

Health Policy NEWSLETTER

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FROM THE EDITOR

“TAP Your Feet”

Imagine for a moment how you might react if you were asked to participate in a project to design performance measures to guide the prescribing of various medications in the ambulatory setting for all physicians across the nation. In addition to these measures, you were asked to come up with a system outlining accountability for the use of these measures and, finally, whether these measures were appropriate for a national report card on physician ambulatory prescribing behavior. Who would be brave enough, or as the case might be, “silly enough,” to join such an effort and maintain one’s sanity!

Having been asked to participate in just such an effort, via the National Quality Forum (NQF), I would like to describe an updated version of the work of the NQF and specifically the Technical Advisory Panels (TAPs) charged with implementing the project known as “Standardizing Ambulatory Care Performance Measures.” I will briefly review the work of the NQF and then focus specifically on the activities involved with the various TAP committees. Finally, we will see how this work might be relevant to ongoing activities in measuring ambulatory quality across Jefferson University Physicians (JUP).

Astute readers of our newsletter will remember that the NQF (March 2001) is a quasi-public organization headquartered in Washington, D.C., whose mission is to “improve American health care through the endorsement of consensus-based standards for measurement and public reporting of health care performance data that provides meaningful information about whether care is safe, timely, beneficial, patient centered, equitable, and efficient.”¹ Many readers might remember when the immediate past president of the NQF, Dr. Ken Kizer, presented an overview of the organization during his presentation as the 11th Grandon Lecturer on our campus in May of 2002.

A unique feature of the NQF, which many believe represents its strength and weakness, is the open membership representing all healthcare stakeholders. There are member councils that are created with equal voice who help direct a formal consensus development process. Under the Federal OMB circular A-119, this consensus process of the NQF obligates the federal government to adopt voluntary (consensus) standards and encourages the federal government to participate directly in the process itself. In a word, so goes NQF, so possibly goes the Center for Medicare and Medicaid Services (CMS) and how most clinicians might be paid for their work.

The NQF has been hard at work over the past five years with projects that include things like Serious Reportable Events in Health Care, Safe Practices for Better Health Care, National Voluntary Consensus Standards for Hospital Care, and now, Standardizing Ambulatory Care Performance Measures. Space precludes a detailed review of other activities around the nation focused on ambulatory care, but one should recognize that other groups such as the Ambulatory Quality Alliance (AQA), the AMA Physician Performance Improvement Consortium (PPIC) and the National Committee on Quality Assurance (NCQA) are all working hard in the same arena.

In May of 2004, the NQF completed Phase I of the Standardizing Ambulatory Care Performance Measures project and picked 10 priority areas for ambulatory care measurement and evaluation. In 2005, Phase II of this project included the creation of 36 NQF-endorsed and physician-focused consensus standards in seven priority areas. The 36 consensus standards included such things as measures to improve the care of patients with asthma, depression, heart disease, hypertension, and guidelines for prevention, immunization and screening, all in the ambulatory context. Readers can go directly to www.NQF.org to get a more detailed idea of the scope and depth of these ambulatory performance measures.

I think it is appropriate to characterize these measures as evidence-based, detailed, and probably quite challenging for most practices from a compliance perspective. In some respects, this should not come as a surprise to most of our readers as organizations like CMS now pay hospitals like

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Jefferson a small additional increased percentage on key diagnoses (provided our outcomes meet national threshold standards) in exchange for Jefferson posting its outcomes (on multiple quality indicators) on the CMS website. This is known as the Hospital Quality Alliance project, or HQA. Importantly, there are parallels here. As we create greater systems of accountability on the inpatient side of the ledger, so will NQF lead the struggle to create comparable systems of accountability for what we do in the ambulatory setting. This is, in a word, inevitable.²

Back to some of the measures then. Detailed aspects of measures include, for example, (within the label of coronary disease) documentation of a cholesterol screen and lipid profile for every patient, the effectiveness of cholesterol control, and the presence or absence of anti-platelet therapy. Of course, one cannot overlook how important smoking cessation counseling and intervention also is to the measurable quality of ambulatory care. As I noted earlier, how would one operationalize these lofty goals and objectives to improve what we do in the office? To tackle these issues, the NQF has created a series of TAPs all charged with specific project deliverables. I would like to focus on the TAP that I chair, namely, the Medication Management Technical Advisory Panel.

