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Pressure to reduce repeat C-sections can have consequences for outcomes

Preventing primary cesareans now preferred approach

Amid growing pressure to reduce cesarean rates, the American College of Obstetricians and Gynecologists (ACOG) in Washington, DC, is urging physicians to take a more cautious approach toward vaginal births after cesarean (VBACs). Instead, leading obstetricians are advocating more modest changes in labor management that can prevent primary cesareans.

ACOG's revised *Practice Bulletin* on VBACs and an accompanying news release take aim at aggressive health plan policies: "Because individual risk factors must be considered, ACOG rejects as inappropriate any 'global mandates' by third parties for a trial of labor after a previous cesarean delivery."

The ACOG bulletin reflects concerns that overreaching policies towards VBACs can lead to poor outcomes. Last spring, the *Los Angeles Times* reported that a county hospital's policy of requiring a trial of labor in virtually all cases led to $24 million in legal settlements for fetal injuries and deaths. The hospital currently restricts or discourages VBACs in certain circumstances and requires signed consent for all women who choose vaginal deliveries after cesareans.

"Over the past two to three years, there were increasing reports of

EXECUTIVE SUMMARY

As concerns emerge about policies that require all women to undergo a trial of labor before repeat cesareans are performed, efforts to reduce cesarean rates are turning toward an emphasis on better labor management.

- The American College of Obstetricians and Gynecologists in Washington, DC, has released an updated *Practice Bulletin* urging a more cautious approach toward vaginal births after cesarean.
- The "Healthy People 2000" project set a national goal of reducing cesarean rates from about 21% to 15%. Rates for the procedure hovered at about 5% until the 1970s.
- The Institute for Healthcare Improvement in Boston recommends ensuring that women have cervical changes and are in active labor before admitting them to labor and delivery.

cases of uterine rupture of patients who were undergoing a trial of labor with a previous cesarean delivery," says **Stanley Zinberg**, MD, MS, ACOG's vice president for practice activities. "These reports became numerous enough, and the impacts of these uterine ruptures were serious enough, to warrant another look at the issue."

Zinberg says he knows of one health plan that required a trial of labor for patients with prior cesareans, which he says is "absolutely against the ACOG policy, which calls for the patient to make this decision."

VBACs, which represent about a third of all cesareans, were once considered a prime opportunity for lowering rates for these procedures. While the ACOG bulletin states that a VBAC may be beneficial for women with a prior low-traverse cesarean, the cautionary tone is likely to lead to fewer attempted VBACs.

"It's a pendulum. Very often things will swing too much in one direction," acknowledges **Bruce Flamm**, MD, FACOG, area research chairman of Kaiser Permanente Medical Center in Riverside, CA, and chairman of the C-section collaborative of the Institute for Healthcare Improvement.

"We went from just a couple thousand VBACs a year a decade ago to 100,000 VBACs a year," he says. "That's a huge change in the course of a decade."

Liability worries fueled C-section boom

Cesareans, which cost about twice as much as vaginal births and carry risks associated with surgery and anesthesia, were relatively rare in the United States until the 1970s. Yet legal concerns and new technologies spurred a growth in the procedures, and by the late 1980s, one in four births occurred by cesarean.[1] **(See chart, p. 143.)**

Physicians now face unprecedented pressure to reduce their rates. Cesarean rates have become a quality indicator of hospitals and health plans measured by the National Committee for Quality Assurance in Washington, DC, and are included in various consumer report cards. The federal "Healthy People 2000" project set a goal nationally of reducing cesarean rates from about 21% to 15%.

Yet that target rate is arbitrary, not based on scientific evidence, contends Zinberg. And it doesn't reflect the individual patient characteristics that affect rates at hospitals and medical groups. "Most people agree that the national cesarean rate is probably too high," he says. "Those who understand the problems related with obstetrical delivery know that a specific benchmark cannot be cited at this time."

Artificial targets can plague physicians, he says. "I've received letters from ACOG members who were threatened with being de-listed because they had a 50% cesarean rate in one month," he says. "They had four deliveries. Two were cesareans. Both were prolapsed cords. There's no intelligent evaluation of what the [cesarean] data represent."

Rates of serious complications related to VBACs remain low — about 1% for uterine rupture, for example. And ACOG continues to recommend VBACs as an option for women with low-traverse scars. But ACOG is underscoring the importance of a patient's informed choice.

"It is ultimately up to the patient and her physician whether to attempt VBAC or undergo a repeat cesarean delivery after thorough counseling of both benefits and risks," says Zinberg.

The answer for many physicians: Prevent primary cesareans with a back-to-basics approach — less reliance on technology, better labor management, and revival of alternative birthing techniques such as breech deliveries.

"A lot of us are working more aggressively on lowering the primary cesarean section so the VBAC issue doesn't come up," says **Barry Smith**, MD, chairman of obstetrics and gynecology at the Dartmouth-Hitchcock Medical Center in Lebanon, NH, and director of the New Hampshire Cesarean Birth Quality Improvement Project.

