

What Are You Doing About Health Care Quality in Your Practice?

Part II (with Appendices)

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Designate Someone in Your Practice to Be Responsible for Quality and Quality Improvement

Select one physician within your practice as the leader for your quality and quality improvement efforts. He/she will take a lead role in understanding the state-of-the-art, obtaining standards that are relevant for your

practice, and in guiding your entire team to work with those standards to make systematic process improvement.

Take an Objective Look at Your Practice

I get calls all the time about a common state of affairs. Physicians tell me: "My practice is a mess. Can you do an operational audit, tell me what is wrong, and tell me how to fix the problems." Sure I can, and I do. More often than not, however, the physicians know exactly what the problems are but are less clear on how to document the issues, correct what is wrong, and measure the change.

The operational audit that so many of you request has at least three components: analysis of structure, workflow, and outcomes. Let's look at them one at a time. With respect to structure, I regularly see two problems that have a negative impact on quality of care. One is the lack of a competent practice administrator or manager and the second is ambiguous physician responsibility for practice management. Some of you tell me with a straight face that you "sort of have a practice manager." Others tell me that you "love seeing patients, hate practice management, and rotate the physician in charge so that nobody has to spend too much time doing the terrible job of managing the practice." Both of these common structural problems produce the same result: your practice doesn't know what management entails, what steps you need to take, and who is responsible for each task. If you adjust and improve your structure, you'll have a better chance of improving your processes and outcomes.

Workflow process is a second issue, and it's a big one. Many of you haven't changed the way you run your practices in 30 or 40 years. If you introduce EMR into your practice before you improve your workflow,

you'll automate your inefficiencies instead of correcting them. Ask yourself about the processes that are currently in place for every aspect of your practice, including but not limited to appointment scheduling, check-in, collection of demographic information, review of systems, moving the patient into and out of the exam room, prescriptions (ordering and refill), check-out, ordering ancillary tests and routing the results to physicians and patients themselves, and billing and collections. Does every process that you now have contribute positively to the delivery of care to your patients in the way in which you would like it to do? I recently asked one of my clients if I could use a stopwatch to look at his practice workflow. He corrected me and suggested I use an hourglass!

If your workflow analysis identifies many problems, see if you can measure them, fix them, and measure them again. Here are some examples. How many patients did your practice turn away because you couldn't book a convenient appointment? How many claims denials did you receive because information was incomplete and/or inaccurate? How many more patients could you have seen each day if you weren't saddled with administrative work that could have been done by someone else or electronically? Would your nurse have treated more patients if she had been able to communicate with health plans and pharmacies electronically rather than by phone? How much money did you lose because you filed claims late? How much money do your patients and insurance companies owe you?

Finally, what about outcomes? Can you do a diagnostic test on your practice to see if you can improve a quality gap? Here are practical suggestions.

- Explore reliable national registries to which you can submit information on your patients and from which you can receive comparative information. For example, in January 2006, Medicare implemented its Physician Voluntary Reporting Program enabling physicians to voluntarily report information on 36 evidence-based measures to the Centers for Medicare & Medicaid Services (CMS).
- Select a nationally accepted quality measure and apply it to 20 consecutive patients to see how good a job you are doing. There are excellent evidence-based measures available for diabetes, asthma, congestive heart failure, and preventive care.
- Given the structure and workflow of your practice, extract useful information about the patients for

"Does every process that you now have contribute positively to the delivery of care to your patients. . . ?"

whom you care from your practice management, electronic health records, and other systems. Organize the information to tell you about patients as individuals and about subsets of patients. Do you know patients' ages and where they live? If you are a primary care physician, do you know how many of your patients have chronic conditions such as asthma, diabetes, or heart disease? For these chronic patients, do you keep careful track of important measurements, medications, and other indicators? If you are a specialist physician, do you know your most common diagnoses or procedures? If you do, are you sure that the care that you and your partners provide to this group(s) of patients meets the standards that your specialty society promulgates? Do you know how to use evidence-based medicine at the point of care?

