CHP PCOR STANFORD

Center for Health Policy CENTER FOR PRIMARY CARE & OUTCOMES RESEARCH

CHP/PCOR

Quarterly Update

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INSIDE THIS ISSUE:

Study: routine HIV testing is cost-effective, extends life

Expanding HIV screening would be a relatively cost-effective way to increase life expectancy for HIV-positive individuals and decrease transmission of the virus that causes AIDS. That is the key finding of a study led by CHP/PCOR core faculty member **Doug Owens**, whose research team conducted a cost-effectiveness analysis of routine HIV screening. "We're convinced based on what we've done that there needs to be more screening," Owens said.

The study results, which received widespread news coverage, were published in the Feb. 10 issue of the *New England Journal of Medicine,* with CHP/PCOR co-authors **Gillian Sanders** (first author, a former CHP/PCOR faculty member now at Duke University); **Vandana Sundaram** (the centers' assistant director); **Kristof Neukermans** (former research staff member); and **Laura Lazzeroni** (CHP/PCOR associate), as well as Owens (senior author). Their paper appeared alongside a report on a separate cost-effectiveness study that yielded similar findings.

CONTINUED ON PAGE 3

Alum meets Clinton via China HIV work

CHP/PCOR trainee Jessica Haberer (top, 3rd from left) met former President Bill Clinton while working for his foundation's HIV/AIDS initiative in China. Story, p. 6.

'Quality Gap' series assesses strategies for improvement

Healthcare organizations in recent years have implemented a variety of quality improvement strategies aimed at bridging the so-called "quality gap," the difference between optimal treatment of a medical condition using best-practice guidelines, and the care patients actually receive. While several studies have evaluated the effectiveness of specific quality improvement initiatives, a recently published technical review series called "Closing the Quality Gap," prepared by the Stanford-UCSF Evidence-based Practice Center, is one of the first efforts to comprehensively assess all QI strategies targeting particular clinical conditions.

The series was commissioned by the Agency for Healthcare Research and Quality (AHRQ) to give healthcare leaders and providers guidance on how best to narrow the nation's quality gap. When complete, it will evaluate QI strategies for a selection of national priority areas identified by a 2003 Institute of Medicine Report.

The first volume of the series, published in September 2004, outlines the challenges to translating research into clinical practice and describes the methodologies used in "Closing the Quality Gap." The second and third

CONTINUED ON PAGE 4

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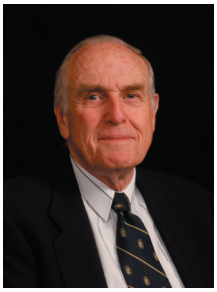
Universal health vouchers plan would preserve choice, competition

While health policy experts agree the U.S. healthcare system is irreparably flawed, none have yet come up with a solution that doesn't alienate politicians and the public. But a healthcare vouchers proposal co-authored by CHP/PCOR core faculty member **Victor Fuchs** could provide a viable blueprint for comprehensive, universal health coverage, in a way that would contain costs while preserving consumer choice and market competition. The proposal, which was covered by several newspapers, was published in the March 24 issue of the *New England Journal of Medicine*.



Victor R. Fuchs

"Our plan is more feasible than previous reform efforts because it's more congruent with American values," said Fuchs, the Henry J. Kaiser Jr. Professor, emeritus, and an emeritus professor of economics and of health research and policy. "Our society values equality, but it also puts tremendous value on individual freedom, choice and competition."

Fuchs wrote the proposal with Ezekiel Emanuel MD, PhD, an oncologist, bioethicist and expert on medical decision-making at the end of life. An accompanying editorial in the *New England Journal of Medicine,* which discussed the health vouchers proposal along with a related article on financing universal coverage, called the plan "a thought-provoking suggestion" for "a universal coverage system … that would be less chaotic and more affordable."

Under the proposal, every American under age 65 would receive a voucher that would pay for a standardized package of health services, including regular doctors' visits, inpatient and outpatient hospital care, preventive services, mental health care, and prescription-drug benefits. Patients would choose a participating health plan from several alternatives. Those who wanted additional benefits, such as more comprehensive mental health services or a wider choice of specialists, could purchase them with their own after-tax dollars.

The delivery of health care would not be run by the government but would continue to be provided through the existing system of private health plans, clinics and hospitals. To oversee the system, a federal health board would be created that would define the basic benefits package, set reimbursement rates for providers, and offer guidelines for regional boards, which would be responsible for administering specific geographic areas. Under the

CONTINUED ON PAGE 8

CHP/PCOR-led collaboration will conduct Medicare reform project

A research collaboration of CHP/PCOR and the Stanford Institute for Economic Policy Research (SIEPR) has been awarded a $350,000 grant to conduct a detailed analysis of the Medicare program and develop a comprehensive plan for Medicare reform.

Recent controversies over the solvency of Social Security and the far more difficult financial challenges facing Medicare have underscored the timeliness of the project, which is funded by a private, family-run foundation.

"Medicare poses perhaps the most important single challenge to the federal budget in the coming years," according to the project investigators. "Rising per capita health expenditures and demographic change make a fiscal crisis inevitable if Medicare does not undergo significant change."

CHP/PCOR director **Alan Garber** is the principal investigator for the project, which will run from June 2005 through June 2008. The other members of the core research team are **Victor Fuchs**, the Henry J. Kaiser Jr. Professor, emeritus, and a CHP/PCOR core faculty member; John Shoven, the Charles R. Schwab professor of economics and the Wallace R. Hawley director of SIEPR; and Dana Goldman, director of the Program in Health Economics at the Rand Corp.

