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- Stayed up late reviewing clinical practice guidelines
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- Flown in from the Neighbor Islands to participate in quality management meetings
- Helped us provide evidence of improved outcomes for members
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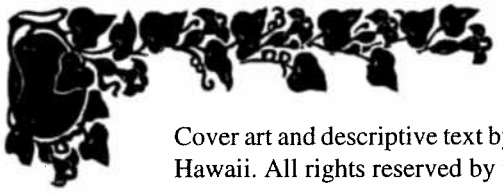

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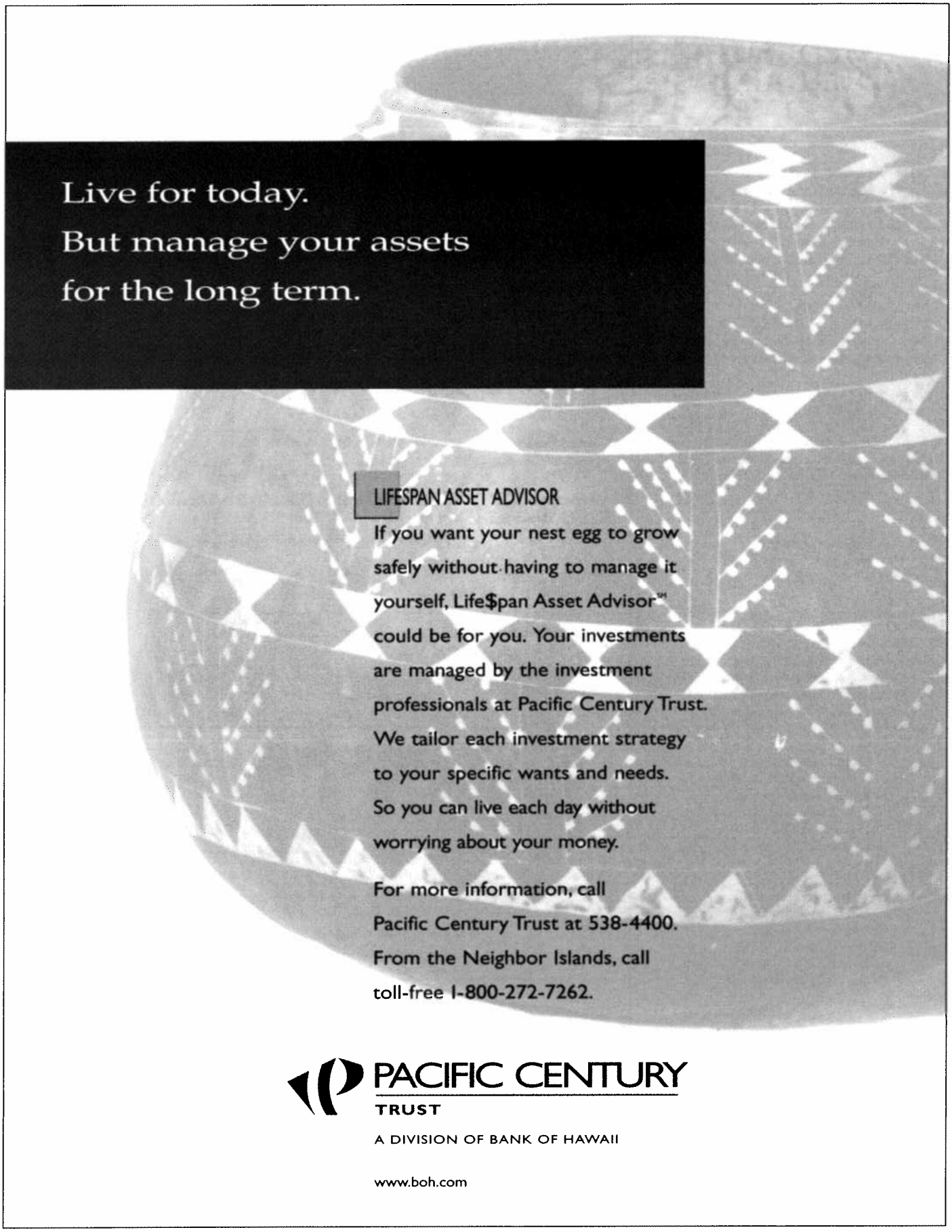
Ē Pele Ē

Depicting the goddess of Hawaiian volcanoes surrounded by images related to her myth

A Call to Physician Authors

We are always looking for interesting scientific articles and we would like to hear from more of you. The *Hawaii Medical Journal* is a peer reviewed publication and covers a wide variety of topics. To submit a manuscript please call us for manuscript guidelines. Fax or call for your requests to: Hawaii Medical Journal, 1360 S. Beretania Street, Second Floor, Honolulu, Hawaii 96814, Phone (808) 536-7702 or Fax us at (808) 528-2376, e-mail: hma-assn@aloha.net.



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Editorial

Norman Goldstein MD

CHIS—Consumer Health Information Service Hawaii Medical Library

Every medical student at the John A. Burns School of Medicine, as well as most practicing physicians, know of the vast reference material available at the Hawaii Medical Library. The journal and book collections, the computer access programs, and especially the knowledgeable, helpful Library staff enable us to keep right up to date with our practices, our research and teaching curricula.