My TAP has been charged with the following deliverables, namely, to review multiple sets of previously endorsed consensus standards and make specific recommendations for implementation and suggest further research issues for each set. We are going to start by reviewing the work of other organizations such as the NCQA and PPIC so as not to reinvent the proverbial wheel every time a group gets together. Our TAP reports up to a Steering Committee charged with oversight of all the TAPs tackling ambulatory care. Here is where it gets dicey. One can just imagine the tough medical politics and horse trading involved in: Where do we go first? Which disease is most important? What measures really work? Who judges the validity of the evidence basis behind every measure, and so on? One has to be part clinician, part medical diplomat, and part process engineer to successfully navigate the charge we have been given by the NQF and the Steering Committee overseeing our work.

Fortunately, we have an outstanding group of staff from the NQF, many with advanced training in public health, medicine, and quality measurement and improvement to help us through the maze of existing standards and to navigate the treacherous policy waters. For now, our committee is focused on key candidate measures that have been assessed against established evaluation criteria including characteristics such as the rationale behind the measure, its clinical importance, its scientific acceptability, and so on. Specifically, we are already knee deep in looking at measures that call for specific drugs to be avoided

in the elderly population, a measure we have adopted from the NCQA. We have also already made recommendations up to the Steering Committee to approve another NCQA-like measure concerned with the therapeutic monitoring for patients on persistent medication for certain chronic diseases. We are going to slug our way through at least 10 candidate measures for possible approval knowing that there is a population of over a hundred measures we might eventually be called upon to tackle.

I am aware that while we “TAP” our feet, skeptics out there contend that there are simply too many organizations and too many measures for the average well-meaning clinician to sort through. In part, they might be right! I see my role as chair of this particular TAP to not only accomplish the goals we have been assigned, but also to inject a dose of real-world thinking based, in no small part, on our work with the JUP Clinical Care Committee. Here’s what I mean. We have been working as the JUP Clinical Care Committee for nearly two years creating a series of ambulatory measures in both primary care and non-primary care specialties. We recently “Celebrated Our Gains” at an offsite practice-wide meeting with more than a hundred JUP members in attendance including nine chairs of clinical departments. I know from our first-hand, ground-level experience just how tough it is going to be to translate these activities into a national effort that will eventually become a part of a possible pay-for-performance mechanism implemented by Medicare.

So, while it might appear that we are “tapping our feet” in Washington, D.C. and dealing with untold numbers of policy wonk details, the final analysis is this – one way or another, CMS may use aspects of our work to create a pay-for-performance ambulatory care reimbursement mechanism. I am grateful for an opportunity to play a small policy role in this nationally important arena. I am also grateful to the work of our colleagues, most especially on the JUP Clinical Care Committee, who have demonstrated their willingness to lead this effort at the local level. I promise to keep our readers posted on the progress of our TAP and the greater work of the NQF in general. Stay tuned as we learn not only how to “TAP” our feet but also to possibly execute a beautiful ballroom dance with our many partners across the dance floor! As usual, I am interested in your views and you may reach me at my email address, which is david.nash@jefferson.edu.

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Letters to the Editor

Thank you to those who wrote to me about the December 2005 Editorial, “A Blink in Health Care”. Below I have shared excerpts from a few of the responses.
– David B. Nash, MD, MBA

...Enjoyed your review of *Blink* and your pointing out the relevance of Gladwell’s message to decision making in medicine. As you suggest, several of the people we had recently discussed this with (both physicians and non physicians) found his thesis uncomfortable, dismissing it as “too simplistic.”

Deborah Shlian, MD, MBA
Executive/Physician Recruiter

Congratulations on a very thoughtful and provocative review. Regarding decision theory, a framework known as “fuzzy trace theory” (Dr. Valerie Reyna) posits that decision making is influenced strongly by the perceived “gist” of a given situation.

Ron E. Myers, PhD, DSW
Thomas Jefferson University

I’m writing to respond to the question raised in the December 2005 Health Policy Newsletter – **Consumer Driven Health Plans: Wave of the Future?** I certainly hope not. While the article provides a good overview of a very complex issue, I don’t agree with the article’s conclusion that employers and employees who are early adopters should be “commended.”