Organize Your Findings

If you have done a thorough job of looking at your practice, you are likely to find many areas that need improvement. Make your list of issues and organize it in a way that makes sense to you. Here's an example. One of my clients asked me to do a practice audit and report back on workflow issues. Once that was done, we had a long and overwhelming list of problems that required attention. We then looked at the implications of each problem. Some issues had a direct impact on patient care (eg, communications between front office and clinicians). Other issues had financial implications for the practice (eg, absence of a revenue-cycle management process). Still others were related to compliance. Clearly we couldn't tackle everything at once. Rather than work only on dollars or patient care, we selected several issues from each category, addressing those we knew we could fix sooner rather than later. With a well-organized work plan, we watched our list of tasks shrink. A step-by-step template that takes you through a meaningful improvement effort can be found at www.clinicalmicrosystem.org.

Document Your Quality Efforts

Quality improvement should be an ongoing activity in your practice. Document exactly what you do so that you can determine progress and self-correct your improvement process as you continue to learn. Documentation will also help you with accountability—to yourself, to your practice, to professional organizations, to public and private payers, and to your patients. If you do regular satisfaction surveys for patients and for your colleagues in the medical community, check to see if your quality improvement activities have a positive impact on the results.

Appendices

Appendix 1: Glossary of Terms (Source: National Quality Measures Clearinghouse Sponsored by Agency for Healthcare Research and Quality and CMS)

Incidence: rate, showing how many new cases of a disease occurred in a population within a specified time interval. It is usually expressed as the number of new cases per time unit per fixed number of people (e.g. number of new cases of cancer per 10,000 persons within a year).

Institute of Medicine: private, not-for-profit institution that provides objective, timely, authoritative information and advice on health and science policy to government, the corporate sector, the professions, and the public under a congressional charter.

Quality Measures

Clinical performance: degree of accomplishment of desired health objectives by a clinician or health care organization.

Clinical performance measure: a subtype of quality measure that is a mechanism for assessing the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient within the optimal time period.

Measure: a mechanism to assign a quantity to an attribute by comparison to a criterion.

Quality measure: a mechanism to assign a quantity to quality of care by comparison to a criterion. A quality measure relies on the definition of clinical performance, clinical performance measure, measure, and quality of care.

Quality of care: the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Rationale for the Measure: a brief statement describing the patients and the specific aspect of health care to which the measure applies. The rationale may also include the evidence basis for the measure and an explanation of how to interpret results.

Reliability: the degree to which the measure is free from random error.

Standard of Comparison:

External comparison at a point in time: comparison using the same measure for multiple comparable entities (e.g. non-teaching hospitals, large health plans, states).

External comparison of time trends: comparison using the same measure for multiple comparable entities tracking change over time.

Internal time comparison: comparison using the same measure in the same organization at two or more points in time to evaluate present or prior performance.

Prescriptive standard: standard set as a goal that ought to be achieved or as a threshold that defines minimum performance. The standard may be derived from studies using different measurement methods.

Validity: the degree to which the measure is associated with what it purports to measure.

Vulnerable populations: groups of persons who may be compromised in their ability to give informed consent, who are frequently subjected to coercion in their decision-making, or whose range of options is severely limited, making them vulnerable to health care quality problems. Examples are: children, disabled, frail elderly, homeless, illiterate/low-literate populations, immigrants, medically uninsured, mentally ill, minority groups, non-English speaking populations, poverty populations, prisoners, rural populations, terminally ill, transients/migrants, urban populations, and women.

Appendix 2: National Quality and Quality Improvements Initiatives

- **Accreditation Council for Graduate Medical Education (ACGME):** this organization now requires all resident physicians to be competent in quality improvement. (www.acgme.org)
- **Agency for Healthcare Research and Quality (AHRQ):** this agency is the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decisionmaking. (www.ahrq.gov)
- **American Board of Medical Specialties (ABMS):** all twenty-four certifying boards now require physician competency in practice based learning and improvement to main-

“Quality improvement should be an ongoing activity in your practice”

tain board certification. (www.abms.org)

