

Why Now Is the Time to Enact Health Care Reform

By George Halvorson

The following is an excerpt from the forthcoming book, Health Care Reform Now!, by George Halvorson, to be published by Jossey-Bass Publishing in August 2007. Published with permission of Jossey-Bass.

We spend more money on health care by far than any other country and yet nearly 50,000,000 Americans are uninsured at least part of the time each year.¹ To make matters worse, well-documented studies show us that nearly 50% of the time American patients are receiving less than adequate, inconsistent, and, too often, unsafe care.²

We have reached the point where both health care delivery and health care financing in America need new directions. The old approach isn't technically broken—because it continues to function—but it performs at unacceptable and unaffordable levels in far too many ways for far too many people. Our current approaches to care delivery and health care financing are sadly inadequate for what we need health care to do in this country today.

We don't really have a health care delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited micro systems, each interacting in ways that too often create suboptimal performance both for the overall health care infrastructure and for individual patients. Our current approach to financing both care and health care coverage too often leaves us with major operational problems as well as serious ethical issues relative to resource allocation. Our current approach to health care resource consumption can lead to unconscionably inadequate access to quality care for far too many Americans. Those problems are exacerbated for minority Americans. When it comes to racial and ethnic disparities in care and coverage, we very sadly have grown to accept as the status quo in America what should be seen as completely unacceptable differences in care delivery and care outcomes for our various minority populations. Our current nonsystem is expensive, frequently ineffective, and the distribution of care resources are often dangerously and shamefully inequitable.

This is clearly the wrong place to be.

What we need to do at this point is bring everyone—labor, management, consumers, carriers, the uninsured, the underinsured, caregivers, government agencies, patients, and the community—together to form a consensus on an approach that can truly get the job done. Then we need to turn that consensus into practical, functional operational reality as soon as we can get that whole agenda in place.

Eight Developments That Finally Make Health Care Reform Possible

Major health care reform is achievable right now in this country to a degree that literally was not possible until now.

Why do I say that? Because there are eight recent developments in American health care that have combined to give us, for the first time ever, a very real opportunity to systematically improve both care delivery and reduce the costs of care on a large scale in a relatively short time frame. I have touched on several of these issues in the prior chapters already. But I think we need to look at them in terms of a package of events, opportunities, and issues that, taken together, give us a chance to make a real difference in American health care.

Those eight developments are creating what might be a “perfect storm” in favor of health care reform.

Without those specific developments, care delivery improvement and real market reform would be extremely difficult, if not impossible. With them, if we do the right things in the most effective ways, health care reform can actually happen. Soon.

So what are the magical eight recent developments that make health care reform much more possible right now?

We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited micro systems, each interacting in ways that too often create suboptimal performance both for the overall health care infrastructure and for individual patients.

George Halvorson is the CEO and Chairman of the Board of Kaiser Foundation Health Plan, Inc, and Kaiser Foundation Hospitals.



1. Common Provider Number

The first key new health care reform ingredient is the common provider number. All health care providers in America will soon have, by law, a single identification number that clearly identifies each individual provider for all payers and for all care. That new single ID requirement is a huge step forward for health care data use.

The national single provider code requirement is a recent development, created by an extension of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This particular HIPAA provision requires use of the common provider number by May of 2007.³

The common provider number is an extremely important new tool. It changes access to care data in a critically important way. Until now, it has been functionally impossible to track individual provider performance using available electronic databases about care. The only electronic databases that exist have been

created and held by the various payers of claims—the health plans, insurers, third-party administrators, and public program payment shops. Each of these private and public payers has used their own unique, proprietary provider-coding system, so there has been no way to link data from the various payers' claims-payment databases in ways that could create either overall provider accountability or performance measurement. A single provider could and did have multiple identification codes, each code limited to a single payer's database, so the various payer databases could not be coordinated or aggregated in any effective way.

Tracking how well a given provider did in taking care of a chronic disease like asthma was made extremely difficult—if not impos-

sible—by the fact that no two existing electronic records of his or her care could be linked together.

If we really believe that data is the essential first step for any continuous improvement process or model, then the importance of having a single, unique longitudinal numerical code for each provider becomes glaringly obvious. Health care reform becomes possible when we have real performance data about care.

