Jefferson Health System

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FROM THE EDITOR

Hepatitis C: A Stakeholder Analysis

Imagine the following clinical scenario. A robust 45-year old female executive goes to her family doctor for an annual screening physical exam. She has been well her entire life and has been responsible for coordinating the health care of her husband and their adolescent children. Several days after her primary care doctor visit, she receives a telephone call alerting her to the fact that her liver enzymes (the test used to gauge liver function) are slightly elevated.[1] After an additional follow-up visit, she is diagnosed with a chronic viral infection of her liver that could slowly destroy this vital organ and, indeed, kill her in the next decade. This is the clinical face of infection with the hepatitis-C virus (HCV).

HCV is now the most common cause of viral-related cirrhosis in the United States and is currently the leading indication for liver transplantation. Nearly four million Americans, about 2% of the adult population, are infected with the hepatitis-C virus - most of them without knowing it. The numbers are undeniable. Nine thousand people die each year in the U.S. from complications of HCV (a number that is expected to triple by 2010).[2] Once infected, only 15% of patients are able to clear the virus. The other 85% suffer chronic infection; 3 of these, about 20% will suffer from progressive liver disease.

Where did this silent killer come from, and is any effective therapy currently available? Clinicians know that diagnosis of infection with different hepatitis viruses has been an important part of primary care practice for decades. Dr. Baruch Blumberg received the Nobel Prize for identifying the hepatitis-B virus in the mid 1960s, which paved the way for researchers to develop reliable blood tests for the virus. When new tests for hepatitis-A and B became available in the 1970s, researchers soon found that a substantial portion of cases of post-transfusion hepatitis were caused by neither of these two viruses.[2] This was labeled so-called non-A non-B hepatitis. It took another 15 years for researchers to identify many of these cases as hepatitis-C related.

Risk factors for hepatitis-C virus infection[3] include intravenous drug use (even if only once), transfusion of blood or blood products before 1992, intranasal cocaine use, history of multiple sexual partners, hemodialysis, needle stick injuries, history of sexually transmitted diseases, extensive body piercing, tattoos, and a history of having been in prison; resulting in tens of millions of Americans who are at risk.

While this is not the appropriate setting to evaluate all of the clinical trials for the therapy of HCV, it is appropriate to summarize the current treatment options as follows. After clinical evaluation, which may include a liver biopsy and an assessment of viral load, clinicians can offer patients therapy, which may include interferon alfa 2b alone or in combination with ribavirin.[3] When used at the recommended dosages, interferon alfa normalizes liver enzyme levels in 40 to 50% of patients and HCV becomes undetectable in 30 to 40% of patients during treatment. Yet, overall, only 10 to 15% of patients treated achieve long-term viral eradication.[4] Combination of inteferon plus ribavirin increases long term eradication to 35-40% only.

Certainly, many important clinical challenges remain about the most effective therapy for HCV infection. I would like now to turn to a stakeholder analysis and

review the impact of this silent epidemic on providers, patients, payers, and employers. This stakeholder analysis will focus on the future challenge for successful HCV therapy from each of the unique perspectives.

For providers, the key clinical mission may be to eradicate HCV in all patients for whom it is possible to do so and to stem the progression of liver disease.[5] As always, providers should seek to maximize the underlying health status of the individuals, prevent disability wherever possible, and maintain a reasonable quality of life. All of this must be done, of course, within the context of minimizing cost to the health care system. Collectively, it is a formidable challenge for the provider stakeholders.

In addition, from the provider perspective, we need to implement wide-spread physician education programs to help providers recognize the risk factors for HCV infection, to specifically motivate them to ask their patients about these risk factors, and to design appropriate referral tools to help primary care providers send select patients on to subspecialists for definitive care. Our collective track record as providers in implementing best practices and coordinating care across multiple caregivers could certainly be improved. HCV presents a "double whammy" to providers in terms of the complexities of disease screening and the uneven evidence about disease treatment.[5]

A case-in-point is, for providers who graduated from medical school as late as 1981, this disease was never taught in the classroom!

