Reader Feedback

Modify Clinical Reminders for Cancer Screening

The article "Problems with Using Women's Cancer Screening Rates to Measure Performance," which appeared in the June 2009 issue (starting on page 17), raises questions that we all need to address. The article discusses how the authors' institution fared in terms of periodic breast mammographic and cervical Papanicolaou testing over a three-year time span (2004 to 2007). The authors assert that the auditors who were determining screening rates for these conditions counted patients who had serious psychiatric or medical illnesses as screening failures, which, they say, ultimately contributed to the overall failure of their institution to meet the target screening rates.

> *The use of reminders, coupled with performance measures, has honed the VA's oversight of cancer screening to a level that has made the VA a respected leader in cancer care.*

We are all sensitive to the inappropriateness of a risky screening procedure for the fragile patient who might not tolerate the screening test—nor even tolerate appropriate therapy (including chemotherapy, radiation, or surgery) if cancer were found. Why not apply what is already in place for influenza vaccination to cancer detecting tests? Our clinical reminder for influenza vaccination has a checkable sentence that, in essence, states that the provider has educated the patient fully and the patient knowingly and persistently refuses the vaccination. The specific comorbid disorder has to be described and has to be detailed so a reader (or auditor) is convinced that the comorbidity indeed precluded testing. And, of course, it is best if this caveat is placed in the record at the time the decision is made rather than subsequently. Ultimately, the patient's fragility, or alternatively his or her fully informed negative decision, must be respected.

The use of reminders, coupled with performance measures, has honed the VA's oversight of cancer screening to a level that has made the VA a respected leader in cancer care. These are new, somewhat uncharted, waters and the team from University of California has identified an area that should be easy to improve. I thank them for bringing the issue forward, but let us improve and keep the reminders.

—Everett Shocket, MD
Sarasota, FL

The corresponding author responds:
I'd like to thank Dr. Shocket for his comments, which I think reflect the majority view of those working in the VA quality assurance infrastructure. I largely agree with them. The problem, however, is too complex to be solved simply by modifying clinical reminders.

Dr. Shocket treats performance measures and clinical reminders as if they are equivalent, which they are not. Reminders are tools used by providers working with individual patients to remind themselves of potentially important care issues and to help them document the care they provide. When optimally designed, reminders also document clinical decision making and informed consent. We at the San Francisco VA Medical Center have developed such reminders for cancer screening and influenza shots. Yet we still have failed those VA performance

Let Your Voice Be Heard!

Do you have comments on a column, article, or department in *Federal Practitioner*? Write us and add your voice to discussions of today's important issues in federal health care.

E-mail your letter to fedprac@qhc.com or mail it to:

Reader Feedback
Federal Practitioner
Quadrant HealthCom Inc.
7 Century Drive, Suite 302
Parsippany, NJ 07054-4609

The opinions expressed in reader letters are those of the writers and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom, Inc., the U.S. government, or any of its agencies.*

Continued on page 19

Continued from page 14

measures because they currently do not respect the clinical judgment or patient decision not to have the intervention. Dr. Shocket's suggestion to improve clinical reminders would have no impact on the problem that we identified.

VA performance measure developers purportedly have lowered fully successful goals to account for clinical decision making and informed consent. They also desire to use a methodology that is comparable to that of the Health Effectiveness Data and Information Set (HEDIS) so they can compare the VA to the private sector.

Another important issue in translating clinical information into performance measures is how that information is gathered. For the VA, this is done by either the External Peer Review Program (EPRP) or by studying data from the computerized patient record system. EPRP data reviews only a small number of charts and is more subject to the sampling biases we described in our article.

What can be done? The first step is to abandon EPRP completely. The second, as Dr. Shocket suggests, is to create interactive reminders that appropriately address clinical situations and patient preferences. The third is to recognize and publicize that VA data will contain this higher level of clinical judgment and, therefore, will be better than HEDIS data—but won't be completely comparable. It will set a higher standard that HEDIS should strive to meet.

An added benefit of this approach is that providers will see performance measures as less intrusive and directive. They will feel that their clinical judgment is respected and, therefore, will have greater respect for clinical reminders as helpful tools. And who can argue with encouraging patient-centered care and respecting informed patient decisions?

—Paul A. Heineken, MD
Clinical Professor of Medicine
University of California, San Francisco
Former Associate Chief of Staff for Ambulatory Care
San Francisco VA Medical Center
San Francisco, CA