- **American Board of Quality Assurance and Utilization Review Physicians (ABQAURP):** this is the largest organization of interdisciplinary healthcare professionals in the country. The organization's ultimate goal is to improve the quality of care in the US, and it is dedicated to providing healthcare education and certification to physicians, nurses, and other professionals. ABQAURP has an examination that is developed, administered, and evaluated through the National Board of Medical Examiners. (www.abquaurp.org)
- **American College of Medical Quality** is the specialty medical association for physicians and other professionals in the fields of clinical quality improvement, quality assessment, and medical quality management. ACMQ publishes the American Journal of Medical Quality. (www.acmq.org)
- **Centers for Medicare & Medicaid Services (CMS):** the Physician Focused Quality Initiative includes the Doctor's Office Quality (DOQ) Project, the Doctor's Office Quality Information Technology (DOQ-IT) Project, the Vista-Office E H R, and several Demonstration Projects and Evaluation Reports. Appendix 7 has additional information on these programs. (www.cms.hhs.gov/quality/pfqi.asp)
- **California Health Care Foundation's Quality Initiative** coordinates quality measurement and outreach projects in Health Care Quality. (www.chcf.org)
- **Hospital Quality Alliance** is a voluntary alliance of the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), and the Federation of American Hospitals (FAH). Its national effort publicly reports quality performance on ten measures for three conditions, acute myocardial infarction, heart failure, and pneumonia. The data is posted on the Web site. (www.aamc.org/quality/hospitalalliance/start.htm)
- **Institute for Healthcare Improvement (IHI)**, founded by Donald Berwick, MD in 1991, is an independent not-for-profit organization located in Boston, MA. Its focus is acceleration of improvement in health care systems in the US, Canada, and Europe through collaboration, not competition. IHI sponsors an annual International Summit on Redesigning the Clinical Office Practice as well as other resources to help individual physicians and larger systems of care make changes toward better quality of care. (www.ihl.org)
- **National Association of Healthcare Quality** is dedicated to improving the quality of healthcare and supporting the development of professionals in healthcare quality. (www.nahq.org)
- **National Committee for Quality Assurance (NCQA)** is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, including HMOs. NCQA uses HEDIS measures. (www.ncqa.org)
- **National Quality Forum for Health Care Quality Measurement and Reporting** is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr William Roper, chief executive of the University of North Carolina Health Care System, is a new member and chairman-elect of this group. (www.qualityforum.org)
- **Professional societies** such as the American College of Physicians (ACP), American Academy of Family Practice (AAFP), and the American Academy of Pediatrics (AAP) offer programs to assist practicing physicians improve the quality of care. See their respective web sites.

Appendix 3: North Carolina Quality and Quality Improvement Initiatives

- **Blue Cross Blue Shield of North Carolina:** Don Bradley, M.D., Executive Medical Director for the company, notes that the concept of quality is embedded in the Blue Cross mission to provide "quality information, services, and products that help members maximize their healthcare." Blue Cross Blue Shield has actually dissolved its Quality Department; the entire organization is responsible for quality improvement.

With respect to meeting patient needs, quality means that the company not only provides covered services to members, but also helps members access services that may not be covered but that may help them get meet their needs. Patients have on-line access to policies so they know the rules on which decisions are based. Blue Cross depends heavily on the use of data to make decisions and to help members make their own decisions. The company tracks HEDIS indicators, and its PPO is the only NCQA-accredited plan in the state. Data also drives Blue Cross' decisions on centers of excellence for bariatric surgery, colon-cancer screening centers, and other programs. Each year, primary care physicians receive report cards that enable them compare their own performance with that of other physicians.

As a former family practitioner in South Boston, VA Dr. Bradley encourages physicians to be proactive about quality within their own practices. He suggests they select key indicators for their own practices and sign up to participate with patient registries. Dr. Bradley is cautious about some of the Pay-for-Performance programs that are receiving so much attention. He believes that measures are valuable to physicians if they are appropriate, actionable, and applicable to a member's well-being. If measures don't meet these criteria, they are not particularly helpful in providing quality care to patients. (Bradley, July 13, 2005).

- **The Carolinas Center for Medical Excellence (CCME), formerly Medical Review of North Carolina, Inc.:** a physician-sponsored, nonprofit health care quality improvement organization, CCME has been designated by the Centers for Medicare and Medicaid (CMS) as the Quality Improvement Organization (QIO) for North Carolina. With input from the medical community, CCME develops cooperative quality improvement projects on clinical topics affecting seniors. Through the DOQ.IT program, the organization provides technical assistance to primary care practices (except pediatrics) that request assistance in selecting and implementing Electronic Medical Records.
- **Center for Children's Healthcare Quality (CCHI):** this center within the University of North Carolina School of Medicine works with medical practices in North Carolina and nationally to do quality improvement projects in office redesign and clinical care.
- **Mid-Carolina Physician Organization/FirstCarolinaCare and FirstHealth of the Carolinas:** Mid-Carolina Physician Organization is the physician component of a community collaborative that includes FirstCarolinaCare and FirstHealth of the Carolinas. The provision of high quality care is one of the organization's major goals. The organization has selected specific HEDIS scores to be in the top 25th percentile for member physicians, and it also provides case management services to help members improve quality and manage the cost of care. MCPO also ensures that its members adopt and commit to nationally recognized guidelines for clinical care with appropriate local modifications (Hendrickson, 2005).
- **North Carolina Business Group on Health (NCBGH):** this not-for-profit employer coalition was founded in 2001 and now includes 41 self-insured employers that are located primarily but not exclusively in the seven-counties of the Raleigh-Durham MSA. The group's sole focus is on health care price and quality, and its goal is to identify lead institutions and physician groups, publicly acknowledge them, and reward them for their commitment.