You may not be aware of another very important section of the Hawaii Medical Library, CHIS.

This service is helping your patients to:

- understand their illnesses and treatment options
- make informed decisions about their health care
- learn about overall health and wellness

In the past year, CHIS averaged 285 questions per month, and sent an average of 62 information packets per month to the inquiring public. Services are increasing exponentially with the CHIS web site (http://hml.org/CHIS/) getting 2,800 hits per month. Amazing!

CHIS also has many excellent models and charts available for classroom and health fair exhibits, and is currently expanding its alternative medicine resources.

In a recent survey of CHIS users, 97% were satisfied with the services provided, 28% were repeat users, and 90% said they used the information provided to make a healthcare decision.

Our legislators, Hawaii hospitals and physicians and, yes, even attorneys, should be encouraged to continue to support the activities of CHIS at the Hawaii Medical Library.

Cancer Pain Guidelines: Are They Being Used?

This excellent manuscript on page 655 by Pat Kalua, RN was to appear in our Special Issue on Pain. This issue has been delayed because of updating manuscripts as well as production problems. It will hopefully be published in January 1999.

The Kalua manuscript is so important, in view of the recently completed Governor's Blue-Ribbon Panel on Living and Dying with Dignity—we publish it at this time. Look forward to the Pain Special Issue.

An Assessment of Hawaii Quest Medical Plans Performance Using Medicaid HEDIS Measures, 1996-1997

Because of initial controversy and questions about the Hawaii QUEST programs, Lynette Honbo, MD Medical Director of the MED-QUEST Division of the State Department of Human Services, was asked to submit this Assessment of QUEST on page 662.

As Director, she supervises 15 healthcare professionals in the Medical Services Branch and helps to clarify the QUEST Medical/Dental/Behavioral Health and Pharmacy benefits of QUEST as well as the Medicaid fee-for-service programs and the QUEST-NET program. Mahalo, Lynette and Matthew Loke, Ph.D.

On a personal note, Lynette is married to OB/GYN Clayton Honbo MD.

President's Message

Where do we go from here?

Leonard Howard MD
President, Hawaii Medical Association

In this, my last message to you as your president, I would like to make some observations about the practice of medicine in Hawaii as seen from the heart of the Hawaii Medical Association. This has been a year of relevancy. Everything that we have done this year has been directed towards being relevant to the practice of medicine. The results have been equivocal. On the plus side, the physicians of Hawaii are now seen by the lay public as speaking more with a single viewpoint than ever before. More points of view are now being represented in the consensus voice of medicine. Our voice is being heard in more task forces, more focus groups, and more socio-political arenas than ever before. This is what we set out to do during this past year.

So what are the results of this course of action? Our membership is roughly what we started with last November, but the rotating door has never stood still. If we could ever figure out how to retain members our dues problems would be solved. The problem is that physicians in a tight economic market do not see an immediate return on the money spent for HMA/AMA membership. I would venture to say that membership in Specialty societies, if judged by the same immediate return on investment, would also come up wanting, but for some reason are given priority over the HMA and AMA. I am a life member in my specialty organization, but do not see how it provides any more immediate return than does the HMA.

In our quest for relevancy we find the need for considerable staff support. In the legislative arena we need four full-time people to maintain our presence in the big square building, in addition to the many physicians who donate many hours each week to present testimony. The committee work necessary to support the legislative process is tremendous, but the cost of this support is never mentioned as an immediate benefit of membership. Ask yourself if you personally have the time to spend in the committee hearings, presenting your own testimony. If you are not there, don't you think there should be someone there representing your interests? To do this costs money. Money comes from members. It is your choice.

I do not see any prospect for any less managed care in the future, since the demand for more and more care will ever increase as the percentage of our population that is in the Medicare age group increases. The whole concept of medical ethics is changing. Many of the injunctions of the original oath of Hippocrates are ignored in current medical practice, and the oath itself has been often rewritten to be more politically correct. Yet one of its legacies is the demand

that a physician, if unable to heal or cure, shall do no harm. To some physicians, this means that they must do everything possible to ensure the physical well-being of their patients, or more problematic, everything that might help their patient. Many patients and policymakers have the same expectations. In economic terms, this means that we are required by medical ethics to devote such resources to the care of our patients that the marginal effect of the last dollar spent approaches zero. If we follow this injunction rigorously, we can easily spend our entire gross national product on health care many times over. Thus the shift of managed care or managed-cost. The new ethic of health care says "Perform procedures until the marginal health benefit is greater than or equal to the marginal monetary cost." This new ethic results in less medical care, but it ensures that whatever we get for the expenditure of the health-care dollar is worth the cost of providing the care. Physicians and healthcare administrators for most of the post-World War II period were encouraged to believe that money should never be a consideration in the medical decisionmaking process. Today, we are being told that money should always be considered. Moreover, the decisionmakers in healthcare financing gravitate towards a cost-benefit standard - a collectivist standard not always in the best interest of individual patients.

It is for this reason that organized medicine must continue to represent the patients in this social equation. This can only be done when organized medicine has the financial and staff assets to be part of the bureaucratic decisionmaking process. If organized medicine is unable to continue to function in our society, the practice of medicine will truly become a service industry rather than a profession, something that many social planners are strongly advocating at the present time. It is only by flexing the muscle that comes through unity that we will ensure our ability to practice our profession. This requires that every physician who wishes to continue to practice as a professional do their part to support organized medicine. If we do not do so, the medical profession as we know it will disappear and we will have only ourselves to blame. The choice is ours. I pray we make the right one.

