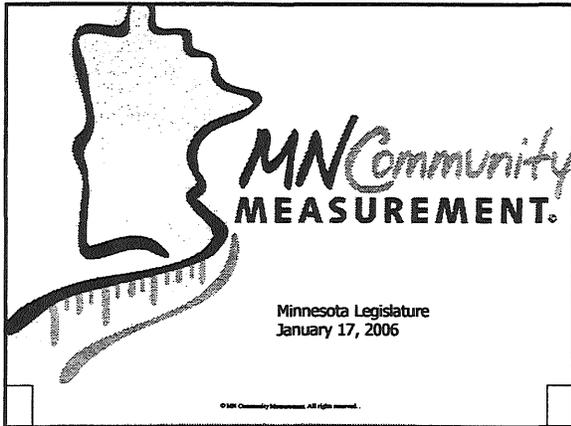
Land mines on the Road to Success

- Culture issues--autonomy, "silo" effect
- Reimbursement mechanisms
 - Present system promotes piecemeal, limits opportunities to move forward
- Looking for the quick fix, expecting HIT alone to fix the problems
- Project approach vs. process/journey

The Minnesota Journey Where are we now?

- ICSI-over 75% of providers in state involved
 - Providing resources for systems approach, QI
- Minnesota Community Measurement
 - Great movement and increasing acceptance
- Spirit of collaboration and sharing high
 - Recognition of need for more change
- Nationally, #1 in health--but need much more

Jim Chase



MN Community Measurement

Accelerating the Improvement of Health Through Public Reporting

A community effort of providers, purchasers, health plans

- Report results on health care quality measures
- Provide resources for patients and providers to improve care
- Increase efficiency of reporting

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The Healthcare Environment

"Between the health care we have and the care we could have lies not just a gap, but a chasm."
IOM Report

"Every system is perfectly designed to get the results that it gets."
Donald Berwick, MD

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Key Ingredients for Change

- Agreement on Standards
- Support for Improvement
- Recognize/Reward Results
- Measure and Report

MNCM Governance Structure

- MNMCM Founding Members
 - Seven Minnesota Health Plans
 - Minnesota Medical Association
- MNMCM Board of Directors
 - Representatives from employers, consumers, health plans, medical groups, hospitals, and quality improvement organizations
- Reporting Advisory Group
- Data Planning Workgroup

Community Measurement - Background

- Fourth year of report
 - 2002 diabetes
 - 2003 nine clinical topics, 20 measures
 - 2004 first public report
 - 2005 group comparisons
- Report on 54 medical groups - where 90% of Minnesotans get their primary care.
- Includes Medicare, Medicaid, Commercial, Self-Insured

Medical Groups Representing 700+ Clinics

<ul style="list-style-type: none"> • Affiliated Community Medical Centers • Allina Medical Clinic • Altru Health System • Aspen Medical Group • Avera Health/Tri-State Health Affiliates • Brainerd Medical Center, P.A. • Buffalo Clinic, P.A. • Camden Physicians • ContraCare Health System • Central Lakes Medical Center, P.A. • Columbia Park Medical Group • Crossroads Medical Centers, P.A. • Dakota Clinic, Ltd. • Fairview Health Services • Family Health Services of Minnesota • Family Practice Medical Center-Wilmar • Fergus Falls Medical Group, P.A. • Grand Tassara Clinic • Gunderson Clinic • HealthEast • HealthPartners Central Minnesota Clinics • HealthPartners Medical Group and Clinics • Hennepin County • Hutchinson Medical Center, P.A. • Lakeview Clinic, Ltd • Maricabo Clinic, Ltd 	<ul style="list-style-type: none"> • Mayo Clinic • Mayo Health System • MeritCare • Minnesota Healthcare Network • Minnesota Rural Health Cooperative • Multicare Associates of the Twin Cities • Neighborhood Health Care Network • North Clinic • North Memorial Clinic • Northstar Physicians • Northwest Family Physicians • Olmsted Medical Center • Park Nicollet Health Services • Quallo Clinic, Ltd. • Regina Medical Center • Ridgeview Care System • Riverwood Albin Clinic • St. Cloud Medical Group, Ltd. • St. Luke's Clinics • St. Mary's/Duluth Clinic Health System • Stillwater Medical Group • SuperiorHealth Medical Group • University of Minnesota Physicians • Western Wisconsin Medical Associates • Winona Clinic, Ltd.
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Why Reporting Matters

- Improvement requires measurement
- Reporting provides
 - Recognition for those performing well
 - Motivation for those who are not
- Health care bedrock
 - Desire to provide excellent patient care

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Why Community Driven?

- The public and the providers need to set the priorities
- Must be reliable for providers and consumers
- Patients and the community have a role in the results

MN Community Measurement™ Impact on the Community

- Results are improving
- Medical groups are engaged
- The public is interested
 - 30,000 website visits in November
 - Included in state employee open enrollment
- Employers and payors are recognizing results

Diabetes Results are Improving (percent of patients at target)

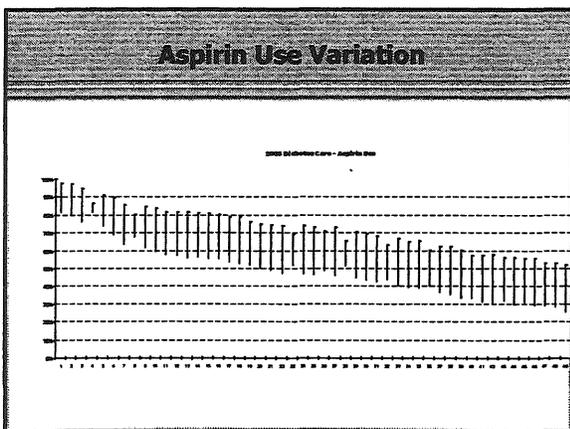
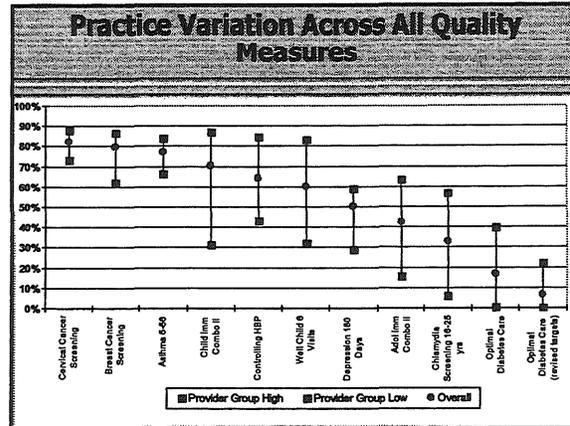
	2001	2002	2003	2004
Optimal Diabetes <small>(All cardiovascular risks at target)</small>	8%	12%	12%	16%

MN Community Measurement™ What Does This Mean?

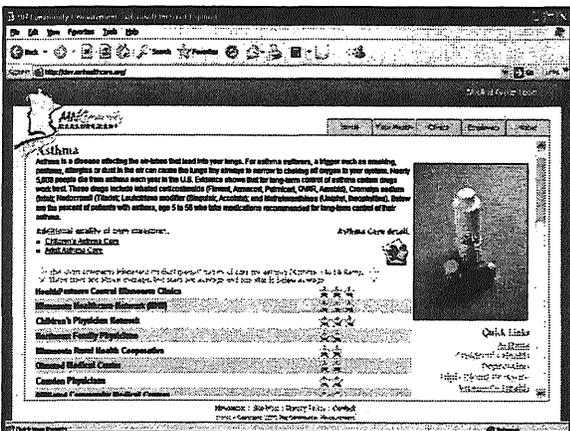
- Hundreds of people in Minnesota will avoid serious adverse outcomes:
 - fewer deaths
 - fewer strokes
 - fewer heart attacks
 - fewer eye complications
 - fewer kidney complications
 - fewer amputations

Other Results

	2002	2003	2004
Asthma	71%	74%	76%
Depression	49%	51%	49%
Childhood Immunizations	63%	64%	68%
Adolescent Immunizations	27%	35%	39%
Well Child Visits	45%	53%	59%
Blood Pressure Treatment	57%	60%	64%
Breast CA screening	76%	75%	74%
Cervical CA screening	76%	78%	78%
Chlamydia screening	26%	29%	32%



- ### Public Website
- Information on the patient and provider role in improving care
 - Shows comparisons across medical groups or regions
 - Multiple views of data
 - Much work to be done to engage the consumer



- ### Conclusions
- Quality measurement and reporting can improve results
 - Measures should be community-wide
 - Measures should be community based
 - Measures must be consistent and credible
 - Engage the public in using results

Recommendations

- Encourage Medicare to work with regional organizations on public reporting of health care quality.
- Support new measures
 - Specialty care
 - Measure results across care locations
 - Patient experience
 - Cost
- Expand the populations included in measurement
- Include public programs in the same measurement process. Should we use the same measures, but report separate public program results?

Questions or Comments

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Rural Health Resource Center

**Issues Facing Rural:
HIT Implementation
and Public Reporting**

Tami Lichtenberg
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Duluth, Minnesota

Rural Health Resource Center

- Located in Duluth, Minnesota
- Private, Non-profit
- National scope
- Seven federal contracts
- Funding from federal ORHP

Rural Health Resource Center

Current Federal Contracts and Contracts

- Technical Assistance & Services Center (TASC)
- TASC HIT Supplement
- Small Hospital Improvement Program (SHIP)
- Delta Rural Hospital Performance Improvement (RHPI)

Rural Health Resource Center

Consumer-Driven Health Care

Supply regulation 1980s Managed behavior modification 2000s

1970s Price regulation 1990s Consumer-driven health care

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CDHC

- CDHC driven nationally by:
 - High cost
 - Questionable quality
 - More demanding consumer

Rural Health Resource Center

Quality Care

“The stunning high rates of medical errors, resulting in deaths (44,000 to 98,000 annually), permanent disability, and unnecessary suffering, are simply unacceptable in a medical system that promises first to do no harm.”

- William Richardson,
IOM Committee Chair

CDHC Initiatives

- Insurance/HSAs
- Public Reporting
- P4P

Hospital Campaign

- Scores publicly reported – April 2005
- 3,839 out of 3,906 participated
- Reporting hospitals received full 3.3% Medicare update
- CAH participation limited and problematic
- CAH Participation ranges from 0-86% and averages 41% nationwide.