Small changes can bring results. When the Institute for Healthcare Improvement (IHI) in Boston recently convened a national congress on safely reducing cesarean rates, the recommendations focused on such things as reducing time

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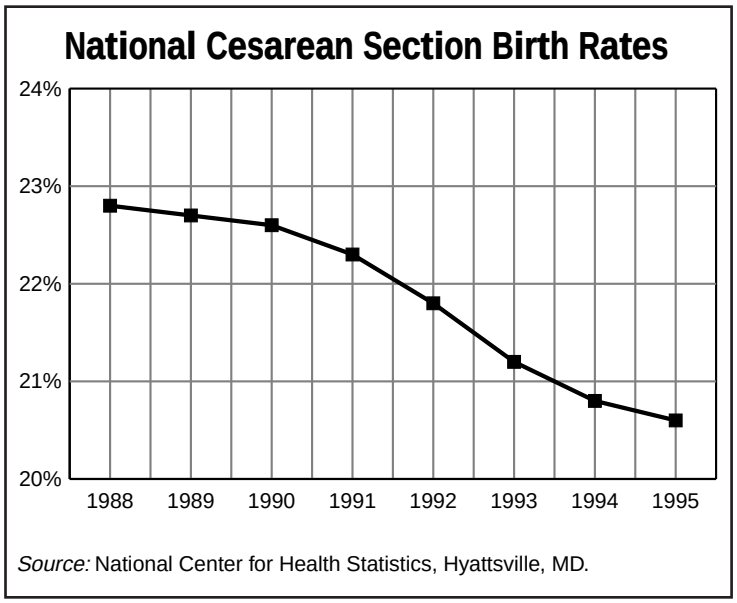


Source: National Center for Health Statistics, Hyattsville, MD.

pressures and making policies more conducive to vaginal birth. **(For a list of recommendations, see box, p. 144.)**

For example, Lawrence (MA) General Hospital reduced its cesarean rate from 26% in 1993 to 17% in 1997, primarily through changes in identifying and managing the active phase of labor, says **Susan Leavitt**, RN, MSN, nurse manager of antepartum and intrapartum services.

Dystocia, or failure to progress in labor, accounts for 35% of all cesareans nationally, and many of them are unnecessary, says Leavitt, who participated in the IHI breakthrough series on cesareans and then became an IHI faculty member. "We focused on why we have had such a high rate of dystocia in the past 25 years," she says. "Women's pelvises shouldn't have changed that much."

Make sure women are really in labor

Many cases of "dystocia" actually involve women who haven't yet attained the active phase of labor — a fact Leavitt and her colleagues found when they analyzed the hospital's labor and delivery practices. "We discovered that we did a lot of latent phase C-sections," says Leavitt. "They had closed cervixes." Physicians performed cesareans after 16 or 20 hours of no progress in the labor and delivery room. "In reality, they weren't ever in active labor to begin with," she says.

Lawrence General now does not admit women unless they are in active labor, which is defined by cervical change.

Dartmouth-Hitchcock Medical Center also implemented guidelines designed to reduce cesareans due to lack of progress. For example, women are encouraged to walk during labor and to get into positions they find comfortable. "We're trying hard to get people not to lie in bed in labor," says Smith. "We're trying to encourage ambulation, which we think allows people to make more progress in labor."

Smith also is involved in training medical residents and other physicians in age-old techniques to avoid cesareans. "In our program, we're going back to teaching and trying to make sure that the skills of forceps delivery are not lost," he says. "There are many patients for whom forceps delivery is appropriate."

Some physicians, including Smith, perform vaginal breech deliveries. The breech option "depends on a lot of factors, including the experience and training and skill of the obstetrician," says Smith.

Physicians bring in second opinion

A focus on policies that lead up to cesareans can create a better working environment in labor and delivery.

New York University Medical Center in New York City studied obstetrical practice for two years and came up with internal best practices and guidelines, says **Jesse Green**, PhD, senior director for clinical evaluation. Physicians also seek a second opinion before performing a cesarean. In reality, physicians "consult with each other all through the process."

Rethinking policies that lead to cesareans can benefit all women in labor, says Leavitt. Overall perinatal morbidity and mortality for infants actually declined from 3.5% to 2.7% during the four years when Lawrence General Hospital focused on reducing its cesareans. Leavitt speculates that the improvement came from overall changes in labor and delivery policies.

"It's back to basics," she says. "It's back to believing that women were created to give birth. You give women the opportunity to do that. You take that technolog, and you use it judiciously.

"We wanted to change the emphasis from reducing section rates to improving the birthing experience," she says.

