

E-Health

E-BULLETIN

VOL 2, ED 2 2008

Centre for Military & Veterans' Health

Editorial.

Dear reader,

Firstly I would like to introduce myself, I'm Lieutenant Commander Steve Pullman, having just returned from a two and a half year exchange posting with the United States Navy, working as the head of the Operational Medicine and Joint Support department at the Naval Medical Information Management Centre located in Bethesda, Washington DC. I am very happy to be once again passed the baton by my life long friend and colleague Lieutenant Commander Bob Curtis. One thing I have observed is that Bob always leaves the place much better than when he arrives and develops strong interpersonal and interdepartmental relationships that set the foundation for years that follow.

One of the most noticeable differences with having worked in the Health IT area of the US Department of Defence is the scale of their organisation. The number of people who their DoD and VA health system supports is close to 20 million people, of all ages and across all areas of medicine. This is a separate health system for defence and is comparable to the size of the population of Australia.

The US has recognized that the only way sustainable health care can be delivered for now and in the future is by completely re-evaluating the way that health care is delivered. The cost of health care is skyrocketing and is absorbing over 15% of the GDP of the US economy and continues to rise at an unsustainable rate.



Temporary image of new Editor.....

Governments are looking to technology to reduce the costs and move health care out of the hospitals and into the homes when home monitoring and minimal intervention is all that is required and essentially a hospital visit or stay can be avoided.

The area that I worked in was responsible for Telemedicine, in particular, teleradiology. This is the most developed field of telemedicine in the USN in regards to moving large amounts of data (images) around the world for interpretation and the results being sent back to support the care of the patient. Our department supported teleradiology currently installed on 29 major fleet units and within 26 Medical Treatment Facilities across

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The Blog Spot
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-3 topics of interest.

Book of the Week

Inside:

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Recent health blog activity -3 topics of interest.

Editors suggested reading and book of the week.

Article: Doctors continue resistance to EHR due to high costs

New Developments in training at CMVH

New electives added to the program list from 2008

Three new courses have been added to the elective list for the Master of Public Health (Defence) and Graduate Certificate in Public Health (Defence) programs. These are:

- ★ PUBH7116 - Communicable Disease Control
- ★ PUBH 7009 - Substance use and Misuse in special populations
- ★ HLTH 7001- Healthcare in Cyberspace

Anyone who would like to know more can contact LT Roland Oak 07 3346 4860 or r.oak@uq.edu.au



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continental USA, Europe and the Pacific (Guam and Japan). Teleradiology has become so entrenched as part of the normal way of doing business that soon the distinction of “tele” will be removed from their terminology and revert back to Radiology only.

Well enough about me for now. I intend to continue on with the E-Bulletin in a similar way to Bob by looking for articles from various sources with a view to how this may affect or influence our thinking in what we are trying to achieve in health care delivery for our defence and veteran personnel.

Just two little bits of housekeeping, when I say something or put in my two Bob's worth I will put it in italics and underline so you know it's me speaking. Also the content of the Newsletter does not necessarily reflect my own views or those of CMVH. This is designed to distill a large amount of circulating information and to be a valued addition to the coffee table set. A special binder will be forwarded to the first reader who emails me at s.pullman@uq.edu.au and I will include the entire back collection of Bulletins. (Previous Editors are not eligible to apply).

I hope that you find this current edition informative and look out for the Bumper Christmas Edition early December.

Steve Pullman

Lieutenant Commander, RAN
CMVH E-Health Coordination Officer

http://www.signonsandiego.com/uniontrib/20080831/news_1b31records.html

The Blog Spot

I was informed about this site below by one of our military medical officers CMDR Mark Parrish, RANR who is also employed as the Physician Executive Asia Pacific for Microsoft. This article has comments made by Peter Neupert who runs the Health Solutions Group at Microsoft. He writes an occasional health blog focussing on the link between the issues in healthcare, strategy, and how software can help them. He has links and references to a number of useful articles: some good stuff in Health Affairs most recently. The link to the blog is below:

<http://blogs.technet.com/neupertonhealth/>

You can add this as an automatic "feed" to your computer so it checks for updates regularly (if you don't know how to do this click the "RSS" link at the top of the blog and follow the prompts).

"Peter Neupert writes":

I love the **fresh debate** about standards and the evolution of Health IT raised by the three **Health Affairs** articles.

