AMERICAN HEALTH CONSULTANTS®

Copublished by The Medical Group Management Association

PATIENT SATISFACTION & OUTCOMES MANAGEMENT™

IN PHYSICIAN PRACTICES

INSIDE

APRIL 1999

VOL. 5, NO. 4 (pages 37-48)

American Health Consultants® is A Medical Economics Company
For more information about MGMA, see www.MGMA.com

Cleveland Clinic, related hospitals pull out of report-card project

Move threatens future of six-year-old Cleveland effort

Criticizing one of the nation's oldest health care report cards as an expensive experiment that ultimately failed, the Cleveland Clinic and its affiliated hospitals have pulled out of Cleveland Health Quality Choice (CHQC), leaving the program's future in doubt.

The move comes even as purchaser coalitions and others work toward creating a national forum to encourage performance assessment and reporting. **(See related story, p. 40.)** And the departure highlights the underlying conflicts and weaknesses that could befall other report-card efforts.

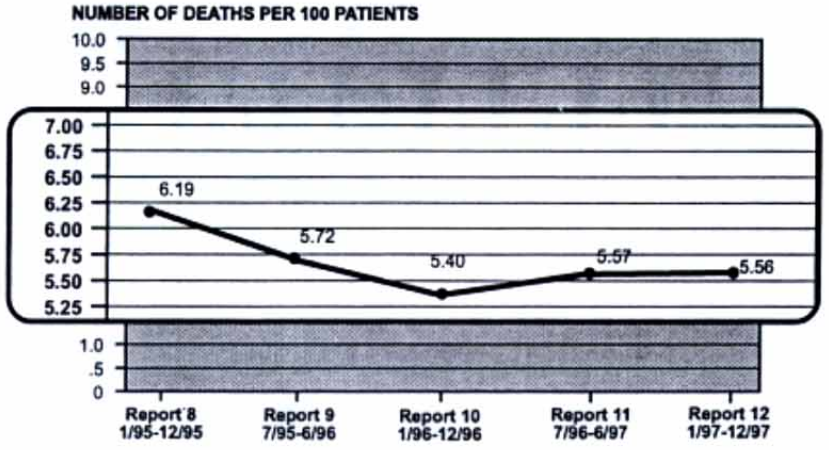
"The biggest issue really is that nobody used it," says **John Clough**, MD, chairman of health affairs for the Cleveland Clinic. "The whole point of this program was to add the dimension of quality to the selection process [of health care providers by purchasers], which had always been based on cost alone," he says. But Clough noted that in five years of reporting data, CHQC had not moved beyond hospital mortality, length of stay, cost, cesarean rates, and patient satisfaction. Employers who wanted information on quality would make individual requests.

But to **Patrick J. Casey**, JD, executive director of the Health Action Council of Northeast Ohio, a coalition of about 70 Cleveland-area

EXECUTIVE SUMMARY

- One of the nation's oldest report-card efforts may restructure or dissolve after the Cleveland Clinic and its eight affiliated hospitals decided to pull out, citing what the organization viewed as serious inadequacies.
- Cleveland Health Quality Choice (CHQC) began as a collaborative of local business coalitions and hospitals and first reported data in 1993.
- The report card issued biannual ratings of in-hospital mortality for various medical conditions, length of stay, and patient satisfaction.
- Although 16 of 18 remaining hospital participants are using the program as an approved ORYX vendor for the Joint Commission on Accreditation of Healthcare Organizations, the future of CHQC was in doubt.

Trend for All Greater Cleveland Hospitals:
Mortality Rates for Selected Medical Diagnoses



The graph above shows the aggregate trend for all Greater Cleveland hospitals for mortality rates for medical patients over five of the 12 CHQC Reports. The mortality rate represents the number of deaths in selected medical categories per 100 hospital patients (e.g. on average, 5.56 deaths per 100 patients).

Source: Cleveland Health Quality Choice.

corporate health care purchasers and a prime supporter of CHQC, the clinic's departure sends a more ominous message about the vulnerability of voluntary efforts.

"The argument by the clinic that the program wasn't as good as it should have been, so we're just going to kill it — I don't really know how to characterize it," he says. "You would suspect that there are other reasons involved."

Cleveland Health Quality Choice began with consensus-building meetings in 1989, and its sponsors included purchaser coalitions, the hospital association, and the local physician society. The Cleveland Clinic served on its board and provided input.[1] "We wanted it to be a voluntary system, community-based," says Casey.

When CHQC prepared to release its first data in 1993, *Business Week* stated that "the Cleveland program stands out for its attempt to build its own measure of quality and for its broad-based support."[2]

Yet even that laudatory article pointed to concerns about a risk-adjustment model developed specifically for CHQC by Michael Pine & Associates of Chicago. The Cleveland Clinic and others asserted that the model underestimated the additional mortality risk of the most severely ill and didn't properly take into account hospital transfers of the sickest patients to tertiary care centers.

"There were political problems along the way. Some of them dealt with risk adjustment; some of them dealt with other aspects," explains Clough. "I think we were uncomfortable with the risk adjustment, but if that was all that was wrong with it, we probably would have stuck with it."