The idea behind the so called consumer driven health plans is that the financial crisis in the healthcare system will be alleviated because we consumers will become more prudent shoppers when we have to spend our own money. I won’t run to the doctor for every mole or every little pain. But what if the mole is melanoma? And what if that pain is cardiac and not the spicy food from last night’s dinner?

Consumer driven health plans are clearly a great deal, as long as my family and I stay healthy. Instead of sharing the risk with my colleagues who may have heart disease or diabetes mellitus or cancer or get injured in an automobile accident, I can watch the money grow in my Health Savings Account. But what will happen to the cost of the PPO and HMO plans if the healthier people choose consumer driven health plans? I think the answer is obvious.

It is interesting that Dr. Nash in his editorial in the same issue of the Health Policy Newsletter praises the insight in Malcolm Gladwell’s book *Blink* as it applies to health care. Mr. Gladwell’s article *The Moral Hazard Myth: The Bad Idea Behind Our Failed Health Care System* (The New Yorker, 8/29/2005), expresses quite eloquently the flawed logic of consumer driven health plans.

Daniel Z. Louis, MS
Jefferson Medical College

Having given the book to many others, I realize that there is a positive correlation between people who like the book and those persons who I would rate high on “blink-ability.” I enjoyed Gladwell’s book because it explained to me why others have not seen/do not see what to me is obvious. In the past I thought everyone saw/experienced what I did; now, I understand that others do not.

Jane Delgado
National Alliance for Hispanic Health

You mentioned that Gladwell’s observation of “extra information is more than useless; it’s harmful; it confuses the issue” resonated with you. I couldn’t agree more – seems to me this is one of the major struggles I have every day – meetings where people ask for more and more information and have no idea why they are asking for it or how they will use it, frequently obliterating what might be a more logical, simplistic, commonsense, approach, and then spending interminable time trying to work their way out of the maze. Sort of a can’t see the forest for the trees problem.

Alan G. Adler, MD, MS, FACP
Independence Blue Cross

The December article relating to Health Quality Report cards is interesting and certainly representative of current realities. The fact that available data has not caused behavioral change has been a persistent concern to me. One perspective is the one noted in the article, the information and the process has not been around long enough. That may be the case; however, I wonder if there is not another factor. Specifically, do we understand how people buy any consumer good? If one looks at the relationship between buying behavior and product information in non-healthcare settings, such as autos or investment options, it does not appear that quality information affects the buying decision as much as one would expect. Why do people buy or persist in owning mutual funds that have consistently demonstrated poor performance as an example? I don’t know if the buying decision is different for health care than retirement investment but both appear to be core concerns, yet people do not seem to make the best use of the data that is available. Understanding how and why Americans buy, in general, may be more important than giving them more of the same information.

Michael J. Kryda MD
Ministry Health Care

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The Institute for Healthcare Improvement's 100,000 Lives Campaign

December 14, 2004 marked an important shift in the patient safety movement. It was this day that the 100,000 Lives campaign (100k Lives), created by the Institute for Healthcare Improvement (IHI), launched with a determined effort to improve patient care and prevent avoidable deaths in U.S. hospitals.¹

"The Institute for Healthcare Improvement is a not-for-profit organization driving the improvement of health by advancing the quality and value of health care."² "The Institute helps accelerate change in health care by cultivating promising concepts for improving patient care and turning those ideas into action."² The president and CEO of IHI, Dr. Donald Berwick was named the third most powerful person in U.S. health care in 2005.³ A nationally representative survey of hospital quality improvement directors and senior executives found that IHI was among the most cited outside sources of helpful advice.⁴ Dr. Berwick and organization's leadership have clinical and research experience that have been key to the success of IHI and the development and roll out of the 100k Lives campaign.

This campaign is designed to accelerate current progress to build a safer health system. The aim of the project is to implement evidence-based safety practices in hospitals that result in better care for patients across the nation. 100k Lives encourages participating hospitals to take part in any or all of **six changes** to improve patient safety.

1. Deploy rapid response teams. These teams, which may consist of dyads such as an ICU MD/RN team or an ICU RN/Respiratory Therapist team, may be called at any time by anyone in the hospital to care for a patient who shows the signs of deterioration that often occur prior to cardiac arrest.