I agree whole heartedly with the perspectives of Carol and Clay - and frequently reinforce these comments to customers, policy makers and audiences alike. It's about the patient - not about the standards. Value in the form of patient care and business results can be improved by moving/reusing the data already in the system! There is no need to wait for 'standards'. Ultimately we need to be focused on solutions that provide value to patients....better quality of care.

If it's about the patient, we need to empower consumers to be active and engaged participants in the system and they will demand 'connected' care and more health and wellness choices.

They will increasingly make physician choices based on the ability and willingness of physicians to leverage communications/connected care to improve patient convenience and outcomes. In order to have more choice, consumers need to be able to access and leverage health IT solutions: the same ones that are being used by their physicians and other stakeholders across the spectrum of care. Health IT is a great enabler for many things (outcomes, safety, results, employee productivity, employee satisfaction) but not an end in itself.

System design matters a lot - metadata is the answer to enabling exchange of info today to evolve to standard exchange tomorrow. Health IT is only one piece of the puzzle, but we can't wait for all the pieces to be in place; We need to start improving outcomes today. These beliefs have informed the design principles of the software products we introduced in the marketplace - both HealthVault and Amalga.

In addition to consumers as a change agent, I remain hopeful that the buyers of large health IT systems will wake up and demand more from their vendors; Not in terms of custom features, but in terms of a real commitment to interoperability and to unlocking the data that exists in systems already. Health IT buyers are critical stakeholders/components of the ecosystem and need to demonstrate leadership in getting us to real solutions that extract the value from HIT - and not let themselves be positioned as victims controlled by the vendors. Unlocking the data that providers and patients need to make the right decisions should be the priority, with the goal of improving patient outcomes.

Posted: [Wednesday, August 20, 2008 8:52 PM](#) by [pnblog](#) | [1 Comments](#)



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Another topic that came up on the Blog was: **Can technology help the doctor/patient relationship?** Tara Parker-Pope had a thought provoking column about the strains in the doctor/patient relationship – and there are some good additional anecdotes and discussion on her blog, **Well**.

I have maintained for a couple of years that doctors are missing an opportunity to leverage their “trusted brand” (a.k.a the trusted relationship) by embracing basic Internet technologies to communicate more effectively, consistently with their patients.

The simplest example is think of all the information a doctor’s office has and needs to distribute to patients – info about their disease (pamphlet anyone), info about the drugs they prescribe, info about what to do before the procedure, info about post-visit instructions and so on. The doctor could “push” this information to the right patients easily – using a basic Customer Relationship Management CRM type system. It may not be “personalized” – but it would be relevant, timely, delivered in a form that patients could use/reuse the information and perhaps learn more, if they chose to in a self-directed way.

I first learned about “information therapy” and the key role it played in improving outcomes from the founders of **Healthwise** – and they are still pursuing this mission, with an expanded set of services.

When you think about – you want information from the doctor – and we know from our consumer market research – the consumers want “trusted information” – but they also want a lot more than the 2 minutes, shorthand version today’s economic model supports in the typical office visit or phone call.

The opportunity is physicians could differentiate their services, extend their reach beyond the office visit and improve the value of their services (and customer satisfaction measures) – if they could figure out how to deliver “information therapy” or other content they believe in – to their patients.

If physician offices were like other small/medium sized businesses – they would have figured out how to do this – like many successful businesses in other industries have done.

I am sure lots of docs have done some really great things - but why isn’t it more widespread? My hypothesis is – the economic motivation is not there. Because of the fee for service, bureaucratic nature of physician reimbursement – the innovative doc can’t capture the incremental value being delivered. See my previous post on the need for supply side flexibility to stimulate innovation – this (information therapy, relationship management, brand extension) is precisely the type of service obviously being demanded by consumers – but is not being ‘supplied’ by physicians - because they don’t have the tools/flexibility to capture the value (or even experiment to find out).



This next item is particularly relevant regarding current efforts within our DoD and E- Health. I found it an interesting read:

Demand to spend government \$’s on Health Information Technology (HIT) hits Medical Safety Monitor (MSM)

Recently the **NYT editorial** chastised physicians and the U.S. health system for not adopting electronic medical records adds a new MSM voice to the debate regarding technology as the no-brainer foundation of health reform. Naturally this is a frequent **topic** in the trade mags/blogs in my inbox.