Reference

1. Flamm BL, Berwick DM, Kabcenell A. Reducing cesarean section rates safely: Lessons from a "Breakthrough Series" collaborative. *Birth* 1998; 25:117-124. ■

Careful analysis needed on C-section rates

One hospital lowered morbidity along with rates

Cesarean rates have become a ubiquitous measure of quality. Health plans report that data and various report cards cite the rates by hospital or medical groups.

Yet without other information, cesarean rates may tell little about the actual obstetrics practice or outcomes. In quality improvement projects, physicians generally track related items, such as indications for the primary cesarean, Apgar scores less than 7 at five minutes after delivery, uterine rupture, and infant injury or trauma.

While complications and fetal injuries or death are rare, tracking negative outcomes allows clinicians to ensure that policies to reduce cesarean rates remain safe, say leading obstetricians.

"You can't just look at the one measure without looking at how it's affecting [other] outcomes," says **Barry Smith**, MD, chairman of obstetrics and gynecology at the Dartmouth-Hitchcock Medical Center in Lebanon, NH, and director of the New Hampshire Cesarean Birth Quality Improvement Project. "If you just show that a hospital had a low cesarean section rate, you have to show they had a low cesarean section rate without complications."

Furthermore, physicians who specialize in high-risk pregnancies would be expected to have

Safely Reducing C-section Rates for Failure to Progress/Dystocia

The following recommendations are from a collaborative of the Institute for Healthcare Improvement in Boston:

1. Better practice

❒ **Avoid unnecessary inductions:**

— Inductions are done only for clear medical indications, such as post 42 weeks.
— Criteria for inductions are agreed upon and used by OB medical and nursing staff.
— Patients who do not enter labor after induction attempt are allowed to go home, unless some other reason forces more intervention.

❒ **Sample targets:**

— Primary C-section rate decreases by 30%.
— C-sections for FTP/Dystocia decrease by 50%.
— Decrease in C-sections following failed inductions by 75%.

2. Better practice

❒ **No C-sections for FTP in latent phase of labor:**

— Patients are not admitted for false labor, or before 3-4 cm dilation, unless they have a risk factor that necessitates admission.
— A triage capacity is available to assess and monitor patients prior to admission.
— OB staff use active labor management, including careful assessment of labor progress, use of oxytocin to augment labor, and guidelines to manage slow progress in the latent phase.

❒ **Sample targets:**

— C-sections for FTP in the latent phase decrease by 100%.
— Admission with cervical dilation less than 4 cm decrease by 75% in low-risk, nulliparous patients.
— Median cervical dilation on placement of epidural anesthesia to at least 4 cm.

3. Better practice

❒ **Alleviate pain:**

— Physicians offer adequate pain relief to patients.
— Nursing staff assess pain and provide a variety of pain relieving techniques (hydrotherapy, positioning).
— Epidurals are used judiciously, and placement is often delayed until 4 cm dilation. A walking epidural is available.

❒ **Sample targets:**

— Patients stating that their pain was the key factor in wanting a C-section decrease by 50%.

4. Better practice

❒ **Support every patient in labor:**

— Patients receive 1:1 labor support from nursing staff, doulas, or midwives.
— Patients are encouraged to ambulate and are given oral fluids during labor.

❒ **Use patience:**

— Allow patients in second stage of labor to "rest in descent," delaying pushing until the patient feels the urge to push.
— Eliminate arbitrary time deadlines for second stage of labor.

higher rates, notes **Jesse Green**, PhD, senior director for clinical evaluation at New York University Medical Center in New York City. However, the Health Plan Employer Data and Information Set (HEDIS) of the National Committee for Quality Assurance in Washington, DC, doesn't risk-adjust its data.

"You can't look at somebody's C-section rate and say from that that they're doing too many or too few," says Green. "It depends so much on the type of patients that they see."

The Pacific Business Group on Health in San Francisco uses 15 risk-adjustment categories to filter out appropriate and necessary cesareans, so that patient medical history and risk factors are taken into account. Those risk-adjusters include:

- ✔ breech presentation;
- ✔ previous cesarean;
- ✔ antepartum infection;
- ✔ antepartum hemorrhage for women older than 35 and for women younger than 35;
- ✔ other malpresentations;
- ✔ multiple delivery;
- ✔ fetal distress for women older than 35 and younger than 35;
- ✔ hypertension;
- ✔ postdate pregnancy;
- ✔ prolonged ruptured membranes;
- ✔ diabetes;
- ✔ dystocia.

"Even after controlling for this, we're seeing huge variations in C-section rates at hospitals," says **Anne Castles**, MA, MPH, senior project manager for the Pacific Business Group on Health. "If that variation is not explained by these risk-adjusters, that's when you start wondering." ■

Better health plans report quality data

Poor performers still able to avoid scrutiny

Here's evidence that health care accountability works: Health plans that publicly report quality data not only perform better, but they show more improvement than those that don't, according to a recent report from the National Committee for Quality Assurance (NCQA) in Washington, DC.