For patients, HCV presents comparable sociologic and economic challenges. What are the best methods for educating those patients who have tested positive for HCV? If one believes that the patient's role in the doctor-patient relationship is changing, especially with the advent of medical consumerism, how then can we take advantage of some of the new tools and techniques to engage patients in their own care? Once patients are diagnosed with HCV, how can we work together to improve their access to care and determine where a patient may be relative to their "readiness to change" index? What can we learn from studies demonstrating low patient compliance with the therapy for other chronic illnesses such as hypertension and hyperlipidemia? All levels of the industry must encourage patient adherence to appropriate therapeutic regimens.

Because HCV affects nearly 2% of the U.S. population, all payers should be concerned about reducing future expenses. No managed care organization can escape the burden of HCV! As a result, these stakeholders need to harness the tools of disease management and demand management to assess a population at risk for HCV and to deliver targeted services for them. Once patients are identified, new technologies linked to case management programs may be called for. Perhaps payers can facilitate appropriate physician network development to handle the "connections" needed among primary care doctors, patients, and subspecialists. How can we help to hold payers responsible and accountable for their care of persons with HCV? What rate-based measures of quality might apply to this population such as percentage of eligible patients who were successfully screened, or who completed a particular therapeutic regimen? Given the rapid turnover of patients enrolled in any single managed care plan and the uneven economic incentives to practice primary prevention; no single payer can be held responsible for society's obligation to treat HCV. In short, the public health dimensions of the HCV challenge transcend all payers. In our diversified health care economy, this could be a particularly vexing problem in the near future.

HCV infection has a major impact on employers, the last of our four stakeholders. Some analysts believe that HCV contributes to an 8% drop in productivity in a typical work month in the United States due to absenteeism and related causes.[6] Employers, after all, bear much of the economic risk for both the direct and indirect costs of disability for persons infected with HCV. In certain job categories, especially many of those in the health care sector, employees are at a higher risk exposure level to get HCV in the first place. Employers will need to seek out innovative pharmaceutical coverage programs for those stricken with HCV. They will need to design worker's compensation plans appropriate to the risk that their employees may face both on and off the job site. Employers will have to interpret performance information provided by managed care plans for example, and share this with their employees. Perhaps one could envision a day when a particular plan's performance with regard to the care and therapy of persons with HCV far exceeds another plan, resulting in a shift of employees from one plan to another stimulated by data provided by the employer itself. Maybe employers should be actively involved in efforts to educate employees about HCV and to provide confidential screening at the workplace.[6]

HCV infection is a major public health problem affecting all the stakeholders in our system. No one can hide. What is your organization doing about this challenge? As always, I am interested in your views and you can contact me at david.nash@mail.tju.edu.

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Letters to the Editor

I just finished reading your editorial in the most recent Office of Health Policy Newsletter. It is one of the most clear-headed calls to action that I have read on such a complex topic.

I have worked in the Medicare arena for over 20 years, the past six years as the head of the largest M+C health plan in Minnesota and now as the CEO of the Peer Review Organization in Minnesota, Stratis Health. I have testified to Congress about the inequity of the current Medicare reimbursement system that allows drugs to be covered in some markets, but not in efficient ones like Minnesota.

Thank you for weighing in on this subject and for encouraging others to get involved as well. You should submit your editorial to The New York Times. It is very well written and you have made it easy to understand the issue.

Patricia Riley, CEO
Stratis Health
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Your editorial in the Office of Health Policy Newsletter, "Drug Benefits in Medicare: Where Are We Headed?" was excellent.