The chief implication in the MSM editorial however is that “public financing” is the key factor that would accelerate Electronic Medical Record (EMR) adoption in this country, as it seemingly has in other countries. Not surprisingly, there is also an active **number of bills** in Congress looking to **increase the government spend on health information technology** – with varying formulas and priorities. There is no doubt that if the government provides a lot of financing for EMR adoption by physicians that there will be

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more computers in doctor's offices and hospitals. The real question however is will the **right technology investments** be made that generate the most value - for the physician, for the citizen/patient and for health outcomes.

Unfortunately, the health IT landscape is littered with large, often government sponsored projects, that consume resources but fail to deliver the expected outcomes for a variety of reasons – poor design, lack of adoption by users, too slow, automate the wrong things and so on.

Just spending more money on information technology – without looking at all the factors driving behavior in our health ecosystem (payment reform in terms of what we pay for and who pays it and consumer expectations) is unlikely to achieve the expected outcomes.

Clearly, I believe information technology is a critical component of improving health outcomes...or I wouldn't be investing time and resources in **building solutions**. Further, I believe that payers need to work with providers to finance investments in improving health outcomes – of which information technology is a key factor. At an early stage, some good work is going on with good early results, such as in **Massachusetts**. Given that the Federal government is involved as a payer in a **significant portion of health spend** (nearly 40% by some accounts) - it needs to participate in the solution or other payers won't.

So what is my main point? We (our government) has scarce resources...they should use them wisely and carefully. I want to make sure that investments in information technology have a high return to users, payers, citizens and health outcomes. There is lots of electronic data out there today – medication histories, lab results, diagnostic images – and just making these available to physicians and patients alike at the point of decision making – may generate desired outcomes (lower cost and better care) at a much lower technology spend level. Yes, **paper charts are archaic and sub-optimal** and will ultimately be replaced by digital systems. We can achieve our shared goals of better “value” from our health system (better outcomes for the spend) – faster and cheaper – by unlocking the digital data that already exists (**Esther Dyson** made **this call for data liquidity** several years ago) and incentivizing physicians and consumers to use the data. Let's not be satisfied with waiting for Electronic Medical Record (EMR) adoption to happen.

Posted: Wednesday, June 25, 2008 9:03 AM by pnblog | 0 Comments

More

The Editors suggested reading and

Book of the Week:

**E-Health, Telehealth, and Telemedicine:
A Guide to Startup and Success**

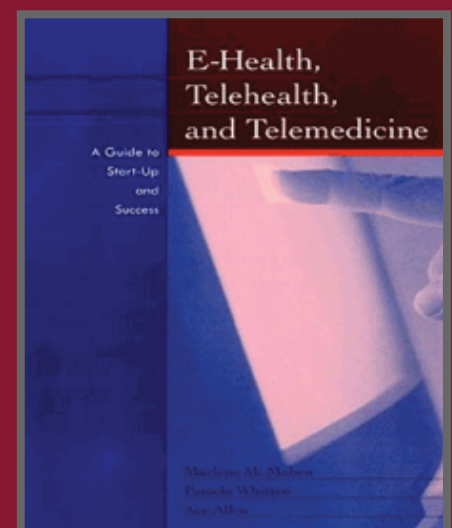
Marlene Maheu, Pamela Whitten, Ace Allen

ISBN: 978-0-7879-4420-9

Hardcover

400 pages

February 2001, Jossey-Bass



Finally a view on high costs associated with Electronic Health Record (EHR) conversion. However the bottom line is that there will be considerable cost savings from the EHR.

Doctors Continue Resistance to EHR Conversion due to High Cost.

President Bush's goal of providing a portable EHR to every U.S. resident is in jeopardy: Doctors and hospitals continue to resist making the technological leap from paper to EHRs due to high cost. Recent surveys by Harvard and the American Hospital Association note that few physicians use a fully electronic record system, in part because it can cost \$70,000 or more to convert from paper to electronic. Smaller practices may find that cost too significant to bear, according to Dr. Ashish Jha, professor of health policy at Harvard School of Health. Much of the cost could be eventually recovered through savings generated from EHRs, but there's no guarantee that those reaping most of the savings - insurance providers and government agencies - will share their windfall with those firms that shoulder the upfront costs, Jha said.



http://www.signonsandiego.com/uniontrib/20080831/news_1b31records.html