Medical School Hotline

An Update on the USMLE Performance of Medical Students at the John A. Burns School of Medicine and Computer-Based Testing

Gwen S. Naguwa, MD
Associate Dean, Office of Student Affairs

As reported in this annual update on the United States Medical Licensing Exam (USMLE), the students at the John A. Burns School of Medicine (JABSOM), continue to do well, especially on the Step 1 exam. Also, at its June 1998 meeting, the Composite Committee, which consists of members representing the Federation of State Medical Boards, the National Board of Medical Examiner and Educational Commission for Foreign Medical Graduates, formally voted to implement Computer-Based Testing (CBT) beginning in 1999.

Students in the JABSOM Class of 2000, who challenged the Step 1 exam this past June, achieved a post-Problem-Based Learning curriculum high passing rate of 98%, compared to the national passing rate of 95%. The mean score for JABSOM students was identical to the national mean of 216. The passing rate for our current seniors on the Step 2 exam, taken in August 1997, was 96%, as compared to the national rate of 95%; however, the mean score for JABSOM students was 214, slightly higher than the national mean of 209. As before, although the National Board of Medical Examiners steadfastly states that it is a licensing exam and should not be used as a method of evaluation of curricula, the faculty continues to feel that the students' performance is an indication that they have mastered the skill of learning, or at least solved the problem of how to pass the USMLE.

As a brief review, the USMLE is the only path to licensure in the U.S. and its territories, and a passing score in all three steps is one of the requirements. Step 1 is designed to assess a student's ability to apply knowledge and understand key concepts of basic biomedical science, with an emphasis on principles and mechanisms of health, disease, and modes of therapy. The Step 2 exam is to determine whether a student can apply basic science knowledge and understand the clinical science necessary to care for patients under supervision, and now includes health promotion and disease promotion. Step 3, usually taken near or after completion of one postgraduate year of clinical training, assesses the ability to apply the medical knowledge and understanding of biomedical and clinical science considered essential for the unsupervised practice of medicine with emphasis on patient management in ambulatory setting.[1]

While the purpose and fundamental content of the USMLE will not be affected significantly by the conversion to the computer-based format, the effect of the Composite Committee's

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decision to proceed with the conversion in 1999 means that the standard large-group paper-and-pencil exam will no longer be offered. Instead, beginning in April 1999 for Step 1, July/ August 1999 for Step 2, and October 1999 for Step 3, eligible candidates will be able to self-schedule their exams at any time at one of over 1,500 Sylvan Prometric Test Centers around the world, or at an approved Medical School Center. Consequently, it is anticipated that the last administrations of the paper-and-pencil exams will be October 1998, March 1999, and May 1999 for Steps 1, 2, and 3, respectively.

As previously noted in our 1997 update, the major rationale for the switch to CBT was concerns regarding exam security and the advantages of the format for enhancing assessment methods and flexibility in scheduling. The physical security of the exam will be controlled through computerized, electronic transmission of encrypted data, and the proctoring of examinees will be aided by use of audio and video monitors. Also, hundreds of content-parallel test forms created from very large banks of test questions will be used on different days, in different locations, and even on the same day in the same center.[2]

New assessment methods will include clinical and laboratory simulations and multimedia presentations of sounds and images, as well as adaptive testing, which involves altering the difficulty of subsequent blocks in response to an individual's proficiency to improve the precision of the final score. However, while the blocks may vary in average difficulty, they will meet the same content specifications and, therefore, every examinee will be tested on equivalent content.

Implications of the scheduling flexibility for students have many medical schools struggling to anticipate and respond to it's impact on curricula and scheduling. For example, schools which require students to take or pass Step 1 in order to progress to the third year will be faced with the logistical problem of insuring that sufficient resources exist to examine all students in what is anticipated to be a short period of time, or whether to grant delayed start dates to those who choose not to or are unable to take the exam prior to the scheduled start date. However, the shortened score report date, which will eventually be two weeks as compared to the current seven weeks, will be a distinct advantage in initiating appropriate remediation.

In response to the concern regarding having a sufficient number of computer stations for our students, and the belief that this format will become a significant part of the future assessment methodology, JABSOM has submitted a request to the National Boards to become an exam site by May 1999. Hawaii currently has only one Sylvan Technology Center (in Kailua), which plans to expand from it's current four stations to eight by April 1999, but also administers licensing exams for a number of other specialists, including paramedics, nurses, medical technologists, and air traffic controllers. Given the structure of our current curriculum it is anticipated that the majority of our students would prefer to take the Step 1 exam after the end of their second year and before the start of their third year, a span of approximately three weeks. The exam, which is seven hours long with a total of one hour of break time, would require exclusive use of the Sylvan Center's eight stations for nearly 10 days, given additional time for those needing special accommodations, etc. for our students alone; a situation Sylvan will not guarantee. The proposal for JABSOM to become a Medical School Center represents a significant investment in terms of space and resources, but reflects our commitment to our students and remaining at the forefront of advances in medical education.