Unfortunately, plans with poor performance can still avoid scrutiny simply by declining to release their results. And so far, better performance on quality indicators hasn't guaranteed plans or medical groups a competitive advantage.

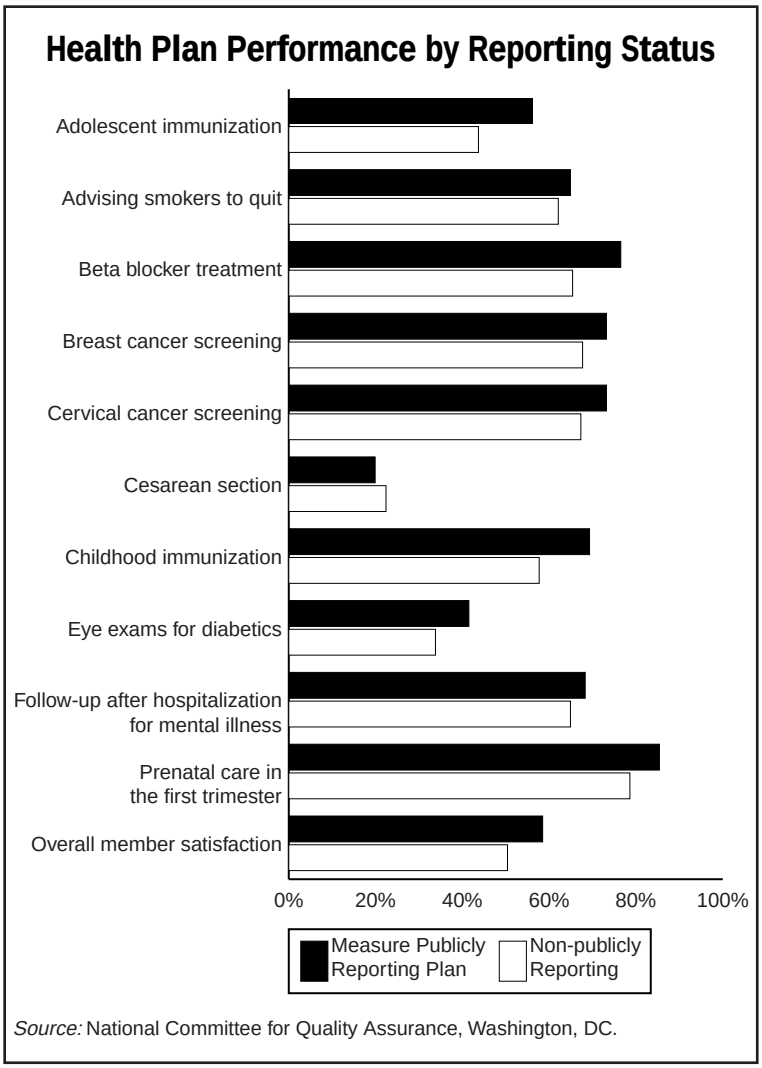
While an estimated 90% of the country's 650 health plans collect at least some Health Plan Employer Data and Information Set (HEDIS) data and 447 reported 1997 HEDIS results to NCQA, only 330 pursue accreditation, and only 292 allowed their data to be made public. Meanwhile, preferred provider organizations and indemnity plans do not participate in HEDIS and report no quality information to NCQA or other national bodies.

"I think purchasers and regulators need to be more aggressive in saying we're going to get the same information about everyone," says **Andrew M. Wiesenthal**, MD, associate medical director of Colorado Permanente Medical Group in Denver

How satisfied are patients with their health plans?

When asked about overall satisfaction with care, 55.7% of health plan members surveyed said they were "completely" or "very" satisfied with their care, the National Committee for Quality Assurance in Washington, DC, stated in its *1998 Quality Compass* report. Here are some specific findings:

- ☐ Members who did NOT have a problem with delays in their medical care while they waited for approval by their health plans — 82.2%
- ☐ Members who did NOT have a problem getting a referral to a specialist that they wanted to see — 81.2%
- ☐ Members who did NOT have a problem receiving care they and their doctors believed was necessary — 85.3%
- ☐ Members who rated the plan as very good or excellent on the availability of information from their plan about eligibility, covered services, or other issues — 38.0%
- ☐ Members who rated the plan as very good or excellent on the number of doctors they had to choose from — 41.7%
- ☐ Members who rated the plan as very good or excellent on the length of time they had to wait between making an appointment for routine care and the day of the visit — 41.1%
- ☐ Members who rated the plan as very good or excellent on the ease of making appointments by phone — 53.1% ■



Source: National Committee for Quality Assurance, Washington, DC.

and a member of the NCQA board of directors. "If you can't provide the information, [regulators should say] you can't provide the services."

George Isham, MD, medical director and chief health officer of HealthPartners, a managed care organization based in Minneapolis, believes the trend is moving toward greater accountability. He notes that 121 plans allowed their data to be released for the first time this year. "I think people are paying attention to these numbers," he says. "I think this is a matter of momentum and building. It's moving in the right direction."