CHQC executive director **Dwain Harper**, DO, says the program responded to the clinic's concerns and tested additional risk-adjustment variables but didn't find that they altered the results, in which in-hospital mortality, length of stay, and patient satisfaction are reported as "better than expected," "as expected," and "lower than expected."

Mortality, C-section rates improved

Public reporting of data had both an immediate and long-term positive impact on the community, say Casey and Harper. **(See charts, above left and p. 39.)**

"Death rates for six major medical conditions [including heart failure, stroke, and pneumonia] in 27 hospitals have dropped 30%. That's significant," says Harper. "C-section rates have declined about 15% and are right around the Healthy People 2000 [national preventive health goals

COMING IN FUTURE MONTHS

- Special issue on cardiac outcomes, including: Will NCQA's new quality measures save lives?
- Counteracting variation in cardiac care
- How medical groups approach cardiac QI to achieve better outcomes
- At what point does patient volume impact outcomes?
- Predicting risk of congestive heart failure

Total C-Section Rates Over All Patients
Observed vs. Predicted Rate

	Report 8 7/94-6/95	Report 9 1/95-12/95	Report 10 7/95-6/96	Report 11 1/96-6/96 1/97-6/97	Report 12 1/97-12/97
Allen Memorial	⇔	⇔	⇔	⇔	⇧
Cleveland Clinic	‡	⇔	⇧	⇔	⇔
Community Health Partners	⇔	⇔	⇔	⇔	⇔
EMH Regional Med Ctr	↓	↓	↓	↓	↓
Euclid	⇔	⇧	⇔	⇩	⇔
Fairview	↑	⇧	↑	↑	↑
Hillcrest	⇔	⇩	⇔	⇔	⇔
Lake East	⇔	⇔	⇔	↑	↑
Lakewood	↑	↑	⇔	⇔	⇔
Marymount	↓	↓	↓	⇩	⇩
MetroHealth Med Ctr	↑	⇔	⇔	⇔	⇔
Parma Community	⇩	⇩	⇔	⇔	⇔
PHS Deaconess	↓	↓	⇔	⇩	↓
PHS Mt Sinai - Univ Ctr	⇔	⇔	⇔	↓	⇔
St John West Shore	⇔	⇔	⇔	⇔	⇔
Saint Luke's Med Ctr	⇔	⇔	⇔	⇔	↑
Southwest General	⇩	⇔	⇔	⇔	⇩
UHHS Bedford	⇔	⇔	⇔	⇔	⇩
UHHS Geauga	↑	↑	↑	↑	↑
University Hospitals	⇔	⇔	⇔	⇔	⇔

↑ C-section rate lower than predicted. There is only a 1 in 100 chance that this hospital is listed in this group by chance alone.

⇧ C-section rate lower than predicted. There is only a 1 in 20 chance that this hospital is listed in this group by chance alone.

⇔ C-section rate as predicted.

⇩ C-section rate higher than predicted. There is only a 1 in 20 chance that this hospital is listed in this group by chance alone.

↓ C-section rate higher than predicted. There is a 1 in 100 chance that this hospital is listed in this group by chance alone.

Source: Cleveland Health Quality Choice.

developed by a consortium of public and private organizations]. Vaginal birth after cesarean rates have increased almost 20%. Length of stay has declined almost 30%.

"There are studies out that have suggested that that rate of improvement does not occur in a community where there is no report [of health care performance] available," he says. "It's one of the benefits a community gets from this project."

Clough asserts that those improvements and cost savings may have resulted simply from the evolution of better and more efficient medical care nationally over the seven years of the project. "It had much more to do with the changing of the marketplace and changes in the way patients are taken care of. There was never any clear relationship to Health Quality Choice that any of us could discern."

Meanwhile, efforts to expand the reports to include such data as mortality rates within 30 days of discharge and functional health status dragged on.

Ironically, the business community was poised to levy a surcharge to fund measures of post-discharge mortality and satisfaction with outpatient surgery. The program had overcome concerns about patient confidentiality, which could be breached by use of Social Security numbers to identify deceased patients.

The results of 30-day mortality would have been reported in the spring, says Harper. "We finally broke through on that," says Casey.

CHQC had designed a patient satisfaction survey for outpatient surgery and could have reported those results by the end of 1999, adds Harper.

As for other issues, "The Cleveland Clinic's concerns about the program were heard in detail in 1996," he says. "All its suggestions were analyzed. Many of its ideas were simply rejected by the remaining participants as either too costly or things they were not interested in. Some of its suggestions have been taken into account."

But the Cleveland Clinic's most deadly criticism was that the report card had become irrelevant. Studies have shown that consumers often don't understand report-card information and don't use it to make choices about their physicians.[3] Health plans, not a primary target audience of the Cleveland report card, generally developed their own performance assessment systems.

Casey says the business community found the CHQC information valuable. "Purchasers of care were using it, were used to it, and had much discussion about the meaning of it."

But according to Clough, "We have surveyed our people who contract with us to provide care, and pretty much across the board, found they don't use it." Instead of spending $2 million a year to produce the CHQC data, the Cleveland Clinic will concentrate on its own disease-specific benchmarking and quality improvement, beginning with diabetes care, he says.