In summary, JABSOM students, under the Problem-Based Curriculum, have continued to improve on their ability to pass the USMLE, especially on the Step 1 exam. It is anticipated that, given there will be no change in the exam content and the students will receive support from the medical school in the form of our own test center, conversion to the computer-based testing format should not have any significant impact on their future performance.

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1. Bulletin of Information, United States Medical Licensing Examination,™ 1998.
2. Plans for Administering the Medical Licensing Examination on Computer, Special Bulletin on Computer-Based Testing for the United States Medical Licensing Examination,™ 1998.

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Commentary

Change in Medical Care Has Come Too Fast

Reprinted from the Honolulu Advertiser, July 1998

by Frederick C. Holschuh MD

I have seen the enemy: It is not only disease and suffering but denial of care and disruption of the patient-doctor relationship.

We now save public funds by not offering routine adult dental care, and yet, in the emergency room I see patients daily with dental abscesses and facial infections, often requiring costly antibiotics and/or hospital admissions.

We discontinue programs for alcohol and other drug treatments, and then pay horrendous amounts in money and human suffering for the end results of substance abuse: violence, ravaged minds and bodies, the spread of viral infections and damaged fetal brains.

Prior to the managed-care approach to cost control, it was not uncommon for a young man to drop into an emergency room for pain medication rather than wait for an appointment, just so he could get to the beach sooner; or, for patients to tell me they had changed their disability from "back pain" to "psych" because it was easier to scam the system.

Change was needed, but it is going too far, too fast.

We physicians do not feel that all is lost, even with the horrendous Mainland examples of managed care that is obscene in its denial of benefits and care to patients and the treatment of physicians.

Locally, legislation has passed to allow patients to seek emergency room care when the patient feels it is an emergency, and that provides for protection for the patient in a patients' bill of rights.

We must seek an appropriate balance, never forgetting that the patient must always be the focus.

Managed "fright"

My physician colleagues and I know there have been dramatic, chaotic and sometimes frightening changes in our health care delivery system. For physicians, the "fright" is simply to wake up one morning to find that all of your patients have been taken to some other "provider of care" and that reimbursements will continue to be slashed.

For patients, it is the restrictions on benefits, the denial of care, the inability to see a physician of their choice, and the loss of "connection" with their doctor.

For both patients and physicians, it is frightening to lose control of decision making.

The changes are in large part due to the phenomenon called "managed care" — or what we physicians see more as "managed cost" — much to the detriment of patients.

I believe every patient should have a "choice" of health care delivery system, whether it be closed-panel health maintenance organization, large multi-specialty clinic or independent private physician. In the recent past, the physician and the patient decided together on care options; now, the decision and choices are taken away by the "payer" or insurance company health plan.

The managed part of health care arose because of abuse and waste in the health care system. Many other sectors of our society also experience abuse and waste but have not been taken care of by the most restrictive and burdensome governmental regulations that we see in the health care industry.

Patients must act

Now thankfully, the patient and the doctor — as the patients' advocate — are challenging the managed care organizations and their counterproductive bottom-line mentality at the expense of the patient.

The only way to bring back true patient-physician decision-making in health care is for our greatest allies, our patients, to demand that it be done.

Fred Holschuh MD is an emergency room physician at Hilo Medical Center. He was named 1998 Physician of the Year by the Hawaii Medical Association.

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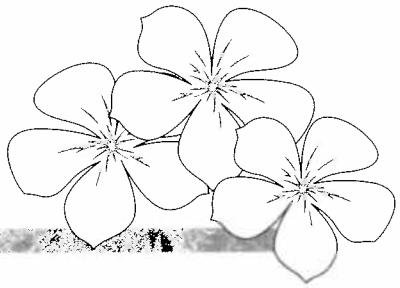

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Harry L. Arnold Jr. MD Case of the Month

Eosinophilic Meningitis / Angiostrongyliasis From Eating Aquaculture-raised Snails: A Case Report

Christopher M. Marsh MD

A 68-year-old recently-retired Chinese-American telephone switchman developed a headache and a short-lived papular rash about one week after eating home-cooked ("Chinese style"; stir-fried) fresh snails, a gift from his neighbor, a home aquaculturist. He developed worsening confusion and hallucinations, fell twice at home, and was admitted to the hospital. His medical history was remarkable for mild hypertension and gout. Routine medications were nadolol, colchicine, and probenecid.

Examination revealed that he was alert and oriented to month and year, but not to day or date; he was unable to perform "serial sevens" or "serial fives." Vital signs and general examination were unremarkable. Fever and meningismus were absent. Laboratory tests were normal except for serum sodium of 118 meq/dL. Several normal serum sodium levels had been documented during the years prior to this illness. MRI scan of the brain was normal.

After hospitalization and IV fluid administration hyponatremia was corrected, but his condition worsened. He began to hallucinate, seeing imaginary people and objects in his room. Agitation, and acute urinary retention developed. Lumbar puncture revealed cerebrospinal fluid (CSF) white blood cell count 1,300, with 73% eosinophils; glucose was 31 mg/dL, protein was slightly elevated. All cultures and stains were negative. He was treated supportively for a diagnosis of eosinophilic meningitis. Empiric therapy for tuberculous meningitis was administered for one week.