Oliver E. Owen, MD

I read your June 2000 article, "Drug Benefits in Medicare: Where are We Headed?" with great interest. As long as pharmaceutical companies continue to pour $80 million into political campaigns each year, I won't be waiting for Congress to force them to:

- Change the rules that currently allow the first pharmaceutical company to develop a generic to be paid by the original patent holder and marketing a generic substitute;
- Change their domestic and international pricing structure; and
- Demonstrate through scientific evidence, improved performance of a new drug over existing drugs.

John C. Greene

I loved your editorial on Medicare prescription benefits. Clearly the cost of drugs is spiraling out of control and clearly the US consumer is subsidizing international consumers. It's a complex issue since the profitability of drug companies, their stock prices and many retirement funds are inter-linked, but the need for information that links cost and outcomes has never been greater. As consumers and their physicians make decisions about drug plans and drug choices, they need to understand if the regimen of choice is "worth it".

Randy L. Thomas
Eclipsys Corporation

A Business Case for Low Molecular Weight Heparin

A Symposium for Medical and Pharmacy Directors, Physicians, Pharmacists, and Case Managers

Continuing Education for Physicians and Pharmacists

Complimentary Registration

Thursday, September 14, 7:30 a.m. to 4:30 p.m., Hotel Sofitel, Philadelphia, PA

Program Directors: David B. Nash, MD, MBA, Associate Dean, Jefferson Medical College and Director, Office of Health Policy and Clinical Outcomes; Geno J. Merli, MD, Ludwig A. Kind Professor and Director, Division of Internal Medicine and Vice Chairman, Primary Care, Jefferson Medical College.

This one-day program will feature national experts who will present evidence of the economic, clinical and humanistic outcomes regarding the use and implications of low molecular weight heparin (LMWH). Representing different perspectives within the healthcare environment (the managed care organization, the integrated delivery system, the economist, the physician, the pharmacist) the speakers will report on studies and clinical experiences with LMWH and traditional unfractionated heparin.

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

This program is supported by an unrestricted grant from Aventis Pharmaceuticals.

To receive a program brochure please call 215-955-6969.

Jefferson Medical College Office of Continuing Medical Education
Selected Activities

September 21-23, 2000
11th Annual Jefferson Urology Symposium
Loews Philadelphia Hotel, Philadelphia, PA
Course Directors:
David E. McGinnis, MD, Stephen E. Strup, MD and Sandip P. Vasavada, MD
Credit Hours: Maximum of 19 hours
Who should attend: Urologists
Sponsored by: The Department of Urology and The Office of Continuing Medical Education of Jefferson Medical College

October 13-15, 2000
9th Annual Symposium by the Sea
Rehoboth Beach Country Club, Rehoboth Beach, DE
Course Directors:
James Beebe, MD and Peter Chodoff, MD, MPH
Who should attend: Primary Care Physicians, Family Practice Physicians, Nurses, Nurse Practitioners and Physician Assistants
Jointly sponsored by: Beebe Medical Center and The Office of Continuing Medical Education of Jefferson Medical College

October 14-18, 2000
The Original 2000 Philadelphia Board Review Course in Cardiovascular Diseases
Wyndham Franklin Plaza Hotel, Philadelphia, PA
Course Director:
Arnold J. Greenspon, MD
Credit Hours: Maximum of 42 hours
Who should attend: Cardiovascular Fellows or Physicians who wish an intensive, thorough review before the initial Board Examination and physicians preparing for the re-certification examination
Sponsored by: The Division of Cardiology and The Office of Continuing Medical Education of Jefferson Medical College
Co-Sponsored by: The Council on Clinical Cardiology of the American Heart Association

October 23-27, 2000
9th Annual High Risk & Critical Care Obstetrics
Bluemle Life Sciences Building, Philadelphia, PA
Who should attend: Physicians, subspecialty fellows and nurses interested in learning more about critical care obstetrics
Sponsored by: The Division of Maternal-Fetal Medicine, The Department of Obstetrics & Gynecology and The Office of Continuing Medical Education of Jefferson Medical College