That could eventually evolve into a Cleveland Clinic report card, incorporating its nine hospitals and 2,500 physicians. But Clough says, "Until we know that it's a valid methodology, we will not report it publicly."

The departure of the Cleveland Clinic and its hospitals has a fallout for the other participating hospitals. CHQC is an approved vendor for the ORYX quality assessment program of the Joint Commission for Accreditation of Healthcare Organizations.

Of the 18 remaining hospitals, 16 used CHQC as their ORYX vendor, as did about four other Cleveland-area hospitals, says Harper. As of early March, the program staff had been downsized, but the directors were considering options ranging from restructuring to dissolution. "There are still many hospitals in the city that are interested in the performance measurement information," says Harper. "There is a possibility that the organization could change its mission and serve different needs."

Meanwhile, will the Cleveland experience produce shock waves in other report-card efforts? That's not likely, say advocates of public accountability in health care.

Conflicts over methods and indicators aren't surprising, says **Cheryl Damberg**, of Pacific Business Group on Health in San Francisco, who notes that "all report cards are in their infancy." The California purchaser coalition has developed an extensive report card of hospital and medical group performance called Physician Value Check Report. She calls the Cleveland program "a respected report card."

"It takes time and resources to gather the information and put it together," she acknowledged. "I did think they were on the right path."

In Cleveland, purchasers were considering pressing for a state-mandated release of health care data. Casey called the recent events "a speed bump" in the road toward public reporting of health care information. "The genie is out of the bottle as far as information such as this."

References

1. Rosenthal GE, Harper DL. Cleveland Health Quality Choice: A model for collaborative community-based outcomes assessment. *Jt Comm J Qual Improv* 1994; 20:425-442.
2. Schiller Z, Galen M. A consumer's guide for health-care shoppers. *Business Week* May 3, 1993; 53-54.
3. Hibbard JH. Use of outcome data by purchasers and consumers: new strategies and new dilemmas. *Int J Qual Health Care* 1998; 10:503-508. ■

New forum will boost demands for care data

Alliance will set agenda for accountability

In an effort to turn up the heat on health care accountability and performance measurement, a new national Forum for Healthcare Quality Measurement and Reporting is forming and will meet for the first time this spring or summer.

Creation of such a forum was one of the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which issued a final report last July. The forum board will include representatives of major health care purchasers, health plans, provider groups, and consumer organizations.

One of the most "compelling" findings of the President's commission involved the need for greater quality improvement in health care, says **Chris Queram**, MHA, CEO of The Alliance, a purchaser coalition based in Madison, WI, and a member of the President's commission and the forum planning committee.

For example, the report cited studies of medication errors and hospital-based adverse events, underused lifesaving therapies such as beta blockers, and overused procedures such as hysterectomies.

Meanwhile, quality measurement currently is inconsistent, the report states. While various accrediting bodies, state agencies, and purchaser coalitions require performance measurement, those efforts aren't coordinated, says Queram, who is also chairman of the board of the National Business Coalition on Health, a Washington, DC-based alliance of business coalitions.

"Provider organizations and health plans are pulled in any number of directions by different reporting standards and requirements," says Queram. "It's costly, inefficient, and it makes it very difficult to compare providers and plans across communities.

"We need a common platform for quality measurement," he says. "The forum is designed to be the vehicle to do that."

The need for reporting comparative data on health care quality was at the heart of the report and recommendations of the President's commission. "All participants in the health care industry must be accountable for improving the quality of

health care in the United States," the report says.

Specifically, the commission favored a "health care error reporting system to identify errors and prevent their recurrence," as well as a comprehensive plan for quality measurement and data collection at all levels of health care.

"As much attention as the Patient's Bill of Rights has received, which is important and politically attractive to legislators, the real important recommendations of the commission's work are in the area of quality," says Queram. "They have the potential to transform the way health care services are delivered around the country."

The "Patient's Bill of Rights" refers to a list of "consumer rights and responsibilities" that the commission outlined, covering such issues as access to providers, appeals of denial of coverage, and confidentiality.

As a private sector initiative, the forum will endorse standardized measures of quality and encourage their adoption at all levels of health care and by health care purchasers. It would seek to educate consumers about health care quality. The forum will report to the Advisory Council for Health Care Quality, a public body that would set improvement goals and monitor progress.

"The visibility of this whole area [of health care quality measurement] is going to be heightened," says **Pat Powers**, executive director of the Pacific Business Group on Health, a California purchaser coalition that has been active in reporting quality measures for medical groups, hospitals, and health plans. "Most of our employers are [located] in multiple states, and they're very eager to see the kinds of activities we're doing in California spread to other communities."

Christina Bethell, PhD, director of research for the Foundation for Accountability in Portland, OR, echoes those sentiments. "It adds an important leadership and visibility to the cause. The forum can help frame an agenda and push it harder than others can on their own."

New pressures on docs to prove quality?

For medical groups, the forum may mean new pressures to collect and report on a set of quality indicators and to upgrade information systems to make outcomes reporting more efficient. But it also should lead to less duplication of effort as medical groups provide quality information to different health plans and purchasers.