Taking its lead from the activities of the National Quality Forum and Leapfrog, NCBGH has asked area hospitals to participate in surveys for Leapfrog and to make the results available on a public Web site. With respect to quality of care in physician practices, the coalition is looking at Bridges to Excellence. IBM and CIGNA are both active in this effort.

- **North Carolina Healthcare Information and Communications Alliance (NCHICA):** NCHICA is a nonprofit collaboration among providers, professional societies and associations, payers, state and federal government agencies, and vendors and consultants. It is dedicated to "improving

healthcare in North Carolina by accelerating the adoption of information technology.” NCHICA focuses on safety, quality, effectiveness, and efficiency in the systems and processes that are used in healthcare. It undertakes demonstration projects that meet a defined clinical need and that can be met with standards-based solutions. Past projects include collaboration with the North Carolina Division of Public Health for an Internet-based combined immunization database for children and the collection of emergency room clinical data for public health surveillance and best practice development. NCHICA is currently developing a North Carolina Quality Initiative. Phase I revolves around medications management (i.e. access to medication history, formularies, automation of refills, and electronic prescribing). Phases II and III will focus respectively on electronic lab and radiology orders and reports and electronic health records. (www.nchica.org) (Anderson, July 20, 2005)

- **North Carolina Medical Society:** the Quality of Care and Performance Improvement Committee chaired by Clyde Brooks, M.D. has a broad agenda that includes but is not limited to: supporting Ini's 100,000 Lives Campaign and participating as a campaign partner for that initiative to raise physician awareness and facilitate campaign communications to physicians; collaborating with Medical Review of North Carolina on an Enhanced Safety and Performance (or Innovations) Project that seeks to identify, evaluate, and communicate innovative ideas and measures implemented by physician offices across North Carolina that have led to enhanced safety, quality and clinical effectiveness; pursuing an ambitious project to restructure primary care; developing a quality web page that would include resources for clinicians, office staff, and patients; with AHEC, identifying CME opportunities so physicians can earn both I and II CME credit for performance improvement activities; and participating in the AMA Physician Consortium for Performance Improvement (Phelps, July 15, 2005).
- **Orthopaedic and Sports Medicine Associates PLLC:** this private practice in Raleigh has five physicians and three Physician Assistants in one location. The senior Physician Assistant is the Medical Director for the Practice. Since the practice opened in 2000, it has measured quality in four areas: patients, people (i.e. staff), financial management, and facility/environment. In the patient care area, the practice sends out 200 satisfaction surveys each quarter; its goal is 95% satisfaction. The physicians and other clinical staff developed specific protocols for 25 common procedures and conditions; these protocols serve as a guide for clinical care. As in most practices, the physicians were trained in different places, and so each has his/her unique style of practice. In an effort to share knowledge, when time allows, the physicians perform as co-surgeons. The practice also allows and encourages non-physician staff to come into the operating room and watch the surgeons in order to get a better idea of what is going on with patients (Adkins, 2005).
- **Quality Council of North Carolina:** this organization of healthcare professionals in medicine, nursing, research, management, and administration was formed in 2002. Its mission is to improve the quality and value of medical care available to the people of North Carolina, and its vision is to be an integrative force. Three areas of focus are education, collaboration, and action. The Council's annual Innovations in Clinical Practice Symposium is held in April.
- **State chapters of professional societies:** state chapters of the American Academy of Physicians and the American Academy of Family Physicians have sponsored quality improvement efforts.
- **UNC Health Care System:** The UNC Health Care System is a not-for-profit integrated health care system owned by the state of North Carolina. UNC Hospitals in Chapel Hill has 688 licensed beds, 959 attending physicians, and 5,800 FETs. It's big! Brian Goldstein, M.D., the Executive Associate Dean for Clinical Affairs for the UNC School of Medicine and Chief of Staff for the UNC Hospitals is responsible for

most although not all of the system's initiatives in quality and quality improvement. Dr. Goldstein heads the Performance Improvement Department for the health care system. Major programs include:

Support for the Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign. UNC supports six working interventions and has also developed a pediatric rapid response team. Works in process include an adult rapid response team and a program for medication reconciliation.