November 11, 2000
Jefferson HealthCare College: Headache Management for Primary Care Physicians
Loews Philadelphia Hotel, Philadelphia, PA
Course Co-Directors:
Jeffrey L. Lenow, MD, JD, Geno J. Merli, MD, Stephen D. Silberstein, MD and Richard C. Wender, MD
Who should attend:Primary Care Physicians, General Practitioners, Family Medicine Physicians, Neurologists, Internists and Physician Assistants

Various Dates
2001 Ultrasound Education Programs
Thomas Jefferson University Campus, Philadelphia, PA
Course Director:
Barry B. Goldberg, MD
Sponsored by: The Division of Diagnostic Ultrasound, The Department of Radiology of Thomas Jefferson University and The Office of Continuing Medical Education of Jefferson Medical College

For more information on these courses call 215-955-8533 or fax 215-923-9452.

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

For more information, call the Office of CME at 215-955-6992 or 1-888-JEFF-CME (533-3263).

Postscript: The Centers for Disease Control (CDC) posted on its World-Wide Web site an interactive web-based training program titled: "Hepatits C: What Clinicians and Other Health Professionals Need to Know." The Program is at http://www.cdc.gov/hepatitis.

This program provides users with up-to-date information on the epidemiology, diagnosis, and management of hepatitis C virus (HCV) infection and HCV-related chronic disease. Users also can test their knowledge of the material through study questions at the end of each section and case studies at the end of the program. Continuing medical and nursing education credits are available free from the CDC on completion of the training. The American Academy of Family Physicians also will grant the academy's education credits on completion of training and filing with the academy.

Please note: the comments expressed by the authors in this publication do not necessarily represent the views of the Editorial Board, Thomas Jefferson University, Jefferson Medical College, Jefferson Health System or of the Office of Health Policy and Clinical Outcomes.

The Jefferson Health System Consortium for Medical Directors in Long Term Care

Elizabeth White MD
Medical Director,
Senior Health
Jefferson Health System
at Bryn Mawr Hospital

The Jefferson Health System (JHS) Consortium for Medical Directors in Long Term Care (Consortium) was established in January 1998 by JHS Senior Health, to support JHS physicians who serve as medical directors or lead physicians in nursing homes, continuing care retirement communities, subacute units and assisted living facilities across the Delaware Valley.

Recognizing the importance of planning to meet the needs of the rapidly growing elderly population in its service area, the JHS is in the process of developing relationships with local long term care providers with the goal-just recently reached-of access to 6,800 beds by the end of 2000. Most of these affiliations entail the placement of a Jefferson physician (including independent practitioners with ties to any of the member hospitals) as medical director. This is in recognition of the central role of the medical director in overseeing and ensuring the quality of medical services in the long term care facility, particularly in face of the increasing acuity, diversity of care needs and consumer expectations in most long term care settings.

Membership in the Consortium, now totaling approximately 40 physicians, is open to any JHS physician who is involved in Long Term Care in a leadership role. Currently the Consortium, which is directed by the JHS Medical Director of Senior Health, provides a forum for education as well as discussion and problem solving of issues encountered in the daily routine of the nursing home medical director.

Members of the Consortium plan the educational programming. Six seminars are offered annually, focusing on a mix of clinical and administrative topics pertinent to the medical director's role. For example, this fall a presentation on wound care is planned, which will cover both latest advances in treatment as well as institution of preventive programs in a facility. Other topics have included an update on the pharmacological treatment of Alzheimer's disease; detection and prevention of abuse in the nursing home; and hospice care. All seminars are approved for American Medical Association (AMA) Continuing Medical Education (CME) Category-one credits and are acceptable towards certification and re-certification for the Certificate of Medical Director (CMD) offered by the American Medical Director's Association (AMDA), the premier national organization representing physicians in long term care management. In addition, the Consortium plans to develop a program on medicine in the nursing home with the Primary Care College at Thomas Jefferson University (TJU).