Variation remains high

As in last year's report, the *1998 Quality Compass* data again showed a huge variation between the highest and lowest performing plans. For example, rates of beta blocker treatment for patients experiencing a heart attack ranged from 52% to 92%, with a national average of 74%. On average, plans publicly reporting their data outperformed their counterparts by more than 10%. Overall, New England outperformed other regions in the country.

Patients were more likely to say they were "completely" or "very" satisfied with care from plans that publicly reported data (58.5% vs. 50.4%) and those publicly accountable plans performed better on every HEDIS measure. **(See chart, at left. For more information on the study, see related story, p. 145.)**

Physicians often find fault with HEDIS as an assessment of quality care, pointing out that most indicators measure a process of care, such as screening patients for breast cancer, rather than an outcome, such as lower stage of cancer at diagnosis and better survival rates. NCQA points out that better cancer screening and beta blocker treatment can save lives. And at the same time, NCQA acknowledges that HEDIS is a work in progress.

"This is a beginning step, an exceedingly important step," says **Gary Krieger**, MD, a San Pedro, CA, pediatrician and representative on the PMCC, commenting on the *Quality Compass* results. "We must refine it so the consumer and the purchaser of health care can make informed decisions."

"You can point up many fallacies in what's being reported," acknowledges Krieger. "But we are constantly improving."

In fact, overall, plans showed little progress on 10 effectiveness of care measures, including mammograms, immunizations, cervical cancer screening, and prenatal care. But plans that publicly reported their data for the past two years did show significant improvement. For example, plans that report data improved their adolescent immunization status from 53.6% to 57.8%.

Unfortunately, most purchasers and consumers aren't yet attuned to the quality indicators. That means there is little pressure on poor performers and few advantages accruing to the high performers. Isham notes that some large employers, such as General Motors and Xerox, are rewarding better-performing health plans. But that trend is far from widespread.

"I think purchasers and regulators need to be more aggressive in saying, 'We're going to get the same [quality] information about everyone,'" says Wiesenthal.

Despite talk about "value-based purchasing," he says his group model HMO has yet to see marketplace benefits from its quality data.

"We have comparable [premium] rates to major competitors in our market and demonstrably better quality on the public measures," says

Wiesenthal. "People ought to be beating my door down to become members. Big employers ought to be insisting that we're one of their offerings."

They're not, he adds. But Wiesenthal remains optimistic that the health care market will become more focused on quality. "I like to see the good things that appear about us in the press when these reports are released," he says. "I'd like to think it helps [competitively], but there are no data that it does." Still, he says, "In the long run, it's going to be what [matters]."

Medical groups need incentives

Even fewer independent medical groups collect and report HEDIS data, notes Wiesenthal. The California Cooperative HEDIS Reporting Initiative (CCHRI) will begin public reporting of HEDIS rates by medical groups next year.

Leaders of the medical groups involved with CCHRI are committed to accountability, says **Alfredo Czerwinski**, MD, a principal with Lawson & Assoc. consulting firm in Sacramento and a member of the executive committee of CCHRI. But currently those groups see little material benefit to their involvement.

"The overarching issue is this: Will the group end up getting 10,000 more covered lives after it goes through all the work of pulling the charts, calculating the measures, and publishing the data?" says Czerwinski, who specializes in physician organizational development and quality improvement. "Will some economic advantage accrue to those who take the trouble to publish and have good scores?"

Slowly, NCQA and other organizations are trying to expand the scope of performance assessment. In 1999, all plans that seek accreditation must report HEDIS data that are verified by an approved auditor. Business coalitions such as the Pacific Business Group on Health are reporting information from patient surveys on medical group report cards.

"There is no question that the movement is going toward much more accountability of all segments of health care," says Krieger. ■

Hard lessons: Texas docs wrestle with measures

Coalition lets physicians set the indicators

Like many of their colleagues around the country, physicians in Dallas and Fort Worth, TX, were wary of "quality measures" they felt had little to do with quality care. So when a major business coalition offered to let them craft their own indicators and assessment tool, the physicians jumped at the chance.

Those doctors learned that defining and measuring good medicine is not an easy task. And after a pilot project involving some 30 OB/GYNs, the Dallas County Medical Society is back to the drawing board, revamping the data collection instrument.

"We wanted to make sure that the criteria that were used were really an indication of the good practice of medicine, rather than just having something that is easy to survey," says **Robert Gunby**, MD, a Dallas OB/GYN and president of the medical society.

But as the physicians attempted to analyze variations in office-based prenatal practice along with birth outcomes, the form became lengthy. "It was so complex and so difficult to answer and get correct information that we felt it was really not going to be utilized by most physicians," says Gunby. "It was taking 45 minutes to an hour for each patient to code someone. As a practical matter, that was not going to work."