Looking back at the Future

HIT Initiatives have been around since the 1950's:

- Computers used for dental projects at the National Bureau of Standards
- Expert systems developed
 - * MYCIN
 - * INTEREST - 1

FAST Forward

1990's

- Health Security Card proposed by HHS
- National Health Information Infrastructure via Clinton Health Reform- rewritten as HIPAA
- HIPAA standards for transmission of billing and clinical health information
- IOM "To Err is Human"

HIT in the 2000's

- IOM "Crossing the Quality Chasm"
- 9/11 Emergency Preparedness and Public Health Infrastructure Development
- MMA fosters electronic prescribing
- ONCHIT established
- IOM "Quality Through Collaboration"

What Everyone is Missing: Some Planning Considerations

- Governance
- Principles & Key Objectives
- Stakeholder Perspectives
- Establishing a Business Case
- Needs Assessment
- Legal & Regulatory Challenges
- Defining Interoperable Architectures
- Evaluation Methodologies

* Courtesy of Health Tech Strategies, LLC

Rural Health Resource Center

Some Additional Practice Issues

- Small rurals may have no IT support let alone an IT Department
- Hard to find M.D. or Adm. leaders / change agents
- Other business priorities i.e. "surviving"
- No business case for connectivity / linkages to other institutions (stand-alone EHRs?)
- No aggregate buying power (hence pooled vendor selection processes)
- Need to address critical referral pattern issues, disruptions, patient flows, etc...
- Rural health care organizations will need special legislative consideration

* Courtesy of Health Tech Strategies, LLC

Rural Health Resource Center

Technical Assistance and Services Center (TASC) HIT Support

Working with the AHRQ National Resource Center (NRC):

- Compile a list of expertise needed to assist rural hospitals with HIT
- Build expertise within the organization or retain consultants
- Develop tools and resources
- Customize a rural HIT portal for the NRC web site
- Develop a compendium of HIT consultants and technical experts for rural health providers

Rural Health Resource Center

Focusing Attention on Rural Communities

"Efforts to develop local and national health information technology infrastructures should focus specific attention on rural communities"

Further, the benefits of HIT "may be even more substantial in rural communities" ("Quality Through Collaboration: The Future of Rural Health Care", Institute of Medicine, November 2004.)

* Courtesy of Health Tech Strategies, LLC

Rural Health Resource Center

Policy Considerations

- Reimbursement & Capital Costs
 - Aligning Financial Incentives
 - Driving Cost-Effectiveness (i.e. Chronic Care & Disease Mgmt)
 - Start-up Costs Capital Investment
- Standards (Clinical & Communications)
 - Quality & Safety
- Infrastructure Issues
 - Network Infrastructure / Access / Interoperability
- Human Dimension Issues
 - Practitioner and Patient Acceptance
 - Licensure, Accreditation, Certification
 - Legal (Stark Law, Liability, FDA, HIPAA)

* Courtesy of Health Tech Strategies, LLC

Rural Health Resource Center

We need to re-evaluate...

HIT needs to support strategic planning and needs to have a purpose and benefit.

It needs to be part of the solution to enhanced quality and patient safety – not another barrier.

Rural Health Resource Center

Infrastructure Issues

- \$400 B Needed to Build NHIN Over 5 Years (Commonwealth Fund Study)
- Rural Broadband Access Continue to Lag Behind (California HealthCare Foundation)
- Yet, deployment of fiber and wireless in rural areas has accelerated sharply in the past year. (Verizon Foundation)
- Infrastructure support, limited technical investment, ongoing support – Top Listed Barrier in Surveys (First Consulting)

* Courtesy of Health Tech Strategies, LLC

Reimbursement and Incentives

- Financial Incentives targeted toward physicians and providers
- Reimbursement for implementation of EHRs and other incremental applications
- Access to capital for EHR purchases
- Matching grants, clinical IT purchasing contracts
- EHRs as a Tax Credit rather than Business Expense
- Reduce liability insurance premiums for HIT users

* Courtesy of Health Tech Strategies, LLC

Number of Partners

- Federal Government
 - Congress
 - Agencies (HHS, DoC, Ag, DoD, VA, IHS, NASA)
- States
 - Statewide Initiatives (Governors, Legislatures, Regional Networks)
- Private Sector
 - Coalitions/Consortia (ATA, HIMSS, eHI, AHIMA, AMIA, NAHIT, CCHIT) Capital Hill Steering Committee on Telehealth and Healthcare Informatics)
 - Standard Groups
 - Foundations (Markle, RWJ, Commonwealth, eHI)

* Courtesy of Health Tech Strategies, LLC

Major HIT Efforts

- AHRQ THQIT \$139 M DHHS effort, over 100 Grants to Communities, Hospitals, Providers, Systems for planning, implementation, RHIOs
- eHealth Initiative – “Connecting Communities for Better Health” \$6.9 M
- RWJ – “Health e-Technologies Initiative” \$10.3 M
- Markle – “Connecting For Health” collaboration of 100 partners

* Courtesy of Health Tech Strategies, LLC

Complementary Partner Efforts

Working to address the issues:

- eHealth Initiative “Connecting Communities for Better Health” \$6.9 M
- Robert Wood Johnson “Health e-Technologies Initiatives” \$10.3 M
- Markle Foundation “Connecting for Health” – 100 partners
- Commonwealth Fund

* Courtesy of Health Tech Strategies, LLC

Rural Health Resource Center

- Facilitating Planning Committee for National Rural HIT Conference in September '06
- Creating HIT Assessment tool for rural hospitals
- Gathering rural health HIT tools and resources, best practices

Technical Assistance and Services Center (TASC) HIT Support

Working with the AHRQ National Resource Center (NRC):

- Compile a list of expertise needed to assist rural hospitals with HIT
- Build expertise within the organization or retain consultants
- Develop tools and resources
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Rural Health
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Minnesota e-Health Initiative: Update on Progress, Plans, Opportunities

January 17, 2006

Speakers
* Scott Leitz
Director, Office of Policy, Statistics and Informatics
* Marty LaVenture, MPH PhD
Director, Center of Health Informatics
Minnesota Department of Health

Minnesota e-Health Initiative



Overview of Presentation

- * E-Health Initiative History
- * Progress to Date
- * Challenges
- * Opportunities and Next Steps

Minnesota e-Health Initiative



Vision for the Minnesota e-Health Initiative



Minnesota e-Health

“... accelerate the adoption and use of Health Information Technology to improve healthcare quality, increase patient safety, reduce healthcare costs and enable individuals and communities to make the best possible health decisions.”

Source: Committee Report to the Legislature, January 2005
Minnesota e-Health Initiative



Minnesota e-Health Initiative Focus

- * Private-Public collaboration
“Dedicated to accelerate the use of Health Information Technology (HIT) in all areas of the state...”
- * For the purpose of:
 - Improving health and health care quality
 - Increasing patient safety
 - Reducing health care costs
 - Improving public health

Minnesota e-Health Initiative



Minnesota e-Health Initiative Key Elements

- * Motivated by need and legislation: 2004 and 2005
- * Inclusive of private and public healthcare and public health settings, including LTC
- * Strengthened by “culture of collaboration”
- * Broad statewide vision
- * Phased implementation
- * Guided by Advisory Committee
- * MDH role: neutral convening body, facilitation, assist in measurement, assessment and communications

Minnesota e-Health Initiative



Minnesota e-Health Initiative: Legislative History

- * 2004: Electronic Health Records Work Group
(Laws 2004, Chapter 288, Article 7, section 7)
- * Established work group to:
 - Identify barrier to EHR adoption
 - Assess status of EHR implementation in MN
 - Coordinate with Federal initiatives
- * Report to Legislature, January 2005
- * E-health Initiative Summit: June 2005

Minnesota e-Health Initiative

Minnesota e-Health Initiative: Legislative History

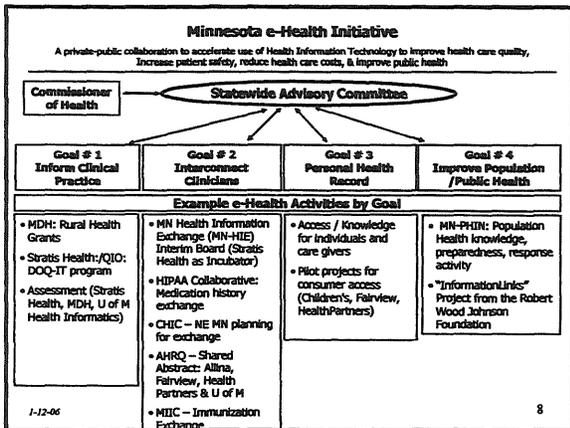
- * 2005: Health Information Technology and Infrastructure Advisory Committee (Laws 2005, 1st Special Session, Chapter 4)
- * Establishes Advisory Committee to Commissioner of Health on assessment of and recommendation for implementing health information technology
- * Annual reports to legislature on progress and recommendations

Minnesota e-Health Initiative 7

MN e-Health Advisory Committee Representation

- * Co-Chairs: Mary Brainerd, Mary Wellik
- 25 Members Representing:**
 - * Hospitals
 - * Health plans
 - * Physicians
 - * Nurses
 - * Pharmacies
 - * Long Term Care
 - * Academic institutions
 - * State government purchasers
 - * Local and state public health agencies
 - * Citizens
 - * Experts with Informatics knowledge and experience

Minnesota e-Health Initiative 8



Important Progress... Continuing Need

- * **Electronic Health Record Adoption**

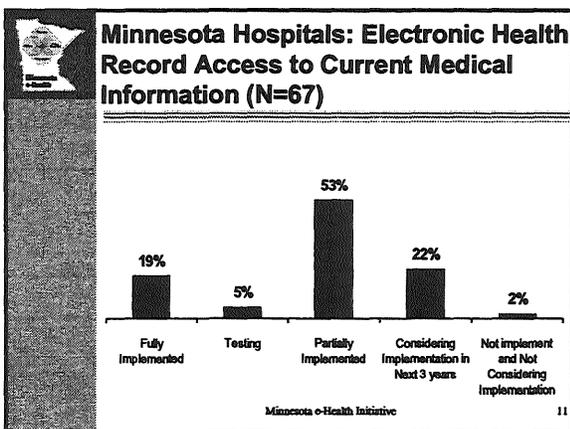
Progress

- Clinics: 2005 Stratis Health Survey: (300/651) **46% have Implemented EHR or in process**
- Hospitals: 2005 AHA survey 19% are fully implemented
- DOQ-IT informatics support project