Assisted by experts at universities and think tanks around the country, the research team will examine and prepare white papers on key issues related to Medicare reform, including: defining eligibility for the program; identifying alternative financing options, such as the use of a consumption tax; changing the structure of Medicare benefits; and estimating the impact of Medicare reform on revenues, expenditures and the health of the elderly. The researchers expect to develop a detailed reform proposal that could be implemented within the next decade.

Garber notes that several weaknesses of the Medicare program make it a prime candidate for reform. Among them: Medicare relies heavily on an antiquated fee-for-service system that leads to fragmented acute-care services and does not reward high-quality care; the program has little ability to ensure that expensive new technologies are introduced and used appropriately; and there is little connection between the costs of care provided and the benefit patients receive from it. ❖

HIV SCREENING, FROM PAGE 1

"The dovetailing of these two studies is breathtaking," said A. David Paltiel, PhD, associate professor of health policy and administration at Yale University and lead author of the second study. "One rarely achieves such strong, external validation of model-based results, and it really seals the deal regarding the value of expanded HIV counseling, testing and referral in the United States."

Experts have long known the importance of identifying HIV infection early on. Delays in a patient's treatment can lead to irreversible immunologic damage and complications, as well as transmission of the virus through risky behavior. The federal Centers for Disease Control and Prevention estimates that up to 20,000 new infections annually can be attributed to people who don't know they are HIV-positive.

A 2003 CDC initiative recommended making voluntary testing a routine part of medical care, yet Owens said screening is still not widespread. (Money is an issue, he said, as well as disagreement among experts over whether blanket or targeted screening is more effective.) Most HIV-positive patients are diagnosed only after they exhibit symptoms that prompt testing; the CDC reports that more than 40 percent of these patients don't learn of their infection until very late in the game.

"We know from other studies that people find out late in the course of the HIV infection, when they're almost to AIDS or already have AIDS," Owens said. "The current approach to screening is clearly inadequate."

Owens and his team at Stanford, the VA Palo Alto and St. Michael's Hospital in Toronto, developed a decision model to estimate the health benefits and expenditures of performing voluntary HIV screening programs in health-care settings. They followed a group of patients over their lifetime and looked at the costs and health consequences of screening and counseling, HIV transmission and current treatment guidelines and testing. The researchers used historical data to determine rates of disease progression for HIV-positive patients not receiving treatment, and they assumed a 20 percent reduction in risk behaviors for patients whose infection was identified.

The team used its model to determine the benefits of screening due to early identification of HIV and reduced transmission of the virus. The researchers found a 21 percent reduction annually in the transmission of HIV with the use of screening, as compared with no screening.

They also found that earlier identification through screening would lengthen by 1.5 years the life of an HIV-infected person. In a population with a 1 percent prevalence of unidentified HIV infection — which is consistent with the CDC's recommended prevalence for screening — the researchers' model showed that one-time screenings throughout the United States would cost $15,100 per quality-adjusted life year, while routine screenings every five years would cost $57,100 per quality-adjusted life year gained. By comparison, routine screenings for hypertension, colon cancer and Type-2 diabetes range from $48,000 to $56,000 per quality-adjusted life year.

"Our analysis indicates that screening for HIV infection is cost-effective relative to other commonly accepted screening programs and medical treatments," Sanders noted. "This finding suggests that in many healthcare settings, HIV screening will provide important health benefits for a reasonable investment in healthcare resources."

In the second *New England Journal of Medicine* study, researchers at Yale and Harvard developed a computer model of HIV screening and treatment to compare routine voluntary screening with current practice. They found that in all but the lowest-risk populations, routine HIV screening once every three to five years is "justified on both clinical and cost-effective grounds." The researchers concluded that "efforts to promote, finance and expand existing national HIV-testing guidelines should be pursued aggressively."

"It's exciting that a completely independent analysis had the same findings we did," said Owens. "Both studies show that screening prolongs life and is affordable."

Now that researchers have determined that HIV screening should be done routinely, the next question to be answered is how. Owens plans to conduct an analysis of different methods of screening, including newly approved rapid-testing protocols.

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This research was funded by the Department of Veterans Affairs' Health Services Research and Development Service, the National Institute on Drug Abuse, and the Ontario HIV Treatment Network. Articles appeared in *USA Today*, the *Chicago Tribune*, the *Contra Costa Times*, *Chicago Sun-Times*, *Miami Herald*, *New York Times*, New York *Newsday*, *Philadelphia Inquirer, Pittsburgh Post-Gazette, San Jose Mercury News, Wall Street Journal*, *Salt Lake City Tribune* and *Yale Daily News*. Articles appeared on Web sites including WebMD, ABCNews.com, CBSNews.com and MSNBC.com. Segments aired on TV news broadcasts in Las Vegas, Baltimore, Oklahoma City, Greensboro, N.C., and Nashville, Tenn. ❖

This article was produced by the Stanford School of Medicine's Office of Communication and Public Affairs.

QUALITY GAP, FROM PAGE 1

volumes, published in December 2004 and January 2005, respectively, assess QI strategies aimed at diabetes and hypertension.

The researchers found that most of the quality improvement strategies studied appeared to be successful in increasing clinicians' adoption of best-practice guidelines and improving patients' outcomes. They found that multiple QI strategies appeared to work better than just one for improving diabetes care, and strategies involving organizational change appeared particularly effective in improving hypertension management.

Still, the researchers were unable to determine which individual QI strategies worked better than others, because of several confounding factors related to study design and sample size.

"We wanted to pinpoint exactly which strategies work best and under what circumstances, but unfortunately the studies didn't lend themselves to those conclusions," said CHP/PCOR executive director **Kathryn McDonald**, an editorial team member for the report. Still, McDonald said the report's findings are cause for some optimism. "What we can say is that all the strategies we studied show some promise for improving patient care, and in some cases, using several strategies seems to work better than just one."