Perhaps the greatest accomplishment of the project so far has been the relationship among the business group, health plans, hospitals, and physicians. A separate group of physicians is just beginning work on cardiovascular measurement.

"We spent two years building a relationship of trust with the physicians," says **Marianne Fazen**, PhD, executive director of the Dallas-Fort Worth Business Group on Health, which includes such major employers as Texas Instruments, JCPenney Co., and Exxon Corp. "We're really confident now that we're partners in this."

The Health Care Value Initiative began in 1995 with a focus on employers' concerns, which they identified, in order, as:

- pregnancy and childbirth;
- cardiovascular disease;
- musculoskeletal problems;
- mental health and substance abuse;
- cancer.

"The employers are interested in value-based purchasing," says Fazen. "We want to know we're getting the best quality for the right price."

But the coalition also wanted to approach the

project as a true collaboration without any negative or potentially punitive overtones. The baseline results of indicators for the area's 45 hospitals were expected in December, including cesarean rates, infection rates, uterine rupture, and unplanned neonatal readmissions. Hospitals received their individual measures, but all the aggregate results were blinded to the coalition and others.

"We wanted to assure the hospitals and the physicians that we want it done right," says Fazen. "By agreeing to mask the baseline information, [we're giving] them the opportunity to correct problems. Down the road, all the hospital comparative reports will be made public."

The coalition moved even more cautiously with the physicians, who sought to measure variation in office-based practice. The project encompassed routine blood pressure and abdominal measurements as well as treatment of problems such as preeclampsia and gestational diabetes.

Physicians will decide whether to release their rates to health plans, employers, or consumers. "It's a completely market-based initiative," explains Fazen. "Ultimately, the physicians who choose not to participate will be answerable to their patients and the community as to why they didn't."

For physicians, the Health Care Value Initiative prompted discussions about what constitutes quality care and how to measure it. "We wanted to be sure that the criteria that were used were really an indication of the good practice of medicine, rather than just having something that is easy to survey," says Gunby.

It was easy to find fault with commonly used indicators. "Everybody uses C-section rates. Most of us feel C-sections are not really an indication of quality of care," says Gunby. "It's really more a measure of physician attitude about how much risk aversion they have."

The physicians were interested in learning about differences in their office-based prenatal practices. But, again, defining a standard of quality was difficult. "We can't come to agreement on what significance it is, whether you have 12 prenatal visits or six," says Gunby.

Nonetheless, a core group of physicians moved forward with a data collection tool, gathering data retrospectively from the 30 most recent charts.

In some regards, the project confirmed some fears that physicians have about the validity of "report cards." For example, Gunby noted that in some cases, the hospital data counted a patient's cesarean to one doctor when it was actually performed by a colleague on duty at the time.

The quality of the data also related to the experience of the person filling out the form. Gunby says he had his secretary complete the form, but she didn't understand all of the items. "She put down some of the wrong answers, [such as saying] I didn't do genetic counseling, which I do," he explains. "Since it's a pilot program, that's not critical. If that were being done for real and that data were going to be released, I would be real upset."

While some aspects of the Dallas project were discouraging, the physician input proved valuable. Gunby recalls that the vendor developing hospital indicators planned to risk-adjust the data based on socioeconomic information. In other words, since women with higher socioeconomic status tend to have more cesareans, the rates would account for that. There is no medical justification for that disparity, says Gunby.

"They were giving artificial risk benefits for something that had been erroneous to start with," he says. "That was giving people permission to do the wrong thing for the wrong reasons." Gunby also has advice for other physician groups that seek to design their own performance assessment projects: "Don't get into such a complex research tool that it's impossible [to implement].

"You just have to start somewhere, pick some indicators, go with it, and alter it as you go," he says. "Physicians are bad about wanting to do everything to perfection, and sometimes that bogs us down." ■

Free help is available with outcomes measures

Imagine your medical group could obtain this help free of charge: nurses to abstract outcomes data from patient charts, outcomes experts to analyze data and provide comparisons, or feedback sessions to discuss interventions, education, and consensus-building.

Would you jump at that offer? Peer review organizations around the country hope you will.

Armed with contracts from the Health Care Financing Administration to improve care for Medicare patients, these organizations are developing collaborative projects with medical groups and other providers. If you have the desire for

Ohio Diabetes Project Indicators

Demographics	Percent of all Visits	Percent of patients with one or more per year
● Age ● Gender ● Insulin-treated	● Hypoglycemia ● Dietary advice ● Weight measurement ● Foot exam	● Diabetes education ● Fundoscopic exam ● Ophthalmology referral ● HbA1c test ● Cholesterol screen ● Urinalysis ● Dietetic referral

Source: Ohio Diabetes Project for Peer Review Systems, Columbus.

quality improvement, they will provide the means.