2. Computerized Databases

The second major development that makes systematic health care reform finally possible is the emergence of computerized databases for all payers. Until very recently, a minority of health care claims were submitted

electronically from care providers to insurers, health plans, and government payers. The resultant nonelectronic data flows were inconsistent and undependable in ways that significantly undermined the potential effectiveness of the final data sets for use in tracking health care delivery.

Today, with HIPAA regulations making the electronic data flow from providers to payers a standardized, more efficient, confidentially protected process, the databases for the payers are pretty much all electronic. The new HIPAA and industry standards for electronic data transmission also are set up to create a more uniform data flow.⁴ As a result, the old, relatively inaccurate and inefficient paper claim is being replaced very rapidly by far more accurate electronic claims submissions.

To make the process even more useful, the time frames between actual care delivery for a given patient and the electronic filing of a claim about that patient's incident of care have recently shrunk precipitously, to the point where the new electronic database for payers now has increasing value as a relatively current care management and provider support tool as well as a history-based performance tracking tool.

3. Electronic Claims Data Portability

The value of that claims-payment based electronic data reporting tool is being further enhanced by the new willingness of the entire health care payer industry to commit as an entire industry to both data portability and data interoperability. The industry set itself a major new and almost revolutionary goal in 2006 to achieve a functional ability on the part of all insurers and payers to electronically move data between payers in ways that closely resemble comparable data flows in the banking industry. That ability is being piloted even as you are reading this book. So a significant supply of health care data is now becoming electronic, timely, standardized, and portable.

That is a data bonanza for health care. We are going from all data being held exclusively in separate paper medical records—inert and inaccessible—or in a myriad of fragmented electronic claims payment files with different data standards and unusable provider ID codes to a new world of interchangeable electronic data and consistent, national provider ID codes. From a data perspective, that is revolutionary. It's a huge change.

There are, as I noted earlier, two major potential users for that new data. That new data flow can create longitudinal databases for each individual patient in the form of a Personal Health Record (PHR) and it can also create communitywide databases that can be used to

If we really believe that data is the essential first step for any continuous improvement process or model, then the importance of having a single, unique longitudinal numerical code for each provider becomes glaringly obvious.

track patterns of care and caregiver performance.

Pulling electronic claims payment data out of paper-based insurance company files and making it available for measurable process improvement is a huge step forward for health care reform. We are at the first stages of that process, but I expect it to unfold very quickly once the database is available.

Again, the very best, most complete, and most useful database about patient care is the electronic health record. The number of providers putting those complete automated medical record systems in place is growing rapidly. But many smaller provider sites are still several years away from having those full electronic health record systems operational. In the meantime, however, as I described in earlier chapters, a lot of heavy lifting on health care accountability and reform can be done using the new electronic database created by the claims payment process and facilitated by HIPAA, the single provider ID number, and the new industry accords on data portability.

4. Governmental Transparency About Payment Data

A fourth major new element that enables and encourages reform is the unprecedented recent willingness of the government to create much greater levels of transparency about provider performance data using information from the current Medicare and Medicaid databases. The government has historically been both relatively secretive and extremely selective in its use of that data. The current administration is calling for a broad and sweeping transparency—a new level of data sharing from the government that could quickly prime the pump for important comparisons of provider performance.

In an Executive Order of August 22, 2006, the White House stated the following:

It is the purpose of this order to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers. It is the further purpose of this order to make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector.⁵

That is another revolutionary development. Medicare is the largest single purchaser of care in America.⁶ To make that massive Medicare database about provider

performance transparent is a huge step toward real market reform. That work isn't done yet, but it is now underway—and the enlightened intentions of the senior policy makers are pretty clear.

5. Universal Awareness of the Quality Issues

The fifth major development that is making health care reform possible now is the emergence, finally, of a widespread awareness across policy makers, politicians, buyers, care providers, and patients that our current health care infrastructure is badly flawed, perversely incented, inadequately coordinated, incredibly inconsistent, strategically unfocused, and too often dangerously dysfunctional. The powerful and persuasive Institute of Medicine studies⁷ combined with John Wennberg's work at Dartmouth⁸ and Beth McGlynn's work at RAND² have shown beyond any doubt that our health care delivery infrastructure nonsystem leaves a lot to be desired.

Until recently, quite a few health care policy makers wanted somehow to restructure health care to get back to some level of entirely mythical "good old days"—the days when Marcus Welby-like physicians knew everything about care and made great, science-based decisions for each patient with no interference from any outside influences like health plans, government regulations, or scientific, performance-tracking databases.