Forum will set standards and create priorities

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry called for the creation of a Forum for Health Care Quality Measurement and Reporting that would "develop and implement effective, efficient, and coordinated strategies for ensuring the widespread public availability of valid and reliable information on quality." According to the commission's report, the forum's activities will include:

- ☑ developing a comprehensive plan for implementing quality measurement, data collection, and reporting standards;
- ☑ establishing measurement priorities that address the national aims for improvement and that meet the common information needs of consumers, purchasers, federal, and state policy-makers, public health officials, and others;
- ☑ periodically endorsing core sets of quality measures and standardized methods for measurement and reporting;
- ☑ making recommendations to the Advisory Council for Health Care Quality regarding an agenda for research and development needed to advance quality measurement;
- ☑ developing and fostering implementation of an effective public education, communication, and dissemination plan to make quality measures and comparative information on quality most useful to consumers and other interested parties;
- ☑ encouraging the development of health information systems and technology to support quality measurement, reporting, and improvement needs. ■

Major accrediting bodies, the American Medical Association, and the Foundation for Accountability have been involved in the creation of the forum.

"One of the great opportunities of the quality forum is to bring about greater alignment on a quality platform," says Queram. "Consumers and employers are all across the board in how much they use quality information in their decision making.

"We've focused a lot of cost and premium because it's easier to measure and influence across a bargaining table," he says. "The great opportunity is to integrate quality information to make sure you're focusing on value as opposed to just cost."

[A copy of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry is available on-line at http://www.hcquality commission.gov. Or you can contact Consumer Bill of Rights, Box 2429, Columbia, MD 21045-1429. Telephone: (800) 732-8200.] ■

HEDIS measures focus on hypertension, asthma

Many patients are poorly managed, tests show

Treatment of chronic disease is moving to the forefront with a new collection of performance measures focusing on asthma and high blood pressure from the National Committee for Quality Assurance (NCQA) in Washington, DC.

The newest version of the Health Plan Employer Data and Information Set (HEDIS), which becomes effective in the year 2000, also mandates reporting of a six-indicator measurement set for control of diabetes and includes indicators on chlamydia screening and counseling about menopause.

Medical groups and health plans will have much room for quality improvement as they address the new performance assessment indicators. For example, about a third of the adult U.S. population has high blood pressure. But in a field test of the new NCQA measure, only 32% to 42% of those with hypertension had their blood pressure under control.

"I think that these measures, particularly the cardiovascular measures, are of historic significance," said **Thomas Lee**, MD, representing the American College of Cardiology at a recent press conference unveiling the measures. "Probably five to 10 years from now, we are going to look back on this and realize that the introduction of these measures have as much public health significance as almost anything we were involved with in our careers."

The measures also move HEDIS far from its beginnings as indicators focusing mostly on preventive health screening, notes NCQA spokesman **Brian Shilling**. "With HEDIS 2000, we have a much-approved ability to measure the care that plans are delivering to their sickest patients," he says. "We're getting a clearer picture of plan performance across the different stages of care."

HEDIS 2000 At-a-Glance

The latest version of the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set, which becomes effective in June 2000, includes several new measures of preventive care and chronic illness. Here are some of the parameters:

✔ **Control of high blood pressure.**

Percent of hypertensive patients 45 years old and older who have their blood pressure controlled below 140/90 mm Hg.

✔ **Use of appropriate medications for people with asthma.**

Percentage of high-risk asthmatic patients ages 4 to 55 who received at least one prescription for anti-inflammatory medication during the reporting year. This is reported by the age groups 4 to 9, 10 to 17, and 18 to 55.

✔ **Emergency department visits for people with asthma.**

Percentage of high-risk asthmatic patients ages 4 to 55 who received care in an emergency department during the reporting year. This is reported by the age groups 4 to 9, 10 to 17, and 18 to 55.

✔ **Chlamydia screening.**

Percent of sexually active women ages 15 to 25 who had at least one test for chlamydia during the reporting year.

✔ **Management of menopause.**

A survey on counseling of perimenopausal women ages 47 to 57 that measures whether and when counseling was provided, whether it included risks, benefits, and alternatives to hormone replacement therapy, and whether it took into account the woman's personal and family history, concerns, and preferences.

✔ **Lipid control after an acute cardiac event.**

Percent of patients who have a low-density lipoprotein (LDL) screening and who have a documented LDL level below 130 m/dL.

✔ **Comprehensive diabetes care.**

For diabetic patients between the ages of 10 and 75, percent receiving greater than one glycohemoglobin (HbA1c) test per year; percent with the highest-risk glucose level (i.e., HbA1c greater than 9.5%); percent assessed for nephropathy; percent receiving a lipid profile once in two years; percent with LDL less than 130 mg/dL; percent with blood pressure less than 140/90 mm Hg; percent receiving a periodic dilated eye exam; and percent receiving an annual documented foot exam.

[For more on these measures, contact NCQA, 2000 L St., N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-3500. Fax: (202) 955-3599. World Wide Web: http://www.ncqa.org.] ■

The new diabetic, asthma, and cardiovascular measures will likely spur health plans to work with clinicians on quality improvement efforts to control these chronic diseases. In fact, physicians may be surprised to find how poorly their patients are managed despite available treatments. Lee said he surveyed his own practice to see how physicians performed on the blood pressure measure, which determines how many hypertensive patients 45 years and older have their blood pressure controlled below 140/90. "There is unbelievable room for improvement," said Lee, who noted that embarrassment over poor performance may become a driving force for change.