Researchers found that most of the quality improvement strategies studied appeared to be successful in increasing clinicians' adoption of best-practice guidelines.

McDonald emphasized that evaluating quality improvement strategies is a relatively new area of inquiry and that much more research is needed to assess the broad range of existing strategies. She said the approach taken by the Quality Gap series — examining QI strategies according to medical condition — is practical because it views quality improvement the way doctors do.

"In the real world, when clinicians focus on improving quality, they don't think about tools, they think about the clinical problem," McDonald said.

The researchers reviewed citations for thousands of potentially relevant articles and based their final report on 121 articles (58 for diabetes and 63 for hypertension). They considered nine types of quality improvement strategies: provider reminder systems; patient reminder systems; relay of clinical data to providers; audit and feedback (including quality report cards and benchmarking); provider education; patient education; promotion of patient self-management; financial incentives (including reimbursement arrangements such as capitation); and organizational change — a broad category encompassing several sub-strategies, including increased staffing, case management/disease management, and multidisciplinary care teams.

For diabetes, the QI targets were clinical measures of disease control — such as reduced blood pressure and blood sugar levels (HBA1c) — and clinicians' adherence to best practices such as monitoring patients' serum counts and performing regular foot exams.

Among all of the studies examining QI strategies for diabetes, the researchers found a clinically meaningful decrease (half a percent) in patients' blood sugar levels and a modest increase (4.9 percent) in clinicians' adherence to best practices. Studies using multiple QI strategies appeared to have a stronger influence on blood sugar levels (.60 percent reduction) than single-intervention studies. Disease management and provider education also showed some evidence of outperforming other QI strategies.

Several confounding factors limit the strength of these conclusions, however. The researchers found a substantial "publication bias," whereby non-randomized studies, and those with smaller samples, were more likely to be published only when they demonstrated large improvements. The researchers also found that older QI studies showed greater improvements, while more recent studies generally showed smaller improvements. "This trend probably means that it becomes more difficult to demonstrate QI impacts over time, at least in the case of diabetes," the report notes.

For hypertension, the QI targets were an increased percentage of patients aware of their condition, and an increased percentage of patients with reduced or target blood pressure levels. Across all of the studies of hypertension care, the researchers found significant improvement on both of these measures; the studies showed a median increase of 16.2 percent in the proportion of patients who had systolic blood pressure within target levels. Significantly, studies involving some form of organizational change appeared to have the largest effects on patient outcomes.

For example, a study published in 2002 in *Pharmacotherapy* evaluated an intervention in which 197 hypertension patients in a Southern California medical group were randomized to receive either "usual care" (managed by their primary care physician) or care co-managed by their primary physician along with a clinical pharmacist, who provided patient education, made

CONTINUED ON PAGE 5

Market forces don't fully explain specialists' higher pay, study finds

A recently published study by CHP/PCOR core faculty member **Jay Bhattacharya** finds that physician specialists in the United States earn substantially more than family practice doctors, and this difference can't be explained by competitive market forces alone.

The study results, published in the winter 2005 issue of the *Journal of Human Resources,* reveal the anti-competitive nature of the physician specialist labor market and suggest that intervention may be in order to boost the supply of specialists.

Bhattacharya set out to learn why medical specialists, such as surgeons and radiologists, earn so much more than family practice doctors. In 2002, for example, the average U.S. general surgeon earned more than $255,000, while the average family practice doctor earned about $150,000. Bhattacharya wondered whether the large earnings difference could be explained by specialists' longer working hours, longer periods of residency training, and more specialized skills. If these three explanations were the whole story, then the substantially higher wages of specialists would represent normal competitive returns for doing a more difficult job.

Using 1985-1995 data from the American Medical Association, and 1991 data from the Robert Wood Johnson Foundation's Survey of Young Physicians, Bhattacharya developed a model of physician specialty choice and competitive wage setting within each specialty. His model depended largely on a natural experiment: While medical students with large amounts of debt at the end of medical school are less likely to choose specialties with long training periods (such as surgery), highly indebted doctors are as skilled as their colleagues who have less debt within each specialty.

This approach enabled Bhattacharya to address key questions: How much money would a particular medical specialist have earned as a family practice doctor? How important are ability differences in explaining the higher income of specialists? And, how important are competitive market explanations in determining the relative lifetime compensation of specialists and generalists?

Bhattacharya found that only half of the income difference between generalists and specialists can be explained by specialists' longer working hours, longer periods of residency training, and more specialized skills — the three competitive market explanations for differences in doctors' incomes across specialties. "Since these differences can't be explained by normal market forces, there must be something else keeping the specialists' incomes artificially high," Bhattacharya explained.

The remainder of the income difference, he concluded, is most likely due to barriers to entry for the medical specialties — specifically, the limited number of residency slots for the specialties, as controlled by the American Council on Graduate Medical Education. Bhattacharya also considered but discounted other possible explanations, such as differences in average career length between specialists and generalists, or extra compensation for unpleasant job characteristics of medical specialties.

The results, Bhattacharya said, suggest that action should be taken to boost the supply of specialists, such as increasing the number of residency slots, or providing partial debt relief for physicians who choose to be specialists. He emphasized, however, that such options should be considered carefully, as they could bring about negative unintended consequences; increasing the number of residency slots for surgery, for example, could lead to a decrease in the quality of surgeons.