The Consortium members cover a wide geographic area, mirroring the locations of the JHS members and affiliates. This is a major barrier to regular on-site physician participation in educational meetings and information exchange. In response, the consortium has implemented the following strategies:

1. Meeting sites are being rotated among central locations - the TJU Ford Road Campus and Consortium member nursing homes across the Delaware Valley.

2. A member directory listing specialty and area of expertise in long term care medicine/administration has been published, allowing quick access to a member who is equipped to answer a specific question.

3. An E-newsletter is being planned that will summarize information pertinent to the medical director's daily clinical and administrative duties; for example, changes in state or federal regulations; clinical research specific to the long term care patient; reports of successful implementation of patient care protocols; as well as information on JHS activities of value, such as Premier Years, (see March issue of *Office of Health Policy Newsletter*), and Case management initiatives.

At the request of several Consortium members, plans for the coming year include the development of templates for policies and procedures for clinical services in the nursing home that can be shared and amended by JHS Medical Directors as necessary in their facilities.

For further information on the JHS Medical Directors Consortium in Long Term Care, the American Medical Directors'Association, or the Pennsylvania Medical Directors'Association (state affiliate), please contact Dr. Elizabeth White, Medical Director, Senior Health, JHS, at 610-526-8324, or Whitee@MLHS.org.

Jefferson Health System Quality Council

STANTON N. SMULLENS, MD
CHIEF MEDICAL OFFICER
JEFFERSON HEALTH SYSTEM

At its initial meeting on December 15, 1997, the Jefferson Health System (JHS) Quality Council discussed its mission to promote a quality agenda among the members of the JHS and to encourage them to maintain high standards of clinical quality and patient service. Additionally, it agreed its role was to coordinate educational efforts in these critical areas. This was and remains the core purpose of the Quality Council. In the two and half years of its existence, the Council has evolved into an active forum for interchange of information between the member organizations. Initially consisting of Thomas Jefferson University Hospital and the Main Line Health System, it expanded in 1998 to include representatives from the Albert Einstein Health Network, Frankford Health Care System and Magee Rehabilitation Hospital. The members are a cross section of the medical and nursing leadership of the JHS with input from the Dean's office of the Jefferson Medical College. As envisioned by Douglas S. Peters, President and CEO of JHS, the Quality Council reports to the JHS Clinical Affairs and Quality Committee, chaired by Carter Buller, Esq. The Quality Council itself is chaired by Stanton N. Smullens, MD, Chief Medical Office of the JHS. The members of the Council include the Senior Vice Presidents of Medical Affairs of the member networks, medical directors of the quality committees of the member institutions, the medical directors of the risk networks, and heads of nursing. The Dean's Office is represented by Thomas J. Nasca, MD, Acting Dean, Jefferson Medical College; and David B. Nash, MD, Associate Dean and Director, Office of Health Policy and Clinical Outcomes.

The Council set as its initial agenda to inventory the quality programs of the member institutions and to develop a JHS Quality Performance Report. To assist in the development of the performance report, a permanent subcommittee of the Council was established consisting of the quality directors and coordinators of the member organizations. The subcommittee is lead by Barbara Turk, RN, MS, Director of Performance Improvement for the JHS.

During the first year the Council met quarterly and reviewed the member quality programs. It began to develop performance indicators for the Performance Report Card planned for release in January 1999. Using the JHS Mission Statement as the JHS definition of quality, categories of indicators were selected. These included clinical outcomes and processes in acute care, nursing care, long-term care and home health. Patient satisfaction indicators in similar areas were also selected. Additionally, efficient use of financial and other resources was examined, and indicators in support of the academic mission reviewed. The process was long and involved because of differing definitions of the same quality indicators, varied systems and approaches to collecting data, and differences in assuring data reliability. The first Performance Report Card was released in January 1999, and 38 indicators were chosen. Although data are collected quarterly, the report is released semi-annually. Reports were released in July 1999, January and July 2000. The Council meetings are now held monthly.