Similar failings have led to unnecessary admissions to emergency departments to treat asthma. One asthma indicator will measure whether health plan members are being prescribed appropriate anti-inflammatory medications. The measure focuses on high-risk children and adults — ages 4 to 55.

A second asthma measure tracks emergency department visits for asthma among high-risk patients. "Inhaled corticosteroids are extremely effective in reducing the frequency and severity of asthma attacks, but they are vastly underused," says Shilling.

Two measures relate to STD, menopause

Two measures that relate to women's health are also significant in their scope and potential impact. Chlamydia is the most common sexually transmitted disease in the United States, affecting some three million people a year. However, 60% to 70% of women with chlamydia experience no symptoms. They are at risk for pelvic inflammatory disease, infertility, or future ectopic pregnancies if not treated.

The new HEDIS measure determines the percentage of sexually active women between 15 and 25 years of age who received an annual test for chlamydia. In NCQA field tests of the measure, on average only 16% of eligible women were screened for the disease.

HEDIS 2000 also uses a patient survey to learn about counseling of perimenopausal women (ages 47 to 57). The survey asks women whether they have talked to a doctor or other health professional about "ways to deal with menopause," and it asks about information they received on the benefits and risks of hormone replacement therapy.

In another development, the Performance Measurement Coordinating Council (PMCC) moved forward by appointing a staff director and agreeing to integrate its measures.

The PMCC is a collaboration of NCQA, the American Medical Accreditation Program of the American Medical Association, and the Joint Commission on Accreditation of Healthcare Organizations. The member groups announced they will merge their expert panels to streamline development of new measures.

This collaborative also will make sure that indicators used to measure performance have parallel criteria and specifications, says Shilling. For example, if they are measuring childhood immunization rates, the three organizations will draw the same sample populations and use the same technical definitions, so health plans and medical groups don't have to duplicate efforts. "You'll see measures that are broadly applicable," says Shilling. ■

Trust and good data keys to physician change

Physicians respond to one-on-one learning

As medical groups strive to improve care, they invariably face their most difficult question: How can you change physician behavior?

There is no simple answer. But trust and loyalty, combined with data on evidence-based medical practices, form the foundation for change, says **Jeffrey Lenow**, MD, JD, medical director of JeffCare, a physician hospital organization for Thomas Jefferson University Hospital in Philadelphia.

In fact, Lenow says he was so committed to the goal of physicians accepting him as their peer, he put his career on hold while completing a residency in family medicine. An obstetrician, Lenow had spent 13 years as a medical director of various organizations. "You have to establish trust and credibility. You're only as good as your credentials in the eyes of your peers.

"You have to show that you know what you're doing; you have to be one of the group," he says. "That's why I still practice in the academic setting. I think it's important to the people with whom I have to share performance and

management data to be able to say, 'I'm one of you.'"

Loyalty among physicians may come from standing up for them on an issue they care deeply about. Physicians should be involved in creating the internal "report cards" and even deciding what data elements will be measured.

After all, the feedback is designed to help physicians improve care for their patients. "Merely providing high-quality data is a potent motivator among many physicians," says **Tom McAfee**, MD, chief medical officer for Brown & Toland Medical Group in San Francisco.

Starting with physician input

What data should you give physicians? And how should you present the information?

In an effective feedback system, the physicians themselves largely determine that, says Lenow, who is chairman of the disease management committee for Jefferson Health System. "We involve our physicians as much as we can on our committees in which we design disease management and study evidence-based practice," he says. "If we get their buy-in early, they become partners in the cause. They become standard-bearers."

At Brown & Toland, primary care physicians receive quarterly score cards showing what percentage of their patients have received certain types of care, such as mammograms for women 52 to 69 and cervical cancer screening. **(See sample score card, inserted in this issue.)** They also receive a list of patients who haven't been screened and letters they can sign to send to those patients asking them to come in for care.

In the beginning of the feedback program, the screening percentages and lists included all patients assigned to the physician. But some of those patients signed up with a primary care physician and never came for a single office visit.

"There may be a whole lot of reasons why people don't come in to see their physicians," says **Sharon Katz**, RN, ND, corporate director of quality and care management with Brown & Toland Physician Services Organization. For example, a patient may sign up with Brown & Toland as part of a secondary insurance plan, while seeing a primary care physician with another practice.

So now, Brown & Toland physicians learn how many of their active patients they've screened. The Brown & Toland physician services organization tries to contact the other patients to encourage them to come for an office visit and receive necessary screening.

Physicians also have a chance to correct the information on the score cards and accompanying lists, notes McAfee. "If, in fact, our records are wrong, we allow the doctor to send us some kind of proof," he says. "Then they can improve their score."

The medical group voluntarily publishes some of its overall Health Plan Employer Data and Information Set (HEDIS) measures, which are indicators required for health plan accreditation by the National Committee for Quality Assurance (NCQA) in Washington, DC. Those HEDIS measures have improved for the past three years the medical group has reported data to physicians.

