African American Heart Attack Patients Are Disproportionately Likely To Be Admitted To High-Mortality Hospitals

African American heart attack victims who live in racially segregated areas are disproportionately likely to be admitted to hospitals with higher-than-average mortality rates, even when the hospital closest to them has lower mortality rates, according to a new study published on March 3 on the *Health Affairs* Web site. The study suggests that eliminating health care disparities will likely require addressing the social factors that lead to segregation. Researchers looked at hospital admissions of Medicare enrollees for acute myocardial infarctions, or heart attacks, in 118 health care markets over the period 2000-2005. They found that blacks were 35 percent more likely than whites to be admitted to hospitals classified as "high mortality," in which relatively high percentages of heart attack patients did not survive: 45 percent of African American patients were admitted to such hospitals, as compared to only 33 *p*ercent of white patients. (*Health Affairs*, March 3, 2009)

New Report Highlights Health Care System's Financial Squeeze on Cancer Patients

Cancer patients can face severe challenges in paying for life-saving care – running up large debts, filing for personal bankruptcy and even delaying or forgoing potentially life-saving treatment – even when they have private health insurance, according to a new report by the Kaiser Family Foundation and the American Cancer Society. The report profiles 20 patients and illustrates the potential difficulties people diagnosed with cancer or other serious illnesses have in maintaining affordable health insurance and paying for their health care. (Kaiser Family Foundation, Feb. 5, 2009)

Finding a Way To Ask Doctors Tough Questions

Waiting to see his dermatologist about a skin rash, John Barnett heard the doctor sneeze loudly before he came into the exam room. The Seattle-area retiree says it took all his courage to ask, "Are you going to wash your hands before you examine me?" Despite efforts by advocacy groups and others to empower patients, challenging a doctor or nurse on whether they are correctly doing their jobs remains downright intimidating. Signs and posters in hospitals urge us to "Speak Up" if we see a potential medical error. More nurses wear buttons these days that say "Ask Me If I've Washed My Hands." But even the most outspoken and assertive among us may suddenly turn meek when we are sick or vulnerable in a hospital, fearing that our treatment will suffer if we antagonize caregivers. (*The Wall Street Journal*, March 4, 2009)

Recession Now Hits Jobs in Health Care

Employment in health care, the only major industry outside the federal government still adding jobs, is succumbing to the recession. In the latest sign, the president of New York City Health & Hospitals Corp. wrote Friday, April 10 to community organizations as well as employees and unions at its 11 hospitals and four nursing homes, saying the agency will lay off more workers even after slashing 400 jobs last month. He blamed the job losses on state cuts in Medicaid payments to the public-health system. Across the country, hospitals are taking financial hits. They are seeing losses in the portfolios that they rely on for investment income. And with state governments continuing to cut budgets and talk of health-care reform from Washington, industry executives are preparing for even leaner times. (*The Wall Street Journal*, April 13, 2009)

Genetic Embryo Screening: Questions Grow Along With Number of Procedures

According to a recent article featured in the *Chicago Tribune*, both the number of families checking embryos for genetic defects and the number of conditions being tested are growing rapidly around the world. Determining the ethical and regulatory guidelines for such screening is proving difficult. Testing that at first focused on eliminating genetic defects certain to cause early suffering and death has expanded to defects such as genetically linked breast and ovarian cancer, which are not always fatal, hit somewhat later in life and affect 50 - 85 percent of those who carry the gene rather than 100 percent. A new study by Johns Hopkins University researchers shows that, as of 2006, 65 percent of about 200 U.S. clinics carrying out screening on embryos allowed parents to select the sex of the embryo implanted, even if the child was their first or they were not trying to create a family with a balanced number of girls and boys. That – and a recent scandal in which a California-based genetics lab advertised its ability (since disproved) to select a baby's eye and hair color – have raised concerns among many Americans about the genetic selection of embryos. (*Chicago Tribune*, March 25, 2009)

Putting Muscle Behind End-of-Life Wishes

Millions of Americans have living wills that they think provide clear instructions to medical personnel about what should and should not be done if their lives hang in the balance and they cannot speak for themselves. Yet in case after case, study after study, it seems that these documents do not result in the desired end among patients in hospitals and nursing homes. Now a new study confirms that confusion about interpreting living wills prevails in prehospital settings, as well. The study, conducted among 150 emergency medical technicians and paramedics by a team at Hamot Medical Center in Erie, Pa., and published in February in *The Journal of Emergency Medicine*, found that concern for patient safety can collide with confusion about the intent of living wills and do-not-resuscitate orders. (*The New York Times*, Feb. 24, 2009)

N.B.
Students from the Center for Health Law Studies at Saint Louis University School of Law contributed the following items to this column. Amy N. Sanders, Assistant Director, Center for Health Law Studies, supervised the contributions of health law students Meghan McNally (JD anticipated '10) and Phillip Terrell (JD/MHA anticipated '11).

Comprehensive EHR System Used By 1.5 Percent of Hospitals.

