CLINICAL PEARLS

Clinical Pearls: 2007 Contest Winners, Part 2

BY BRUCE L.. FLAMM, M.D.

Before we get to the next contest-winning pearls, here is a very bizarre transcription blooper sent in by Dr. George P. Chambers Jr. of Las Vegas. This is not a joke. He had performed a laparoscopic salpingostomy on a patient who had an ectopic pregnancy. The fallopian tube was bleeding, so he desiccated the bleeding vessel with the Bovie device and dictated that he had done this. To his great surprise, perhaps even shock and awe, the operative report stated that he had defecated on the bleeding vessel. Yikes! If there was a prize for the most outrageous transcription error, this one would be a sure winner.

Sorry, Dr. Chambers, no prizes are offered for bloopers, but we certainly appreciate your having the courage to share this one with us.

Moving on to a category for which prizes actually are offered, here are the next two prize-winning clinical pearls. The authors of each of these pearls will receive a high-resolution digital camera along with our sincere congratulations!

Copy the Wheel

Joseph P. Harmon, M.D., of South Bend, Ind., thought of a simple prenatal charting protocol that he has instituted in his office to make things easier and more efficient for the nursing staff and the physicians. After the early ultrasound examination, they "wheel out" the patient's final EDD, but instead of just writing the EDD at the top of the page, they make a photocopy of the actual wheel and place it in the patient's chart. This allows anyone who picks up the chart to just look at the current date and be able to determine how many weeks' gestation the patient is without having to wheel the EDD at every prenatal visit. According to Dr. Harmon, this basic procedure also prevents any discrepancies between different pregnancy wheels and minimizes errors that can occur with frequent wheeling by various staff members.

Trump the Stump

No, this has nothing to do with "The Donald." … In this case, "trump" means "to get the better of." Bleeding from the cervical stump in the months or even years after supracervical hysterectomy, either laparoscopic or traditional, is a frustrating occurrence for both the patient and the surgeon. Rob Wood, M.D., of Mobile, Ala., offers a double pearl for this problem, one to prevent it and the other to treat it. Most of us already cauterize the cervical canal from above after removing the fundus of the uterus to decrease the incidence of subsequent bleeding from the cervical stump. In fact, this was a previous clinical pearl. But Dr. Wood suggests that you also cauterize the canal from below, transvaginally, to destroy glandular tissue that might be missed from above. This mimics the "treatment" for the problem, but before it occurs. If the problem occurs despite all your efforts to prevent it, Dr. Wood notes that it can usually be remedied in the office by freezing the endocervical canal with a thin cryoprobe using a similar technique as with the treatment of mild cervical dysplasia. ■

Send Us Your Clinical Pearls!

Please include your name, affiliation, and phone and fax numbers. Mail to:

Dr. Bruce L. Flamm
Kaiser Permanente
10800 Magnolia Ave.
Riverside, CA 92505

Or send them by fax to 909-353-5625 or by e-mail to bruceflamm@aol.com.

DR. FLAMM *is clinical professor of obstetrics and gynecology at the University of California, Irvine, and a practicing ob.gyn. at the Kaiser Permanente Medical Center in Riverside, Calif.*

Premier Inc. Launches Its New P4P Hospital Project

Building on the success of its Hospital Quality Improvement Demonstration, Premier Inc. is launching a new initiative to pay hospitals that perform at the top of a scale measuring improvements in mortality, the percentage of patients receiving appropriate care, efficiency, harm avoidance, and patient satisfaction.

Premier introduced the QUEST (Quality, Efficiency, Safety, and Transparency) initiative in late July and said it was recruiting hospitals to participate through the end of September. In a briefing with reporters, Premier president and CEO Richard A. Norling said that 60 hospitals had expressed interest so far, but he declined to name them.

Premier is an alliance owned by 1,700 nonprofit hospitals. Premier's purchasing network also serves 46,500 health care entities. The alliance's previous project—HQID—was a joint effort with the Centers for Medicare & Medicaid Services that began in 2003 and concludes in November.

QUEST will initially focus on hospitals' risk-adjusted mortality ratio, and on how well they deliver appropriate care, measured by the percentage of patients who receive perfect care according to evidence-based guidelines. Hospitals will also be measured on the severity adjusted cost per discharge, a reflection of efficiency.