Financial incentives don't work

Financial incentives aren't a key motivator for changing physician behavior, says Lenow. And if they have a punitive aspect, they won't work, he says. "Physicians are so worn out by the promise of financial incentives; I don't think they're thinking about it that much."

In fact, the incentive is inherent in providing good care, says Lenow. Physicians see their patient outcomes improve, while the medical group receives cost savings from early diagnosis and chronic illnesses that are better managed.

Physicians also may qualify for outside recognition, such as the Provider Recognition Program sponsored by the NCQA and the American Diabetes Association in Alexandria, VA, indicating that the physician met quality goals for diabetic patients.

Brown & Toland's Managed Care Quality Incentive Program previously produced a financial incentive for physicians. But that has been canceled for this year, and McAfee doesn't expect its absence to change the physicians' attitude toward quality improvement.

Katz notes that previous feedback on patients receiving diabetic retinal exams wasn't included in the financial incentive, yet that indicator improved significantly.

"Physicians, when all is said and done, want to do a good job," she says. "When they see their score compared to other physicians, it is a motivator. Also, when they see people who haven't had preventive health screening and they have a tool that can help encourage that, I think they're big supporters." ■

How JeffCare changed its physicians' behavior

A different approach to physician education

Medical groups use many methods to educate physicians about guidelines and protocols and to encourage their use. But those strategies aren't always successful.

A systematic review of literature found proven success with reminders, patient-directed interventions, and educational interventions that included opinion leaders and one-on-one visits to physicians.[1] Without linking them to other strategies, traditional continuing medical education conferences had little impact.

JeffCare, the physician-hospital organization for Thomas Jefferson University Hospital in Philadelphia, took those findings to heart and used them to shape a program of influencing physician behavior. Here are some of the strategies it uses:

• **Primary care physicians receive one-on-one preceptorships with specialists.**

Instead of attending didactic sessions, physicians learn from experts while they are tending to their own patients, says **Jeffrey Lenow**, MD, JD, the medical director of JeffCare and chairman of the disease management committee for Jefferson Health System.

For example, primary care physicians may schedule appointments for several diabetic patients back-to-back on a particular morning. "We'll have one of our specialists come out and spend time with [these doctors] while they're seeing patients," says Lenow.

"It's a different approach to education," he says. "It's part of what we call our physician-champion model. If you can influence key decision makers, they will disseminate good practices and ultimately you'll be able to reduce variation."

Both the specialist and primary care physician receive a token compensation for their time in the preceptorship, but Lenow notes that the money isn't of primary importance to them. The program has other ancillary benefits. "It's a way for our specialists to get out and meet our primary care doctors, and relationships can develop that wouldn't have otherwise," he says.

• **Educational programs are interactive and problem-oriented.**

Sometimes it's best for physicians to share information in a group setting. But JeffCare makes sure these sessions remain focused on the real-life problems of physicians and how they can solve them.

For example, a half-day symposium for physician leaders gave them a forum for working through problems with improving compliance to guidelines and quality improvement goals. "We focused on problems related to evidence-based medicine and application to problems they specifically brought with them to the symposium," he says.

• **Physician leaders share detailed data twice a year.**

While data alone may capture a physician's curiosity, he or she will have questions. Lenow spends much of his time visiting offices to discuss individual performance profiles and what they mean. "You're only as good as your data and you're ability to explain it in a user-friendly way," he says.

For some disease-management programs, teams of nurses pull every patient's chart and use the data both for benchmarking and drafting specific suggestions for intervention. One site targeted 65 pediatric asthmatics in a Medicaid population. Nurses designed classes for parents, home visits, and family counseling to help them manage the asthma.

"With eight months of physician training and focused intervention and patient outreach, [the asthma patients] reduced their [emergency department] admissions by 80% and missed days from school by 60%," he says. "It's not that a lot of physicians don't know what to do. They're not organized enough. They're not getting enough help identifying the patients at need, and things start falling through the cracks."

• **Guidelines are provided in a simple format that is easy to use in clinical practice.**

Guidelines that are wordy and difficult to read simply won't be effective, Lenow says. JeffCare reworks guidelines to place them in a format that provides true guidance to a busy primary care physician. "You can just narrow the choices of therapy or show a physician the 11 things that need to be done with a diabetic on a regular basis," he says. "They're straightforward. All we're looking for is support measures. We're looking to reduce clinical variation."

• **Physician leaders influence their peers on targeted clinical issues.**

If you want change, start at the top. A study of physician leadership found that their strong

support of a certain protocol, such as beta blocker use after a heart attack, could improve adherence.[2] "The best practices out there need to be disseminated by the people who have the most influence," says Lenow. "That is a very key strategy for modifying physician behavior."

References

1. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance: A systematic review of the effect of continuing medical education strategies. *JAMA* 1995; 274:700-705.

2. Soumerai SB, McLaughlin TJ, Gurwitz JH, et al. Effect of local medical opinion leaders on quality of care for acute myocardial infarction: a randomized controlled trial. *JAMA* 1998; 279:1,358-1,363. ■

Pap tests don't work as well as many believe

But analysis supports 3-year screening intervals

Pap smears only detect about half of existing cervical abnormalities, a lower accuracy rate than is generally cited in cervical cancer screening recommendations, according to an analysis by the Duke University Evidence-based Practice Center in Durham, NC, a project of the Agency for Health Care Policy and Research.

