

Healthcare Organizations: [Financial Management Strategies]

August 2009 Newsletter



The Health Information Technology for Economic and Clinical Health Act, of 2009 - Discerning “Meaningful Use” and “Certification” Nomenclature -

Welcome to the August issue of Healthcare Organizations [*Financial Management Strategies*]. This quarter, we briefly review what the HITECH ACT means to you.

What it is?

Congress enacted the Health Information Technology for Economic and Clinical Health (HITECH) Act, in President Barack Obama's American Recovery and Reinvestment Act (ARRA), of 2009. The Act offers funding and penalties to help healthcare entities and physicians transition to clinical and administrative electronic interchange. The aim is to improve the quality and decrease the medical costs.¹ More than \$19 billion is available from the economic stimulus to those who qualify, and implement eHRs by 2011.²

How to qualify?

In order to qualify for incentive programs, health entities must demonstrate “meaningful use” of a “certified” eHR platform. Unfortunately, the Department of Health and Human Services (HHS) did not define either term. However, some believe the Certification Commission for Healthcare Information Technology (CCHIT) will be the certifying body, and that “meaningful use” involves three major features:

1. Electronic and interoperable information interchange³
2. Electronic prescribing
3. Electronic clinical quality reporting benchmarks⁴

Report [187 pages]: <http://democrats.science.house.gov/Media/File/Commdocs/HealthIT%20Bill.pdf>

Future developments

Now, we do not necessarily agree with all of the above, especially the contentious CCHIT certification platform. But, we will keep you updated as DHHS releases more data on eHR initiatives. And, related topics will be addressed in future issues of Healthcare Organizations [*Financial Management Strategies*].

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PS: *Don't forget to review-read-rave and rant online at our web-blog and new communications forum.*

Fraternally,

David Edward Marcinko

Hope Rachel Heticio

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1. Manos, D: "Obama to Congress: healthcare reform must not wait." Healthcare IT News. February 25, 2009.
2. King, P: "Stimulus package and EMR use by physicians." netdoc.com.
3. "Health Information Technology Incentives, ARRA of 2009, FAQs; Quality First. American College of Cardiology
4. Anderson, H. "Lieber: Stimulus Demands Fast Action." Health Data Management: February 18, 2009

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Subscriber Feedback

SEE WHAT OUR READER'S ARE SAYING ABOUT COMPARATIVE MEDICAL EFFECTIVENESS

“Quite simply, comparative medical effectiveness research does exactly what it says: compares the effectiveness of two or more medical treatments for the same medical issue. This enables healthcare decision-making based on evidence instead of opinion, preference, or marketing hype.

Today, this research is largely unavailable except in limited circumstances. Pharmaceutical and medical device manufacturers, for example, have zero incentive to test against their competition because the FDA approval process requires testing against a placebo, not competing treatments. Once FDA approval is received, a manufacturer can gear up the marketing machine and capture market share – even if the newly-approved drug or device is not as effective as existing treatments.

In many cases, this drives increased cost without commensurate improvements in clinical care or patient outcomes”.

Winifred S. Hayes; RN, MS, PhD
President and CEO
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Hospital Industry Summary for 2008*

By Richard Frye; PhD

Forte Information Resources, Denver, Co.

An overview of the 2008 managed care industry as a summary report on Major Hospital Systems [MHS].

- In 2006, 52.4% of the 4,956 short-term, acute care; nonfederal hospitals in the U.S. were affiliated with major hospital systems [MHS] up from 51.8% of the 4,911 in 2005.
- The average number of hospital days per 1,000 members of HMOs not owned by MHSs grew 6.6% in 2006, to 302.2 from 283.6 in 2005, the fifth consecutive annual increase.
- The average number of prescriptions dispensed to non-Medicare members of MHS-owned HMOs decreased slightly in 2006, to 8.5 from 8.7 the previous year.
- In 2006, total hospital outpatient revenue was \$103.6 million, up 9.9% from \$94.3 million in 2005. As a consequence, the outpatient revenue percentage of total hospital revenue increased to 38.1% from 37.4% the prior year.
- Between 2005 (11,485.8) and 2006 (11,292.9), the average number of admissions fell at hospitals in MHSs that owned HMOs, the first such decline in this measure since 2001 (9,799.7).
- Between 2005 and 2006, the ratio of FTE registered nurses (RNs) to occupied beds rose both at hospitals in MHSs that owned HMOs (to 2.08 from 2.05) and at hospitals in MHSs that did not own HMOs (to 2.02 from 2.00).
- In 2006, total costs per occupied bed were just over \$1.0 million at hospitals that were part of MHSs that owned HMOs, up 4.7% from \$987,827 in 2005. Since 2001 (\$821,194), these costs have risen by more than one-quarter (26.0%).

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- Non-MHS hospitals averaged 164.7 outpatient visits per day, up 5.2% from 156.6 in 2005, the fourth consecutive annual rise.
- After rising notably between 2004 (60.2%) and 2005 (66.4%), the average intensive care unit (ICU) occupancy rate for MHS hospitals fell slightly in 2006, to 65.3%.
- Pharmaceutical expenses per discharge at hospitals tied to government-run MHSs fell 27.9% in 2006, to \$1,380 from \$1,915 in 2005, reversing two straight years of double-digit growth.

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