Repeat lumbar puncture two weeks later revealed moderate improvement in the CSF eosinophilia. However, he remained delirious and delusional, with hallucinosis. Transfer to a care home for six weeks was required before his family was again able to care for him. Bladder catheterization was successfully discontinued shortly thereafter. Mental function improved slowly, although twelve months following onset of illness, he remained unable to perform "serial sevens" calculations.

Serology specimens were sent to the Faculty of Tropical Medicine in Thailand.[10] Results revealed Angiostrongylus cantonensis antibody titers of 1:3200 by ELISA; Gnathostoma spinigerum antibody by Western blot was "weakly positive". There may be considerable cross-reaction among helminthic antigens within these tests.

Gnathostomiasis[1,6] typically causes painless migratory subcutaneous swellings lasting several days, and subsiding spontaneously ("larva migrans"). Immature worms can cause eosinophilic meningitis when they migrate to the CNS. The usual presenting symptom is sharp, agonizing cranial nerve root pain, or sudden impairment of sensorium due to cerebral hemorrhage. CSF is usually bloody or xanthochromic. Snails are not a known host of Gnathostoma spinigerum.

Although presenting some unusual features, the clinical diagnosis of eosinophilic meningitis due to Angiostrongylus cantonensis is unequivocally established in this case based upon CSF results, serology, ingestion of snails, and the clinical course of the illness.

Discussion

Almost all cases of eosinophilic meningitis are caused by *Angiostrongylus cantonensis*, the nematode lungworm of rats. Other parasitic helminths (e.g. *Taenia solium, Paragonimus westermani, Gnathostoma spinigerum)* may rarely cause CSF eosinophilia, but usually as part of distinctive illnesses (cerebral cysticercosis, etc.) readily distinguished clinically from *Angiostrongylus cantonensis*. The first human case of eosinophilic meningitis was reported in Taiwan in 1944, followed by thousands of cases in Southeast Asia and the Pacific basin over the ensuing fifteen years. *Angiostrongylus cantonensis* was first etiologically linked to eosinophilic meningitis in Hawaii and Tahiti in 1962.[1,4] The first case from mainland China was reported in 1984,[2] and the first case in North America in 1995[3].

Angiostrongylus cantonensis is a zoonosis affecting rats as the primary hosts. Several land mollusks (over 40 species of snails and slugs) are the intermediate hosts. A number of land planaria, freshwater prawns and crabs, frogs, and occasionally swine and cattle may serve as paratenic, or "carrier" hosts, but do not directly participate in the life cycle of *Angiostrongylus cantonensis.*[4] *Achatina fulica*, the giant African land snail, was introduced progressively across the Pacific, both willfully and unintentionally, during the 1940's and 1950's, and has played a major role as an intermediate host in the dissemination of *Angiostrongylus cantonensis.*[5] Rats infected with *Angiostrongylus cantonensis* have been found in all areas reporting eosinophilic meningitis.

Human infections are usually acquired by accidental or purposeful ingestion of raw or partially cooked terrestrial mollusks, planaria, and freshwater crustaceans containing infective larvae. Ingestion of contaminated water or vegetables are other possible sources of infection. The incubation period is about one week. Clinical manifestations typically consist of severe headache, paresthesias, occasionally meningismus and cranial nerve palsies, and rarely

fever. The eye may become involved, occasionally with permanent visual impairment. The majority of cases are self-limiting, with acute symptoms lasting for one to two weeks. Rare residual neurological symptoms (diplopia, ataxia) usually resolve within several months. Incomplete neurological recovery is probably seen in less than one percent of cases.

Exceptionally severe cases, and chronic cases, have occasionally been reported. Pathogenesis of eosinophilic meningitis involves migration of third stage larvae via the systemic circulation to the brain (and spinal cord), where they die, causing an intense inflammatory, eosinophilic reaction. In the primary host, the rat, the larvae migrate within the brain, eventually reaching the subarachnoid space.[6] Several autopsy studies of fatal human eosinophilic meningitis have found parasites, and oval worm tracks, throughout the white matter of the brain and spinal cord.[1] Characteristic abnormalities on brain CT have been reported. No pathological studies of completely recovered cases of eosinophilic meningitis were found in this literature review.

Diagnosis is based almost entirely on the clinical presentation, the marked CSF eosinophilia (and occasionally demonstration of larvae in the CSF or anterior chamber of the eye), and a history of exposure to (ingestion of) an intermediate or paratenic host. About 60% of cases have peripheral eosinophilia; all have CSF eosinophilia of greater than 20% of total CSF white blood cells, at some time during the course of illness. Patchy lung infiltrates and other abnormalities on chest X-ray have been described, primarily in children.[7] Presentation can rarely resemble bacterial meningitis with meningismus and fever. Urinary incontinence, ataxia, and cranial nerve palsies are symptoms which demand consideration of alternative diagnoses (tuberculous meningitis, syphilis, etc.) when present. Our patient was treated with antitubercular antibiotics for about one week until tuberculosis was confidently ruled out.