Continuing need

- Small and rural Clinics
- Long term care, local public health departments
- other settings
- Extend informatics support to these settings

10



Important Progress... Continuing Need

- * **Connecting Clinicians / Interoperability**

Example Progress

- Shared Clinical Abstract Pilot: Fairview, HealthPartners, Allina, University of Minnesota
- Community Health Information Collaborative (CHIC)
- Non-profit MN-Health Information Exchange – Interim Board established

Continuing Need

- Pilots / models with rural and small clinics
- Pilots / models for long term care, local public health departments and others
- Extend informatics support to these settings
- Others

Minnesota e-Health Initiative 12

Rural & Safety Net Issues

Rural Health

- * HIT can improve quality & coordination across distances
- * Growing demand & potential for tele-mental health, tele-homecare, other tele-health services
- * Hospital interest growing, reflected in response to MDH grant programs
- * Intermittent broadband access in rural areas
- * Cost & staffing barriers remain

Community Clinics

- * Demands of treating uninsured crowding out resources for expensive HIT investments
- * Challenges of small scale:
 - EHR/IT expertise tough to recruit
 - No clout with vendors
 - Recruiting clinicians harder - physicians expect HIT
- * EHR has potential to improve management/care of transient patients, notably in diabetes & other chronic diseases

Minnesota e-Health Initiative 13

Nat'l Critical Access Hospital HIT Survey

(Conducted by Rural Health Resource Center, Duluth)

- * **Biggest Barriers to Initiating HIT:**
 - Capital Needs - 81% of respondents noted
 - Staff Time - 50%
- * **Biggest Barriers to Continuing HIT:**
 - Acquiring hardware/software - 50%
 - Staff time - 50%
- * **Most Helpful Resources?**
 - Grants/loans - 92%
 - Access to best practices - 46%

Minnesota e-Health Initiative 14

Motivation: Preparedness, Response and Electronic Health Records

- * **US Health and Human Services**
"There may not have been an experience that demonstrates, ... more powerfully the need for electronic health records ... than Katrina."
(HHS - 9/13/2005).
- * **Hurricane Katrina**
 - Many paper health and health care records lost permanently - hurting critical health services
 - Many digital records available in days - allowing continuity of care

Minnesota e-Health Initiative 15

Stage of Health Information Exchange 2005 Survey* [n=100 projects]

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
= 12%	= 14%	= 15%	= 37%	= 12%	= 11%
<ul style="list-style-type: none"> ▪ Recognition of the need for HIE among multiple stakeholders in your state, region, or community 	<ul style="list-style-type: none"> ▪ Getting organized vision, goals, & objectives ▪ Defining shared vision, goals, & objectives ▪ Identifying funding sources ▪ Setting up legal & governance structures 	<ul style="list-style-type: none"> ▪ Transferring vision, goals, & objectives to tactics and business plan ▪ Defining needs and requirements ▪ Securing funding 	<ul style="list-style-type: none"> ▪ Well under-way with implementation - technical, financial, and legal 	<ul style="list-style-type: none"> ▪ Fully operational health information organization ▪ Transmitting data that is being used by healthcare stakeholders ▪ Sustainable business model 	<ul style="list-style-type: none"> ▪ Demonstration of expansion of organization to encompass a broader coalition of stakeholders than present in the initial operational model

Source: National e-health initiative HEALTH INITIATIVE

9

Next Steps and Opportunities

- * Sustainable funding for projects
- * Encouraging state wide coordination
- * Assuring underserved needs are met
- * Addressing population health issues
- * Include readiness for preparedness and response
- * Use opportunities for federal funding

Minnesota e-Health Initiative 17

Contact Information

Key Contacts for More Information:
www.health.state.mn.us/e-health

- * **Minnesota Department of Health**
Marty LaVenture - Director of Center for Health Informatics
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- Scott Leitz - 651 282-6361- Director, Office of Health Policy*
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Minnesota e-Health Initiative 18



Delta Dental Plan of Minnesota

As you prepare for the joint committee hearings on the “Health Care Solutions Series,” we want to remind you of the significant differences between medical and dental benefits administration. These hearings, which begin on January 17, represent an opportunity to focus on important issues related to health care.

Dental benefits and administration are different than medical in terms of cost, economics, use of technology, claim forms, provider delivery, quality measurement and many other aspects. For example, the dental claim form is different than the medical claim form, with the dental form established by the American Dental Association and the medical form established by the federal government. The use of technology by dentists is far lower than their physician counterparts, partly due to the nature of provider delivery. Dentists in Minnesota are overwhelmingly sole practitioners, while most physicians are affiliated with large clinics and hospitals. There are no diagnostic codes for dental, only procedure codes, so quality measurement is far more difficult. The average amount of a medical claim is 12 times higher than the average dental claim. The same variance is applicable to the respective premium costs. The cost drivers in medical — chronic disease, long-term care, and prescription drugs — have little to do with dental costs.

The big cost drivers in medical attract, perhaps appropriately, the most attention and analysis, too. The Buyer’s Healthcare Action Group, for example, has no mention of dental on its Web site. The innovative “Minnesota Community Measurement” collaborative includes no dentists or dental experts on its 16-member board and provides no information on the comparative quality of dental providers in Minnesota. These are not criticisms, but facts which support the idea that dental is different and should be treated as such.

We don’t want to imply that oral health and overall health are not related — they clearly are. In fact, this relationship is of great interest to us, and we are leading research on how periodontal disease may be linked to chronic health issues like diabetes, heart disease and low-birth weight babies. Dental’s proven preventive tradition, provider system, economic models, administrative practices and use of technology are all different. Consequently, a one-size-fits-all solution for medical and dental may not be in the best interest of Minnesota companies, dental consumers or dentists.

The topics set for your series of joint hearings represent important discussions involving what most Minnesotans, employees and employers alike, view as critical economic and societal issues. If there are questions specific to dental, please know we are happy to provide information from our extensive databases and nearly four decades of business experience so that you can make informed decisions.

If you have any questions, please contact Joe Lally, Delta Dental’s vice president, at 651-994-5129 or by e-mail at jlally@deltadentalmn.org.

January 2006

Report Cards Could Damage Quality of Care

... reporting on quality may lead physicians to avoid the sickest patients and channel resources to services that are not measured.

By Kip Sullivan, J.D.

For more than 30 years, influential groups and individuals have demanded that someone publish grades on the quality of care offered by physicians, hospitals, and health plans. Advocates of managed care and managed competition have been the most prominent proponents of "report cards," as published performance-measurement reports came to be called in the early 1990s. Paul Ellwood, M.D., the Minnesota physician who coined the phrase "health maintenance organization," has been demanding report cards on physicians and health plans for three decades.¹⁻³ Former President Bill Clinton and the Jackson Hole Group, advocates of managed competition, viewed report cards as an essential feature of such a system.^{4,5}

In its 1993 report to the governor and Legislature, the Minnesota Health Care Commission, which was charged with finding ways to contain health care costs, called for "a system which allows for objective, standardized quality comparisons across provider groups and health plans."⁶ That same year, the Legislature enacted a law authorizing the Department of Health and the now-defunct Minnesota Health Data Institute to develop plan and provider report cards. Commission member and HealthPartners CEO George Halvorson predicted in 1993 that report cards would soon permit patients to "know which health system will give them the best chance of surviving a heart attack."⁷ Two years later, Halvorson predicted that "performance records" on numerous types of medical care would be available by 2003.⁸

An Abysmal Track Record

Despite all the interest in report cards from politicians, employers, and experts in academia and think tanks, accurate reports on the quality of physicians, clinics, hospitals, and health plans are almost nonexistent. The report card on heart surgeons published annually by the New York Department of Health may be the only regularly published report card that can reasonably be characterized as accurate. Virtually all other report cards and rankings touted by health insurance companies, government agencies, business coalitions, business consultants, magazines, and Internet entrepreneurs either do not attempt to measure quality directly (for example, they report whether a doctor is board-certified, a hospital is highly regarded by physicians, or patients of undetermined health status are "satisfied" with a health plan or clinic), or they measure quality directly but with significant inaccuracy.

The primary reason for the scarcity of accurate report cards is the cost and complexity of "risk adjustment" or "case-mix adjustment"—the adjustment of report card scores to reflect variations in factors outside of plan and provider control, notably patient health status and socioeconomic factors that influence patient care-seeking behavior. Accurate measurement of differences in these variables is essential. As Christiansen and Morris put it, "Case-mix adjustments are made ... to account for the differences in provider performance attributable solely to differences in the populations served."⁹ But risk adjustment is expen-

sive because it requires large patient sample sizes, rich clinical data, and, often, socioeconomic information (such as insurance status and income) about patients. (Claims and hospital discharge reports, the basis for all but a few report cards, do not include clinical and socioeconomic data.)

Despite the abysmal track record of the report card movement, and despite the daunting obstacles facing those who seek to publish accurate report cards, the demand for report cards among Minnesota's political and business leaders reached new heights in 2004. In May of that year, the Legislature enacted a bill authorizing the Department of Health to identify "best practices" and to facilitate the production of report cards measuring how well physicians comply with those "practices."¹⁰ The new law (Minnesota Statutes 62J.43) also authorizes the Department of Employee Relations to use report cards in making decisions about which plans to make available to state employees and the Department of Human Services to use report cards in deciding which plans low-income Minnesotans will be allowed to enroll in. Last November, the Minnesota Council of Health Plans posted on a Web site (www.mnhealthcare.org) a report card that allegedly measures quality of care for diabetes, asthma, and several other diseases at the medical group level. In

For another view on performance reporting, see "Our Obligation to Report Our Performance to the Public," p. 36.

that same month, Gov. Pawlenty announced the formation of the Smart Buy Alliance, a partnership of state government and large employers, which the governor claims will prepare report cards on numerous medical services and use them to steer patients to plans and providers with superior grades.¹¹

All three of these actors—the Legislature, the governor, and the Council of Health Plans—claim that public reporting of quality measures will not only improve quality but will also reduce health care costs. In a press release, Gov. Pawlenty specifically cited the Council of Health Plans' recently released report card, which is totally unadjusted for variables outside physician control, as an example of performance reporting that can lead to such results. But these initiatives will, at best, have little impact on quality and, therefore, on cost, and could, at worst, damage quality of care for many patients.

