Steve Jobs, Social Media and iPad enabled voting: Welcome to 2.0 Tuesday! A look at what's next in technology and healthcare.

At Manage My Practice, we have always been fascinated by the opportunities created when innovation and technical advancements are applied to the Healthcare system. The intersection of technology and medical practice has always been one of the most exciting spaces in research and development because the challenges of the Human Body are some of the most daunting and emotionally charged of our endeavors. Curing diseases, diagnosing symptoms and improving and saving lives are among our most noble callings, so naturally they inspire some of our brightest thinkers and industry leaders.

As managers, providers and employees, we always have to be looking ahead at how the technology on our horizon will affect how our organizations administer health care. In the spirit of looking forward to the future, we present "2.0 Tuesday", a weekly feature on Manage My Practice about how technology is impacting our practices, and our patient and group outcomes.

We hope you enjoy looking ahead with us, and share your ideas, reactions and comments below!

1. ## Steve Jobs thought iCloud had the potential to store Medical Data

Apple's recently announced iCloud service let's you store

pictures, movies, music, and documents in Apple's "cloud", or Internet storage system, and retrieve them with your iPhones, iPods, iPads, and Mac computers. Dr. Iltifat Husain, writing for the IMedicalApps blog notes that in the new biography of the Apple founder, Jobs mentioned that he thought even personal medical data would one day be stored in Apple's iCloud. Cloud storage is all the rage right now in a lot of different areas of technology, but Jobs saying that medical data would be stored on the consumer end next to vacation photos and favorite songs represents a very bold vision of the future of patient data.

Researchers using Social Media to study attitudes about Public Health

A team led by Marcel Salathé, PhD at Pennsylvania State University published a study last month in *PLoS Computational Biology* that used "tweets" gathered from the social network Twitter to analyze how the public felt about the H1N1 influenza vaccine in 2009. Although Social Media research has limitations, Christine S. Moyer, writing for the American Medical Association's Amednews.com notes that the results were similar to traditional phone surveys conducted by the Centers for Disease Control, and provides some other examples of how Social Media has been used to understand public health trends.

Interesting EHR/EMR data from the Soliant Health Blog

Medical staffing specialist Soliant Health had very eye-opening list of statistics about EHR/EMR implementations on their blog last week. My personal favorite: *Hospitals using EHR/EMR systems have a **3 to 4% lower mortality rate** than those that don't*. Very interesting numbers.

HealthWorks Collective predicts changes in healthcare communications after ACA

Healthworks Collective's Susan Gosselin makes some predictions about how the communications between and among providers and patients are going to be changed by the Affordable Care Act (or Healthcare Reform)- and what both groups will demand from a changing system. Great stuff!

Oregon to help disabled voters cast ballots using iPads

In today's local and congressional elections, five counties in the state of Oregon are going to be equipping local officials with iPads preloaded with special touch-interface software to accompany people with physical or visual impairments, or who would otherwise have a hard time making it to the polls. The 9 to 5 Mac blog is reporting that the pilot program features hardware donated by Apple, and could soon spread statewide by the next election.

Be sure to check back next week for another 2.0 Tuesday!

Is Patient Safety Something You Think About in Your Practice?

In 2001, the **Institute of Medicine** (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century*, which outlined fundamental changes that must be made in order to improve healthcare in the United States. Here is a quote from the book:

> *"The U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge—yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm."*

Although the concepts in the books have been widely implemented in the inpatient setting (**100,000 Lives Campaign** and now **5 Million Lives Campaign**), not as much has been done in the outpatient setting, predominantly because inpatient safety has been (rightfully) highlighted by needless deaths and injury (**The Josie King Story**, **The Dennis Quaid Story.**) These same concepts must be applied in the outpatient setting to achieve improved patient care and patient satisfaction. Ultimately, patients will **demand** to know what medical practices are doing to provide safe, effective, patient-centered, timely, efficient and equitable care. This is a great book to read (you can read it online) and think about in preparation for the changes coming with healthcare reform,

“Payment for Performance” (P4P) and electronic medical records promulgation.