Several serological tests for *Angiostrongylus cantonensis* have been evaluated. The only test with promise is an enzyme-linked immunosorbent assay (ELISA) test.[8] The detection of *serum* antibody is much more sensitive than that of *CSF* antibody; sensitivity for IgG antibody is greater than for other antibody classes.[9]

There is no specific effective treatment for eosinophilic meningitis. Several antihelminthic agents (primarily thiabendazole, anecdotally ivermectin etc.) have been evaluated, with inconclusive and inconsistent results. It is thought that live larvae may be less antigenic to the brain than dying or dead larvae, so that antihelminthic

treatment could exacerbate symptoms.[1] The vast majority of cases recover fully with supportive care. Severe symptoms appear to be often due to increased intracranial pressure, and repeated lumbar puncture has occasionally caused marked improvement. Corticosteroids have not been found to be of any value, although several anecdotal cases of improvement with corticosteroids in patients with presumed increased intracranial pressure, were found in a literature review[1] However, as this case demonstrates, eosinophilic meningitis is a disabling and sometimes prolonged illness, often requiring hospitalization, expensive diagnostic testing, and occasionally prolonged post-hospital institutional care.

Presentation with acute delirium and hallucinations, the severe hyponatremia, and the prolonged duration of dementia (three months) seen in this case are all somewhat unusual for eosinophilic meningitis. No previously published cases of eosinophilic meningitis presenting with severe hyponatremia were found in this literature review. Published case studies of eosinophilic meningitis, reporting a preponderance of complete neurological recovery, do not specify the extent of follow-up neurological examination. Detailed mental status examinations, or evaluations of cognitive performance, may not have been done. Since parasites invade and damage brain parenchyma (to some degree) in man prior to their death, it seems surprising that complete neuropsychological recovery would be the common outcome. Our patient has persistent, moderately severe acalculia. Although this was not tested prior to his illness, he had very recently retired from a job requiring an understanding of mathematics, and had successfully conducted a small catering business for many years.

Our patient's aquaculturist neighbor reportedly sells most of his produce to local hotels and restaurants for preparation of "escargots." Since *Angiostrongylus cantonensis* is well-established in Hawaii, it is not surprising that fresh water aquaculture of one of its intermediate hosts would be susceptible to infestation. Presumably, pharmacological antihelminthic treatment for *Angiostrongylus cantonensis* would not be possible in such an environment, without also damaging the snails.

Telephone contact, on several occasions during the course of this case, to the Hawaii Department of Health, disclosed that eosinophilic meningitis is not a "reportable disease" in the United States or Hawaii, and therefore, not under the purview of the Department, or of any other state regulatory agency that they were aware of, even though the aquacultured snails are being sold commercially. However, the Centers for Disease Control in Atlanta, Georgia, would be interested in hearing about any further cases, particularly from an aquaculture source (personal communication).

Special thanks to Thomas S. Reppun, MD, Diagnostic Laboratory Services, Inc, for assistance with the serological testing.

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Cancer Pain Guidelines: Are They Being Used?

Results of a Multi-site Study Conducted by the Hawaii Cancer Pain Initiative

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This study assessed patients' knowledge, experience and satisfaction with their cancer pain management, explored professional documentation and assessment practices and the presence or absence of institutional infrastructures that support pain management. The findings were then compared to the recommended standards and guidelines published by the World Health Organization, American Pain Society and Agency for Health Care Policy and Research.

Introduction

It is well documented that approximately 85% of patients with cancer experience pain during the course of their illness or treatment.[1,2] The literature also suggests that only 70% of all cancer patients experiencing pain feel that their pain management is effective.[3] Studies of pain and patient satisfaction find that patients often rate their satisfaction high even when pain is severe, "suggesting that patients do not expect consistent pain relief and that the use of patient satisfaction questions without other questions about pain ratings may overlook suboptimal pain relief." Hill states that although appropriate opioid analgesics and knowledge about pain is widespread, cancer pain is still widely uncontrolled.[4] Portenoy believes that undertreatment by practitioners is the primary reason for unrelieved cancer pain although 70% to 90% of this pain can be relieved through pharmacological methods alone.[5] The World Health Organization (WHO) devised an analgesic "ladder" approach to cancer pain management based on "the premise that most patients...should have adequate pain relief if health care providers learn how to use a few effective and relatively inexpensive drugs well and administer them...according to the individual needs of the patient."[6] It is estimated that the use of the "three step ladder" devised by the WHO for use in controlling cancer pain effectively controls pain in 71%-97% of patients.[7] However, with the increasing number of adjuvants and analgesics available for use in different strengths and by different routes, factors such as cost, equianalgesia and patient preferences must be considered when defining a pain treatment plan.

Assessment and documentation are essential for successful pain management, providing the baseline data from which prescribing and treatment decisions are made. The AHCPR Clinical Practice Guidelines for Management of Cancer Pain state that "pain management should be evaluated at points of transition in the provision of services to ensure that optimal pain management is achieved and maintained."[2] The APS suggests that standardized assessment and communication is the key to successful pain management.[6] Gathering data and documenting the current status of pain management are important prerequisites to implementing change. Recent studies show that nurses do not always document patient and family teaching or follow the nursing process which requires assessment and ongoing evaluation of patient care and goals.[12] A recent study in Holland of the effects of a continuing education program on nurses' practice in taking pain histories, performing assessments and managing pain showed an increase in the quality of these activities but not in related quantitative activities such as use of pain rating scales. The nurses participating in the study attributed this phenomena to a lack of support from physicians, varied prescriptive practices, a lack of administrative policies supporting a change in practice and their own reluctance to change their daily routine.[13] For cancer pain management to become an integrated standard of practice "the challenge of implementation requires involvement by many individuals within the institution."[8] Since the majority of cancer patients in Hawaii receive their primary and secondary treatment in Honolulu, the importance of standardizing education, assessment and documentation cannot be underestimated.