The Dangers of Report Cards

Report cards could damage quality three ways. First, inaccurate scores could steer patients from superior to inferior clinics and hospitals (either because health plans and self-insured employers refuse to contract with providers falsely categorized as inferior or because patients avoid providers falsely tagged as inferior). But even if report cards are accurate, quality could still be damaged two other ways: by inducing doctors and plans to avoid sicker patients in order to improve their scores and by inducing doctors and plans to shift resources from unmeasured to measured services.

Inaccurate Report Cards

As I have already noted, the cost and difficulty of risk-adjusting report cards is a significant obstacle to report card accuracy. Risk adjustment is required of virtually all “outcome” measures, which measure changes in

patient health, and even many “process” measures, which measure how well doctors comply with standards of care. For example, if a report card on heart surgeons uses mortality rate after surgery (an outcome) as the measure of quality, researchers must adjust the measure to reflect differences in patient health. If that is not done, an inferior heart surgeon who treated otherwise healthy patients in their 50s could score higher than a superior surgeon who treated patients in their 70s who suffered from co-morbidities such as cancer and diabetes. If the quality measure used is a process measure, such as the percent of a clinic's diabetic patients who get a cholesterol test annually, researchers must adjust the score for differences in patient health insurance status and income. If that were not done, an inferior clinic with a primarily upper-income and well-insured clientele could score higher than a clinic with a low-income, uninsured clientele simply because more of the former clinic's patients can afford to visit their doctor and have tests done.

But accurate risk adjustment rarely can be done with readily available administrative data. With the exception of a few simple process measures, such as the percentage of elderly patients with at least one doctor visit between Sept. 1 and Jan. 31 who get an influenza vaccination, accurate risk adjustment requires data on patient health status, and often socioeconomic data as well.^{12,13} Collecting that data is expensive, even for a report published only once, never mind one published annually. The New York report card on coronary artery bypass graft (CABG) surgeons and hospitals, which adjusts postsurgery mortality rates with 72 measures, nearly all of which require patient medical-records data, requires five full-time staff at the state's Department of Health to maintain a database, as well as a “utilization review agent ... to audit a sample of 50 cases from half the hospitals each

year.” Moreover, each of the hospitals graded by the report card must hire a data coordinator, usually full-time, to collect and maintain their databases.¹⁴

In addition to the cost of risk-adjustment, process measures (as opposed to outcome measures) face another obstacle: the need for an agreed-upon standard of care that applies to all patients with a given diagnosis. Relative to the thousands of medical services rendered in America today, evidence-based standards are few. The proportion of medical services for which a science-based consensus on standard of care exists is estimated to be no more than 15 percent to 20 percent.¹⁵ According to Landon et al, “[F]ew medical specialties have an evidence base that is robust and comprehensive enough to support PCPA [physician clinical performance assessment].”¹⁶

Of course, inaccurate report cards will not steer patients to inferior doctors if patients, employers, and health plans do not rely on report cards, or if the scores are all within the margin of error. But report cards that are not used, or which cannot be helpful to purchasers who try to use them, are not worth their production and publication costs.

Rejecting Sicker or Poorer Patients

Physicians who do not believe a report card's risk-adjustment method is accurate will be under pressure to get rid of their sicker, poorer, less well-insured, and generally less-compliant patients to avoid having those patients drag their scores down. This is true regardless of whether physician doubts about a report card's accuracy are warranted. To take perhaps the worst example (from the point of view of report-card advocates), many New York surgeons do not trust the CABG report card published annually by the New York Department of Health, even though this report card is so rigorously adjusted it is considered to be the gold standard across the country even by its

critics.¹⁷ Jeffrey Gold, M.D., a Cornell University cardiac surgeon who placed No. 1 on the report card in 1995, told the *New York Times*, “There is nothing that separates me from the rest of the people on the list. ... I certainly would not use it as the sole way of selecting an institution or a surgeon.”¹⁸ This distrust appears to be causing New York surgeons to avoid sicker patients.^{19,20} “There is a widespread, if unproven, belief among doctors that some of New York State’s 133 heart surgeons are turning away severely ill patients for fear a death will hurt their rankings,” the *New York Times* reported.¹⁸

The strongest evidence that sicker patients are losing access to New York cardiac surgeons as a result of the report card appeared in 2003 in the *Journal of Political Economy*. The article, co-authored by Mark McClellan, the current director of the Centers for Medicare and Medicaid Services, concluded, “Taken together, our results show that [CABG] report cards led to . . . marginal health benefits for healthy patients, and major adverse health consequences for sicker patients.”²¹ The authors noted that their findings contradicted two earlier studies that attributed a decline in CABG-associated mortality rates in New York to the CABG report card. McClellan and his co-authors attributed the difference to the fact that their study examined all patients eligible for CABG surgery, whereas the earlier studies had examined only those patients who actually received CABG surgery.²¹

Hofer et al reached a similar conclusion about a widely used measure of quality of diabetes care—the percentage of patients with hemoglobin A1c below certain levels. (This is one of the measures used in the Minnesota Council of Health Plans’ report card.) The authors concluded: “Ideally, full case-mix models would eliminate or reduce the perverse incentive for physicians to manipulate profiles by

electing not to care for sick patients. However, [we found that] if those physicians with the worst profiles . . . for 1991 managed to discourage the patients with the top 5 percent of HbA1c levels (representing only one to three patients per physician) from returning to their panel, they would in most cases achieve a panel HbA1c profile in 1992 that would be substantially improved. . . . Manipulating their patient pool, based on a patient’s prior year HbA1c level, is the easiest way for physicians to have a substantial improvement in their profile.”²²

If rigorously adjusted report cards can induce physicians to reject sicker patients, obviously poorly or completely unadjusted report cards would have the same effect. Shen found that when Maine began paying its substance abuse providers on a “pay-for-performance” basis with no risk adjustment of the quality measures, providers quickly rid themselves of their “greatest severity” patients “in order to improve their performance outcomes.”²³

Resource Shifting

It is human nature to shift resources away from activities that are not rewarded to those that are. Isn’t this why teachers do not tell students what questions will appear on examinations? Report cards on quality of care will probably damage the quality of care for patients by inducing plans and providers to shift resources from unmeasured services to measured services. This would not occur, of course, if report-card publishers released report cards on the 10,000-plus medical services available today. But that, it is safe to predict, will never happen.

This “teaching to the test” phenomenon (in a medical context, perhaps it should be called “practicing to the report card”) has attracted little research. But what evidence there is indicates plans and providers do shift resources away from unmeasured services. Lee-Feldstein et al uncovered

such evidence in the course of investigating whether HMO physicians detected breast and colorectal cancer in Medicare patients earlier than fee-for-service physicians. They discovered that HMO patients were much more likely to have breast cancer detected early, but fee-for-service patients were much more likely to have colorectal cancer diagnosed early. The authors noted that the nation’s most pervasive HMO report card, the Health Plan Employer Data Set (HEDIS), published by the National Committee for Quality Assurance, graded HMOs on mammography rates but not on a corresponding screening for colorectal cancer. “This suggests that preventive screening for conditions such as colorectal cancer that are not required to be in a report card (such as HEDIS) are more likely to be neglected,” the authors concluded.²⁴

Reports on Numbers of Procedures

It is important to distinguish public information on the number of procedures a hospital or physician performs from report cards that purport to measure quality directly. A report on numbers of procedures performed can be a useful guide to quality if the procedure in question is one of a dozen for which a volume-quality correlation has been shown. Pancreatic cancer surgery and coronary bypass surgery are examples of such procedures.²⁵

It is easy to achieve accuracy in numbers-of-procedures reports. One need only count up the number of operations done each year. Doctors might disagree with studies that show a volume-quality correlation for a given procedure, but they can have no doubt about the accuracy of volume-of-procedure counts themselves and, therefore, would have no incentive to refuse services to sicker patients. And by funneling patients to fewer high-volume hospitals, number-of-procedure reports might free up resources for patients in need of unmeasured services.

Faith-Based Health Policy, Evidence-Based Medicine

Gov. Pawlenty, the Legislature, the Council of Health Plans, and some members of the business community have created high expectations for report cards and the "value purchasing" of health insurance and medical care that they allegedly facilitate. But these expectations are doomed to be unmet. The odds that report cards will improve overall quality of medical care are slim, and the odds that whatever quality improvement occurs will lead to a net reduction in health care costs are probably zero. Under the rosier scenario, all the money now being spent to promote "best practices," "value purchasing," and measurable outcomes will produce a few accurate (which is to say expensive) report cards. These report cards will improve quality for the relatively few patients receiving the measured services, and the net effect on cost will be negligible. Under the worst scenario, the Smart Buy Alliance and other report-card advocates will succeed in pushing numerous inaccurate report cards into the public limelight, and the net effect on quality and cost will be negative.

Before the report-card project proceeds any further, promoters of report cards should undertake the research necessary to determine whether public reporting of health plan and provider performance is a safe and effective means of improving quality. That would require that report-card proponents apply to themselves the "evidence-based" standards they apply to doctors. The Council of Health Plans and others insist that doctors practice "evidence-based medicine," but they are unwilling to practice "evidence-based health policy." Report-card enthusiasts are willing, on the basis of very little evidence, to endorse a health policy that could turn out to be very expensive and damaging to health. That is the antithesis of evidence-based health policy.

If report cards were a new, untested

prescription drug, Minnesota's health insurance industry and its allies in the Legislature and the governor's office would be insisting that the "drug" undergo rigorous testing on a very tiny fraction of the population before the entire population was exposed to it. Report cards may not be the next thalidomide, but they are expensive and they do pose risks to patients. These risks should be acknowledged, discussed, and studied, not ignored.

Evidence-based health policy calls for continued research on report cards using small numbers of patients and providers to determine whether report cards are safe and effective, and, if they are, whether their effectiveness is greater than other methods of quality improvement such as altering factors outside physicians' control (eg, reducing prescription drug prices and providing insurance to all) that prevent millions of Americans from getting high-quality medical care; investing in randomized controlled trials and collaborative research among physicians; and ending the nurse shortage. When that research has been completed, then and only then should report cards be published on a wholesale basis. **MM**

Kip Sullivan is a member of the steering committee of the Minnesota Universal Health Care Coalition.

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Statement of Susan Hasti, MD, Vice Chair, Minnesota Universal Health Care Coalition, to the Joint Senate Health and Family Security Committee and House Health Care Cost Containment Division, January 17, 2006

The Minnesota Universal Health Care Coalition is dedicated to universal health insurance as well as effective methods of reducing the health care inflation that has had such a destructive effect on our health care system, the state budget, and the state's economy. We believe universal health insurance should not be achieved at any cost, but should, rather, be implemented along with effective cost containment.