Bhattacharya added that further research, examining the demand and supply of specialists together, is needed to evaluate whether policies designed to increase the supply of specialists would be socially beneficial. ❖

QUALITY GAP, FROM PAGE 4

treatment recommendations and coordinated follow-up care. At the end of the study, 60 percent of the patients in the co-managed group had reduced their blood pressure to target levels, compared with just 43 percent of patients in the usual-care group.

Overall, the report concludes that a variety of QI strategies appear to be beneficial, but it cautions that "studies that would help patients, providers and policymakers choose how best to close their quality gaps are somewhat confusing. The most striking finding … is the need for additional high-quality research to clarify how best to translate research into practice."

The first three volumes of "Closing the Quality Gap" were edited by McDonald and **Doug Owens** at CHP/PCOR, and by Kaveh Shojania and Robert Wachter at UCSF. Other Stanford-based collaborators are **Mary Goldstein** (senior author of the hypertension review), **Vandana Sundaram** (project director), **Smita Nayak, Sheryl Davies, Robyn Lewis, Jody Mechanic**, Christoper Sharp, **Melinda Henne**, Bimal Shah, and **Jo Kay Chan**. ❖

DISPATCHES from CHP/PCOR alumni

Former trainee meets Bill Clinton as part of AIDS work in China

Former CHP/PCOR post-doctoral fellowship trainee **Jessica Haberer** has been in Beijing, China since September 2004, doing research and health policy work with the William J. Clinton Foundation's HIV/AIDS Initiative. And in late February, she had the opportunity to meet Clinton when he visited China to meet with government health officials and sign an agreement providing free AIDS drugs for children.

"Meeting the former president was a real honor," Haberer said by e-mail, adding that she is "personally a big fan" of Clinton's. Haberer not only spoke briefly with him, but accompanied him to a roundtable discussion with China's minister of health, as well as a local hospital to talk with patients and staff.

Though Haberer is employed by the Clinton Foundation, she is working most directly with the Division of Treatment and Care at the National Center for AIDS in the Chinese Center for Disease Control and Prevention. As a clinical and research adviser for the division, she spends about half her time on research, 40 percent on policy work, and the remaining time seeing patients. Her research focuses on adherence to anti-retroviral medications. Her policy projects include developing a program for pediatric HIV treatment, developing national guidelines for HIV/AIDS care, and training physicians to administer anti-retroviral medications.

Haberer described her experience as "fantastic," saying, "I feel very fortunate to have this opportunity. I have felt extremely welcomed by my Chinese colleagues."

She noted several challenges of working within the very different cultural, political and research environment in China, however. "Chinese politics are quite intricate and difficult for foreigners to understand, so I've had some frustrations there," she said. Due to government restrictions, which have eased in recent years, Chinese physicians and researchers have had little interaction with those in other countries (many foreign medical journals are hard to come by, for example).

With this limited exposure, some Chinese researchers are not familiar with U.S. research standards such as internal review boards and quality control for data collection and analysis — so Haberer has been assisting her Chinese colleagues with these concepts. She speaks some Chinese, but relies on translators for anything technical.

Regarding attitudes toward HIV/AIDS in China, Haberer said the climate is similar to the United States 20 years ago. "There is a lot of misunderstanding, stigma and discrimination," she said. "Fortunately, the Chinese government is being very supportive of HIV/AIDS work related to public education and public health policies."

Haberer — an internist who received her MD from Yale University — participated in the Agency for Healthcare Research and Quality fellowship training program at CHP/PCOR from July 2002 through September 2004. She also completed an MS in health services research at Stanford, to complement her medical training and to prepare her for the kind of research she is now doing in China.❖

News media cover research on COX-2 overuse, ATHENA, EMR savings

In the winter quarter, the news media highlighted work by CHP/PCOR faculty and affiliates on the overuse of COX-2 inhibitors, the successful implementation of the ATHENA system, and cost savings from electronic medical records — in addition to the widespread coverage of **Doug Owens** and **Gillian Sanders'** study on HIV screening *(see article on p. 1)*, and the health vouchers proposal co-authored by **Victor Fuchs** (*article on p. 2)*.

According to a study co-authored by CHP/PCOR fellow **Randall Stafford**, published in the Jan. 25 issue of the *Archives of Internal Medicine,* millions of Americans who were prescribed Vioxx, Celebrex and other COX-2 inhibitors from 1999 to 2002 didn't need the medications and could have safely taken older, cheaper painkillers (like ibuprofen) that work just as well for some patients.

Using data from national databases that tracked patients' doctor visits, and also using a tool developed at Stanford to categorize patients according to their risk of developing gastrointestinal bleeding from non-steroidal anti-inflammatory drugs (known as NSAIDS), Stafford and his colleagues found that patients at low risk for ulcers and GI bleeding accounted for two-thirds of the increase in Vioxx and Celebrex use from 1999 to 2002.

What makes the widespread use of COX-2s so troubling, Stafford said, is that they aren't any more effective at controlling pain than NSAIDs. While they are a welcome alternative for those at greatest risk of gastrointestinal side effects from NSAIDs, they are much more expensive. A daily dose of Vioxx at $2.64 costs about six times as much as a daily dose of ibuprofen at 42 cents.

CONTINUED ON PAGE 7

NEWS ROUNDUP, FROM PAGE 6

Stafford said the problems related to COX-2 inhibitors should serve as a cautionary tale about the growing trend of turning custom-fit medications into one-size-fits-all remedies. The researchers attribute the overuse of the drugs to several non-clinical factors, including heavy marketing and the tendency of patients and physicians to assume that newer medicines are better.

