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The Honorable Barack Obama  
The President-elect  
Washington, D.C. 20270

Dear Mr. President-elect:

During a press conference on November 25, 2008, you described a new policy under which the federal government will assist hospitals and other providers and practitioners in purchasing health information technology (HIT) such as electronic health record systems (EHRs). Your objective is to simultaneously support the technology sector and improve the quality and efficiency of health care. As the association representing the national network of health care Quality Improvement Organizations (QIOs), The American Health Quality Association strongly supports your plan.

By selecting HIT as a focus for economic stimulus assistance, you will address the financial hardships that prevent many providers from investing in HIT. However, HIT alone will not produce improved health outcomes. While HIT may improve processes of care where it is actively used by clinicians, studies have found mere possession of EHR technology does not produce better care quality. Lindner and colleagues cautioned last year that “as EHR use broadens, one should not assume an automatic diffusion of improved quality of care...Policy makers should consider steps to increase the likelihood that further diffusion of EHR has the desired effect of improving quality of care.”<sup>1</sup> A study in the U.K. found even practices with state-of-the-art clinical decision support software were not using this capability in patient care.<sup>2</sup>

Because most hospitals and physician practices lack the infrastructure and experience to implement sophisticated new technologies, there is a substantial risk the government will buy EHRs for thousands of providers without accomplishing your objective of improving care. Commercial consultancy firms could help them, but have little interest in serving typical providers and office practices (80% of physician offices have just one or two doctors)—even if those practices and providers could afford to hire them. Care management is typically implemented months or even years after an EHR “goes live” because a practice starts with the ability to do prescription refills or enter observations in the patient’s chart, and the staff is not trained on the advanced capabilities of their system. Vendors are adept at installation, but are not necessarily in the market to transform a practice’s quality performance.

Fortunately, the federal government has an existing field force of clinical and health information technology experts: the national network of private Medicare QIO contractors. QIOs are trusted independent organizations, active in every state, with a long history of being flexibly responsive to federal initiatives. QIOs worked with hundreds of hospitals and focused on about 3,600 small physician offices from August 2005 to July 2008, assisting them in re-designing their clinical workflow to incorporate HIT into daily practice. These practices exceeded expectations in using their EHRs for care management, and the QIO program influenced HIT vendors to make significant changes in their programming to enable physicians to generate care management reports. Demand was so strong that QIOs had to turn providers away; providers’ strong interest

in obtaining QIO support is a clear signal that implementation of HIT needs to be supported by a local unbiased change agent.

Last year, an independent firm hired by Medicare officials conducted a national satisfaction survey of QIO-assisted physician office practices and found—

- 80% of physicians were satisfied with the QIOs' assistance in improving the quality of care delivered in their office through HIT;
- Three-quarters of physicians were satisfied with QIO assistance in improving practice efficiency through HIT; and
- Three-quarters of physician practices were satisfied with the QIOs' knowledge of technology options and ability to appropriately assess the practice's technology needs.

Recommendation: This is a strong foundation for your new administration to build upon. To minimize costly HIT implementation failures, and reduce the risk that practices with failed implementations will discourage their peers from attempting to implement HIT, your economic recovery package should provide QIO technical assistance for providers and practices to plan for adoption of HIT, select software and hardware, and modify their daily clinical workflow to incorporate this new technology into caregiving processes.

QIO assistance should not be limited to practices that already possess EHRs—a limitation imposed by the current administration—but should be made broadly available to providers and primary care practices to speed the pace of adoption and reduce the number of providers that fail implementation.

We are happy to provide a more extensive briefing to your transition team, explain the Medicare funding mechanism for the QIO program, and suggest methods for reliably evaluating this project. Your staff may reach me here at AHQA by calling 202-261-7568 or by writing to [dschulke@ahqa.org](mailto:dschulke@ahqa.org).

Thank you for your leadership and for your consideration of this suggestion.

Respectfully yours,



David G. Schulke  
Executive Vice President

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References:

<sup>1</sup> Linder et al. Electronic health record use and the quality of ambulatory care in the United States. Archives of Internal Medicine; July 2007.

<sup>2</sup> Eccles et al. Effect of computerised evidence based guidelines on management of asthma and angina in adults in primary care: a cluster randomised controlled trial. BMJ; October 2002.