Aim #1: Care should be **SAFE:** Patients should not be harmed by the care that is intended to help them. Current estimates from the **Agency for Healthcare Research and Quality** place medical errors as the eighth leading cause of death in this country. About 7,000 ”” people per year are estimated to die from medication errors alone ”” about 16 percent more deaths than the number attributable to work-related injuries.

Aim #2: Care should be **EFFECTIVE:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit. Estimates are that about half of all physicians rely on clinical experience rather than evidence to make decisions. But should they? Experts say that physicians in most practices do not see enough patients with the same conditions over long enough time to draw scientifically valid conclusions about their treatment.

Aim #3: Care should be **PATIENT-CENTERED**, respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. One study of physician-patient interactions showed that physicians listen to patients’ concerns for an average of 18 seconds before interrupting. Medical schools are beginning to place greater emphasis on the development of good patient-interaction skills.

Aim #4: Care should be **TIMELY:** reducing waits and sometimes harmful delays for both those who receive care and those who give care. Many hospital Emergency Departments (EDs) are symptomatic of a system that cannot reliably give timely care. One recent survey revealed the average wait at “crowded” EDs was one hour. One third of U.S. EDs report they must periodically divert ambulances to other facilities.

Aim #5: Care should be **EFFICIENT:** avoiding waste, including waste of equipment, supplies, ideas and energy. Some experts estimate that most physicians are productive only 50% of their time, in part because the system works against them. Working smarter, not harder, can reduce non-clinical work and increase "face time" with patients.

Aim #6: Care should be **EQUITABLE:** care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status. There is a growing number of studies showing disparities in care and treatment for some population groups. The implications can be dramatic: for example, the life expectancy of a black child is seven years shorter than that of a white child in Baltimore, Maryland, USA.

You can download a PowerPoint program from the Institute for Healthcare Improvement (IHI) that cover the concepts in the book for free **here**. Registration is required, but it is free and gives you access to lots of tools and resources.

You can also read the book for free online by clicking on the "READ" icon below. No registration is required.

What books, websites, blogs, organizations or people would you add to the list of resources to prepare us for the changes of the future?

Historic Votes on H.R. 3590

and H.R. 4872 Usher In Healthcare Reform

As I write this Sunday night I am listening to the US House of Representatives' discussion/posturing prior to a 'yes" or "no" vote for the Senate's healthcare reform bill H. R. 3590. I don't usually listen to CNN Live, but I want to remember this moment as I think it is the beginning of significant change in healthcare.

I'm not sure what this change will be, but many things that have been status quo for healthcare during my career might change almost beyond recognition by the time I retire. This, I think, is a good thing. I don't think the current system is bad, but I sure think it could be better. As with any change, there will be good things, bad things, and unintended good and bad things. It should be fascinating.

Discussion has now timed out and the representatives are voting; 216 votes are needed to pass. The vote has just been announced (10:45 p.m.) and it is 219 Yeas to 210 Nays and the bill is passed! The next step is for it to be signed into law by President Obama, which might happen tonight or tomorrow.

Now the representatives are voting on H.R. 4872 – "The Health Care and Education Affordability Reconciliation Act of 2010" which contains fixes to H.R. 3590 that have been negotiated between the two chambers. The bill has just passed (11:37 p.m.) with 220 Yeas and 211 Nays! 4872 will now go to the Senate for a vote which some are predicting will pass as early as Tuesday.

President Obama spoke from the White House after the votes and said "Tonight we answered the call of history." The passage of these bills has been compared to the passage of Medicare in 1965 and the passage of Social Security in 1935.

Here are details of both bills.

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Details on H.R. 3590 ”˜”˜Patient Protection and Affordable Care Act’’

Cost: $940 billion over ten years.

Deficit: Would reduce the deficit by $143 billion over the first ten years. Would reduce the deficit by $1.2 trillion dollars in the second ten years.