The study results were covered by several newspapers, TV news broadcasts and Web sites around the country, including *USA Today*, the *Los Angeles Times*, the *Chicago Sun-Times*, the *Seattle Times*, the *Palm Beach Post*, the *Oakland Tribune,* Reuters, Health Day News, American Medical News, WebMD, ABCNews.com, CBSMarketWatch.com, Forbes.com, CNN, and TV stations in Los Angeles, Chicago, Hartford, Conn., and Memphis, Tenn.

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The successful implementation of ATHENA — a computer-based decision support system developed by **Mary Goldstein** and colleagues at CHP/PCOR and the VA Palo Alto Health Care System to improve care for hypertension patients — was highlighted in two healthcare industry magazines. The December 2004 issue of *Healthcare IT News* included a feature article on the system, and the January 2005 issue of *HealthLeaders* magazine discussed ATHENA's implementation in an article that explored the strategies healthcare systems should adopt, and ones they should avoid, when implementing new healthcare technologies aimed at physicians.

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A commentary by CHP/PCOR fellow **Laurence Baker**, published in the Jan. 19 issue of *Health Affairs*, asserted that an article in the same issue might be overly optimistic in predicting that $78 billion a year could be saved by moving to electronic medical records in a network with open communication standards. Baker questioned the article's assumptions about savings from reduced labor costs and redundant tests. The piece was referenced in a Jan. 19 *New York Times* article discussing the current push for a national road map that would encourage open standards for healthcare information technology. ❖

CHP/PCOR job openings

CHP/PCOR core faculty member **Mary Goldstein** is seeking research assistants for VA-based projects on **quality improvement for hypertension management**. For a copy of the position announcements and instructions for applying, contact Arnold Saha, at 493-5000 x63515, or at arnold.saha@med.va.gov

CHP/PCOR has job openings for three positions with the research project **Improving Patient Safety Culture and Outcomes in Health Care** (see descriptions below). For more information, go to Stanford's jobs Web site, at http://jobs.stanford.edu/openings/jobsearch.html, and refer to the appropriate job number.

Project Manager (job #007382)

The project manager will oversee all activities of the patient safety culture study, in collaboration with the principal investigator. He/she will work closely with senior management and hospital staff in 120 hospitals and healthcare systems, assisting them with survey implementation, data analysis, and results presentations to aid in their quality-improvement efforts. The project manager will also secure new funding to support this research; oversee timelines for all major aspects of the project; assist in preparation of reports on the research findings; assist with patient safety survey implementation; and supervise the work of two full-time employees who write technical programs for data analysis.

Intervention Manager (job #007371)

The intervention manager will oversee all activities related to implementing a patient safety culture intervention program at 30 hospitals around the country, in collaboration with the project manager and principal investigator. The intervention manager works closely with senior management and liaison staff at these hospitals. He/she will oversee specific protocols and timelines for all major aspects of the intervention; coordinate site visits and training; monitor adherence to protocols and quickly address potential delays; assist with preparing summary reports on the results of the intervention; and assist 120 consortium hospitals with data analysis to aid in their quality-improvement efforts.

Research Assistant (job #007381)

The research assistant for the patient safety culture study will communicate with 120 U.S. hospitals about their implementation of a patient safety survey; provide the hospitals with project materials and answer their questions; and document communication with the participating hospitals. The research assistant will also work closely with members of the research team to analyze patient safety data; coordinate meetings and correspondence; help with the preparation of manuscripts, reports, and presentations; and perform clerical tasks in support of research activities. ❖

HEALTH VOUCHERS, FROM PAGE 2

plan, Medicaid would disappear, and employer-based health insurance would likely fade away, as companies' health insurance premiums would no longer be considered tax-exempt income. As the population receiving the vouchers aged, Medicare would be phased out.

Fuchs and Emanuel published an earlier version of their plan in a November 2003 op-ed piece in the *New York Times*. In analyzing the financial impact of the voucher system for their latest article, Fuchs and Emanuel found that initially, the nation's total use of healthcare services would rise by about 5 percent, as those who were uninsured receive care they weren't getting before. These associated costs, however, would be offset by huge administrative savings; most of the $100 billion now spent on the sales and administrative costs of private insurance, for example, would be saved.

The exact cost of the health vouchers plan cannot yet be determined, because it would depend on precisely which services, deductibles and co-payments were incorporated into the basic benefits package. Fuchs and Emanuel assert that their plan would cost no more than the current health system, and would reduce costs over time.

Part of the reason for the gradual decline in cost is that Fuchs and Emanuel's plan features the creation of an independent Institute for Technology and Outcomes Assessment, which would be funded by a dedicated portion of the earmarked tax. The institute would assess the effectiveness and value of new and existing medical interventions, and it would disseminate its findings to healthcare providers, thus encouraging them to follow evidence-based guidelines and provide more cost-effective care. The institute would determine which services would be covered in the basic benefits package.

The health vouchers plan would be funded through an earmarked value-added tax, a general consumption tax assessed on the value added to goods and services. Such a provision may not be politically palatable today, Fuchs said, but that doesn't mean it can't be on the table in the future when voters are demanding that their representatives take action. "This is a more efficient and equitable way to replace the expenditures currently made by employers, state governments and the uninsured," Fuchs said.

Fuchs and Emanuel acknowledge that "the voucher system is not politically feasible at this time — neither is any other major reform in health care," their proposal states. Still, they predict, "There will come a time when the inequities, inefficiencies and costs of the current methods of financing health care will be so intolerable that the public will not only accept but demand comprehensive reform. At that time, the political feasibility of the voucher system will be compelling."

Meanwhile, Fuchs has been encouraged by the favorable reaction he's received after presenting the vouchers plan to health policy experts, physicians and community groups. After his recent presentation to a group of more than 100 Stanford doctors, the moderator asked them to indicate who would support the proposal. "Ninety per cent of them raised their hands," Fuchs said. "I was shocked — I would have been happy if two-thirds had supported it."