2. Prevent adverse drug events. This change can be achieved through medication reconciliation; a process by which a comprehensive list of a patient's home medications are compared to those ordered while the patient is in the hospital.

3. Deliver reliable, evidence-based care for Acute Myocardial Infarction (AMI). Seven components of acute AMI care, such as early aspirin and beta-blocker administration and timely initiation of reperfusion, direct care toward evidence-based guidelines.

4. Prevent surgical site infections by using the best perioperative care, including the use of antibiotics and appropriate hair removal.

5. Prevent central line infections. Often called the "central line bundle", a set of five practices, such as hand hygiene and chlorhexidine skin antisepsis provides a foundation to prevent infection.

6. Prevent ventilator-associated pneumonia uses a set of four practices, such as elevation of the head of the bed to between 30 and 45 degrees and peptic ulcer disease prophylaxis.

A major factor contributing to the campaign's success is the practical and applicable nature of the interventions. These six changes target adverse events that occur frequently with modifications that can be readily implemented. The campaign is also very "user-friendly." Each of the six changes has a kit that consists of a How-To Guide, a PowerPoint presentation with facilitator notes designed to familiarize an organization with the intervention and an annotated bibliography. Tools tailored to each

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intervention, including a variety of training videos, checklists, forms, patient education materials as well as conference calls, further support participating hospitals. The feedback loop imbedded in the campaign is also integral to the practical appeal of 100k Lives. Participating hospitals are expected to

provide data over time as the interventions are undertaken and through this process hospitals can monitor their own progress and share stories of success. In addition to publicizing success, the IHI website has a forum for active discussion between participants.

The evidence base supporting 100k Lives, along with the IHI's clinical and research experience with the six changes, has been a major force in fostering support for the program. Organizations such as the American Medical Association, the Joint Commission of Accreditation of Healthcare Organizations, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality have all endorsed the philosophy and activities of the campaign. The philosophical/theoretical framework of the campaign is just as important as the evidence base. The campaign is based on the idea that "health care is a highly complex system" with many broken parts and that a medical error results from a failure of the system and not an individual. 100k Lives seeks to redesign care in order to bridge these gaps in the most critical areas.

It is also significant to note 100k Lives has been effective at using the approach of political campaign to disseminate its message. 100k Lives has a tangible goal of saving 100,000 lives in exactly 18 months, a bus tour, a slogan ("Some is not a number. Soon is not a time"), a communication infrastructure and press release templates. The campaign has garnered media attention from the Boston Globe, USA Today, Forbes, the Chicago Sun Times and Newsweek among others. Enrollment has also been impressive, with involvement of 3,000 out of the almost 5,000 community hospitals in the United States.⁵

Although all of the campaign's strengths, from the practical design to the evidence base interventions to the powerful leadership and organization support, have laid the groundwork for its success, it is the political campaign strategy that makes 100K Lives truly innovative. If this campaign is able to continue its momentum, health care quality improvement initiatives in the future may take on a similar campaign appearance.

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Interclerkship Day 2006: Improving Patient Safety

While of great importance in the practice of medicine, patient safety and quality improvement are rarely included in medical school curricula. On January 3, 2006, Jefferson's 3rd year medical students attended the 3rd annual Interclerkship Day, a program devoted to improving patient safety, with nationally-recognized speakers and focused workshops.

Below are summaries of the three keynote presentations. Summaries of the Workshops are available on the Jefferson Digital Commons at jdc.Jefferson.edu.

Adopting The Right Culture Before Residency: Lessons from the Aviation Industry

John J. Nance

*Founding Board Member and Executive Committee Member
National Patient Safety Foundation*

John Nance began with the premise that American medical schools have focused on preparing students to be “perfect practitioners” – practitioners who will never make a serious medical error. Training for perfection makes physicians intolerant of their mistakes and blinds them to the reality that perfection is unachievable.