During the same year, under the direction of the Quality Council, an educational program called "Train the Trainer" was developed by Dr. Nash and assisted by Jeffrey L. Lenow, MD, JD, Medical Director of JeffCARE. It was an interactive program exploring the meaning and implementation of evidence-based medicine.

To improve exchange of information among the members and share performance improvement techniques, the Quality Council decided to select the same ORYX indicators for all the member institutions. This was begun in January 2000. It was also decided that the Atlas MediQual System would be used as the intermediary to send the data to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Atlas was chosen since this system's use is mandated by the state for other reporting and allows risk adjustment of the acute clinical indicators. This risk adjustment was reported in the Performance Report for July 2000. This will also allow the use of "control charts" for data presentation, a technique used by JCAHO.

A second JHS "Train the Trainer" educational program was held in the fall of 1999 and again was an interactive program presented by the Office of Health Policy and Dr. Lenow. The topic was a continuation of the use of evidenced-based medicine as it relates to performance measurement and profiling of individual physicians in their use of established evidenced-based guidelines.

The Council had targeted medication safety for further educational effort when the Institute of Medicine's report was released to the public in November 1999. It became apparent that patient safety needed to be an integral part of the definition of quality care. An inventory of the safety programs and a separate nationally benchmarked inventory of current medication practices was carried out at member institutions in March 2000. This interest in patient safety led to a JHS sponsored conference on May 5, 2000 entitled *Patient Safety Conference: Enhancing Patient Safety by Medical Simulation.*

Future directions for the Council will encourage sharing of performance improvement activities among the members in all areas of quality including patient safety. These activities will concentrate in performance improvement involving the Core Measures announced recently by JCAHO, particularly where they overlap with the Sixth Scope of Work Indicators released by the Health Care Financing Administration (HCFA[SCS1]). JHS is participating in a system-wide Keystone Peer Review Organization (KePRO) evaluation of these Medicare performance measures that will examine current practices. Work will continue in the area of patient safety and will explore common definitions and reporting procedures among the members. Future educational activities will include topics that relate to improving and measuring the quality of care in the JHS.

For more information contact Barbara Turk at 215-955-5176.

New Publications from the Office of Health Policy

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Emerging Opportunities in the Healthcare Environment: The UME21 Program

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The federal Employee Retirement and Security Act of 1974, which introduced new regulations for private retirement funds and employee health benefits, set the stage for managed care by permitting employers to finance their own health insurance plans. Correspondingly, as individual employers abandoned the traditional indemnity insurers, including the Blues, and moved aggressively to forge their own health insurance plans, the ensuing marketplace brought about unprecedented changes in physician autonomy and clinical decision-making that have challenged clinicians and presented new opportunities for medical educators.[1]

Medical schools soon recognized the implications of these forces and began to experiment with curricular changes in the 1970s and 1980s.[2] Nevertheless, industry leaders as well as students and young physicians expressed dissatisfaction and have criticized new graduates' preparation for practice in the new environment of managed care.

In 1998 the Health Resources and Services Administration (HRSA) conceived an innovative program to foster changes in selected medical schools to strengthen medical students' preparation for careers in the evolving healthcare environment. HRSA invited proposals from medical schools to develop novel partnerships with health plans, insurers, community health agencies or other types of managed care organizations, to provide innovative and relevant clinical experience for third-year medical students in the program dubbed UME-21, or Undergraduate Medical Education for the Twenty-first Century.[3]

The nine content objectives of the UME-21 Medical School Curriculum are: health economics, organization and delivery systems; evidence-based medicine, Epidemiology and population-based medicine; ethics in individual patient care and health care organizations; patient-provider communication and relationships; leadership and teamwork with other health professionals; measurement and improvement of quality, patient satisfaction and cost; delivery of care in integrated systems; medical informatics; and wellness and prevention.