In the second year, QUEST hospitals will have to show how well they prevent health care–related infections and adverse drug events, and how well they serve patients, measured through CMS Hospital Consumer Assessment of Healthcare Providers and Systems. QUEST participants are also expected to share best practices.

The hospitals that show the most improvement from baseline will receive an incentive payment, most likely in year 3. Premier has provided seed money for the incentives, said Susan DeVore, the alliance's chief operating officer. The company is in discussions with the Blue Cross Blue Shield Association to provide more funds.

QUEST results will be made public at some point, though in aggregate only.

"Transparency has arrived and should be considered a good thing for providers," said Dr. Ken Davis, chief medical officer of North Mississippi Health Services, at the briefing. The Tupelo, Miss.–based hospital is a member of Premier and will be a QUEST participant, he said.

—Alicia Ault

Medicare Demo Project Sheds Light On Pay-for-Performance Approaches

BY MARY ELLEN SCHNEIDER
New York Bureau

Preliminary results of a demonstration project that allows physician groups to share in savings they earn for the Medicare program has also resulted in quality gains, according to the Centers for Medicare and Medicaid Services.

The Medicare Physician Group Practice Demonstration is a 3-year project that encourages group practices to improve coordination of care for patients with chronic diseases. The project offers the practices financial incentives that meet clinical targets and save the Medicare program money above a certain threshold. In the first year (April 2005–March 2006), 10 participating practices were assessed based on their performance on evidence-based diabetes measures. All of the practices improved their clinical management of diabetes and met targets on at least 7 of 10 measures; two practices improved on all 10 measures.

Measures for the first year included hemoglobin A_{1c} management and control, blood pressure management, lipid measurement, LDL cholesterol level, urine protein testing, eye exam, foot exam, influenza vaccination, and pneumonia vaccination.

In addition to improving care, the demonstration saved the Medicare program about $9.5 million, Herb Kuhn, CMS acting deputy administrator, said during a press conference to announce the first-year results.

"We are seeing substantial and verifiable improvements in the quality of care for patients and improved efficiency in the delivery of that care," Mr. Kuhn said. The results show that Medicare is "on the right track" in terms of providing incentives for coordinating care, he said.

The demonstration includes 10 large, multispecialty group practices with a total of about 224,000 Medicare beneficiaries. The 10 group practices are Dartmouth-Hitchcock Clinic, Bedford, N.H.; Deaconess Billings (Mont.) Clinic; the Everett (Wash.) Clinic; Geisinger Health System, Danville, Pa.; Middlesex Health System, Middletown, Conn.; Marshfield (Wisc.) Clinic; Forsyth Medical Group, Winston-Salem, N.C.; Park Nicollet Health Services, St. Louis Park, Minn.; St. John's Health System, Springfield, Mo.; and University of Michigan Faculty Group Practice, Ann Arbor.

The demonstration encourages physicians to coordinate Part A and Part B Medicare services, invest in new care management programs, and redesign care processes. If these investments save money for the Medicare program, the physician groups are able to share in a portion of the savings. These performance payments are in addition to the regular fee-for-service Medicare payments received. Physician groups may share up to 80% of the savings, which are distributed based on financial performance and achievement of benchmarks in care quality measures, Mr. Kuhn said. To receive a performance payment, the practices' total Medicare spending growth rate must be more than 2 percentage points lower than a comparison population of Medicare beneficiaries in their local market area.

While all the practices met clinical targets for at least seven diabetes measures, only two practices received performance payments.

The Marshfield Clinic and the University of Michigan Faculty Group Practice earned performance payments for quality and efficiency improvements. In total, the two groups earned $7.3 million in payments; however, the two practices that met benchmarks in every clinical area—St. John's Health System and the Forsyth Medical Group—did not receive payments.

While other participating practices did achieve lower Medicare spending growth rates than comparison populations in their local markets, their savings did not meet the 2% threshold to share in the Medicare savings, Mr. Kuhn said.

Part of the problem may be that not all practices were able to fully deploy their initiatives in the first year, Mr. Kuhn said. "I think, overall, it's trending in a very positive way."

The first-year evaluation revealed an emphasis among the practices on care coordination, chronic disease management, efforts to avoid unnecessary hospitalizations, proactive case management, timely follow-up after hospital stays, and the use of health information technology. ■