Coverage: Would expand coverage to 32 million Americans who are currently uninsured.

Health Insurance Exchanges:

- The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level.
- Separate exchanges would be created for small businesses to purchase coverage – effective 2014.
- Funding available to states to establish exchanges within one year of enactment and until January 1, 2015.

Subsidies: Individuals and families who make between 100 percent – 400 percent of the Federal Poverty Level (FPL) and want to purchase their own health insurance on an exchange are eligible for subsidies. They cannot be eligible for Medicare, Medicaid and cannot be covered by an employer. Eligible buyers receive premium credits and there is a cap for how much they have to contribute to their premiums on a sliding scale. *Federal Poverty Level for family of four is $22,050.*

Paying for the Plan:

- Medicare Payroll tax on investment income – Starting in

2012, the Medicare Payroll Tax will be expanded to include unearned income. That will be a 3.8 percent tax on investment income for families making more than $250,000 per year ($200,000 for individuals).

- Excise Tax – Beginning in 2018, insurance companies will pay a 40 percent excise tax on so-called “Cadillac” high-end insurance plans worth over $27,500 for families ($10,200 for individuals). Dental and vision plans are exempt and will not be counted in the total cost of a family’s plan.
- Tanning Tax – 10 percent excise tax on indoor tanning services.

Medicare:

- Closes the Medicare prescription drug “donut hole” by 2020. Seniors who hit the donut hole by 2010 will receive a $250 rebate.
- Beginning in 2011, seniors in the gap will receive a 50 percent discount on brand name drugs. The bill also includes $500 billion in Medicare cuts over the next decade.

Medicaid: Expands Medicaid to include 133 percent of federal poverty level which is $29,327 for a family of four.

- Requires states to expand Medicaid to include childless adults starting in 2014.
- Federal Government pays 100 percent of costs for covering newly eligible individuals through 2016.
- Illegal immigrants are not eligible for Medicaid.

Insurance Reforms:

- Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition.
- Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.

- Insurance companies must allow children to stay on their parent's insurance plans through age 26.

Abortion:

- The bill segregates private insurance premium funds from taxpayer funds. Individuals would have to pay for abortion coverage by making two separate payments, private funds would have to be kept in a separate account from federal and taxpayer funds.
- No health care plan would be required to offer abortion coverage. States could pass legislation choosing to opt out of offering abortion coverage through the exchange.

***Separately, anti-abortion Democrats worked out language with the White House on an executive order that would state that no federal funds can be used to pay for abortions except in the case of rape, incest or health of the mother. (Read more here)*

Individual Mandate: In 2014, everyone must purchase health insurance or face a $695 annual fine. There are some exceptions for low-income people.

Employer Mandate: Technically, there is no employer mandate. Employers with more than 50 employees must provide health insurance or pay a fine of $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Fines applied to entire number of employees minus some allowances.

Immigration: Illegal immigrants will not be allowed to buy health insurance in the exchanges – even if they pay completely with their own money.

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Details on H.R. 4872 – "The Health Care and Education Affordability Reconciliation Act of 2010" (fixes to 3590)

COST: $940 billion over 10 years, according to the

Congressional Budget Office.

HOW MANY COVERED: 32 million uninsured. Major coverage expansion begins in 2014. When fully phased in, 95 percent of eligible Americans would have coverage, compared with 83 percent today.

INSURANCE MANDATE: Almost everyone is required to be insured or else pay a fine. There is an exemption for low-income people. Mandate takes effect in 2014.

INSURANCE MARKET REFORMS: Major consumer safeguards take effect in 2014. Insurers prohibited from denying coverage to people with medical problems or charging them more. Higher premiums for women would be banned. Starting this year, insurers would be forbidden from placing lifetime dollar limits on policies, and from denying coverage to children because of pre-existing medical problems. Parents would be able to keep older kids on their policies up to age 26. A new high-risk pool would offer coverage to uninsured people with medical problems until 2014, when the coverage expansion goes into high gear.