Support for unit level clinical and operations improvement projects. Units that approach the Performance Improvement Department receive a pre-formatted spreadsheet that helps them capture and use data.

Reporting for the CMS Hospital Quality Alliance, JCAHO, and other external agencies.

The Performance Improvement Department is not the only place within the UNC Health Care System that is concerned about quality and quality improvement. The Department of Hospital Epidemiology, which predates the creation of IHI, has been successful in motivating the entire workforce to support hand hygiene. As a result, UNC's hand-washing rates are consistently excellent. Within the Department of General Internal Medicine, care teams focus on diabetes, congestive heart failure, and chronic pain management. The National Institute for Children's Health Quality focuses on office-based improvement.

UNC attributes the progress that it has made in quality and quality improvement to several factors, including but not limited to dedication of the caregivers at the bedside, support from top leadership, and an outstanding electronic health record system (Goldstein 2005). As in many organizations, a barrier to progress is resistance to changing processes of care.

- **UnitedHealth Premium Designation Program:** United's Premium designation programs recognize specialty and primary care physicians and cardiac facilities that meet or exceed certain evidence and consensus based quality and efficiency standards. Physicians who are Board Certified or Board Eligible may meet the "quality only" or "quality and efficiency" criteria and see an increase in volume of patients accessing their practice. As part of the program, physicians also have access to evidence based information and peer-to-peer comparison data. Eligible designated physicians who perform at the highest levels may also participate in a limited pilot program called Practice Rewards that provides enhanced reimbursement. (UnitedHealthcare, 2005).
- **WellPath/Coventry Healthcare Plan:** According to Dan Barco, MD, Vice President for Medical Affairs for WellPath Select, Inc., health plans have an obligation to look at the quality of what they themselves do. They need to monitor member complaints and satisfaction, regularly review appeals, and make sure that health plan processes do not have a negative impact on patient care. With respect to the quality of patient care that is delivered within each physician's practice, Dr Barco believes that health plans and other external organizations are not the most appropriate change agents; at best, they can have a limited influence on what goes on behind the closed doors of exam rooms. Having made that important distinction between the internal responsibilities of physicians themselves and that of external organizations, Dr Barco described WellPath/Coventry's two-part quality effort. The plan has a series of programs to evaluate and improve the quality of service and care it provides to members. The focus is on claims payment, utilization review, and the appeals process. It also has a number of small pilot projects to evaluate the potential impact of Pay for Performance programs with larger physician organizations, as opposed to individual practices. WellPath/Coventry's disease management programs have had an impact on care in certain areas. Rather than dealing with the processes of care within physician offices, these programs focus on making sure that patients are aware of the needed preventive services associated with their chronic diseases. (Barco, July 2005).

Appendix 4: Recommended Books and Articles

Audet, M.D., Doty, M.M., Shamadin, J., et al. (2005). Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement. *Health Affairs*. May/June 24 (3): 843-853.

Berwick, D. (2003). *Escape Fire: Designs for the Future of Health Care*. Washington, D.C. Institute for Healthcare Improvement.

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Agency for Health Care Research and Quality (AHRQ) (2004). *2004 National Healthcare Quality Report*.

Institute for Healthcare Improvement Breakthrough Series Guides:

- “Improving Asthma Care in Children and Adults”
- “Improving Outcomes and Reducing Costs in Adult Cardiac Surgery”
- “Reducing Adverse Drug Events”
- “Reducing Cesarean Section Rates While Maintaining Maternal and Infant Outcomes”
- “Reducing Costs and Improving Outcomes in Adult Intensive Care”
- “Reducing Delays and Waiting Times throughout the Healthcare System”

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Ransom, S.B. and Pinsky, W. Editors (1999). *Clinical Resource and Quality Management*. Tampa, FLA. American College of Physician Executives.

Reinertsen, J. and Schellekens, W. (2005). *10 Powerful Ideas for Improving Patient Care*. Washington, D.C. Institute for Healthcare Improvement.

