HHS Program Aims to Boost Transparency, Quality

BY DENISE NAPOLI
Assistant Editor

WASHINGTON — The Bush administration aims to move forward on its goal of health care price and quality transparency through its new Value-Driven Health Care Initiative.

The initiative, which will certify and support regional collaboratives of health care payers, providers, and purchasers, was announced by Health and Human Services Secretary Michael Leavitt at a press briefing sponsored by the journal Health Affairs.

Participants in the program's collaborative groups, called Value Exchanges, will be able to share practices for increasing quality with fellow members through a federally funded learning network, for which $4 million has been earmarked in the proposed 2008 federal budget. Providers who can demonstrate improved transparency and quality are also likely to reap rewards from payers.

Mr. Leavitt gave as an example one private insurer affiliated with a pilot Value Exchange in California that paid out as much as $50 million to physicians who'd met certain standards of quality care.

"[Insurers] rewarded the quality practice. But if you don't have a standard way of measuring [quality], then those [bonuses] are not able to be developed or executed," he said.

Dr. John Tooker, executive vice president and chief executive officer of the American College of Physicians (ACP), said that it is too soon to determine the success of the pilot programs.

'This is a very significant change, and it requires people to work together collaboratively.'

MR. LEAVITT

"I think the [level of physician] engagement in the program will determine how much value is to be derived from the program," he said. However, "You've got to start somewhere. The ACP and many other medical societies have been supportive of moving the evidence-based performance measures into meaningful field testing. …These Value Exchanges provide an opportunity to test these measures."

Quality standards by which care will be measured are being formulated by physician groups.

"The standards are being established by the medical family," said Mr. Leavitt.

Leadership from groups such as the ACP, the Society for Thoracic Surgery, and the American Academy of Family Physicians, as well as the American Medical Association's Physician Consortium for Performance Improvement, will provide the basis, said Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality. "This is what the profession believes is the best science," said Dr. Clancy at the meeting.

Though the program will use national measures of quality, it will be governed locally.

Local control is important for two reasons, Mr. Leavitt said. The first deals with the initial collection of medical records with which the program would develop comparisons between providers. "Until we have a robust system of electronic health records, the [process of acquiring] this information is essentially going in and looking at medical records—most of the time, paper records—to determine what quality is and when it occurs. That, by its very nature, is local." The second reason why local facilitation is important has to do with trust, he said. "This is a very significant change, and it requires people to work together collaboratively in order to be comfortable. [Doctors] will be much less likely to work with Washington, where they can't affect the process, [rather than local networks]."

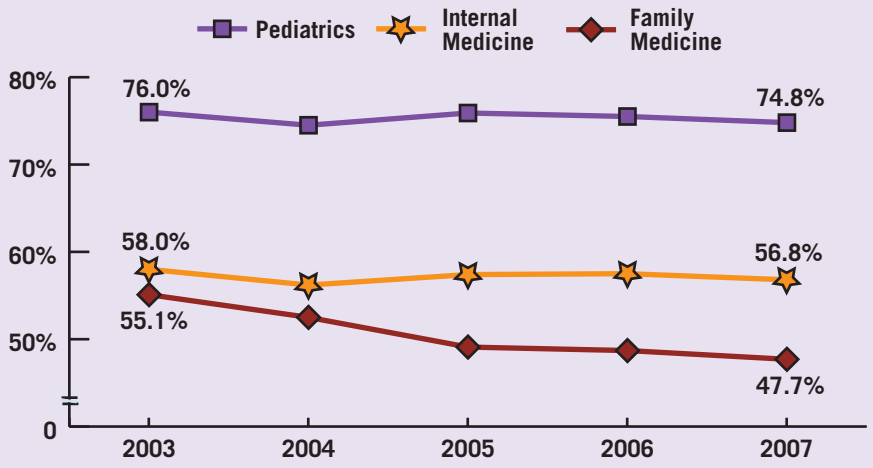
To become a Value Exchange, a collaborative must submit an application to HHS detailing its adherence to four "cornerstones" of the program. In addition to the adoption of an electronic medical records system, these include public reporting of performance; public reporting of price; and the support of incentives rewarding quality and value.

Mr. Leavitt sketched a rough timeline for widespread adoption of the program.

"Five years from now, the word 'value' will be a regular part of the medical lexicon," he said. "Ten years from now, this network will have matured into a national network." He added that in order for this widespread collection and pooling of data to occur, "electronic medical records, as you can see, have to be the backbone of this system." ■

DATA WATCH

Percentage of Residency Positions Filled By U.S. Seniors Decreasing in Primary Care



Source: National Resident Matching Program

ELSEVIER GLOBAL MEDICAL NEWS

Learn to Say 'I'm Sorry' for Unanticipated Outcomes

BY DENISE NAPOLI
Assistant Editor

WASHINGTON — An empathetic disclosure that a medical error has occurred, accompanied by a genuine apology, may help avoid a malpractice lawsuit, according to Dr. Neil S. Prose, of Duke University Medical Center, Durham, N.C.

On an almost daily basis, doctors are called upon to deal with patient disappointment. Some cases involve medical mistakes and others do not. In any case, "How we communicate with patients and their families is really half of the work we do as doctors, and the other half is diagnosis and treatment," Dr. Prose said at an annual meeting of the American Academy of Dermatology. "Unfortunately, we spend a lot of time on diagnosis and treatment and never talk about what we say to patients and how they respond."

In a presentation designed by the Institute for HealthcareCommunication (formerly the Bayer Institute), a nonprofit group dedicated to improving communication between physicians and patients, Dr. Prose discussed empathetic ways of speaking with patients when they have experienced disappointing outcomes, either with or without a medical mistake on the health care provider's behalf. He stressed, however, that his recommendations are generic skills and that, when appropriate, the counsel of a lawyer or risk management team should be heeded:

► **Create the right setting.** Close the door and make sure that the room is quiet. If possible, turn off any phones or pagers. Sit down. Offering the apology while seated, rather than standing, can aid in the patient's eventual acceptance of the apology.

► **Be as sincere and specific as possible.** In addition to telling the truth about what happened—whether the mistake is a small one or something more serious—Dr. Prose said that offering a sincere and simple apology can make a huge difference. Also, specificity is crucial. Saying, "I'm sorry that your family has been through so much pain this last week as a result of this procedure" is preferable to "I'm sorry this happened."

► **Have a plan.** A pledge to correct the mistake also is important. "People want to know how you're going to prevent this from happening again. You want to have a plan before you go in the room," he said.

► **Be aware of your own feelings.** Often, the fear of confrontation and the desire to rectify the situation as quickly as possible can prevent physicians from taking into account their own feelings about the situation. Being either defensive or overly despondent, for instance, can alienate the patient and his or her family. "Seek a balance by knowing who you are and what you tend to do," he advised.

► **Get permission to proceed.** Finally, after telling the truth and listening patiently, "you reach a point where you actually ask permission before moving on. Say, 'Would this be an okay time for me to tell you what I think we should do next?' That process has a remarkable effect," said Dr. Prose. ■