By "effective cost containment," I mean methods that reduce health care inflation immediately or in the near term, not decades from now, and which do not harm patients. The proposals about which the joint committee is taking testimony today do not fit this definition of effective cost containment.

In determining what constitutes an effective method of cost containment, we urge this committee to use the equivalent of the standard the Legislature expects doctors to use in making medical decisions, namely, the standard that has come to be known as "evidence-based medicine." We urge the Legislature to honor a standard that might be called "evidence-based health policy." The proposals listed on the agenda for today's hearing do not meet that standard. Therefore, they should not be styled as "solutions," and they should not be imposed or subsidized on a large scale by the Legislature. They should be treated as the equivalent of a new drug that has been shown to have some promise and to present some risk to patients. That is, they should be studied on a small scale and not endorsed or subsidized until they have been proven to be effective.

The proposals on the committee's agenda today are essentially two: information technology (including electronic medical records), and report cards. We have little doubt that information technology (IT) has already cut the cost of administrative tasks such as claim processing and appointment scheduling. And we think it is reasonable to expect that IT will some day cut costs in other areas, such as ordering and administering prescription drugs. But current research on the role of IT in medical care, including EMRs, does not allow us to conclude that IT can reduce health care costs, either directly or indirectly by improving health.

Similarly, existing research does not support the claim that report cards can reduce costs by improving quality. In fact, research has demonstrated that some report cards are harming sicker patients because they encourage doctors to avoid them for fear their "grades" will be dragged down by the below-average outcomes of sicker patients.

I urge this committee to allow MUHCC to testify at your January 31 hearing. We would use that opportunity to review the scientific literature that supports our arguments and to outline briefly several cost-containment methods that deserve to be called "effective." We would also like to use that opportunity to comment on the evidence supporting claims for "disease management," a topic on your January 31 agenda. In the meantime, on the attached page we submit to you quotations from studies that document my statements.

Thank you.

EMRs and IT

“With the exception of pharmacy settings, there is little consistent evidence that IT [information technology] systems save time for providers. In some instances, the literature suggests the reverse.” Medicare Payment Advisory Commission, *Report to Congress: New Approaches in Medicare*, June 2004, 163.

“Only 13% of [100] trials evaluated the impact of the CDSS [clinical decision support systems] on clinician workflow, with more than half of these CDSSs requiring more time and effort from the user compared with paper-based methods.” Amit X. Garg et al., “Effects of computerized clinical decision support systems on practitioner performance and patient outcomes: A systematic review,” *Journal of the American Medical Association* 2005;293:1223-1238, 1226.

“Fifty-two trials [of clinical decision support systems] assessed patient outcomes Only 7 trials reported improved patient outcomes. . . .” Amit X. Garg et al., *op cit.*, 1231.

“In 2001, the Agency for Healthcare Research and Quality ... determined that 14 safety practices had greater strength of evidence regarding their impact and effectiveness than any practice which relied on IT. These include such low-cost items as appropriate provision of nutrition ... and use of maximum sterile barriers while placing central intravenous catheters to prevent infections.” Medicare Payment Advisory Commission, *Report to Congress: New Approaches in Medicare*, June 2004, 162.

Report Cards

“Performance-based contracting gave providers of substance abuse treatment financial incentives to treat less severe OSA [Office of Substance Abuse] clients in order to improve their performance outcomes. Fewer OSA clients with the greatest severity were treated in outpatient programs with the implementation of PBC [performance-based contracting].”

Yujing Shen (“Selection incentives in a performance-based contracting system,” *Health Services Research* 2003;38:535-552, 535).

“[M]andatory reporting mechanisms inevitably give providers the incentive to decline to treat more difficult and complicated patients” (p. 581). “[O]ur results show that report cards [on heart surgeons] led to increased expenditures for both healthy and sick patients, marginal health benefits for healthy patients, and major adverse health consequences for sicker patients. Thus, we conclude that report cards reduced our measure of welfare over the time period of our study” (p. 577). “[M]ore severely ill ... patients experienced dramatically worsened health outcomes” (p. 583). David Dranove et al. “Is more information better? The effects of ‘report cards’ on health care providers,” *Journal of Political Economy* 2003;111:555-588.

“Report cards led to a decline in the illness severity of patients receiving CABG in New York ... relative to patients in states without report cards” (p. 583).

David Dranove et al. (“Is more information better? The effects of ‘report cards’ on health care providers,” *Journal of Political Economy* 2003;111:555-588)

Disease Management

“Results of this study show that it is possible to increase SFDs [symptom free days] in children [with asthma].... However, the improvements were realized with an increase in the costs associated with asthma care.”

Archives of Pediatrics and Adolescent Medicine (S.D. Sullivan et al., “A multisite randomized trial of the effects of physician education and organizational change in chronic asthma care: Cost-effectiveness analysis of the Pediatric Asthma Care Patient Outcomes Research Team II (PAC-PORT II),” 2005;159:428-434, 428).

“Although interest in ... disease management programs is growing, evidence of their clinical and cost effectiveness remains limited. ... Without many attractive alternative mechanisms to control costs, many employers are adopting disease management despite the lack of evidence.”

Center for Studying Health System Change (Ashley Short et al., “Disease management: A leap of faith to lower-cost, higher-quality health care,” October 2003, Issue Brief No. 69, 3)

“On the basis of its examination of peer-reviewed studies of disease management programs..., CBO finds that to date there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health care services.”

Congressional Budget Office (*An Analysis of the Literature on Disease Management Programs*, October 13, 2004, <http://www.cbo.gov/showdoc.cfm?index=5909&sequence=0>, accessed September 25, 2005)

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Despite all the interest in report cards from politicians, employers, and experts in academia and think tanks, accurate reports on the quality of physicians, clinics, hospitals, and health plans are almost nonexistent. The report card on heart surgeons published annually by the New York Department of Health may be the only regularly published report card that can reasonably be characterized as accurate. Virtually all other report cards and rankings touted by health insurance companies, government agencies, business coalitions, business consultants, magazines, and Internet entrepreneurs either do not attempt to measure quality directly (for example, they report whether a doctor is board-certified, a hospital is highly regarded by physicians, or patients of undetermined health status are “satisfied” with a health plan or clinic), or they measure quality directly but with significant inaccuracy.

The primary reason for the scarcity of accurate report cards is the cost and complexity of “risk adjustment” or “case-mix adjustment”—the adjustment of report card scores to reflect variations in factors outside of plan and provider control, notably patient health status and socioeconomic factors that influence patient care-seeking behavior. Accurate measurement of differences in these variables is essential. As Christiansen and Morris put it, “Case-mix adjustments are made ... to account for the differences in provider performance attributable solely to differences in the populations served.”⁹ But risk adjustment is expen-

sive because it requires large patient sample sizes, rich clinical data, and, often, socioeconomic information (such as insurance status and income) about patients. (Claims and hospital discharge reports, the basis for all but a few report cards, do not include clinical and socioeconomic data.)

Despite the abysmal track record of the report card movement, and despite the daunting obstacles facing those who seek to publish accurate report cards, the demand for report cards among Minnesota’s political and business leaders reached new heights in 2004. In May of that year, the Legislature enacted a bill authorizing the Department of Health to identify “best practices” and to facilitate the production of report cards measuring how well physicians comply with those “practices.”¹⁰ The new law (Minnesota Statutes 62J.43) also authorizes the Department of Employee Relations to use report cards in making decisions about which plans to make available to state employees and the Department of Human Services to use report cards in deciding which plans low-income Minnesotans will be allowed to enroll in. Last November, the Minnesota Council of Health Plans posted on a Web site (www.mnhealthcare.org) a report card that allegedly measures quality of care for diabetes, asthma, and several other diseases at the medical group level. In

For another view on performance reporting, see “Our Obligation to Report Our Performance to the Public,” p. 36.

that same month, Gov. Pawlenty announced the formation of the Smart Buy Alliance, a partnership of state government and large employers, which the governor claims will prepare report cards on numerous medical services and use them to steer patients to plans and providers with superior grades.¹¹

All three of these actors—the Legislature, the governor, and the Council of Health Plans—claim that public reporting of quality measures will not only improve quality but will also reduce health care costs. In a press release, Gov. Pawlenty specifically cited the Council of Health Plans' recently released report card, which is totally unadjusted for variables outside physician control, as an example of performance reporting that can lead to such results. But these initiatives will, at best, have little impact on quality and, therefore, on cost, and could, at worst, damage quality of care for many patients.

The Dangers of Report Cards

Report cards could damage quality three ways. First, inaccurate scores could steer patients from superior to inferior clinics and hospitals (either because health plans and self-insured employers refuse to contract with providers falsely categorized as inferior or because patients avoid providers falsely tagged as inferior). But even if report cards are accurate, quality could still be damaged two other ways: by inducing doctors and plans to avoid sicker patients in order to improve their scores and by inducing doctors and plans to shift resources from unmeasured to measured services.

Inaccurate Report Cards

As I have already noted, the cost and difficulty of risk-adjusting report cards is a significant obstacle to report card accuracy. Risk adjustment is required of virtually all "outcome" measures, which measure changes in

patient health, and even many "process" measures, which measure how well doctors comply with standards of care. For example, if a report card on heart surgeons uses mortality rate after surgery (an outcome) as the measure of quality, researchers must adjust the measure to reflect differences in patient health. If that is not done, an inferior heart surgeon who treated otherwise healthy patients in their 50s could score higher than a superior surgeon who treated patients in their 70s who suffered from co-morbidities such as cancer and diabetes. If the quality measure used is a process measure, such as the percent of a clinic's diabetic patients who get a cholesterol test annually, researchers must adjust the score for differences in patient health insurance status and income. If that were not done, an inferior clinic with a primarily upper-income and well-insured clientele could score higher than a clinic with a low-income, uninsured clientele simply because more of the former clinic's patients can afford to visit their doctor and have tests done.