Many details of the plan still need to be worked out, the authors acknowledge, such as defining the universal benefits package, determining when and how it can be modified, and developing procedures for qualified health plans to participate. To iron out these details, Fuchs and Emanuel plan to undertake a separate research project that will enlist the help of physicians, economists, health policy experts and others at Stanford and elsewhere. ❖

The health vouchers plan was featured in articles in the Washington Times, in a United Press International (UPI) story, in the Palo Alto Weekly and the Stanford Daily. The San Jose Mercury News published an op-ed by Fuchs and Emanuel describing their plan.

Grants for the winter 2005 quarter

Grants submitted:

"ICOHRTA" (continuation)
NIH/Fogarty International Center
Principal investigator: Alan Garber
Project period: 5/1/05-4/30/06

"Health Insurance Provision for Vulnerable Populations"
NIH
Principal investigator: Jay Bhattacharya
Project period: 12/1/05-11/30/10

"Medical Devices - Research and Education Center"
University of Utah
Principal investigator: Paul Heidenreich
Project period: 7/1/05-6/30/10

Grants awarded:

"Whom does Medicare Benefit"
RAND Corp. subcontract
Principal investigator: Jay Bhattacharya
Project period: 8/15/04-7/31/05

CHP/PCOR Profile: Tamara Sims

Where she's from: grew up in Victorville, Calif.

Research interests: health behavior modification; adolescent risk behaviors; social/psychological influences on older adults' health decisions

Education: received a BA in psychology from UCLA and an MA in psychology (research emphasis) from California State University-Long Beach

Her work at CHP/PCOR: Sims joined CHP/PCOR in August 2003 as a research assistant for the Disutility of Functional Limitations in the Elderly project (FLAIR). She has since taken on new responsibilities, and now serves as project manager for FLAIR and two other projects: the Center on the Demography and Economics of Health and Aging (CDEHA) and the Center on Advancing Decision Making for Aging (CADMA). For FLAIR, Sims trains and supervises RA's, does data analysis, and helps prepare manuscripts and annual reports. For CDEHA and CADMA, she manages operations related to IRB approval, budgets, requests for research proposals, and more. Sims describes her job as "a lot of juggling — which is OK because that's the way my mind works."

Earlier career interests: When Sims started college, she wanted to be a movie producer, and planned to go to film school. During an internship at Miramax, she screened movie scripts and got to work on *Cider House Rules*. But Sims was put off by the superficiality she saw in Hollywood, and later changed her major to research psychology, prompted by her enthusiasm for a course on research methods in psychology.

Previous research experience: As assessment coordinator for a UCLA study on HIV/AIDS prevention among homeless and runaway youths, Sims developed the assessment interview for the study, conducted interviews among at-risk youths, helped to implement group sessions that discussed safe sex and other HIV prevention strategies, and worked with homeless shelters to secure their cooperation for the study.

Volunteer work: For two summers in college, Sims worked as a counselor for a week-long Los Angeles county camp program for at-risk inner-city youths — an experience she called "trying but satisfying."

Hobbies: renovating the 93-year-old Daly City house she lives in with her husband, Dacien; playing with her dog Sami; going to Oakland Raider games

Little-known fact: Sims has gone bungee jumping seven times.

Publications from the winter 2005 quarter

Baker LC. "Benefits of Interoperability: A Closer Look at the Estimates." Commentary in *Health Affairs* 24, no. 1 (Jan. 19, 2005): Web exclusive.

Barr DA, Wanat SF. "Listening to Patients: Cultural and Linguistic Barriers to Health Care Access." *Family Medicine* 37, no. 3 (March 2005): 199-204.

Chun C, **Cronkite R**, **Moos R**. "Stress generation in depressed patients and community controls." *Journal of Social and Clinical Psychology* 23 (December 2004): 390-412.

Dai C, **Stafford RS**, Alexander GC. "National trends in cyclooxygenase-2 inhibitor use since market release: nonselective diffusion of a selectively cost-effective innovation." *Archives of Internal Medicine* 165, no. 2 (Jan. 24, 2005): 171-177.

Emanuel EJ, **Fuchs VR**. "Health care vouchers — a proposal for universal coverage." *New England Journal of Medicine* 352, no. 12 (March 24, 2005): 1255-1260.

Garber AM. "Evidence-based guidelines as a foundation for performance incentives." "Perspective" piece in *Health Affairs* 24, no. 1(Jan/Feb. 2005): 174-179.

Henne M, Amin AA, Westphal LM. "Monochorionic triplet gestation after in vitro fertilization using donor oocytes: case report and review." *Fertility and Sterility* 83, no. 3 (March 2005): 742-748.

Hlatky MA, Sanders GD, Owens DK. "Evidence-based medicine and policy: the case of the implantable cardioverter defibrillator." *Health Affairs* 24, no. 1 (Jan/Feb. 2005): 52-54.

CONTINUED ON PAGE 10

PUBLICATIONS, FROM PAGE 9

Holahan CJ, **Moos R**, Holahan CK, **Cronkite R,** Randall PK. "Unipolar depression, life context vulnerabilities, and drinking to cope." *Journal of Consulting and Clinical Psychology* 72 (December 2004): 269-275.

Holahan CJ, Ragan J, **Moos R**. "Stress." Chapter in the *Encyclopedia of Applied Psychology, Vol. III,* editor C. Spielberger. San Diego: Academic Press (2004): 485-493.