Now, everyone knows that the world of unstructured care has given us a real quality chasm to cross—and a lot of people are ready for someone to design and build a bridge across that chasm. People are ready for some level of reform.

A number of recent reformers have believed and hoped that if patients had to pay part of the bill then somehow—with no actual performance data of any kind—those patients would be able to make important decisions about caregivers in ways that would reward the best caregivers and introduce real market forces to health care. That theory is turning out to have some shortcomings. Deductibles obviously do not magically create data. Even financially incented, uninformed consumers have a hard time making truly informed choices. That's the bad news.

There is also some very good news associated with that particular high-deductible-benefit design experiment. One unintended positive consequence of test-

People have begun to appreciate how little data people have to make important care decisions.

ing those high-deductible plans was that people who wanted to make informed choices became very aware that they had no real information to use in making those choices.⁹ People have begun to appreciate how little data people have to make important care decisions.

People who know health care well now understand that those good old Marcus Welby days were an illusion and that the health care nonsystem we have today is too data free, too often uncoordinated, too often outdated, usually badly structured, and even dangerous for far too many patients. The needs of the quality agenda for American health care are becoming very clear. Simply asking patients to make more choices won't create a marketplace based on best medical science. Buyers, patients, policy makers and even care providers are all beginning to understand those realities.

The public trust has also been shaken by incidents like the Vioxx recall in 2004¹⁰ and by a series of visible care direction missteps—like discovering that hormone replacement therapies for women did more harm than good¹¹ or that autologous bone marrow transplants for women with breast cancer made the death process more painful for the patients and added no length to those women's lives.^{12,13}

Markets and industries do not change when customers aren't ready to change.

So we have reached a point where large numbers of people are ready to look at change because there is a growing belief that the current pathway is both unaffordable and too often dysfunctional and even unsafe.

Timing is everything. People are losing faith in the old quality agenda for care right at the point when a new agenda is possible.

6. Buyers Are Ready For A Change

In that vein, the sixth major factor that will accelerate the agenda for change is that the primary buyers of health care—the employers and government bodies who already purchase large quantities of health care—are now very ready for a change. It's hard to find a happy buyer. Companies look at how much their employees' and retirees' health care actually costs and they compare those costs to their competitors in other countries. For cars made in the US, health care costs not only exceed the cost of steel—health care costs just for the retirees from American auto companies now exceeds the cost of steel in each car. In 2005, GM spent \$5.3 billion on health care; \$4 billion covered retirees and their families.¹⁴ Annual steel costs are about \$3 billion.¹⁵ The price tag of every GM car built in the United States includes \$1525 just for the health care of 1.1 million employees,

retirees, and their families. Contrast this to the portion of a Toyota sticker price that accounts for health care: \$97 for every vehicle built in Japan and \$400 to \$425 for each vehicle produced in the US.¹⁶

Buyers are ready for new answers. So are the government agencies that pay for government employees, as well as the government agencies that provide increasingly expensive health care to public program beneficiaries. This is actually a major sea change for the marketplace. It is needed.

Many employers over the past five to ten years have insisted that stricter versions of available cost containment approaches not be applied to their employees—and many employers relatively recently refused to allow their health plans or benefit administrators to restrict access to certain providers and rejected proposals to channel patients to a select group of proven, cost-effective caregivers. Those particular buyer constraints are fast fading away, and buyers are now cutting benefits and imposing coverage eligibility restrictions. Many are now considering using more tightly managed care networks to significantly reduce costs. On a more drastic level, many buyers are now canceling or freezing health care coverage for their retirees, and, sadly, large numbers of smaller employers are even dropping employee coverage all together. Less than half of all firms with less than ten workers now offer health benefits, compared to more than 90% of firms with 50 or more employees.¹⁷

It's a time of change for many buyers. Buyers are ready for new answers—answers that work. That readiness makes change possible. Markets and industries do not change when customers aren't ready to change. In this case, the buyers are now ready for change a bit before the vendors have figured out how to change. Reform will be possible when that happens. Vendors will, I expect, rise to the occasion. That's how markets work.

7. Internet Functionality Used for Care

The seventh major factor that is currently strongly enabling an environment of change in health care is the Internet. The Internet has already had a huge impact on other areas of the economy. Purchasing, banking, investing, and education are all areas where the Internet has made massive inroads into how we do business.