But accurate risk adjustment rarely can be done with readily available administrative data. With the exception of a few simple process measures, such as the percentage of elderly patients with at least one doctor visit between Sept. 1 and Jan. 31 who get an influenza vaccination, accurate risk adjustment requires data on patient health status, and often socioeconomic data as well.^{12,13} Collecting that data is expensive, even for a report published only once, never mind one published annually. The New York report card on coronary artery bypass graft (CABG) surgeons and hospitals, which adjusts postsurgery mortality rates with 72 measures, nearly all of which require patient medical-records data, requires five full-time staff at the state's Department of Health to maintain a database, as well as a "utilization review agent ... to audit a sample of 50 cases from half the hospitals each

year." Moreover, each of the hospitals graded by the report card must hire a data coordinator, usually full-time, to collect and maintain their databases.¹⁴

In addition to the cost of risk-adjustment, process measures (as opposed to outcome measures) face another obstacle: the need for an agreed-upon standard of care that applies to all patients with a given diagnosis. Relative to the thousands of medical services rendered in America today, evidence-based standards are few. The proportion of medical services for which a science-based consensus on standard of care exists is estimated to be no more than 15 percent to 20 percent.¹⁵ According to Landon et al, "[F]ew medical specialties have an evidence base that is robust and comprehensive enough to support PCPA [physician clinical performance assessment]."¹⁶

Of course, inaccurate report cards will not steer patients to inferior doctors if patients, employers, and health plans do not rely on report cards, or if the scores are all within the margin of error. But report cards that are not used, or which cannot be helpful to purchasers who try to use them, are not worth their production and publication costs.

Rejecting Sicker or Poorer Patients
Physicians who do not believe a report card's risk-adjustment method is accurate will be under pressure to get rid of their sicker, poorer, less well-insured, and generally less-compliant patients to avoid having those patients drag their scores down. This is true regardless of whether physician doubts about a report card's accuracy are warranted. To take perhaps the worst example (from the point of view of report-card advocates), many New York surgeons do not trust the CABG report card published annually by the New York Department of Health, even though this report card is so rigorously adjusted it is considered to be the gold standard across the country even by its

critics.¹⁷ Jeffrey Gold, M.D., a Cornell University cardiac surgeon who placed No. 1 on the report card in 1995, told the *New York Times*, "There is nothing that separates me from the rest of the people on the list. ... I certainly would not use it as the sole way of selecting an institution or a surgeon."¹⁸ This distrust appears to be causing New York surgeons to avoid sicker patients.^{19,20} "There is a widespread, if unproven, belief among doctors that some of New York State's 133 heart surgeons are turning away severely ill patients for fear a death will hurt their rankings," the *New York Times* reported.¹⁸

The strongest evidence that sicker patients are losing access to New York cardiac surgeons as a result of the report card appeared in 2003 in the *Journal of Political Economy*. The article, co-authored by Mark McClellan, the current director of the Centers for Medicare and Medicaid Services, concluded, "Taken together, our results show that [CABG] report cards led to ... marginal health benefits for healthy patients, and major adverse health consequences for sicker patients."²¹ The authors noted that their findings contradicted two earlier studies that attributed a decline in CABG-associated mortality rates in New York to the CABG report card. McClellan and his co-authors attributed the difference to the fact that their study examined all patients eligible for CABG surgery, whereas the earlier studies had examined only those patients who actually received CABG surgery.²¹

Hofer et al reached a similar conclusion about a widely used measure of quality of diabetes care—the percentage of patients with hemoglobin A1c below certain levels. (This is one of the measures used in the Minnesota Council of Health Plans' report card.) The authors concluded: "Ideally, full case-mix models would eliminate or reduce the perverse incentive for physicians to manipulate profiles by

electing not to care for sick patients. However, [we found that] if those physicians with the worst profiles ... for 1991 managed to discourage the patients with the top 5 percent of HbA1c levels (representing only one to three patients per physician) from returning to their panel, they would in most cases achieve a panel HbA1c profile in 1992 that would be substantially improved. ... Manipulating their patient pool, based on a patient's prior year HbA1c level, is the easiest way for physicians to have a substantial improvement in their profile."²²

If rigorously adjusted report cards can induce physicians to reject sicker patients, obviously poorly or completely unadjusted report cards would have the same effect. Shen found that when Maine began paying its substance abuse providers on a "pay-for-performance" basis with no risk adjustment of the quality measures, providers quickly rid themselves of their "greatest severity" patients "in order to improve their performance outcomes."²³

Resource Shifting

It is human nature to shift resources away from activities that are not rewarded to those that are. Isn't this why teachers do not tell students what questions will appear on examinations? Report cards on quality of care will probably damage the quality of care for patients by inducing plans and providers to shift resources from unmeasured services to measured services. This would not occur, of course, if report-card publishers released report cards on the 10,000-plus medical services available today. But that, it is safe to predict, will never happen.

This "teaching to the test" phenomenon (in a medical context, perhaps it should be called "practicing to the report card") has attracted little research. But what evidence there is indicates plans and providers do shift resources away from unmeasured services. Lee-Feldstein et al uncovered

such evidence in the course of investigating whether HMO physicians detected breast and colorectal cancer in Medicare patients earlier than fee-for-service physicians. They discovered that HMO patients were much more likely to have breast cancer detected early, but fee-for-service patients were much more likely to have colorectal cancer diagnosed early. The authors noted that the nation's most pervasive HMO report card, the Health Plan Employer Data Set (HEDIS), published by the National Committee for Quality Assurance, graded HMOs on mammography rates but not on a corresponding screening for colorectal cancer. "This suggests that preventive screening for conditions such as colorectal cancer that are not required to be in a report card (such as HEDIS) are more likely to be neglected," the authors concluded.²⁴

Reports on Numbers of Procedures

It is important to distinguish public information on the number of procedures a hospital or physician performs from report cards that purport to measure quality directly. A report on numbers of procedures performed can be a useful guide to quality if the procedure in question is one of a dozen for which a volume-quality correlation has been shown. Pancreatic cancer surgery and coronary bypass surgery are examples of such procedures.²⁵

It is easy to achieve accuracy in numbers-of-procedures reports. One need only count up the number of operations done each year. Doctors might disagree with studies that show a volume-quality correlation for a given procedure, but they can have no doubt about the accuracy of volume-of-procedure counts themselves and, therefore, would have no incentive to refuse services to sicker patients. And by funneling patients to fewer high-volume hospitals, number-of-procedure reports might free up resources for patients in need of unmeasured services.

Faith-Based Health Policy, Evidence-Based Medicine

Gov. Pawlenty, the Legislature, the Council of Health Plans, and some members of the business community have created high expectations for report cards and the "value purchasing" of health insurance and medical care that they allegedly facilitate. But these expectations are doomed to be unmet. The odds that report cards will improve overall quality of medical care are slim, and the odds that whatever quality improvement occurs will lead to a net reduction in health care costs are probably zero. Under the rosiest scenario; all the money now being spent to promote "best practices," "value purchasing," and measurable outcomes will produce a few accurate (which is to say expensive) report cards. These report cards will improve quality for the relatively few patients receiving the measured services, and the net effect on cost will be negligible. Under the worst scenario, the Smart Buy Alliance and other report-card advocates will succeed in pushing numerous inaccurate report cards into the public limelight, and the net effect on quality and cost will be negative.

Before the report-card project proceeds any further, promoters of report cards should undertake the research necessary to determine whether public reporting of health plan and provider performance is a safe and effective means of improving quality. That would require that report-card proponents apply to themselves the "evidence-based" standards they apply to doctors. The Council of Health Plans and others insist that doctors practice "evidence-based medicine," but they are unwilling to practice "evidence-based health policy." Report-card enthusiasts are willing, on the basis of very little evidence, to endorse a health policy that could turn out to be very expensive and damaging to health. That is the antithesis of evidence-based health policy.

If report cards were a new, untested

prescription drug, Minnesota's health insurance industry and its allies in the Legislature and the governor's office would be insisting that the "drug" undergo rigorous testing on a very tiny fraction of the population before the entire population was exposed to it. Report cards may not be the next thalidomide, but they are expensive and they do pose risks to patients. These risks should be acknowledged, discussed, and studied, not ignored.

Evidence-based health policy calls for continued research on report cards using small numbers of patients and providers to determine whether report cards are safe and effective, and, if they are, whether their effectiveness is greater than other methods of quality improvement such as altering factors outside physicians' control (eg, reducing prescription drug prices and providing insurance to all) that prevent millions of Americans from getting high-quality medical care; investing in randomized controlled trials and collaborative research among physicians; and ending the nurse shortage. When that research has been completed, then and only then should report cards be published on a wholesale basis. **MM**

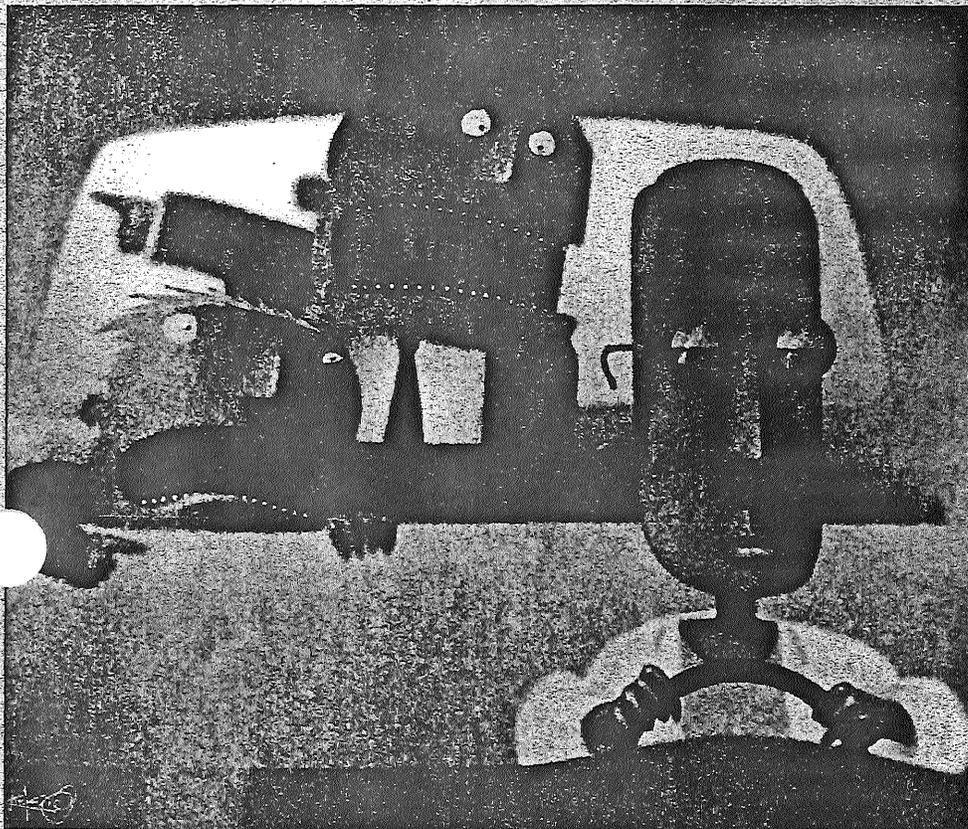
Kip Sullivan is a member of the steering committee of the Minnesota Universal Health Care Coalition.