Borrowing a quote from Donald Berwick (“Every system is perfectly designed to produce the results that it consistently achieves.”), Mr. Nance cautioned that if we try to improve patient safety without changing the culture we are destined to fail. He shared his “three basics of patient safety”:

1. Improvement in patient safety will depend primarily upon physician leadership.
2. Most medical tragedies and near-misses result, to a substantial degree, from communication problems.
3. No physician, nurse, or other healthcare provider can avoid making mistakes. The only reliable defense is constant expectation of errors.

Mr. Nance made a convincing case that the lessons learned by other industries can be adapted and effectively applied to medicine. “Think of physicians as pilots and operating room nurses as copilots.” The problems, he suggested, are not ones of technical ability but ones of human relations and teamwork issues. The “societal pathogen” in the case of patient safety is a collection of “killer assumptions”:

1. **Human perfection.** Re-shaping the goal from, “I will never make an error,” to, “I know how to minimize my chances of making an error.”
2. **Flawless communication.** Studies show that communications between people who speak the same language are not understood 12.5 percent of the time. The rate goes up in high stress situations.

3. **Flawless handoff.** Handoffs tend to be viewed as charting activities rather than patient care. It should come as no surprise that 33 percent of medical error reports contain stories of botched handoffs.

4. **Intelligent control of technology.** Too often, the technology is permitted to control the user.

The aviation industry learned its safety lessons in the wake of spectacular events that killed hundreds of people at one time. Mr. Nance delivered riveting accounts of a series of airline disasters that precipitated an in-depth analysis of aviation culture and the ensuing changes in aviation culture. Acknowledging that even the best pilots are not perfect, the industry dissected its culture and discovered how crucial information failed to be passed and acted upon. The end product is a nonhierarchical aviation culture that is collegial, with every team member sharing responsibility for solving problems and preventing errors.

The risk for error is reduced when all team members work in collegial fashion toward a common goal. An effective leader (i.e., chief resident or attending) leads with participation from the team, listening before making decisions. The standard for other team members is “assertiveness with respect”. In an atmosphere of assertiveness, personalities and egos are subverted and the welfare of the patient becomes the common goal.

Once we accept the reality that even the best practitioners are not perfect, we can eliminate “blame” (i.e., which doctor or nurse is at fault) from the culture. The question is not, “Who did it?” but rather, “What, in the underlying system, contributed to it?” Because errors are usually wired into the system design, isolated changes made by individuals and departments are rarely effective in improving safety. According to Mr. Nance, the most dangerous phrase in medicine is, “This is the way we’ve always done it.”

In summary, we must work toward a culture in which physicians are judged by how well they work in, or lead, a team approach to achieving an optimal, safe, outcome for the patient. Someone on the team usually has the necessary information, and the culture should facilitate sharing information at all levels. “As students of medicine, it is your duty to be part of the team. As future practitioners, it is your duty to become angry if team members do NOT speak up.”

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Safer, Alert, and Fatigue Education in Residency (SAFER)

Judith Owens, MD, MPH
Associate Professor of Pediatrics
Brown Medical School

Dr. Judith Owens, Director of the Pediatric Sleep Disorder Center at Brown Medical School and internationally-recognized authority on sleep, put a challenge to the third year medical students to do their part to minimize the adverse effects of sleep deprivation. Dr. Owens, the author of the recent JAMA paper, *Neurobehavioral performance of residents after heavy night call vs. after alcohol ingestion*, helped dispel some of the common myths about sleep and work performance.

Myth 1: Medical students and residents can adapt to less sleep.
Reality: All sleep debts need to be paid, sooner or later.

Myth 2: People have a good sense of how sleepy they are.
Reality: Sleepy people underestimate their level of sleepiness and overestimate their alertness.

Myth 3: People can try harder when they're sleepy, so that it does not effect their performance. Reality: Try as you may, you cannot compensate for the effects of sleep deprivation, which harm performance as much as several alcoholic drinks.

What to do about the problem is less clear. Though more intensive call schedules do lead to significantly higher error rates, adding a night float has not shown to make a difference in these error rates. A reason for this is that residents often do not sleep as they should, outside of the hospital. Dr. Owens made clear that, as high quality medical care depends on staying up on the latest research, doctors are similarly responsible personally for showing up to work well-rested.