MEDICAID: Expands the federal-state Medicaid insurance program for the poor to cover people with incomes up to 133 percent of the federal poverty level, $29,327 a year for a family of four. Childless adults would be covered for the first time, starting in 2014. The federal government would pay 100 percent of the tab for covering newly eligible individuals through 2016. A special deal that would have given Nebraska 100 percent federal financing for newly eligible Medicaid recipients in perpetuity is eliminated. A different, one-time deal negotiated by Democratic Sen. Mary Landrieu for her state, Louisiana, worth as much as $300 million, remains.

TAXES: Dramatically scales back a Senate-passed tax on high-cost insurance plans that was opposed by House Democrats and labor unions. The tax would be delayed until 2018, and the

thresholds at which it is imposed would be $10,200 for individuals and $27,500 for families. To make up for the lost revenue, the bill applies an increased Medicare payroll tax to investment income as well as wages for individuals making more than $200,000, or married couples above $250,000. The tax on investment income would be 3.8 percent.

PRESCRIPTION DRUGS: Gradually closes the "doughnut hole" coverage gap in the Medicare prescription drug benefit that seniors fall into once they have spent $2,830. Seniors who hit the gap this year will receive a $250 rebate. Beginning in 2011, seniors in the gap receive a discount on brand name drugs, initially 50 percent off. When the gap is completely eliminated in 2020, seniors will still be responsible for 25 percent of the cost of their medications until Medicare's catastrophic coverage kicks in.

EMPLOYER RESPONSIBILITY: As in the Senate bill, businesses are not required to offer coverage. Instead, employers are hit with a fee if the government subsidizes their workers' coverage. The $2,000-per-employee fee would be assessed on the company's entire workforce, minus an allowance. Companies with 50 or fewer workers are exempt from the requirement. Part-time workers are included in the calculations, counting two part-timers as one full-time worker.

SUBSIDIES: The proposal provides more generous tax credits for purchasing insurance than the original Senate bill did. The aid is available on a sliding scale for households making up to four times the federal poverty level, $88,200 for a family of four. Premiums for a family of four making $44,000 would be capped at around 6 percent of income.

HOW YOU CHOOSE YOUR HEALTH INSURANCE: Small businesses, the self-employed and the uninsured could pick a plan offered through new state-based purchasing pools called exchanges, opening for business in 2014. The exchanges would offer the same kind of purchasing power that employees of big companies

benefit from. People working for medium-to-large firms would not see major changes. But if they lose their jobs or strike out on their own, they may be eligible for subsidized coverage through the exchange.

GOVERNMENT-RUN PLAN: No government-run insurance plan. People purchasing coverage through the new insurance exchanges would have the option of signing up for national plans overseen by the federal office that manages the health plans available to members of Congress. Those plans would be private, but one would have to be nonprofit.

ABORTION: The proposal keeps the abortion provision in the Senate bill. Abortion opponents disagree on whether restrictions on taxpayer funding go far enough. The bill tries to maintain a strict separation between taxpayer dollars and private premiums that would pay for abortion coverage. No health plan would be required to cover abortion. In plans that do cover abortion, policyholders would have to pay for it separately, and that money would have to be kept in a separate account from taxpayer money. States could ban abortion coverage in plans offered through the exchange. Exceptions would be made for cases of rape, incest and danger to the life of the mother.

STUDENT LOAN OVERHAUL: Requires the government to originate student loans, closing out a role for banks and other private lenders who charge a fee. The savings ”“ projected to be more than $60 billion over a decade ”“ are plowed into higher Pell Grants for needy college students and increased support for historically black colleges.

MEDICARE: Extends Medicare’s solvency by at least nine years and reduces the rate of its growth by 1.4 percent, while closing the doughnut hole for seniors, meaning there will no longer be a gap in coverage of medication.