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Are we there yet?

Reviewing the evidence for EMRs

By Kip Sullivan, J.D.

It does not occur to the average physician to lecture General Mills on how to make corn flakes, Toyota on how to make cars, or politicians, professors, and pundits on how to do their jobs. But legions of people who have never examined a patient—including many business executives, politicians, professors, and members of the media—think nothing of lecturing doctors on how to practice medicine. For most of the last quarter century, the sermons delivered by these non-physicians (and a few physicians who went over to the Dark Side) harped on the need for doctors to reconcile themselves to oversight by managed care plans.

When it became clear in the late 1990s that managed care had failed, the sermon

changed. Now the dominant message physicians are hearing from the non-physicians in the peanut gallery is that they must embrace "information technology" (IT). IT refers to any process that relies on computers to store, process, and transfer information. Because the fantastic claims being made for IT rely heavily on physician adoption of electronic medical records (EMRs), the most fundamental demand from the peanut gallery is that physicians buy the hardware and software necessary to convert from paper records to EMRs.

Physicians, including the 80 percent to 90 percent who have not converted to EMRs (Tyler Chin, "Are physicians at the infotech tipping point?" *American Medical News*, March 14, 2005, 16; Richard H. Hillestad et al., "Can electronic medical record systems transform health care? Potential health bene-

Bioethics: A discipline that's here to stay

Improving care across settings

By Jeffrey Kahn, Ph.D., and Dianne Bartels, Ph.D., R.N.

Prior to 1985, bioethics education in the health sciences at the University of Minnesota consisted of a spring quarter lecture series sponsored by the multidisciplinary Student Committee on Bioethics. The lectures were not providing the ethics education students and faculty wanted, so they requested additional resources. The university's vice president for health sciences at the time, Neal Vanselow, M.D., responded by appointing a university-wide task force to consider the request.

The task force recommended centralizing and using available university ethics resources and created a mission statement that described a center that would address newly emerging biomedical ethics



BIOETHICS
to page 14

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Are we there yet?
from cover

fits, savings, and costs," *Health Affairs* 2005, 24:1103-1117), should view this unsolicited advice with the same skepticism with which they viewed the propaganda about managed care that engulfed the nation in the 1980s and early 1990s. Like the claims made for managed care, the claims being made for EMRs are vastly exaggerated. As was the case with managed care, EMRs will fail to make a dent in the health care crisis.

A chorus of voices

Calls for EMRs have been audible for two decades, but they have become deafening in the last two years. In January 2004, President George W. Bush endorsed EMRs in his State of the Union address, and Democratic senators Hillary Clinton and Ted Kennedy announced legislation that would subsidize the purchase of EMR software by doctors and improve the capability of com-

puters to share patient records. In April 2004, Bush called not only for universal adoption of EMRs but also for "interoperability" among the computers holding EMRs, and then-DHHS Secretary

Tommy Thompson claimed EMRs would cut total health spending by 10 percent. In October 2004, presidential candidate John Kerry announced in the pages of the *Journal of the American Medical Association* that he supported widespread adoption of EMRs.

And those are just some of the more prominent political

voices. Think tanks like the RAND Corporation and Newt Gingrich's Center for Health Care Transformation, government agencies such as the Institute of Medicine and the Centers for Medicare and Medicaid Services, foundations such as the Markle and Robert Wood Johnson foundations, labor groups such as the AFL-CIO, and business groups such as the Leapfrog Group and the Chamber of Commerce have also joined the choir. Last, but not least, corporations that stand to make lots of money off the EMR craze, including Siemens, Intel, Microsoft, IDX, GE, McKesson, Cisco Systems, and IBM, participate in and finance the choir (Chin op. cit., www.connectingforhealth.org/steeringgroup).

Hype déjà vu

The similarities between the claims made by managed care advocates in the 1980s and 1990s and the claims made today by EMR advocates are striking. As was the case with managed care, EMR proponents level exaggerated and unsubstantiated accusations against doctors, they make grandiose and unsubstantiated claims for EMRs, and they say virtually nothing about the costs their proposal will inflict on doctors and the damage to privacy their proposal will inflict on patients.

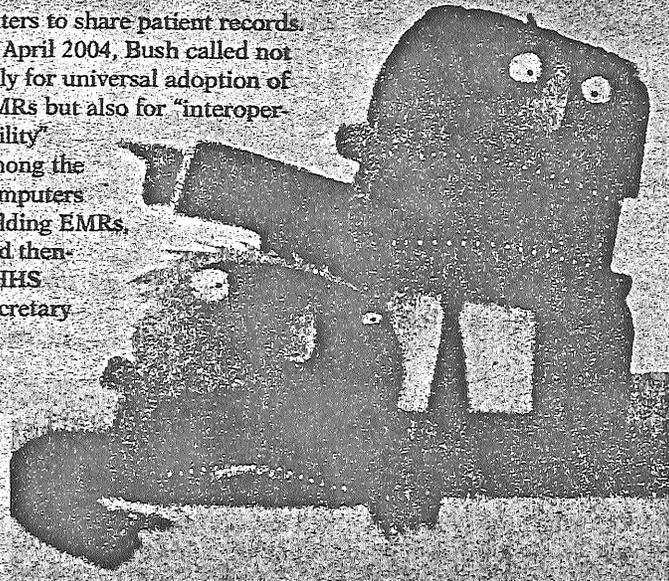
The most common criticism EMR advocates level against doctors is that doctors are

Like the claims made for managed care, the claims being made for EMRs are vastly exaggerated. As was the case with managed care, EMRs will fail to make a dent in the health care crisis.

Luddites. "Most industries in America have used information technology to make their businesses more cost-effective, more efficient, and more productive, and the truth of the matter is, health care hadn't," asserted President Bush in a speech in Cleveland in January 2004.

In an interview with *American Medical News* published later that year, Newt Gingrich claimed that doctors who continued to rely on paper files were killing their patients. "No serious person can debate that having disaggregated paper records [whatever that means] isn't an invitation to killing people," asserted Gingrich. As if that were not glib enough, Gingrich went on to declare, "In the long run it will be malpractice to have paper records" and "Paper kills." (Tyler Chin, "Gingrich's grand vision," *American Medical News*, Aug. 9, 2004, 13.)

These claims are not based on anything resembling solid evidence. It is debatable whether IT has made "most industries" more efficient, it is not true that doctors refuse to use computers, and the claim that "paper kills" is absurd. It is clear that some industries, such as telecommunications and banking, improve the efficiency with which they performed simple, routine tasks by automating the performance of those tasks. As a scientist at the University of Colorado wrote in a paper published in *Scientific American* in 1997, "What IT payback we've seen has been confined largely to low value transaction-processing functions: moving trades, clearing



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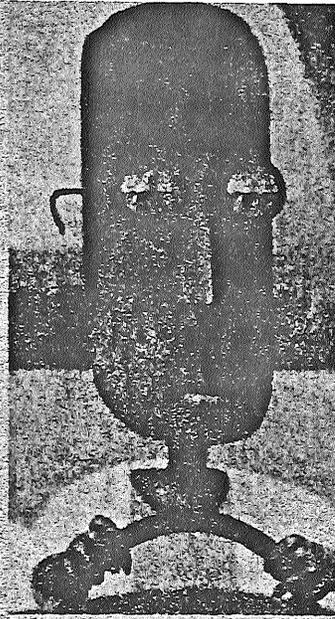
Like other actors in the economy, many clinics and virtually all hospitals employ computers where the business case for doing so is clear. Clinics and hospitals use computers for billing, submitting claims, ordering supplies, and scheduling appointments. When people like Bush and Gingrich complain that doctors "resist" using computers, what they really mean is, "doctors refuse to convert to EMRs and use them on a daily basis in making professional judgments about what care to give their patients."

Unlike the sweeping statement that doctors are Luddites, that statement is true. Only 10 percent to 20 percent of all U.S. doctors have computerized their medical records. (Chin, op. cit., Hillestad et al., op. cit.) And for good reason: There is no reliable evidence supporting the claims that the large investment required to switch to EMRs will improve quality of care and that all or even most improvements in quality must inevitably lead to reductions in cost.

IT and quality improvement

The scientific literature on the effect of IT on quality of care is woefully thin, and what little there is does not justify the confident claims being made for IT. The Medicare Payment Advisory Commission (MedPAC), an agency established by Congress to advise Congress on health policy, reviewed this literature in its June 2004 report to Congress. The agency took note of "the widespread belief that adoption of IT in health care will improve quality," but concluded that "much remains unknown about the role of IT in the health care setting" and that the few studies at have shown "that some technologies lead to better care [came] primarily from select institutions that developed their own systems and may not represent the average facility."

MedPAC summarized a 2001 study by the Federal Agency for Healthcare Research and Quality that "determined that 14 safety practices had greater



strength of evidence regarding their impact and effectiveness than any practice which relied on IT." For example, "such low-cost items as appropriate provision of nutrition ... and use of maximum sterile barriers while placing central intravenous catheters to prevent infections" were more evidence-based than any intervention based on IT.

MedPAC found several studies demonstrating that computerized provider order entry (CPOE) for medications and clinical decision support systems (CDSS), software that helps doctors make diagnoses and treatment decisions, have a positive effect on quality. But MedPAC warned that "nine out of 11 formal analyses [of CPOE] took place at one of two advanced institutions," and further noted that 22 of 65 studies on CDSS found no positive effect on compliance with standards of care, and seven of 14 found no positive impact on patient health. The only type of IT for which MedPAC found unequivocal support in the literature was bar coding for medications (MedPAC cited a total of four favorable papers).

Moreover, studies published since MedPAC issued its report have questioned the value of both CPOE and CDSS. Papers published in the March 9, 2005, edition of *JAMA* found that a computer system installed at the hospital affiliated with the University of Pennsylvania intro-

The scientific literature on the effect of IT on quality of care is woefully thin, and what little there is does not justify the confident claims being made for IT.

duced 22 new types of medication errors and that CDSS improved patient outcomes in only seven of 52 trials. A paper in the July 27, 2005, edition of *JAMA* found that CDSS slightly improved the rate at which diabetic eye examinations and pneumococcal vaccinations were delivered but had no effect on the rate at which hemoglobin A1c testing, colon cancer screening, mammography, and flu vaccinations were delivered.