A national panel of physicians, including Howard K. Rabinowitz, M.D., Professor of Family Medicine at Thomas Jefferson University (TJU), selected eight of the 50 medical schools that applied for three years of funding. Ten proposals, including one from Jefferson developed by Susan L. Rattner, Associate Dean for Academic Programs at TJU, were also given special recognition and partial funding for three years. Jefferson's Center for Research in Medical Education and Health Care Research, in partnership with the Undergraduate Medical Education Division of the American Medical Association (AMA), was selected to conduct the national, external evaluation of the UME-21 program in the eight schools.

Evaluation of the UME-21 program by the Jefferson/AMA team will focus on program outcomes. At the level of each individual medical school, an important outcome will be the survival of the managed care partnership and the longevity of the curricular change. For example, it is expected that durable partnerships will be established between medical schools and managed care organizations, and that these marriages will spawn enduring curricular change that will better prepare graduates for the current environment. Similarly, the evaluators will look for success in faculty development that is linked to the new curriculum and managed care partner.

Another important measure of the ultimate effectiveness of the UME-21 will be the reports of the graduates themselves. One universal benchmark of curricular effectiveness in US medical schools includes seniors' responses to the Graduation Questionnaire administered annually to seniors by the Association of American Medical Colleges. Students' responses to items in this questionnaire will provide the UME-21 leadership with feedback about the impact of the program on the graduates of the eight schools. A supplemental questionnaire will also capture students' experiences and opinions related to the specific UME-21 objectives.

Finally, the evaluation includes a survey of the residency program directors that will supervise the graduates of the eight UME-21 schools. These physicians will be asked to rate the graduates' abilities in the nine UME-21 content areas such as their awareness of cost implications, ability to use practice guidelines and ability to manage ethical conflicts in complex health systems.

In summary, the changes that have taken place in healthcare over the past three decades continue to present immense challenges to clinicians and medical educators. Jefferson is one of 18 medical schools involved in the national UME-21 program that was designed to enhance students' abilities to practice in the volatile health care environment. Jefferson faculty play key roles in this national initiative, including the evaluation of program outcomes.

For more information contact Jon Veloski at 215-955-7901.

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CME Update

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JEFFERSON MEDICAL COLLEGE

Past columns have talked about various players in CME: The Accreditation Council for Continuing Medical Education (ACCME), the American Medical Association (AMA), and their roles in relation to sponsors of CME like Jefferson.

This time, the focus is on the participant in CME, and what these and other organizations define as the participant's responsibilities.

Why? With increasing frequency, CME administrators find themselves explaining some of the rules to participants. Example: we recently certified a course for credit that had significant commercial support (a grant from a single pharmaceutical company). One registrant submitted his registration with a note saying, "Drug company X is going to send you a check to pay for this registration." The physician, certainly an educated professional looking to improve his knowledge for the benefit of his patients, was unaware that the AMA and ACCME rules forbid a drug company from paying any fees for participants, and for making payments to anyone outside the grant for the conference.

It occurs to me that this is not uncommon, and that it might be a good idea to bring the relevant guidelines to a wider audience.

There are three major sets of guidelines that participants should be aware of and apply in their pursuit of continuing professional development. The AMA has contributed two "Ethical Opinions" (which can be found in the Physician Recognition Award Information Booklet[1] and is also available on the AMA website at http://www.ama-assn.org. The ACCME *Standards for Commercial Support*[2] have relevant clauses that apply, and finally the Association of American Medical Colleges (AAMC) booklet, *Guidelines for Faculty Involvement in Commercially Supported Continuing Medical Education*[3] has a section devoted to participant responsibilities.