The research questions this study addressed include:

1) Is there a significant relationship between patients' level of comfort, knowledge about and satisfaction with their pain control?
2) Is the WHO Analgesic ladder in widespread use?
3) Are the recommendations from the AHCPR and APS guidelines for assessment and documentation reflected in current procedures, policies and practices?

Methodology

This study was conducted over a one-year period in seven major medical centers on the island of Oahu. The Institutional Review Board of each medical center approved the study. Primary data was gathered using a patient questionnaire, chart review and an institutional audit tool. The questionnaires were systematic adaptations of tools from the City of Hope Medical Center and used an analog scale to assess patients' level of pain or agreement or disagreement (0-10; 0 = disagree, 10 = agree) with professional beliefs about cancer pain and its management. Each co-investigator was trained in the use of the tools, in assessing a patient's ability to use the questionnaire and in obtaining a signed consent to participate. Each questionnaire took approximately 15 minutes to complete. Any patient concerns or questions about pain that arose as a result of this study were reported to the participant's physician.

The chart review tool was also a systematic adaptation of the tool used by the City of Hope Medical Center. This tool was used on the day the questionnaire was administered to evaluate the types and

methods of assessment and documentation that were being used by various professionals and to record the medications that were currently ordered and being used by each patient. The institutional audit form was also a replication of the tool used at the City of Hope Medical Center. It was used only once in each setting to determine if policies, procedures and institutional processes were in place to insure quality pain management.

Inclusion in the non-random sample required participants to speak English, have a primary diagnosis of cancer and they must have been on at least one opioid for non-surgical, cancer-related pain. Due to reorganization of the oncology units in two of the medical centers and a large population of patients who were non-English speaking or unable to participate due to their physical condition, the study failed to meet the expected sample size of 20 patients per medical center. However, a total of 100 attempts were made, 69 surveys were collected and 67 were usable.

Results: Survey and Chart Review

There were thirty-six (36) males and thirty-three (33) females surveyed. While most respondents were between the ages of 40 and 80, three participants were under 30 and two were over 80. Figure 1 illustrates the ethnicity of the respondents. Other data includes when the participants were diagnosed and when their pain began. Table 1 illustrates this information.

Table 1.—Length of Time Participants Experienced Cancer and Pain

When was your cancer diagnosed?		When did your pain begin?	
	No. pts/%		No. pts/%
a) in last week	3 (4.7%)	a) in last week	2 (3.3%)
b) in last month	5 (8%)	b) in the last month	7 (11%)
c) in last 6 mos	20 (30%)	c) in last six months	25 (39%)
d) 6 - 12 mos. ago	9 (13%)	d) 6-12 months	12 (18%)
e) 1-2 years ago	5 (8%)	e) 1-2 years ago	0
f) 2-3 years ago	7 (11%)	f) 2-3 years ago	3 (4.7%)
g) 3-5 years ago	8 (12%)	g) 3-5 years ago	6 (9%)
h) >5 years ago	6 (9.5%)	h) >5 years ago	4 (6%)

*Four surveys were unanswered

Participants were asked to fill out a survey that rated their experience with pain over the last week, the last twenty-four hours and at the time of the survey. Respondents diagnoses and the responses to the pain experience questions are illustrated in Figures 2, 3, 4 and 5. All but six of the participants were outpatients during the week prior to the survey. Twelve patients (17%) were receiving radiation therapy, 29 patients (43%) were receiving chemotherapy and 41 patients (39%) were receiving no active cancer treatment. Patients were also asked to rate any side effects of opioid analgesics that they might be experiencing such as nausea, constipation and/or drowsiness. Analog scales were used for all of the ratings (0=none; 10=worst possible). Table 2 illustrates the responses to these questions.

Table 2.—Respondents' Experience with Side Effects

* Rating scale:	0-3	4-6	7-10
		No. of patients	
Do you have a problem with constipation?	36	13	14
Do you have a problem with nausea?	45	11	9
Do you have a problem with drowsiness from your medications?	37	20	9

* 0-3=none to mild; 4-6=moderate; 7-10=severe

Patients' knowledge and beliefs about cancer pain and its management were also assessed to see if they agree with current beliefs among health care professionals about cancer pain and its management. Participants were asked to respond using a 0-10 analog scale (0=disagree; 10=agree) to statements professionals generally believe to be true. The responses, showing patients' agreement or disagreement with these statements, are illustrated in Table 3.

Table 3.—Respondents' Knowledge and Beliefs Regarding Pain and Pain Control

	Disagree	Unsure	Agree
Knowledge Statements	0 - 3	4-7	8-10
Cancer pain can be relieved (7 unanswered)	1	21	37
Cancer pain medicines should be taken before pain becomes severe	8	9	49
It is alright to take more than one type of pain medicine	9	19	25
It is better to take pain medicine around the clock rather than only when needed. (3 unanswered)	16	18	19
Are you satisfied with the treatment you are receiving for pain (3 unanswered)	4	15	45

A concurrent chart review was performed for each respondent to look for the absence or presence of practices that adhere to established standards or guidelines. The chart review specifically looked for consistent use of a pain rating scale, consistent assessment, documentation and prescriptive practices during the time period of the survey, i.e., the twenty-four hours during which the survey was given to the patient to complete. Subjective descriptions of pain, such as, "I feel better today" or "patient states pain continues", were found in 41 respondents' charts. Objective descriptions, specifically analog pain ratings, were found in 50 of the charts reviewed (n = 67). As Figure 6 illustrates, assessment and documentation of pain ratings vary widely between disciplines and within the patient's record.