IT and cost reductions

On the question of whether IT leads to lower costs, the literature is even sparser and more pessimistic. According to MedPAC, "With the exception of pharmacy settings, there is little consistent evidence that IT systems save time for providers. In

some instances, the literature suggests the reverse. ..." The literature on IT in hospital settings, reported MedPAC, "provides scant evidence of return on investment calculations for CPOE and EHR [electronic health records] ..."

The March 9, 2005, paper in *JAMA* reported that more than half the trials that examined the impact of CDSS on "clinician workflow" found "CDSSs requiring more time and effort from the user compared with paper-based methods." A health care system vice president in charge of implementing a systemwide EMR for a local hospital recently remarked that for clinicians, "the interaction with the system, at least initially and potentially

ARE WE THERE YET? to page 38

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**Are we there yet?
from page 11**

forever [emphasis mine], takes more time" (*Medfax*, Aug. 1, 2005).

A paper published last month in *Health Affairs*, which concludes that adoption of

EMRs nationwide will save \$81 billion annually, may be disregarded as little more than a press release from the computer industry. The paper was financed by Hewlett-Packard, three other IT companies, and Johnson and Johnson. It was written by people who

make a living promoting IT and who think medical care can be compared to selling phone services. Plus,

it is based on the opinions of unidentified experts, not on scientific research (Hillestad et al., op. cit.).

Like managed care advocates before them, EMR advocates have been silent or, at best, vague about the cost of their proposal. Last August, the nation finally got an estimate of what it will cost to establish the "national health information network"—an EMR for every patient, and "interoperability" among all computers holding EMRs—proposed by President Bush. According to a paper published in the August 2, 2005, edition of *Annals of Internal Medicine*, the price tag will be \$156 billion in capital costs for the next five years, plus \$48 billion in annual operating costs.

And this estimate does not take into account a major assumption underlying the EMR movement's claim that EMRs will improve quality and reduce cost: that the universal adoption of EMRs will facilitate the production of report cards on doctors, which will in turn

cause doctors to improve quality. This claim, the most fantastic of all the claims made by EMR advocates, is worse than unsubstantiated. As two experts stated in the March 9, 2005, edition of *JAMA*, "some evidence suggests that public reporting [on quality] reduces overall health care quality."

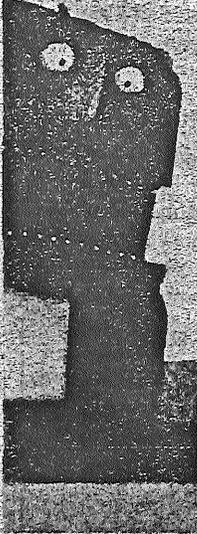
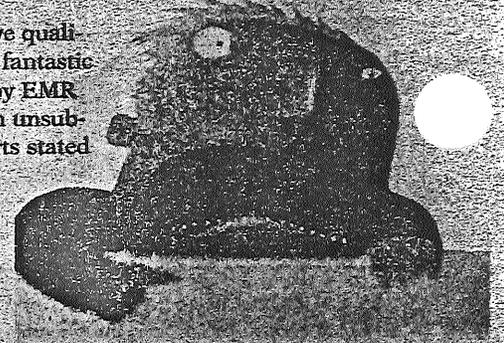
The publication of accurate report cards on a broad scale will be astronomically expensive. Because most report cards require that researchers have access to medical records in order to risk-adjust scores, widespread production of report cards will also destroy what little is left of patient privacy.

Where's the evidence?

The preceding remarks should not be construed to be an argument against EMRs. It is an argument against hyping EMRs and in favor of basing state and federal policy about EMRs on evidence, not faith. It is time for EMR evangelicals to practice what they preach. They insist

that doctors practice evidence-based medicine, but they refuse to practice evidence-based health policy. Evidence does not support the argument that all doctors and hospitals should invest in EMRs. The best that can be said for IT in health care right now is that using computers for administrative tasks and bar coding of medications appears to enhance efficiency. Evidence for policies mandating or subsidizing adoption of other applications of IT does not yet exist. ■

Kip Sullivan, J.D., sits on the steering committee of the Minnesota Universal Health Care Coalition.





January 17, 2006

Dear Senators and Representatives:

In light of the "Health Care Solutions Series" and the January 17, 2006 joint meeting of the Senate Health and Family Security Committee and the Senate Government Budget Division, the Minnesota Hospital Association (MHA) would like to take this opportunity to share with you information regarding our performance reporting efforts and our "Minnesota Hospital Quality Partnership."

As part of the Omnibus Health & Human Services Bill (HF 139) passed during the 2005 Special Session, the Minnesota Hospital Association and Stratis Health (Minnesota's quality improvement organization under contract with Centers for Medicare and Medicaid Services) were called upon to advise the Commissioner on the development of performance measures to be used for inpatient hospital reporting by October 1, 2007. "The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections."

MHA and Stratis Health had contemplated a public report of hospital performance prior to the legislation, and a partnership was formed in January of 2005. Efforts are well underway to produce a web-site which will contain hospital specific performance results as early as Spring of 2006.

CMS is currently collecting and reporting data from hospitals on a voluntary basis for the same categories of care as referenced in the legislation. These data will be the foundation of the Partnership's web-site on hospital reporting in Minnesota as well. By using data that is already being collected, we are able to consolidate and streamline reporting efforts. However, the Minnesota site will include additional information not available through CMS's website.

Along with the Adverse Health Event Reporting law, this performance reporting initiative demonstrates the priority that Minnesota hospitals place on transparency as it relates to quality and patient safety. If you have any questions, please feel free to contact me at the Minnesota Hospital Association.

Sincerely,

Mark Sonneborn
Vice President, Information Services

Excerpted from House File #139 from Special Session

374.2 [EFFECTIVE DATE.] This section is effective January 1, 2006.

374.3 Sec. 43. [256B.072] [PERFORMANCE REPORTING AND QUALITY

374.4 IMPROVEMENT SYSTEM.]

374.5 (a) The commissioner of human services shall establish a
374.6 performance reporting system for health care providers who
374.7 provide health care services to public program recipients
374.8 covered under chapters 256B, 256D, and 256L, reporting
374.9 separately for managed care and fee-for-service recipients.

374.10 (b) The measures used for the performance reporting system
374.11 for medical groups shall include measures of care for asthma,
374.12 diabetes, hypertension, and coronary artery disease and measures
374.13 of preventive care services. The measures used for the
374.14 performance reporting system for inpatient hospitals shall
374.15 include measures of care for acute myocardial infarction, heart
374.16 failure, and pneumonia, and measures of care and prevention of
374.17 surgical infections. In the case of a medical group, the
374.18 measures used shall be consistent with measures published by
374.19 nonprofit Minnesota or national organizations that produce and
374.20 disseminate health care quality measures or evidence-based
374.21 health care guidelines. In the case of inpatient hospital
374.22 measures, the commissioner shall appoint the Minnesota Hospital
374.23 Association and Stratis Health to advise on the development of
374.24 the performance measures to be used for hospital reporting. To
374.25 enable a consistent measurement process across the community,
374.26 the commissioner may use measures of care provided for patients
374.27 in addition to those identified in paragraph (a). The
374.28 commissioner shall ensure collaboration with other health care
374.29 reporting organizations so that the measures described in this
374.30 section are consistent with those reported by those
374.31 organizations and used by other purchasers in Minnesota.

374.32 (c) The commissioner may require providers to submit
374.33 information in a required format to a health care reporting
374.34 organization or to cooperate with the information collection
374.35 procedures of that organization. The commissioner may
374.36 collaborate with a reporting organization to collect information
375.1 reported and to prevent duplication of reporting.

375.2 (d) By October 1, 2007, and annually thereafter, the
375.3 commissioner shall report through a public Web site the results
375.4 by medical groups and hospitals, where possible, of the measures
375.5 under this section, and shall compare the results by medical
375.6 groups and hospitals for patients enrolled in public programs to
375.7 patients enrolled in private health plans. To achieve this
375.8 reporting, the commissioner may collaborate with a health care
375.9 reporting organization that operates a Web site suitable for
375.10 this purpose.

Draft Plan for Public Report on Quality of Minnesota Hospitals

I. Initial Measures:

Heart Attack – 9 measures:

- 1) aspirin at arrival
- 2) aspirin at discharge
- 3) beta blocker at arrival
- 4) beta blocker at discharge
- 5) ACE Inhibitor for LVSD
- 6) percutaneous coronary intervention within 120 minutes of arrival
- 7) thrombolytic agent received within 30 minutes of arrival
- 8) smoking cessation counseling
- 9) percent of patients receiving all of the previous 8 measures when eligible.

Heart Failure – 5 measures:

- 1) assessment of LV function
- 2) ACE for LVSD
- 3) smoking cessation counseling
- 4) discharge instructions
- 5) percent of patients receiving all of the previous 4 measures when eligible.

Pneumonia – 8 measures:

- 1) antibiotic timing
- 2) oxygenation assessment
- 3) pneumonia vaccination
- 4) smoking cessation counseling
- 5) blood culture before antibiotic
- 6) initial selection of antibiotic
- 7) influenza vaccination
- 8) percent of patients receiving all of the previous 7 measures when eligible.

Surgical Infection Prevention – 4 measures:

- 1) timing of prophylaxis antibiotic
- 2) selection of antibiotic
- 3) duration of prophylaxis
- 4) percent of patients receiving all of the previous 3 measures when eligible.

II. Additional Measures:

In addition to this, the Minnesota Health Quality Partnership will identify other measures that may be added to future reports. These include:

- Measures of rural relevance that Stratis Health has helped to develop in conjunction with the University of Minnesota and hospitals in Minnesota, Nevada, and Utah, and that are in the CMS approval process for potential use in the 8th Scope of Work.
- A process measure related to adherence to the ventilator bundle to prevent ventilator associated pneumonia.
- a subset of the AHRQ Quality Indicators. The plan is to share the results of the AHRQ QIs with hospitals prior to proceeding with public reporting so that coding issues may be addressed.
- Other measures approved by the National Quality Forum.

III. Other considerations

Increasing the user-friendliness for consumers is an important objective of this project.