The AMA was first, issuing two Ethical Opinions in the early 1990s. AMA Opinion 8.061, *Gifts to Physicians from Industry*, was issued by the AMA Council on Ethical and Judicial Affairs in December 1990. This document acknowledges the value that can be added by appropriate relationships between industry (pharmaceutical, device and equipment companies) and the individual physician, yet seeks to limit the scope and intent of 'gifts' from industry. Its goal is reduce both the appearance of and actual presence of influence. Therefore, its guidelines emphasize that gifts accepted by physicians should be related to patient benefit or the physician's work, and be 'modest' in nature. So pens, medical textbooks, and modest meals are within guidelines; cash or subsidies toward conference registration, travel or personal expenses are not. There is a specific admonition: "*No gifts should be accepted if there are strings attached*." If you happen to be a 'high prescriber' of drug X, and its manufacturer, Company Y, wants to reward you, "Just say no."

AMA Opinion 9.011, *Continuing Medical Education*, speaks to participant responsibility in the selection of CME activities, and offers criteria to be considered. The first criterion: use the presence of an ACCME/AAFP approved sponsor as a quality indicator. Other criteria to be considered when determining if an activity should be attended include that the activity's content should be relevant to participant educational needs, its faculty should be qualified, and the activity must conform to the AMA's earlier Opinion, "*Gifts to Physicians from Industry*." Additionally, this Opinion emphasizes educational aspects (i.e., content) over 'social amenities.' Participants' ethical behavior under this Opinion also includes claiming credit only for the actual time spent, so if beeped out of a conference not to return, it is the participant's responsibility to adjust the certificate record to reflect reality.

The ACCME's *Standards for Commercial Support*, while primarily directed at sponsors of credit (like universities, hospitals and medical societies), contain sections relating to appropriate social functions, handling of funds (as mentioned above) and award of "scholarships" that participants should be aware of.

The ACCME *Standards for Commercial Support* highlight the same themes as the AMA: funds should not be paid by a corporate sponsor directly to a participant, and expenses of participants cannot be paid utilizing funds "originating from a commercial source" (i.e. travel, lodging, registration fees, honoraria/stipends, personal expenses or "subsidies for hospitality"). "Scholarships" should be limited to those individuals *selected by the CME sponsor*, not the commercial supporter. The *Standards for Commercial Support* reiterate the emphasis on the educational aspects of an activity, and stress that the social events, while certainly recognized as a normal part of many CME activities, cannot take precedence of the educational aspects.

Of particular note are the AAMC *Guidelines for Faculty Involvement in Commercially Supported Continuing Medical Education*. Physician-participants are the catalysts in CME as the consumers of education, they are the ones who may translate educational experience into clinical practice, and, ultimately to patient outcomes.

The AAMC Guidelines split evenly between "DO's" and "DON'T's." **DO** be critical when participating in educational events. Look for evidence of bias; analyze what's been included/excluded in the information presented.

DO require disclosure information from the CME sponsor, commercial supporter, course director and faculty, and evaluate the disclosure information for potential influence on content.

What are the "DON'T's?" **DON'T** accept inappropriate gifts or inducements in relation to attendance at CME events. **DON'T** go to activities that are not truly educational, yet are offered under the guise of educational sessions. Vote with your feet.

There is no doubt that many different parties are accountable for maintaining educational quality of CME activities, especially at a time of increased relationships between traditional non-profit CME sponsors and for-profit companies. Just as the increase in direct-to-consumer (DTC) advertising requires patient-consumers to critically examine their choices, the physician-consumer of continuing medical education becomes responsible for making similarly informed selections in education.

For more information contact Jeanne Cole at 215-955-8411.

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The Health Policy Forum: Upcoming Speakers Fall 2000

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Speaker: Janet M. Henry, Associate Vice President, Ambulatory Services, Main Line Health System

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Topic: An Update on Community-based Teaching
Speaker: Patrick Alguire, MD, FACP, Director, American College of Physicians/American Society of Internal Medicine

December 13, 2000
Topic: An Update on Strategic Plans for the System
Speaker: Jane Herling, Vice President and Executive Director, Main Line Health System

For more information contact Barbara Bozarth at 215-955-2822.

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