Dr. Owens also emphasized how personally dangerous sleep deprivation can be to trainees. Dr. Owens personally suffered a motor vehicle accident during residency and, based on the data she shared, she was not unusual. She cited studies showing that emergency department residents are seven times more likely to have a car accident than before residency and nationally residents are two times more likely to have accidents and nearly six times more likely to have near miss accidents following call.

How about countermeasures, such as caffeine and napping? Unfortunately, there is no magic pill, other than plenty of sleep. Napping can help, as any sleep is better than no sleep. Coffee, unfortunately, as many of these readers know, is a double-edged sword. While it can temporarily increase alertness, and somewhat make up for performance losses due to sleepiness, tolerance develops and subsequent sleep is more disrupted and less restorative. Dr. Owens gave the instructive take-home measure that doctors, including those in training, need to focus on being "alert to take the best possible care of your patients and yourself". We need to consider it our personal, professional responsibility to do all in our power to show up ready to work, whether that means going to bed earlier, getting more naps or strategic cups of coffee. It's our personal health and the health of those we care for that's at risk.

Designing Reliable and Safe Patient Care

Paul Barach, MD, MPH
Associate Professor of Anesthesiology,
Medicine and Public Health
University of Miami Medical School

Although the Institute of Medicine (IOM) sounded the alarm over six years ago, the healthcare system is still plagued with medical errors and adverse events. There is significant variation in quality of care across the nation and inconsistent adherence to national treatment guidelines. For example, two recent studies of cardiopulmonary resuscitation (CPR) quality during cardiac arrest revealed that 50 percent of CPR is not performed according to published guidelines. What is it about medicine that makes practitioners prefer autonomy to improved outcomes?

It is critical that the focus shift from the individual to the team. The goal should be to develop adaptive, safe, professional healthcare teams whose members are equally empowered to take action and who share a common goal and vocabulary.

Why do we fail to deliver care that is safe and reliable? In medicine and other industries, people rely on technology to provide a solution. However, new technology doesn't eliminate errors, rather it moves them further downstream. Technology creates its own breed of errors. For example, computerized physician order entry systems are creating problems unforeseen by their developers. Technology makes us focus more on process. The goal is not to stop errors, but to keep errors from causing harm.

How do we change? Dr Barach posits that the keys to achieving ultra-safe health care are to:

- accept that human beings will make mistakes,
- transition from professional autonomy to professional teamwork,
- evolve from the craftsman mentality to that of an equivalent actor,
- develop system-level arbitration to optimize safety and develop a culture of safety, and
- simplify professional rules and regulations.

The IOM specifies six dimensions of care quality: it must be safe, timely, effective, efficient, equitable and patient centered. Dr Barach added two others: care must be educational (i.e., a reciprocal process in which patients and providers teach each other) and must empower wellness (i.e., it must enhance quality of life for all). Dr Barach opined that you can't achieve the first six dimensions without the additional two.

From a medical student and resident perspective, there are a few key principles supporting the redesign of patient care: patient care and medical education are inextricably linked, patient safety is a key characteristic, and all members of the care team are part of a high-performance clinical microsystem.

Navigating Medicare Part D: A Personal Experience with the New Medicare Prescription Drug Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created the largest expansion of benefits in the 40-year history of Medicare. It is also the first time in the history of the program that a Medicare benefit will not be available through the basic Medicare program but only through enrollment either in a stand-alone private drug plan or through a Medicare Advantage managed care plan. The MMA does not allow Medicare to negotiate volume discounts as is done by the Department of Veterans Affairs. The idea behind the law is that choice among seniors and competition among the private insurers will lead to lower drug prices.

A few days ago, I received a dreaded phone call from my mother. No, she wasn't ill. She was calling to ask me to help her enroll in the new Medicare prescription drug plan.

Coincidentally, I was giving a lecture on Medicare to the JMC first year medical students the next morning. I even had a few slides to explain the new Medicare drug plan. I know people have said it is complicated, but it shouldn't be too hard for me. I'm computer literate; I teach health policy; I've been doing health services research for 25 years. I assumed I could just go on-line, help my mother, and get some material for my class at the same time.

I signed on to Medicare.gov. Right there on the home page I saw what I needed. Just click here, it said, and we'll help you select the correct plan. Easy. I entered my mother's zip code and up came this message:

47 Medicare Prescription Drug plans are available in your area

Under this message there was a table summarizing the 47 plans.¹ For each of them, it told me the monthly premium, annual deductible, cost sharing, coverage in the gap, and formulary (percent of drugs covered).

