Medicare Advisers Object to Publishing PQRI Data

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — A panel of Medicare advisers warned agency officials against moving forward with a proposal to make public a list of doctors participating in a voluntary federal quality reporting effort.

The Physician Quality Reporting Initiative, created under a provision of 2006 tax relief, offers physicians a 1.5% Medicare bonus for sending data on several quality measures to the Centers for Medicare and Medicaid Services. So far, about 16% of Medicare participating physicians have elected to participate in PQRI; about half of those who are not participating see fewer than 50 Medicare patients a year, according to agency officials.

"We have had in place for a number of years public reporting of quality information and now cost information for a number of settings, hospitals most prominently, dialysis facilities, nursing homes, and home health agencies," Dr. Barry Straube, CMS chief medical officer, said at a meeting of the Practicing Physicians Advisory Council. "The agency, the [Health and Human Services] department, the White House, [lawmakers], and many consumer advocates and employers would like for us and everyone to start focusing more on physician office public reporting."

Dr. Straube announced at the meeting that CMS was considering whether to publish the names of physicians who have agreed to participate in the PQRI as well as to indicate whether those physicians were paid the incentive, a proxy for whether they met or exceeded the agency's reporting requirements.

That proposal didn't sit well with several PPAC members.

"I'm concerned that you are taking these PQRI data that were presented to the physician community for one reason and now you're taking that information garnered out of that and you're going to put it on a Web site," said Dr. Tye Ouzounian, an orthopedic surgeon in Tarzana, Calif.

Publishing the names of PQRI participants could create a public perception that physicians who are not on the list are not quality providers, he told Dr. Straube.

The perception might be even worse for those physicians who chose to participate, but were not able to fully comply, said Dr. Fredrica Smith, an internist in Los Alamos, N.M.

"It's not that they are not listed as having participated. They are listed as participating and failing, which has horrible implications," Dr. Smith said. A solo practitioner, she said she spent 1-2 hours a week trying to comply with the reporting requirements, only to be left confused by them.

CMS officials told the council that they were applying the reporting requirements flexibly and that they expected most physicians who chose to participate to receive the incentive payment.

Despite such assurances, PPAC recommended that CMS give physicians and their colleagues enough lead time to consider whether they want to participate in the initiative, knowing their participation will be published, before that information is made available to the public.

"If you are going to put [those] data up there, you need to advise the physician community, with ample notice," Dr. Ouzounian said.

Dr. Straube said he understood council members' concerns, but that it was inevitable, given the push for transparency, that such information will some day be made public.

"I suspect that this is going to happen sometime in the future. I don't see how the physician office setting will not have some need to be publicly accountable," he said. ■

Physicians Often Unsure How to Disclose Medical Errors

BY JANE M. ANDERSON
Contributing Writer

WASHINGTON — Physicians generally believe that medical errors—especially those that cause an adverse event—should be disclosed to patients, but some question whether patients should be told all the details or just the basic facts about what happened, said an internist who has studied the issue.

Dr. Thomas Gallagher, associate professor of medicine at the University of Washington, Seattle, told attendees at the annual meeting of the American College of Physicians that physicians are unsure about what to include when they disclose a medical error. But he added that physicians are actively debating the best way to proceed.

"Over the next 5 years, we're going to see very exciting changes," Dr. Gallagher said. "I think physicians as a profession will be leading the way to set some standards as to how these difficult conversations should go."

Patients conceive of errors broadly and desire full disclosure of harmful errors, while at the same time worrying that health care workers might hide them, Dr. Gallagher said. In disclosure, they want "an explicit statement that an error occurred," details of what happened and the implications for their health, why it happened, and how recurrences will be prevented, he said. In addition, they want an apology, he said, adding, "That really mattered very much to the patient."

Physicians define errors more narrowly than patients do, he said. They agree in principle with full disclosure and want to be truthful, but perceive barriers to disclosure, he said. "Physicians feared that disclosure could be harmful to the patient, and physicians saw disclosure as akin to admitting personal failure," Dr. Gallagher said, adding that most physicians haven't had any formal training in disclosure.

The University of Washington recently surveyed 4,000 physicians about communication with patients, colleagues, and health care institutions about medical errors.

According to Dr. Gallagher, the survey on error disclosure was sent to 2,000 physicians in Washington State and 2,000 Canadian physicians. The survey, which asked about general attitudes regarding disclosure, had a response rate of 63%.

Respondents were randomized to one of four specialty-specific disclosure scenarios and answered five questions to measure the content of their disclosure. Each question offered actual disclosure language that contained no information, a little information, or full disclosure.

When asked about general attitudes regarding disclosure, 98% of U.S. physicians said serious errors should be disclosed, and more than three-quarters said minor errors should be disclosed to patients. Less than one-third, however, said near misses should be disclosed, he said.

But when asked for answers in the specific scenarios, physicians didn't always want to admit that a medical error occurred. For example, one fictitious scenario involved an inpatient insulin overdose: A physician wrote an order for the patient to receive "10 U" of insulin, but the "U" in the order looked like a "0," and the following morning the patient received 100 units of insulin. The patient later was found unresponsive, with a blood glucose level of 35 mg/dL, was resuscitated and transferred to the intensive care unit, and is expected to make a full recovery.

Nearly 65% of physicians said they would "definitely" disclose the error, and about 32% said they "probably" would disclose the error, Dr. Gallagher said. When asked how they would explain the situation, 1% said they would tell the patient, "Your blood sugar went too low and you passed out"; 28% said they would say, "Your blood sugar went too low because you received more insulin than you needed"; and 71% said they would tell the patient, "Your blood sugar went too low because an error happened and you received too much insulin."

When asked how much detail they would provide, 11% said they would not volunteer specific details about the error unless asked by the patient; 36% said they'd tell the patient, "You received more insulin than you needed"; and 54% said they'd tell the patient, "You received 100 units rather than your usual 10 units of insulin."

There were 3% who said they would not volunteer that they were sorry or apologize; 54% would say, "I am sorry about what happened"; and 43% would say, "I am so sorry that you were harmed by this error."

Preliminary conclusions show that physicians support the concept of disclosure, but are uncertain about the core content of any disclosure. Most would disclose less information about errors that would not be apparent to the patient, Dr. Gallagher said, adding that medical and surgical specialties may approach disclosure differently.

There is accelerating interest in disclosure and growing experimentation with disclosure approaches among health care organizations and malpractice insurers. This goes hand-in-hand with the increased emphasis on transparency in health care, he said.

A "disclosure performance gap" also is increasingly evident, and harmful errors often are not disclosed. "When disclosure does take place, it often falls short of meeting patient expectations for what these conversations should be about," he said.

In addition, little prospective evidence exists regarding what types of disclosure strategies are effective, Dr. Gallagher said. "That makes it difficult to know not [only] whether to disclose or not, but [also] what to say to the patient. Effective disclosure ought to have a positive effect on quality."

There are multiple rationales for disclosing errors to patients, Dr. Gallagher said. Error disclosure can be considered a part of informed consent, he added, saying, however, "This is an area where doctors and patients appear to be on somewhat different pages. Physicians focus on informed consent, while patients see it as truth-telling." ■

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