"We do the project design, data collection, analysis, feedback sessions. We assist them with quality improvement plans, and we provide them with tools to use in their interventions," says **Linda Gaskell**, RN, CPHQ, project manager of the Ohio Diabetes Project, a program of Peer Review Systems (PRS) in Columbus. "We offer them a lot. Most physician offices have scant resources when it comes to quality improvement."

The Ohio Diabetes Project provides an example of such a collaborative. So far, 12 medical groups have signed on to measure and seek to improve on 12 indicators, which include patient education, HbA1c and cholesterol testing, foot exams, and ophthalmology referrals. **(See box, above.)**

As the first groups completed their remeasurement after a year-long period of intervention, initial results show improvement. As PRS completed the interim remeasurement for the first groups, after six months of intervention, initial results show improvement. While their identities remain confidential, other medical groups will learn of their successes through blinded reports on baseline and remeasurement data, says **Stephani J. Wilmer**, community relations manager for PRS.

"We're able to identify the collaborators who have the best practice and highlight that practice," she says.

Collaboratives such as the Ohio Diabetes Project represent a fundamental shift from retrospective review of Medicare care that occurred several years ago to a proactive approach. "We've always been concerned with the quality of health care provided to Medicare beneficiaries," says Wilmer. "The method we use to assess and help improve that care has changed."

The Ohio Diabetes Project actually began when a medical group approached PRS with a proposal. Their officials also had been considering a focus on outpatient diabetes care. "We formed a study group of diabetes experts from Ohio," says Gaskell. "We developed the study design and methodology, the data collection tool, the definitions."

The indicators were based on practice guidelines from the American Diabetes Association and are updated to reflect any changes. Medical groups receive free intervention tools that may help them improve their care: Checkpoints, a flowchart that is attached to the patient record, and Checkmate, an educational tool that allows patients to track their needed care. **(See sample copies, inserted in this issue.)**

Once the project design, methodology, and data collection were completed for the first medical group, PRS began soliciting new collaborators. There is no limit on the number of Ohio medical groups that can participate and no time limit on the life of the project. "Every time a collaborator comes on board, we consider that a separate project with them," Gaskell says. "We look at one-year periods of care because a lot of [diabetes] indicators are based on annual events."

Foot exams for diabetics were inconsistent

As PRS gathered baseline data, one consistent opportunity for improvement arose: On average, only 24% of diabetic patients received a foot exam at all visits. Gaskell recommends medical groups to include that indicator in their intervention programs.

"I think sometimes clinics are surprised at their results because the physicians think they're doing better than what our report may show for a particular indicator," she says. "To stimulate change you need to give physicians comparative data, not just education. You have to show them how they're doing and how they compare to others."

Medical groups in the Ohio Diabetes Project design their own interventions, so they all may make different changes in their processes based on their individual needs. But Gaskell has noticed some basic themes as the first groups show improvement:

1. Ensure physician buy-in before launching your quality improvement project.

One medical group used the small group consensus process to promote physician buy-in, which involves meetings in which physicians first reach agreement on the standards of care. In the case of the Ohio Diabetes Project, many of those standards are set by the American Diabetes Association guidelines.

Then physicians identify the opportunities where they want to improve based on their baseline data. They brainstorm with a focus on barriers and possible solutions. In this case, the group even used a pre- and post-test on ADA standards and attitudes toward practicing using the standards of care, says Gaskell.

2. Involve patients in their own clinical improvement.

Physicians have a better chance of improving both clinical outcomes and quality indicators with the support and interest of patients. The Checkmates tool helps patients monitor their own care, including cholesterol screening, foot and eye exam, and blood glucose.

"[Using the form] encourages patients to become more aware of the kind of care they should be receiving and to get them more involved," says Gaskell. "We suggest that [physicians] ask patients to bring it to every visit.

"There's even a place where patients can list their goals, such as blood sugar level," she says. "They can use this to talk to their doctor."

3. Use a team approach to guide improvement.

The Ohio Diabetes Project requires participating medical groups to appoint an interdisciplinary team to work on improvements. In addition to physicians, that team may include nurses, diabetes educators, and the office manager.

Even simple changes can make a difference, Gaskell noted. For example, the staff person who guides a patient into a room can make sure that patient removes his or her socks. The doctor then will find it easier to conduct a foot exam — and harder to forget. ■

Collaborative will seek to spark best practices

Targets purchasers, consumers, providers

A new national collaborative seeks to spark grass-roots support for quality improvement by promoting best practices even beyond the health care community to purchasers and consumers.

The National Coalition on Health Care in Washington, DC, has teamed up with the Institute for Healthcare Improvement in Boston to launch Accelerating Change Today — For America's Health. The initiative will produce best practices reports and will use various methods, including the Internet, to spread the word.

How to spread the word?

"To a large degree, we felt that information wasn't getting out there to providers, purchasers, and consumers," says **Joel Miller**, MSEd, director of policy for the coalition. "What was needed was an extra push to highlight this information and the success stories."