Huang A, Gemperli M, **Bergthold LA, Singer SJ, Garber AM**. "Health Plans' Coverage Determinations for Technology-based Interventions: The Case of Electrical Bone Growth Stimulation." *American Journal of Managed Care* 10 (December 2004): 957-962.

Ilgen MA, Tiet Q, **Moos R**. "Outcomes of substance use disorder treatment in suicidal and non-suicidal male patients." *Journal of Studies on Alcohol* 65 (2004): 643-650.

Linder JA, Huang ES, Steinman MA, Gonzales R, **Stafford RS**. "Fluoroquinolone prescribing in the United States: 1995 to 2002." *American Journal of Medicine* 118, no. 3 (March 2005): 259-268.

Mikami A, Boucher MA, **Humphreys K**. "Prevention of peer rejection through a classroom-level intervention in middle school." *Journal of Primary Prevention* 26 (2005): 5-23.

Russo PA, **Smith MW**, Namjoshi M. "Expenditures in schizophrenia: a comparison of olanzapine and risperidone." *American Journal of Health-System Pharmacy* 62, no. 6 (March 15, 2005): 610-615.

Sanders GD, Bayoumi AM, **Sundaram V**, Bilir SP, **Neukermans CP**, Rydzak CE, Douglass LR, **Lazzeroni LC**, Holodniy M, **Owens DK**. "Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy." *New England Journal of Medicine* 352, no. 6 (Feb. 10, 2005): 570-585.

Stafford RS, Li D, Davis RB, Iezzoni LI. "Modeling the ability of risk adjusters to reduce adverse selection in managed care." *Applied Health Economics and Health Policy* 3, no. 2 (2004): 107-114.

Timko R, **Moos R**. "Trends in acute care for substance use in psychiatric patients." Chapter in *Directions in Addiction Treatment and Prevention, Vol. 8.* Long Island, N.Y.: Hatherleigh (2004): 63-73.

Walsh J, **McDonald KM,** Shojania KG, **Sundaram V**, **Nayak S**, **Davies S, Lewis R, Mechanic J,** Sharp C, **Henne M**, Shah B, **Chan JK, Owens DK, Goldstein MK.** *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Vol. 3 — Hypertension Care*, editors Shojania KG, **McDonald KM,** Wachter RM, **Owens DK.** Technical review: AHRQ publication no. 04-0051-3. Prepared by the Stanford-UCSF Evidence-based Practice Center, January 2005. Agency for Healthcare Research and Quality, Rockville, Md.

Wise PH, Chamberlain L. "Creating an analytic voice in the policy storm." *Ambulatory Pediatrics* 5, no. 1 (Jan/Feb. 2005): 45-46.

Wolfe F, **Michaud K**, Kahler K, Omar M. "The short arthritis assessment scale: a brief assessment questionnaire for rapid evaluation of arthritis severity in research and clinical practice." *Journal of Rheumatology* 31, no 12 (December 2004): 2472-2479.

Presentations from the winter 2005 quarter

Dena Bravata
"Academic Research and Private Practice: Bridging the Gap." Geriatrics Research Education & Clinical Center (GRECC) Lecture Series, March 29, 2005 at the VA Palo Alto Health Care System.

Alain Enthoven
"Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice." Lecture to the Calouste Gulbenkian Foundation's Health Forum, March 22, 2005 in Lisbon, Portugal.

Alan Garber
"How Budgetary Pressures will Change Coverage and Payment for Medical Care." Presented to the Association of American Medical Colleges' Council of Academic Societies, March 11, 2005 in Tucson, Ariz.

Mary Goldstein
"Patient and Physician Satisfaction with Initiation of a Group Medical Visit Model for Patients with Hypertension." Department of Veterans Affairs' Health Services Research and Development National Meeting, Feb. 16-18, 2005 in Washington, D.C.

"Introduction to Medical Decision Making." Department of Medicine Residency Noon Conference, Feb. 22 and 25, 2005 at Stanford University.

"ATHENA Decision Support System: Guideline Implementation for Hypertension in Primary Care Clinics." Presented to Kaiser Permanente's Division of Research, March 1, 2005 in Oakland, Calif.

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PRESENTATIONS, FROM PAGE 10

Mary Goldstein
"Navigating the Maze of Medical Decisions." Participated as a discussant at the Department of Medicine's Multidisciplinary Case Conference, March 17, 2005 at the VA Palo Alto Health Care System.

Keith Humphreys
"Creating a Healthcare Informatics System for Iraq." Action Planning Conference for Iraq Mental Health, March 15, 2005 in Amman, Jordan.

Susana Martins
"Barriers to Hypertension Guideline Adherence Identified from Clinician Feedback to Decision Support." Presented on behalf of the ATHENA group at the Department of Veterans Affairs' Health Services Research and Development National Meeting, Feb. 16-18, 2005 in Washington, D.C.

Ciaran Phibbs
"The Effects of Geriatric Evaluation and Management On Nursing Home Use and Health Care Costs: Results From A Randomized Trial." Veterans Affairs' Health Services Research and Development Service National Meeting, Feb. 18, 2005 in Washington, D.C. Presented on behalf of co-authors **Jon-Erik Holty, Mary Goldstein, Alan Garber**, Y Wang, JR Feussner and HJ Cohen.

Mark Smith
"Child abuse and welfare use." Poster presentation to the Allied Social Sciences Association's annual meeting, January 2005 in Philadelphia, Pa.

Randall Stafford
"Quality of U.S. Outpatient Care: Temporal Changes and Racial/Ethnic Disparities." Seminar at the University of Auckland's School of Population Health, March 1, 2005 in Auckland, New Zealand.