Guest Post: MGMA's Bill Jessee Discusses How MGMA Can Help You Meet 4 Key Medical Practice Trends

By William F. Jessee, MD FACMPE
MGMA President and CEO

Spend one day in the shoes of an MGMA member and you'll experience the challenging, changing environment of a practice administrator. Our industry is always in flux: new healthcare information technology to implement; new CPT and ICD codes to bill; new insurance plans to support. MGMA is changing, too, to support new and current members and help them thrive in the face of change.

While 70 percent of our membership remains directly employed by medical practices, new member trends indicate that about a quarter of all MGMA members who joined in 2009 came from other types of healthcare organizations, including integrated delivery systems (IDS). Also this year, more than half our new members are 45 or younger. More current and new members are attaining or have attained Master's degrees.

As our membership changes, so does the state of healthcare. Members frequently ask me about current healthcare trends. Here are four we're watching and what MGMA is doing to support our members during these changes:

- **Larger systems, influenced by the government, to become the norm**

In 1975, 68 percent of physicians worked in one- or two-person practices (1). By 2005, that proportion had fallen to 32 percent and has probably declined more since then (2). I think group practices will increasingly merge to form larger groups, integrate with other specialties to form multispecialty groups or become fully integrated with hospitals (our new membership numbers reflect this) in order to compete in the marketplace.

Also, much of the Federal reform legislative language favors larger, more complex practices, e.g., incentives for implementing electronic health records, electronic prescribing and quality reporting. Penalties for not adopting new technology could hit smaller practices harder. There is even talk of exempting physicians in systems from any Medicare Part B payment caps that might otherwise apply.

- **Hospital-owned groups already on the rise**

MGMA's physician compensation survey data indicate the proportion of physicians working in hospital-owned groups has steadily grown over the last several years. Both primary care and specialties are affected. The economic reasons for this are clear: Between 2001 and 2009, the Medicare conversion factor rose only 1.1 percent, while the consumer price index rose 24.2 percent; and median practice operating costs (for multispecialty groups) went up 43.1 percent. No matter the business, it's a challenge to remain a viable, free-standing practice when revenue is flat and expenses increase by 6 percent or so a year.

This year we've ramped up efforts to provide **practice management support for organizations that are part of IDSs**. In our various print and electronic member publications, we're featuring more stories and examples of what it takes to successfully run these health systems, and we recently published a book dedicated to the topic. At the MGMA 2009 Annual Conference, Oct. 11-14, we held IDS-specific sessions

that drew more than 900 people, proving this aspect of practice management is here to stay.

- **Practices increasingly collecting from patients**

MGMA polled members earlier this year about their top challenges, and collecting from self-pay patients landed at number four (3). As high-deductible health plans, health savings accounts and uninsured self-pay patients have increased in recent years, collecting the patient's share of the bill has become a greater challenge. MGMA is completing research on patient collections and we will release results early next year.

- **Healthcare reform on the mind**

We couldn't forget about this topic. Impending healthcare reform legislation means even bigger changes to come "" ones that require adaptation so healthcare management professionals and their organizations won't become irrelevant.

No matter what the outcome, health insurance is likely to expand, and new taxes and/or payment cuts seem likely. MGMA is monitoring the latest developments and sending weekly e-newsletters to members through the **MGMA Washington Connexion** (membership required.) Our public policy and advocacy staff in Washington, D.C., is advocating on behalf of medical practices and has **sent numerous comments and letters to Congress and the Administration** regarding proposed legislation, especially to assure that administrative simplification measures are included in any bill that is eventually passed.

Notes

1. Goodman L, Bennet E, Odem R. Current status of group medical practice in the United States. Public Health Rep., 1977;92 430-433.
2. Cook R. Finances driving physicians out of solo practice. American Medical News, Sept. 10, 2007.

3. Schneck L, Margolis J. Medical Practice Today: What you have to say. MGMA Connexion, July 2009, Vol. 9, No. 6, p. 28. www.mgma.com/medpracticetoday