However, since the overall prevalence of cervical cancer is low, screening every three years still is an effective goal, particularly if it is enhanced by new Pap test technologies, says **Douglas McCrory**, MD, MHS, assistant professor of medicine at Duke's Center for Clinical Health Policy Research.

"For any one time a woman goes in and gets a Pap smear, for women who have an abnormality present, there's only a 50% chance that that abnormality will be picked up," says McCrory, who is also a research associate with the Department of Veterans Affairs Medical Center in Durham. "That's part of the rationale for doing regular screening. Any one, single Pap smear is not very accurate."

If the Pap screening occurs every three years instead of every one to two years, new technologies can cost-effectively increase the accuracy of the test, he says. Currently, the U.S. Preventive Health Task Force recommends screening at least once every three years after a baseline and two annual tests. With 13,700 new cases in 1998, cervical cancer is one of the most common cancers among women. Yet there has been a 70% decrease in cervical cancer mortality with the introduction of Pap testing some 50 years ago.

New studies shed light on accuracy

The models of Pap screening have been built around studies that focused on cervical cancer screening in a high-prevalence population, says McCrory. But recent studies focus on the accuracy of the test in a low-prevalence environment, which mirrors the general recommended screening population of women ages 21 to 64.

"There had been some very good new research that was included in our summaries that wasn't included in previous analysis," says McCrory.

Still, some experts believe that there still isn't sufficient evidence to show a false-negative rate that's greater than the previous accepted rate of 20% to 30%. Even a false-negative rate as high as 50% isn't cause for alarm, cautions **Kenneth Noller**, MD, professor and chair of the department of obstetrics and gynecology at the University of Massachusetts Medical Center in Worcester. "We've got the single best cancer screening test ever invented," he says. "There are just not that many cases that are missed."

The Duke team, working with Health Economics Research of Waltham, MA, also analyzed studies relating to three new technologies:

❒ **AutoPap** and **Papnet** involve a computerized rescreening of slides to detect ones with suspicious cells that were initially read as normal.

❒ **ThinPrep** is a thin-layer cytology technology that uses a different method of collecting cells and analyzing them.

In May 1998, the American College of Obstetricians and Gynecologists issued an opinion from the Committee on Gynecologic Practice stating that "appropriate use of these new techniques requires further investigation." No research was available on whether the techniques lower the incidence rate of invasive cervical cancer or improve the survival rate, the committee said.

McCrory's review examined the available literature and analyzed the possible impact of greater detection of abnormalities. "[The new methods] seem to improve the detection rate of the cytologic screening by a very similar margin [of roughly 60%]," he says. "They do it in different ways, but the overall effect was modeled in a

very similar way based on the studies that had been conducted.

"To really understand the implications for cervical cancer screening, we built a cost-effectiveness model that takes into account our new estimates of accuracy of the Pap smear with our understanding of the natural history of the disease and annual screening," he says.

In annual screening, using the new technologies could detect an additional four cancers per 100,000 women over a lifetime of screening. They would also detect many more mild abnormalities, and it's not clear how the tests affect false positives, or screening that incorrectly identifies cells as abnormal.

At three-year screening intervals, 18 cancers would be detected per 100,000 women over a lifetime of screening. "With longer screening intervals, that increase in accuracy of new technologies becomes important," says McCrory.

The Duke analysis doesn't take into account some issues, such as whether the average lab differs in quality from the labs used in the clinical trials. The cost analysis also doesn't include potential legal liability from missed diagnoses.

Regular screenings are most important

Amid this analysis of the Pap test accuracy, McCrory stresses one important fact: Most cervical cancers occur among women who were not screened at all or who did not have regular screenings of any interval.

Improvements in the overall screening of women can save lives, he says. "Getting a screening in the first place, regardless of which technology you use, is the most important issue. It's a major public health problem, as opposed to the problem we addressed [in the analysis], which is a clinical issue."

In fact, the finding that the Pap test is less accurate than believed simply underscores the need for regular screening. "Women need to get the Pap smear repeatedly because a Pap smear isn't perfect," he says.

[Editor's note: A summary of "Evaluation of Cervical Cytology" (AHCPR 99-E009) is available on the Web site of the Agency for Health Care Policy and Research at http://www.ahcpr.gov. Free print copies are available from the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907. Telephone: (800) 358-9295. InstantFax: (301) 594-2800.] ■

SourceKit

• **The Alliance**, Madison, WI. Chris Queram, CEO. Telephone: (608) 276-6620.

• **Brown & Toland Medical Group**, San Francisco. Sharon Katz, Corporate Director of Quality and Care Management. Telephone: (415) 749-4064.

• **Cleveland Clinic**, John Clough, Chairman of Health Affairs. Telephone: (216) 444-2200.

• **Cleveland Health Quality Choice**, Dwain Harper, Executive Director. Telephone: (216) 696-7999.

Patient Satisfaction & Outcomes Management is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Co-publisher is Medical Group Management Association, Web site: WWW.MGMA.com. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Satisfaction & Outcomes Management**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahc.com). Hours of operation: 8:30-6:00 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $319. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $255 per year; 10 to 20 additional copies, $191 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $53 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact Karen Wehye at American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5491. World Wide Web: http:// www.ahcpub.com.