According to a report funded by the U.S. Department of Health and Human Services in *The New England Journal of Medicine*, 1.5 percent of non-federal U.S. hospitals use a comprehensive electronic health record (EHR) system. This does not include Veterans hospitals, which have all adopted EHR systems. If Veterans hospitals were included in the calculation, the combined total would be 2.9 percent. Ashish Jha, lead author of the report, said, "7.6 percent of hospitals have a 'basic' EHR that included capability to record and store physician and nursing notes" and that "10.9 percent had a very basic system" that did not include the above functions. Jha indicated that data on the effectiveness of the technologies and other forms of data sharing were unavailable, stating that "just because they have these systems doesn't mean they are sharing that information with other doctors or hospitals down the street." Contributing author, David Blumenthial, named by President Obama as national coordinator for health information technology, said, "IT [information technology] is one important and ultimately critical way to [support behavior change]." (Joseph Conn, *Modern Healthcare*, March 25,2009)

Details of Executive Compensation Practices Released in IRS Tax Exempt Hospital Report.

In 2006, the IRS began a study about executive compensation in the country's non-profit hospitals. The final report, *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report*, released in Feb. 2009 indicated in most cases "hospitals are following applicable laws and regulations in setting executive pay." The report was based on responses from over 500 nonprofit hospitals. Twenty nonprofit hospitals provided additional information regarding executive compensation practices. While the report does not reach specific conclusions about the appropriate community benefit standard, IRS Director of Exempt Organizations Louis Lerner indicated that he is "'pretty happy' that most hospitals used comparability data when setting executive compensation." The IRS further stated that "as discussion about the community benefit standard continues, additional information will be available as more accurate and complete data on community benefit expenditures become available through Schedule H of the Form 990." This data is not expected to be released until late 2009. (*BNA Health Law Reporter*, Feb. 19, 2009.)

Collaborative Proposes Rules Engine for Interstate Transfer of Electronic Health Information

The federally sponsored Interstate Disclosure and Patient Consent Requirement Collaborative, part of the Health Information Security and Privacy Collaboration (HISPC), recommended the creation of a engine to facilitate efficient exchange of electronic health information among states. The engine will help address obstacles posed by disparate statutory and regulatory provisions governing the release of patient health records across state lines. It will operate via a set of software components to analyze a transfer request and ascertain which privacy and consent laws apply thereto. Progress is currently hampered by uncertainty and confusion regarding differences between state consent and privacy. (*Government Health IT*, March 5, 2009)

Physicians Pressure Medical Associations To Limit Drug Industry-Sponsored Funding

An article in the March 31 *Journal of the American Medical Association* by leading doctors and researchers calls for the nation's specialty medical associations to start refusing general budgetary support from drug and device manufacturers. Expressed as non-binding recommendations, the appeal suggests that associations eliminate industry-based sponsorships from almost all areas of activity except general advertising within publications and booths at trade fairs and physician conferences. "What I don't like is when I can't tell if what I'm hearing is science, or marketing in the guise of science," said lead author David J. Rothman, professor at Columbia University in New York. Opponents to the recommended restrictions – which previously extended to full-fledged branding on conference name tags and physician fellowship support – find that the guidelines could inhibit information received by doctors. Marjorie Powell, senior assistant general counsel for the Pharmaceutical Research and Manufacturers of America, said "Physicians are making decisions based on their scientific and medical knowledge and training." (*The Wall Street Journal*, April 1, 2009)

Health and Human Services Announces Members of Comparative-Effectiveness Panel

The Department of Health and Human Services (HHS) recently announced members of the new Federal Coordinating Council for Comparative Effectiveness Research (Council), part of the Obama administration's health care reform initiatives. Council member, Carolyn Clancy, MD, director of the Agency for Healthcare Research and Quality, explained that HHS will seek recommendations concerning different treatment options, which will later be presented to patients and doctors alike as they make health care choices. This research will take place at AHRQ, the National Institutes of Health and HHS through funding from the recent stimulus bill. Other panel members include representatives from the Substance Abuse and Mental Health Services Administration, the Food and Drug Administration, the Office of Minority Health, the Centers for Disease Control and Prevention, and the HIV/AIDS Bureau at the Health Resources and Services Administration, among many others. (*Modern Healthcare*, March 19, 2009)

CMS Releases 2010 Medicare Advantage Reimbursement Rates

The Centers for Medicare and Medicaid Services (CMS) announced on April 6 its Medicare Advantage reimbursement schedule for next year. Private administrators of Medicare Advantage plans will see a 4-4.5 percent cut in reimbursement beginning in 2010, in accordance with the new administration's efforts to curtail higher expense associated with Medicare managed care beneficiaries (whose coverage has cost on average 14 percent more than traditional Medicare benefits). The move caught managed care plan firms by surprise as cuts in government reimbursement were not anticipated until 2011. Many plan administrators foresee modifications of cost-sharing arrangements resulting in significant increases in monthly premiums. Republicans in Congress balked at the CMS move, especially since it is being implemented alongside a cut in physician reimbursement that Congress is likely to halt later this year. (*The Wall Street Journal*, April 7, 2009)