Health care is poised to follow. Health and medical Web sites receive the highest number of visits from search engines.¹⁸ As an evolving health care economy learns to use the Internet more effectively, we will soon see more doctor/patient e-connections. E-scheduling, e-visits, e-follow-ups and reports, and e-reminders about

needed care all are rolling out now in various places.

The future scope and volume of e-visits and e-connections will, I believe, exceed almost everyone's expectations. Patients will have various kinds of innovative and easy-to-use testing equipment in their homes and will be making e-connections with their caregivers in multiple ways. The current explorations into supporting some levels of in-home care will, I believe, explode over the next several years as the population ages and the availability of some levels of face-to-face or institutional care become problematic.

That's a longer-term view. The short-term view involves a lot of Internet use fairly quickly.

The new market model for health care will rely heavily on the Internet, as patients both choose real live caregivers based on e-data and then get quick and convenient electronic advice about their care from e-consultants. The very best versions of the new market model will rely on the Internet to get information to patients and to caregivers and to facilitate patient choices relative to caregivers, care strategies, care plans, and actual care. Only the computer can facilitate those levels of choices in any workable way. A paper-based, data-rich health care marketplace would be logistically crippled. We need the Web to reform care.

Also, when all patients have electronic PHRs available on the Internet from their payers—and when the PHRs have each patient's diagnosis, tests, prescriptions, and lists of each and every care procedure performed for each patient by each caregiver—patients will be able to plug that electronic PHR information into e-consults, getting virtual second opinions from medical experts in the computerized care business who will be obsessively up-to-date on the best available care options for each diagnosis.

The Internet will make medical science more current. Individual doctors in individual practices may currently have a hard time keeping up with each new scientific development in their specialty, but the new companies and care providers who will sell their services on the Internet to provide e-consults will have "keeping up" with current science as a key value they sell to patients. It will transform care when people with asthma bring e-consult printouts to their real-life, in-the-flesh caregivers, to ask why a particular drug is or is not being used for their care.

The e-consults will say, "You have asthma. You have been in the emergency room three times this year. There are three good drugs that might be used at this point.

Here's a list of these drugs and their normal retail prices. You seem to be using the most expensive of those three drugs now. You could save \$120 a month by switching to the least expensive drug. Here's the

most recent comparative test data about the relative effectiveness of each of those drugs. Do you have any questions?"

Some very bad medical service is now provided over the Web. Current health care Web sites may be credible, or may be charlatans. My sense is that an industry of credible sites will emerge as an option for many patients.

Even the credible independent e-consultant firms that will be on the Web probably would run into real local license problems if they actually tried to practice free-standing Internet medicine. However, those businesses would probably have relatively easy sailing if they simply shared care protocols, pointed out where current treatment for a given patient differed from those protocols, and then suggested that the patient discuss care options directly with their primary caregiver. Since most primary caregivers will be handling e-inquiries from their own patients over the next several years, the medical issue question-and-answer process for some patients might be entirely electronic—from the patient to the e-consultant through to the live local physicians and then back to the patient.

That level of very direct e-dialogue with patients has the potential to significantly impact the delivery of care. It definitely has the potential to significantly shorten the 17-year time frame that the IOM noted is often the length of time before a new best care approach is uniformly used by all physicians.^{7,19}

The Internet, by itself, will help educate people about their medical conditions and their care. The Internet combined with personal health records, virtual consults, and extensive comparative performance data about various caregivers will probably revolutionize some aspects of care.

Couple that functionality with e-visits, e-dialogue, and direct patient e-connectivity with their chosen caregiver or care-teams, and it's easy to see how health care reform could—and will—be significantly e-impacted.

The best care systems will offer e-connectivity to their patients in ways not even dreamed of today. E-visits will be an expectation, a basic level of patient/provider interaction that will allow for whole new levels of care convenience and care growth. Health care will be an e-industry relatively soon.

The future scope and volume of e-visits and e-connections will, I believe, exceed almost everyone's expectations.

8. Lawmakers are Ready for Reform

The final new development that will allow real health care reform to happen is the fact that lawmakers in a great many states have also hit the tipping point on the need for real care reform.

State legislative budgets are being destroyed by the increasing costs of care. Emergency rooms are closing, and innercity hospitals are imperiled. The number of uninsured Americans continues to grow, and the number of underinsured Americans may be growing even faster as high-deductible health plans increase in number.²⁰ Too many of the purely uninsured people do not vote, so it's far too easy for elected officials not to hear their voices.