This continuing medical education offering is sponsored by American Health Consultants®, which is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

American Health Consultants does not receive material commercial support for any of its continuing medical education publications. In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, a statement of financial disclosure of editorial board members is published with the annual index.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Michele Cohen Marill**.
Vice President/Group Publisher: **Donald R. Johnston,** (404) 262-5439, (don.johnston@medec.com).
Executive Editor: **Glen Harris**, (404) 262-5461, (glen.harris@medec.com)
Production Editor: **Ann Duncan**.

Copyright ' 1999 by American Health Consultants®. **Patient Satisfaction & Outcomes Management** is a trademark of American Health Consultants®. The trademark **Patient Satisfaction & Outcomes**

Editorial Questions

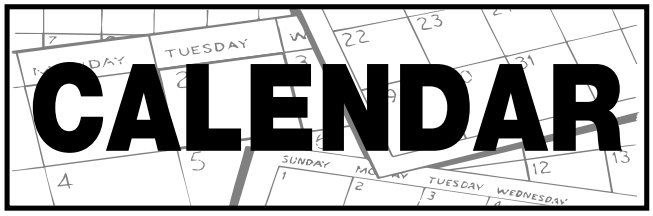
For questions or comments, call **Glen Harris** at (404) 262-5461.

• **Duke University Center for Clinical Health Policy Research**, Durham, NC. Douglas McCrory, Co-director, Evidence-based Practice Center. Telephone: (919) 286-9225.

• **Health Action Council**, Cleveland. Patrick Casey, Executive Director. Telephone: (440) 248-2559.

• **JeffCare**, Philadelphia. Jeffrey Lenow, Medical Director. Telephone: (215) 955-8774.

• **National Center for Quality Assurance**, Washington, DC. Brian Shilling, Spokesman. Telephone: (202) 955-5104. ■



Reducing Adverse Drug Events and Medical Errors — April 8-9, Oakland, CA. Sponsored by the Institute for Healthcare Improvement, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. World Wide Web: http://www.ihi.org.

Spring Managed Care Update: Retaining Clinical Autonomy and Patient Satisfaction — April 9-11, Hilton Head, SC. Sponsored by the Southern Medical Association, 35 Lakeshore Drive, P.O. Box 190088, Birmingham, AL 35219-0088. Telephone: (800) 423-4992. Fax: (205) 945-8885.

EDITORIAL ADVISORY BOARD

Consulting Editor:
Alfredo Czerwinski, MD
Principal
Lawson & Associates
Sacramento, CA

David J. Brailer, MD, PhD
Chief Executive Officer
Care Management
Science Corporation
Philadelphia

Brent C. James, MD
Executive Director
IHC Institute for Health Care
Delivery Research
Salt Lake City

Randall W. Killian
MBA, MS
Executive Vice President
National Association of
Managed Care Physicians
Glen Allen, VA

Peter L. Miller, MS, BA
Market Research Manager
Cleveland Clinic Foundation
Cleveland

Neill Piland
Research Director
Center for Research in
Ambulatory Health Care
Administration
Englewood, CO

Jonathan Seltzer, MD, MBA
Director of Health Systems
Research
Premier Research
Worldwide
Philadelphia

John Ware Jr., PhD
Executive Director
Health Assessment Lab
New England
Medical Center

Building Bridges V-The Health Care Puzzle: Using Research to Bridge the Gap Between Perception and Reality — April 12-13, Chicago. American Association of Health Plans, 1129 20th St., N.W., Suite 600, Washington, DC 20036-3421. Telephone: (202) 778-3269. Fax: (202) 778-8506. World Wide Web: http://www.aahp.org. ■

CME questions

1. Although the Cleveland Clinic had raised questions about the risk-adjustments used in Cleveland Health Quality Choice reports, according to John Clough, MD, chairman of health affairs, what was "the biggest issue"?
   A. Cleveland Clinic didn't have enough input in the program.
   B. Hospitals collected inconsistent data.
   C. Employers didn't use the reports.
   D. Data collection was onerous.

2. Which of the following is one of the major goals of the Forum for Healthcare Quality Measurement and Reporting?
   A. Conducting basic research to develop new performance assessment measures.
   B. Gathering political support for health care initiatives.
   C. Promoting the Patient's Bill of Rights.
   D. Endorsing standardized measures of quality and encouraging their adoption at all levels of health care.

3. What is significant about the new asthma and hypertension measures in the Health Plan Employer Data and Information (HEDIS) 2000 of the National Committee for Quality Assurance in Washington, DC?
   A. They expand performance assessment in chronic diseases.
   B. They use new data collection methods.
   C. They include patient satisfaction.
   D. They are updates of existing measures.

4. According to Jeffrey Lenow, MD, JD, medical director of JeffCare and chairman of the disease management committee for Jefferson Health System, one-on-one preceptorships are more effective than traditional CME courses because:
   A. They cover more educational material.
   B. They focus education on the patient.
   C. They allow physicians to learn from experts while they are tending to their own patients
   D. They focus only on the implementation of guidelines.