Appendix 5: Continuing Education and Training on Quality and Quality Improvement

American Academy of Family Physicians
 American College of Physician Executives
 Institute for Healthcare Improvement
 American College of Physicians
 North Carolina Medical Review
 North Carolina Quality Council

Appendix 6: On-Line Publications Promoting Quality Health Care (from AAFP list)

HealthWeb
 National Guideline Clearinghouse
 PubMed
 Quality in Health Care (e.QHC)
 QualityIndicator.com
 United States National Library of Medicine

Appendix 7: Information on Centers for Medicare & Medicaid Services (CMS) Physician Focused Quality Initiative

The Doctors Office Quality (DOQ) project is designed to develop and test a comprehensive integrated approach to measuring the quality of care for chronic disease and preventive services in physicians' offices.

The Doctors' Office Quality – Information Technology (DOQ-IT) project supports the adoption and effective use of information technology by physicians' offices to improve quality and safety for

Medicare beneficiaries and all Americans. With DOQ-IT funding, the Quality Improvement Organizations (QIOs) in each state will provide assistance to practices that provide care for Medicare patients.

VistA Office E H R: CMS is working with the Veterans Health Affairs (VHA) to transfer health information technology to the private sector. CMS and other federal agencies have funded the development of a VistA-Office E H R version of the VHAs hospital VistA system for use in clinics and physician offices.

Demonstration Projects: One important CMS funded demonstration project for Medicare is testing a combined fee-for-service and a bonus payment derived from savings achieved through improvements in the management of care and services. Another project features a pay-for-performance program to physician groups for promoting the adoption and use of health information technology to improve quality and reduce avoidable hospitalizations.

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Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement, Anne-Marie J. Audet, MD, Michelle M. Doty, MPH., PhD, Jamil Shamadin, and Stephen C. Schoenbaum, MD, MPH, *Health Affairs*, May/June 2005 24 (3).

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Ms Satinsky is president of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in healthcare administration from the Wharton School of the University of Pennsylvania. She is the author of two books: *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997) and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). Her new book, *Handbook for Medical Practice Management in the 21st Century*, is scheduled for publication later this year. The *Forum* has published several articles by Ms Satinsky, including Managing the Implementation of HIPAA and the Privacy Rule, in #4, 2002; How to Determine If Your Practice Could Use a Professional Practice Administrator, in #2, 2003; Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 1, in #1, 2004; Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 2, in #2, 2004; Electronic Medical Records and the Development of Electronic Health Records and Electronic Patient Records, in #3, 2004; and What Are You Doing About Health Care Quality in Your Practice? Part I, in #1, 2005. An adjunct faculty member at University of North Carolina School of Public Health, Ms Satinsky is a member of the Medical Group Management Association. She may be reached at (919) 383-5998 or margie@satinskyconsulting.com.

NCMB Policy Committee Continues Review of Position Statements, Offers Results of Recent Review

The Policy Committee of the North Carolina Medical Board regularly reviews the Board's various position statements. The Board's licensees and others interested in the subjects dealt with by the statements are invited to offer comments on any statement, in writing, to the chair of the Policy Committee, by e-mail (info@ncmedboard.org) or post (PO Box 20007, Raleigh, NC 27619). Comments will be collected over time and considered when the relevant statement is reviewed.

The Policy Committee discusses the position statements in public sessions during regularly scheduled meetings of the Board. The results of each review are published on the Board's Web site and in the *Forum* before consideration by the Board, allowing for further written comments to assist the Policy Committee in preparing the final version for Board action.

ACTIONS

The Board's statement on "The Retired Physician" was reviewed in May 2006 and no revision was proposed or adopted.

The following three statements are being considered by the Board for revision, as noted, in the near future. [The opening paragraph in the first ("The Physician-Patient Relationship") is the only section being considered for revision. Therefore, the rest of the statement is not being reprinted here.]

The Physician-Patient Relationship

The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent

care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

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 (Adopted July 1995)
 (Amended July 1998, January 2000; March 2002, August 2003)
 (Under revision)

Care of the Patient Undergoing Surgery or Other Invasive Procedure* Care of Surgical Patients*

The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative assessment appropriate to the procedure. The assessment shall include a review of the patient's data and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery, advising the patient fully of the risks involved. It is also the responsibility of the operating surgeon to reevaluate the