Announcements from the winter 2005 quarter

CHP/PCOR core faculty member **Mary Goldstein** has been promoted to Professor of Medicine (Center for Primary Care and Outcomes Research) and, by courtesy, of Health Research and Policy at the VA Palo Alto Health Care System. Congratulations to Mary!

CHP/PCOR trainee **Hau Liu** received a GlaxoSmithKline Endocrinology Scholar Award for his presentation on "Late-night Salivary Cortisol as a Screening Test for Cushing's Syndrome in Male Obese Diabetic Veterans." Liu presented the research at the 2005 Western Regional Meeting of the Western American Federation for Medical Research, Feb. 5 in Carmel, Calif. His study examined the feasibility of using a new salivary cortisol test to screen for Cushing's Syndrome. The prize entails a monetary award and membership to the American Federation for Medical Research. Congratulations Hau!

CHP/PCOR fellow **Randall Stafford** is on sabbatical in New Zealand from February through July 2005. He is collaborating with researchers at the University of Auckland's School of Population Health and at the New Zealand Ministry of Health. His work there concerns national strategies for improving chronic disease prevention and management.

Welcome to new trainees, research staff:

In the winter quarter CHP/PCOR welcomed new research staff members **Katherine Cameron, Cristina Galvin** and **Sarah Songer,** as well as new trainees **Guohong Li, Nancy Lin** and **Swati Tole**.

Cameron is an RA with the FLAIR project. She graduated from Stanford with a BA in public policy and economics. For her honors thesis, she designed and conducted a research project in Mexico City that examined what factors influence a woman's decision to place her child for adoption. She also worked as a research assistant at the Morrison Institute for Population and Resource Studies.

Galvin is working on studies investigating the cost-effectiveness of HIV/AIDS prevention programs in the former Soviet Union. She has gathered and analyzed data for several projects regarding HIV/AIDS in this region. She also has extensive experience as a Russian/English interpreter. She received an MA in European studies from Trinity College, an MSc in Russian/public health from Edinburgh University.

Songer is an RA with the FLAIR project who conducts follow-up interviews in Oakland. She previously worked on a research project in the Folklore Department at UCLA, where she received a BA in comparative literature, with a minor in Russian studies.

Li is the new fellow for the China-U.S. Health and Aging Research Fellowship. An associate professor in the School of Public Health at Shanghai Second Medical University, she has studied hospital performance evaluation, the impact of the social environment on postpartum women, and financial incentives for physician performance. She holds an MA in health statistics and epidemiology from Shanghai Medical University, and a PhD in social medicine/health management from Fudan University.

CONTINUED ON PAGE 12

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CHP/PCOR Quarterly Update is written and designed by Sara Selis, outreach coordinator. Comments are welcome at Selis@Stanford.edu.

Research in Progress seminars

Jan. 12: Margaret Brandeau, "Evaluating the Cost-effectiveness of the Bill & Melinda Gates Foundation's India HIV Prevention Initiative: A Blueprint"

Jan. 19: Paul Heidenreich, "The Cost-effectiveness of Different Drugs for the Treatment of Hypertension: An Economic Analysis of ALLHAT"

Jan. 26: Christy Dosiou, "Screening for hypothyroidism in pregnancy: a cost-effectiveness analysis"

Feb. 2: Kathryn McDonald, "Development of Pediatric Quality Indicators using Hospital Discharge Data"

Feb. 9: Susana Martins, "A Functionality and Usability Evaluation of a Software Architecture for Intelligent, Interactive Query and Exploration of Time-Oriented Clinical Data"

Feb. 16: Sumant Ranji, "Quality Improvement Strategies for Appropriate Antibiotic Usage"

Feb. 17: Grant Miller, "Contraception as Development? New Evidence from Family Planning in Colombia"

Feb. 25: Kate Baicker, "Fiscal Shenanigans, Targeted Federal Health Care Funds, and Patient Mortality"

March 2: Dena Bravata, "CoPlot: A Novel Method for Graphical Analysis of Multivariate Data"

March 9: Smita Nayak, "Accuracy of Calcaneal Ultrasound for Identifying Patients Meeting the World Health Organization's Diagnostic Criteria for Osteoporosis: A Systematic Review"

ANNOUNCEMENTS, FROM PAGE 11

Lin is a trainee with the Agency for Healthcare Research and Quality Fellowship. She recently completed her doctoral studies in epidemiology at the Harvard School of Public Health. Her research focuses on safety and policy issues related to childhood immunizations. She has also studied the determinants of prescribing, utilization and adherence to medical therapies, and new technologies aimed at quality improvement. She previously worked for the healthcare consulting firm The Lewin Group.

Tole is also a trainee with the AHRQ fellowship. She most recently served as chief medical resident in the Department of Medicine at UCSF. She is interested in the role of socioeconomic factors, health education and prevention in determining health status. She previously designed and implemented a survey of students at Bombay University regarding HIV risk factors and awareness. She received a BS in biology from Stanford and an MD from UCSF. ❖

About CHP/PCOR

The **Center for Health Policy** (CHP) and the **Center for Primary Care and Outcomes Research** (PCOR) are sister centers at Stanford University that conduct innovative, multi-disciplinary research on critical issues of health policy and healthcare delivery. Operating under the Stanford Institute for International Studies and the Stanford School of Medicine, respectively, the centers are dedicated to providing public- and private-sector decision-makers with reliable information to guide health policy and clinical practice.

CHP and PCOR sponsor seminars, lectures and conferences to provide a forum for scholars, government officials, industry leaders and clinicians to explore solutions to complex healthcare problems. CHP and PCOR build on a legacy of achievements in health services research, health economics and health policy at Stanford University. For more information, visit our Web site at **http://CHPPCOR.Stanford.edu**