Underinsured people vote and they are getting angry.

Underinsured Americans, however—people who are insured but face out-of-pocket costs that are high relative to their incomes²⁰—can create a major new political backlash because underinsured people tend to be fully employed people,²⁰ who are more likely to vote.²¹ Underinsured people vote and they are getting angry. When enough are angry, they will be heard.

So state after state is now aiming at some kind of health care reform, usually targeted at the twin goals of increasing the number of insured people while cutting costs.

So far, there has been a major shortage of proposals that can meet both of those two goals of increasing the number of insured while cutting costs—but the momentum across the country to pass legislation of some kind to make that kind of progress shouldn't be underestimated. Leaders in legislatures and governors' mansions are ready to act, as are labor unions and major employers—once a solid course of action becomes clear.

So buyers are ready, labor unions are ready, consumers are ready, politicians are ready, academics are ready, and even some caregivers are ready. We now have the potential of a new electronic database that could serve as the foundation for systematically improving many areas of care. How do we get those eight developments to merge into a single agenda to reform care?

An Optimal Health Care Market

Let's revisit one more time what an optimal health care marketplace might look like. As business guru Stephen Covey says, "Begin with the end in mind."²² What do we want to see in our care delivery system?

- *Consumers should have complete and easy electronic access to their own health information.* A patient should be able to find which medications

they have been prescribed, which doctors they have seen recently, and which procedures they have had done over their lifetimes. It's amazing, but consumers don't have an easy way to access this information now.

- *Consumers should have complete and easy electronic access to the information they need to make informed decisions about their caregivers.* A patient needing knee surgery should have data available to figure out which surgeons are most likely to achieve a satisfactory result. A patient with asthma should know which teams of caregivers are most likely to manage the disease successfully and help the patient avoid the asthma attacks that undermine the patient's quality of life and sometimes threaten life, itself.
- *Consumers should have complete and easy electronic access to the information they need to make informed decisions about their care.* A patient with heart disease should be able to find out what complications others have experienced from bypass surgery. Patients with asthma should know what drugs are available to best treat their particular triggers. Patients should have the opportunity to get consultations electronically about various approaches possible for their care.

Ideally, consumers should be empowered and educated, supported and encouraged in receiving best care and in making the lifestyle choices that support their own best possible personal health.

Care should be accessible and affordable, with patients having enough appropriate involvement in the cost of care to encourage wise choices by the patients and competitive prices by the caregivers.

Consumers should be able to have confidence that their own caregivers are current relative to medical science and best care and obsessively conscientious about the follow-up needed for their care.

It's not hard to figure out what the ideal health care marketplace might look like. The challenge is to actually make it happen. Someone needs to actually provide the data flow processes and communication infrastructures needed for patients to make those informed choices. The pieces can all be assembled from available components. The need is for a market model that will reward the vendors who can functionally make that infrastructure happen.

The next chapter deals with why market forces have not worked well in health care up to now. The chapter after that suggests a new market model that might work to actually meet our needs for a better system.

For now, the point I'd like to make is that the emergence of a single provider number, electronic personal health records, data portability, and a sense by key parties that change is really needed all work together to set up the best environment and opportunity we've ever had for real health care reform in America. We just need to be very clear on what that reform should be. And we should be clear that we need that reform now. ❖

Copyright ©2007 by John Wiley & Sons, Inc. Reproduced by permission of Jossey-Bass, an imprint of Wiley.