The monthly premiums varied from \$4.10 to \$85.02. Both the \$4 plan and the \$85 plan have a \$250 annual deductible, no gap coverage, and 25 percent cost sharing. Both plans offer a choice of convenient local pharmacies in their preferred network. According to the summary table, the formulary for the \$4 plan covers 95 percent of the 200 most commonly used drugs by people with Medicare while the \$85 plan covers 85 percent. I guess that I need to dig a little deeper.

The monthly premium seems clear as does the annual deductible, but what do they mean by "cost sharing"? No problem, if I just click on the information icon, a pop-up window will explain all. Here's the definition of cost sharing:

The copayment and/or coinsurance amount range you will pay for each prescription. Plans can make changes in the list of prescription drugs they cover and their costs during the year. Call the plan to get all the details of prescription drug coverage, including the list of drugs the plan covers, so you understand any conditions or limits.

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When I clicked on a few of the plan names, I was able to get a bit more information. The copayment and coinsurance seem to differ by "tier." Now what does that mean? I found a glossary:

Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Searching through a few of the plans, I found that some have fixed dollar copayments that differ by tier and some have coinsurance, shown as a percentage, although I'm not quite sure what the percentage is based on. And, if I understand correctly, each plan can define its own list of drugs that goes into each tier. Oops, maybe this isn't going to be so simple. I love my mother, but I'm not sure I really want to call 47 different plans.

Medicare.gov also has a place to enter what drugs you're taking. Ah, I thought, maybe that will help to narrow things down. I called my mom and asked her to gather all her prescriptions and give me a list. Her answer was: "I'm not taking any prescription drugs." That's great for her, but not much help in picking a drug plan.

Now what? I work at a medical school so maybe I could call an epidemiologist and ask what are the diseases that an 80 year-old woman is most likely to develop, then call a pharmacist to ask what are the most appropriate prescription drugs for these diseases, and then I would have what I needed to compare the coverage of the different plans. But that wouldn't work anyway. Since the plans can change their formulary, their prices, and their copayments, I wouldn't know whether a particular drug would be included by the time she needed it and what it would cost.

Apparently, I'm not alone in my confusion. In a national survey, when asked how well they understand the drug benefit, 61 percent of seniors said "not at all" or "not well".² When told that most Medicare beneficiaries will have more than 40 plans to choose from 73 percent say that having so many plans "makes it confusing and difficult to pick the best plan." Readers of the Health Policy Newsletter should take note that 75 percent of seniors expect their pharmacists to be very or somewhat knowledgeable about drug plan choices and 65 percent expect the same of their physicians.

So after all of this, what was my advice to my mother? Don't do anything – yet. The 1 percent per month penalty for not enrolling does not start until May 2006. Maybe some of the plans will close before you have to decide.

Notes:

1. I would have included the table with this article, but at 12 pages it would have taken most of this issue of this newsletter.

2. Kaiser Family Foundation/Harvard School of Public Health Survey. The Medicare Drug Benefit: Beneficiary Perspectives Just Before Implementation (conducted October 13-31, 2005)

NOTICES

College for Advanced Management of Employee Benefits

This four-day training is designed to improve employers' skills in obtaining value (improved quality and/or lower cost) when purchasing health benefits. Upcoming programs are scheduled for:

April 25-28, 2006
Philadelphia, PA

September 18-21, 2006
Charlotte, NC

The Health Policy Forum: Upcoming Speakers 2006

We are pleased to announce our Spring 2006 schedule for the Health Policy Forum. The Forum meets on the second Wednesday of each month from 8:30 a.m. to 9:30 a.m. in Conference Room 218, Curtis Building, 1015 Walnut Street, Philadelphia, PA. A light breakfast is served.

