More Physicians' Offices Are Going Electronic

The number of physicians using electronic health records (EHRs) has skyrocketed since 2009, according to a study reported by the Centers for Disease Control and Prevention's National Center for Health Statistics. In 2012, 72% of office-based physicians were using an electronic record system, compared with 18% in 2001. And the percentage of physicians who can e-prescribe has more than doubled (from 33% to 73%). The number who are communicating with patients and their families via computer has also increased by 46%.

The 2009 Health Information Technology for Economic and Clinical Health Act authorized incentive payments to encourage physicians to adopt EHR systems. To receive payment, physicians must show that they are "meaningfully using" certified EHRs by meeting certain objectives, such as computerizing their practice to check for drug interactions, record and chart vital signs, and provide patients with clinical summaries for each visit. As of 2012, about 66% of physicians intended to participate in the incentive program (41% had already applied), up from 52% in 2011. About one-quarter of those had computerized systems with capabilities to support 13 of the 15 core objectives.

The study was based on a 2012 mail survey of 10,302 physicians in the National Ambulatory Medical Care Survey. A copy of the survey is available at www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm#namcs.

Veteran Homelessness Shows "Robust Decline"

Homelessness among veterans is continuing to decline. The 2012 Annual Homeless Assessment Report, prepared by the Department of Housing and Urban Development (HUD), estimated 62,619 homeless veterans on a single night in January in the U.S., down 7.2% since 2011 and 17.2% since 2009. By comparison, the number of homeless people in the U.S. overall dropped by less than 1%.

The White House has declared a goal of ending veteran homelessness by 2015. The trend "clearly indicates we are on the right track," said Secretary of Veterans Affairs Eric Shinseki. He praised the "hard work" of the VA and HUD, as well as the state and community partners committed to ending veteran homelessness. However, he added, "While this is encouraging news, we have more work to do and will not be satisfied until no veteran has to sleep on the street."

Some of the credit goes to the Supportive Services for Veteran Families Program (SSVF), which awards grants to private nonprofit organizations and consumer cooperatives who work on behalf of very low-income veterans and their families living in or transitioning to permanent housing. The program helps with case management, legal assistance, financial counseling, transportation, child care, rent, utilities, and other services aimed at preventing homelessness. As of late 2012, SSVF had aided about 21,500 veterans and over 35,000 individuals, as well as 8,826 children of veterans. The application deadline for SSVF grants closed in February 2013, but grants are released throughout the year; the VA advises checking back often to see when new funding is available. For more information, visit www.va.gov/homeless/ssvf.asp.

Disabled Adults Use More Emergency Care

Although adults with disabilities represent 17% of the working-age adult population, they account for nearly 40% of annual emergency care visits. They also use emergency department (ED) services nearly twice as often as peers without disabilities, representing almost one-quarter of heavy ED users (4 or more annual visits), according to a National Institutes of Health study.

The study by Rasch and colleagues, published online in the 2012 issue of *Health Services Research*, analyzed pooled data from the 2006-2008 Medical Expenditure Panel Survey, a U.S. health survey of community-dwelling civilians. The researchers compared ED use among 3 groups: those without any self-reported mental or physical limitations; those with a limitation but who did not need daily living assistance; and those who did not need assistance with daily living. The participants answered survey questions about access to primary care services and prescription medications, as well as their use of emergency care services.

The researchers' findings indicate 3 key factors that matter in relation to ED use among adults with disabilities, they say: access to care, the complexity of health profiles, and disability status itself. Generally, more adults with disabilities reported not receiving any medical care or prescription medications, or delayed receipt, compared with the other groups. Further, more of those with poor access to care reported insurance gaps. (This was true of all adults regardless of disability status, the researchers note.)

The most common reason overall for an ED visit was injury. But adults with disabilities dominated

the second most common category: "symptoms, signs, and ill-defined conditions" (ICD9 780-799), representing 11% of all visits. The study found that, for adults with disabilities, the ED is a "source of care for a wide variety of chronic and nonchronic conditions." They visited the ED in "particularly high" numbers for back/neck conditions, hypertension, mental disorders, heart conditions, and pneumonia/bronchitis. The issue is far-reaching: More adults with disabilities were hospitalized and they had more ambulatory care–sensitive conditions—that is, conditions associated with hospital stays that could potentially be avoided through good ambulatory care. A shoulder or hand injury might not require immediate attention for someone who is ambulatory, the researchers point out, whereas it could be functionally devastating for someone in a wheelchair.

"Given the volume of health conditions among people with disabilities," the researchers say, "the ED will always play a role in their care." But, they add, optimizing the ongoing care could help prevent repeat visits. They recommended a 3-prong strategy. First, they advise, "start upstream"—that is, with early detection; community-based nutrition, exercise, and wellness programs; peer support; and chronic disease management programs.

Second, "build a medical neighborhood that includes the ED." While the ED may offer "unique attributes that work," they also advocate programs that rely on a mix of different methods, such as case management, home medical visits, integration of psychosocial care, medication management, and 'round-the-clock access to medical assistance.

Third, they advise "working downstream." Emergency departments themselves, the researchers say, have a role to play in preventing future ED visits. They advocate a steady 2-way flow of detailed medical information between the ED and other health care providers. Such integration has been shown to help reduce medical errors and poor outcomes. But those issues, they conclude, take on special relevance for people with disabilities, because those patients may have functional limitations that interfere with self-advocacy, have multiple health conditions that may involve care from many different providers, and are more likely to be poor.

Streamlining Appointment-Making in the VA

It's time to change the VA's 25-year-old appointment-scheduling software used in the VistA electronic health system—and new ideas are more than welcome. The VA has opened a contest challenging software developers to create new systems that schedule appointments in the VA's nationwide health system. The creators of the winning systems will win prizes for an open-source and open application program interface–based system to replace components of the existing scheduling software.

The Medical Appointment Scheduling System Contest, hosted at www.Challenge.gov, is "driven by the VA's decision to transition VistA into an "openly architected product," with components that can be extended and modified much more easily than customized products, the VA release of January 9, 2013, says. "This contest marks a major change in direction by VA, away from software that is so customized that only VA can use it, toward open standards and commercial systems that build on proven practices," said Secretary of Veterans Affairs Eric Shinseki. He added that the competition will encourage more ideas to provide more personalized care.

The contest was formally announced in the *Federal Register* on October 16, 2012. Registration is due May 13, 2013, and all entries must be finalized by June 13, 2013. The VA plans to announce the winners on or about September 30, 2013. More information is available at http://vascheduling.challenge.gov/.