References

1. Rhoades JA. MEPS statistical brief #130: The uninsured in America 1996-2005: Estimates for the US civilian noninstitutionalized population under age 65 [monograph on the Internet]. Rockville (MD): Agency for Healthcare Research and Quality; US Department of Health and Human Services; 2006 Jun [cited 2007 Mar 27]. Available at: www.meps.ahrq.gov/data_files/publications/st130/stat130.pdf.
2. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003 Jun 26;348(26):2635-45.
3. Centers for Medicare and Medicaid Services. National provider identifier standard (NPI) overview [monograph on the Internet]. Baltimore (MD): US Department of Health and Human Services; [cited 2007 Mar 27]. Available from: www.cms.hhs.gov/NationalProviderStand/.
4. Department of Health and Human Services. Health insurance reform: standards for electronic transactions [monograph on the Internet]. *Federal Register* 2000 Aug 17 [cited 2007 Mar 27]; 65 (160):50312-72. Available from: <http://aspe.hhs.gov/admsimp/final/txfin00.htm>.
5. Bush GW. Executive order: Promoting quality and efficient health care in federal government administered or sponsored health care programs [monograph on the Internet]. Washington (DC): The White House; 2006 Aug 22 [cited 2007 Mar 27]. Available from: www.whitehouse.gov/news/releases/2006/08/20060622-2.html.
6. Iglehart JK. The Centers for Medicare and Medicaid Services. *N Engl J Med* 2001 Dec 27; 345(26):1920-4.
7. Institute of Medicine, Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century [monograph on the Internet]. Washington (DC): National Academy Press; 2001 [cited 2007 Mar 27]. Available from: www.nap.edu/catalog/10027.html.
8. America's health rankings: a call to action for people and their communities [monograph on the Internet]. United Health Foundation: Minnetonka (MN); 2006 Dec 5 [cited 2007 Mar 27]. Available from: www.unitedhealthfoundation.org/ahr2006/index.html.
9. Zwillich T. Patients spend from health savings accounts while uninformed. New York: Medscape [serial on the Internet] 2005 Apr 21 [cited 2007 Mar 27]. Available from: www.medscape.com/viewarticle/50372.
10. Merck announces voluntary worldwide recall of Vioxx® [news release on the Internet]. Whitehouse Station (NJ): Merck and Co; 2004 Sep 30 [cited 2007 Mar 27]. Available from: www.vioxx.com/vioxx/documents/english/vioxx_press_release.pdf.
11. Rossouw JE, Anderson GL, Prentice RL, et al; Writing Group for the Women's Health Initiative. Risks and benefits of estrogen plus progestin in health postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. *JAMA* 2002 Jul 17;288(3):321-33.
12. Rodenhuis S, Bontenbal M, Beex LV, et al; Netherlands Working Party on Autologous Transplantation in Solid Tumors. High-dose chemotherapy with hematopoietic stem-cell rescue for high-risk breast cancer. *N Engl J Med* 2003 Jul 3;349(1):7-16.
13. Tallman MS, Gray R, Robert JN, et al. Conventional adjuvant chemotherapy with or without high-dose chemotherapy and autologous stem-cell transplantation in high-risk breast cancer. *N Engl J Med* 2003 Jul 3; 349(1):17-26.
14. Isidore C. Doctor's orders: GM, UAW cut deal. *CNNMoney* [serial on the Internet]. 2005 Oct 17 [cited 2007 Mar 27]: [about 4 p]. Available from: http://money.cnn.com/2005/10/17/news/fortune500/gm_wagoner/.
15. Corbett B. GM aims to hold down steel costs. *Ward's Auto World* 2003 Jul 1.
16. French R. GM, nation losing out to health care. *The Salt Lake Tribune* 2006 Oct 28. Article ID: 4567855.
17. Health insurance premium growth moderates slightly in 2006, but still increases twice as fast as wages and inflation [press release on the Internet]. Menlo Park (CA): The Henry J Kaiser Family Foundation; 2006 Sep 26 [cited 2007 Mar 27]. Available from: www.kff.org/insurance/ehbs092606nr.cfm.
18. Health and medical Web sites received highest percentage of visits from search engines last week [press release on the Internet]. New York: Hitwise; 2006 Oct 17 [cited 2007 Mar 27]. Available from: www.hitwise.com/press-center/hitwiseHS2004/us-category-search-10172006.php.
19. Balas EA, Boren SA. Managing clinical knowledge for health care improvement. In: *Yearbook of Medical Informatics*. Bethesda (MD): National Library of Medicine; 2000. p 65-70.
20. Schoen C, Doty MM, Collins SR, Holmgren AL. Insured but not protected: how many adults are underinsured? *Health Aff (Millwood)* 2005 Jan-Jun; Suppl Web Exclusives: W5-289-W5-302. Available from: <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.289?ijkey=1hR6oh4Hhh2jc&keytype=ref&siteid=healthaff>.
21. Bass LE, Casper LM. Are there differences in registration and voting behavior between naturalized and native-born Americans? [monograph on the Internet]. Washington (DC): Population Division, US Bureau of the Census; 1999 Feb [cited 2007 Mar 27]. Available from: www.census.gov/population/www/documentation/twps0028/twps0028.html.
22. Covey SR. The seven habits of highly effective people: powerful lessons in personal change. New York: Simon and Schuster; 1989.