For more information on any of these programs please contact David B. Nash, MD, MBA at (215) 955-6969 or david.nash@jefferson.edu

April 12, 2006

Michael Peterson, EdD
Associate Professor
University of Delaware
What People Value at Work

May 10, 2006

Gus Geraci, MD, FAAFP, FACEP, CPE
Local Medical Advisor, Pennsylvania, McKesson Health Solutions
AccessPlus Medical Director
PA ACCESS Plus Program Update

June 14, 2006

David Levin, MD
Professor, Department of Radiology
Jefferson Medical College
The Recent Rapid Rise in Utilization of Diagnostic Imaging

Welcome Alexandria Skoufalos, EdD

The Department of Health Policy would like to welcome Alexis Skoufalos, EdD as the Program Director of Education.

Dr. Skoufalos joined us in early December 2005. Please join us in welcoming Dr. Skoufalos. She can be reached at 215 955-2822 or alexis.skoufalos@jefferson.edu.

Senior Scholars Program: Building Connections with the Department of Health Policy

Welcome to Our Newest Senior Scholars!

For further information, visit the Department website at www.jefferson.edu/dhp or call 215-955-6969.

James P. Boland, MD, MPH, FACS
Professor, Department of Medicine
West Virginia University

Harry L. Leider, MD, MBA, FACPE
Chief Medical Officer
XLhealth

Marshall Z. Schwartz, MD
Pediatric Surgeon
St. Christopher's Hospital for Children



The Department of Health Policy is saddened by the loss of its friend and colleague, Howard Elephant, MD. Dr. Elephant was the Medical Director at Frankford Health Care System and a dedicated member of the Health Policy Newsletter Editorial Board. Our condolences to his family and friends. He will be missed.

New Publications from the Department of Health Policy

Alvarez K, Sciamanna CN. Empowering Patients to Improve Safety. *Am J Med Qual.* 2006;21(1):5-6.

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Hudson LR, Hamar GB, Orr P, Johnson JH, Neftzger A, Chung RS, Williams ML, Gandy WM, Crawford A, Clarke J, Goldfarb NI. Remote Physiological Monitoring: Clinical, Financial, and Behavioral Outcomes in a Heart Failure Population. *Dis Manag.* 2005;8(6):372-381.

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Nash DB. Public Health Genomics. *Biotechnology Healthcare.* 2005;2(6):6.

Nash DB. Best Buy Drugs. *P&T.* 2005;30(11):613.

Nash DB. PPIs and Suppressing Surprise. *P&T.* 2005;30(12):692.

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Singh M, Goldfarb NI. "The Costs of a National Health Information Network" (Literature Review). *Am J Med Qual.* 2005;20(6):362-363.

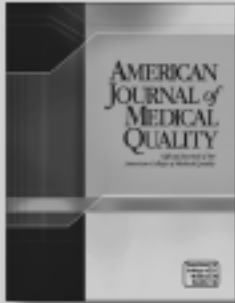
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The Disease Management Colloquium

An Executive Education Course on the Role of Disease Management in Medicare, Medicaid, Healthcare Cost Efficiency, Quality and Medical Errors Reduction

May 10 - 12, 2006

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Hyatt Regency Philadelphia at Penn's Landing



We are very pleased to be able to welcome everyone to Philadelphia. We believe this is an outstanding conference and we know you will all enjoy it immensely. We have assembled a top notch faculty and the interaction will be first rate. Disease Management is a dynamic field and in order to stay on top of the details it takes hard work and attention to what the experts have to say.

David B. Nash, MD, MBA, FACP
The Dr. Raymond C. and Doris N. Grandon Professor of Health Policy and Chair of the Department, Jefferson Medical College

Overview

The Colloquium seeks to better educate government agencies, the health care industry (including health plans and providers), employers, and the general public about the important role disease management programs play in improving health care quality and outcomes for persons subject to chronic conditions.

Who Should Attend:

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- Medical Directors
- Medicare Directors
- Medicaid Directors
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- Managed Care Pharmacy Directors, Pharmacy Managers and Retail Pharmacists
- Chain Pharmacists, Community and Independent Pharmacists
- Directors and Deputy Directors, State Departments of Public Health
- CIOs, CTOs, Vice Presidents and Directors of Information Systems
- Directors of Programs in Asthma, Cardiovascular, Oncology, Pain, Behavioral Health, Women's Health, and Alternative Medicine
- Vice Presidents, Quality
- Vice Presidents, Managed Care
- Directors, Disease Management
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- Psychologists
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- Harvard Health Policy Review
- Health Affairs
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