The coalition, founded in 1990 in the midst of the national health care reform debate, is composed of 90 organizations including corporations, medical groups, unions, consumer and religious organizations, and academic medical centers. The initiative grew out of a report, *As Good as It Should Get: Making Health Care Better in the New Millennium*, commissioned by the coalition and written by **Donald Berwick**, MD, founder and president of the Institute for Healthcare Improvement in Boston.

Berwick cited examples of clinicians and hospitals that have improved care and saved money. But he notes that innovation and quality improvement at individual institutions doesn't spread nationally.

"Not only do the particles of excellence lie lonely, unduplicated, and not spread, but not even one organization has yet had the ability, or perhaps the courage, to collect these many exciting innovations into a new whole," he says.

The coalition plans to release its first report in mid-1999, with a second report by the end of the year. "We hope we will be releasing at least two reports per year," says Miller. "There will be complimentary activities surrounding those reports, such as shorter fact sheets and forums for the media and other groups to highlight the findings."

The coalition also plans to track the use of the reports, although it's not yet clear how that will be done.

Editor's note: For a copy of the report, contact the National Coalition on Health Care, 555 13th St. NW, Washington, DC 20004. Telephone: (202) 637-6830. World Wide Web: http://www.nchc.org. ■

Study to gauge effect of payments, productivity

How do different risk-bearing arrangements with payers impact physician productivity? That's the central focus of a study being conducted by the University of Washington in Seattle and the Center for Research in Ambulatory Health Care Administration (CRASCA) of the Medical Group Management Association (MGMA) in Englewood, CO.

MGMA's research center will analyze data from as many as 500 group practices representing 8,000 physicians and conduct interviews with an administrator, clinical leader, and physicians from 48 medical groups in Washington, Oregon, California, and Wisconsin. The study will compare the effects of capitation, fee for service, and other methods of compensation on provider productivity.

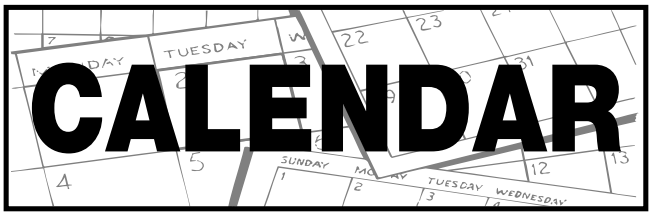
Are patients helped?

The impact on quality of care and clinical outcomes are also important issues that may be addressed in further research, says **Neill F. Piland**, DrPH, CRASCA research director and co-investigator of the study.

"It's not the amount of resources being consumed within the system that is of key importance, but whether the system restores patients to their highest level of health without wasting resources," he says. "That's something we'd like to look at in a future phase."

The study is making use of data collected by MGMA in its annual surveys on physician productivity and compensation and cost.

MGMA recently began collecting data on hours and weeks worked, including time spent with direct patient care, hours in support of direct patient care, and other items (such as research, teaching, and administrative). The organization also collects data on charges, encounters, and resource-based relative value scale units. ■



Improving Efficiency and Access to Care in Physician Offices and Clinics — Dec. 2-3, Atlanta. For more information, contact the Institute for Healthcare Improvement, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4805. Fax: (617) 754-4848. World Wide Web: http://www.ihi.org.

10th Annual National Forum on Quality Improvement in Health Care — Dec. 6-9, Orlando, FL. For more information, contact IHI, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4805. Fax: (617) 754-4848. World Wide Web: http://www.ihi.org.

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CME questions

1. The American College of Obstetricians and Gynecologists in Washington, DC, revised its *Practice Bulletin* on vaginal births after cesarean (VBACs) to state:
   A. VBACs should not be attempted in the majority of cases.
   B. Third-party payers and managed care organizations should not mandate a trial of labor for women who had a previous cesarean.
   C. VBACs are the most promising way to reduce a C-section rate that is too high.
   D. The risks of VBACs outweigh the benefits.

2. Leading obstetricians are focusing on preventing primary cesareans as a way to reduce C-section rate. The techniques include:
   A. Greater use of fetal monitoring and other technology during active labor.
   B. Quicker admission of women in early labor.
   C Ensuring that women aren't admitted to labor and delivery until they're in the active stage of labor.
   D. Providing women with better birthing education.

3. According to *1998 Quality Compass* from the National Committee for Quality Assurance in Washington, DC, how do health plans that publicly report performance data differ from those that do not?
   A. Publicly reporting plans provide more information.
   B. Publicly reporting plans don't fare as well.
   C. Publicly reporting plans have higher performance and show more improvement.
   D. There is no significant difference between the two.

4. What was the major barrier to performance assessment when Dallas and Fort Worth doctors designed their own data collection instruments on office-based prenatal care?
   A. Patients wouldn't fill out required forms.
   B. Physicians didn't want to participate in the project.
   C. Data were incomplete and often unavailable.
   D. It took too long for physicians or staff to complete the forms.