Table 4.—Number of Opioids/Adjuvants and Routes of Administration

Number of patients on one opioid	8
Number of patients on PCA	18
Number of patients with parenteral analgesics and oral opioids/adjuvants ordered	22
Number of patients with more than three routes ordered (IM, oral, transdermal, rectal, IV)	42
Number of patients with more than three medications from the same class ordered	17

Table 4 shows that many respondents had multiple medications ordered by multiple routes. This may have influenced patients' ability to name their medications. Only twenty-six (38%) of those surveyed could name one of the medications they were taking for pain. Eleven respondents (16%) could name two or more medications, however, the remaining patients stated that they could not name their pain medicines.

The responses to the experience and knowledge questions are of interest when coupled with the barriers to pain control that patients themselves identified (Figure 7). While it seems understood that insurance will cover all or most of the costs of hospitalization, it is obvious that patients were also thinking about barriers outside of the acute care setting, where outpatient medications, Patient Controlled Analgesia (PCA) or other therapies are not wholly or partially covered by insurance.

Patients also indicated that they use many alternatives to pharmaceutical pain control methods. Figure 8 illustrates that over half (53%) of those surveyed consider prayer an alternative therapy, while Healing Touch, relaxation, heat and imagery were used as well. One patient stated that he used marijuana and beer, another indicated that music helped and a third indicated that concurrent chemotherapy had relieved some of his pain. Thirty-seven respondents (55%) of those surveyed indicated that they would be willing to use alternatives, twenty-two (32%) respondents indicated they were undecided while only four (5.9%) stated "no"to this option.

When asked to identify health care team members, other than their physician or primary nurse, whom they felt were helpful in controlling their pain, 41% of those surveyed responded "none". Respondents from institutions with formal pain teams indicated that those teams had been helpful as indicated in Figure 9. Patients listed family, self, and friends in the "Other" category.

A nonparametric measure of association between variables, the Spearman rank-order correlation coefficients were computed for the experience (pain and side effect) questions and the knowledge statements. In general, there were significant positive correlations between some of the questions within each group. Only the statement "Cancer pain can be relieved" showed a significant positive correlation with patients' satisfaction with their current pain management (r_s=0.55, p<.001). There was a small but significant negative correlation between the amount of pain patients were experiencing at the time the survey and their satisfaction. (r_s=0.29, p=0.02).

A mean pain experience score was computed for each patient summing the responses to the questions "How much pain do you have right now?," " How much pain have you had over the last twenty-four hours?" and "How much pain did you have in the last week?" and dividing by 3. Similarly a mean knowledge score was computed by dividing the sum of the responses to the knowledge questions by 4. There was a small, significant, negative Spearman correlation between the mean pain score and satisfaction (r_s=0.34. p=0.007) but no significant correlations between mean knowledge score and satisfaction or between the mean knowledge and experience scores.

Respondents were divided into two groups: those who indicated fear of addiction as a barrier to pain management and those who did not. The responses of the two groups were compared for knowledge, experience and satisfaction. The group that did not identify addiction as a barrier had a higher mean level of agreement with the knowledge questions than those who did. There was also a significant difference in satisfaction with pain management between the two groups (x^2=15.13, df=9, p=0.040). The difference between the mean responses to the experience questions was small. The nonparametric Mann-Whitney U (Wilcoxon Rank-Sum) test, which may be used to test whether two independent samples are drawn from the same population, was performed on the mean experience and knowledge scores of the two groups. A significant difference was found between the mean knowledge score of the two groups (U=210.5, p=0.002), but no statistically significant difference was found between the mean experience scores (U=436.5, p=0.71). This is consistent with the results of the analysis of the individual knowledge and experience questions.

Findings: Institutional Audit

Four of the institutions participating in the survey completed the institutional audit form, which identified the presence or absence of processes that support effective pain management. Of the four participating institutions, two have a formal pain team in place. All of the responding institutions have admission forms that screen for pain and all have a flow sheet of some kind for pain, although in one instance it is only if a patient is on a PCA. All of the hospitals have equianalgesic charts or other tools available for staff to use. None use caremaps or critical paths nor do they have a specific mechanism to signal ongoing or severe pain, such as incident reports.

Two of the four medical centers require new staff to have or to learn basic pain management principles as part of orientation. The two institutions with formalized pain management teams offer formal educational programs to patients and families and the opportunity for a formal interdisciplinary pain consultation. These institutions incorporate some assessment of patient satisfaction into continuous quality improvement methods. However, the policies that would trigger some type of professional response for unrelieved pain focuses only on patients using PCAs or other invasive techniques, not patients using oral analgesics or other modalities.

Two of the institutions stated that they were involved in ongoing research with regard to pain (not including this study), that costs are an important part of this research and that they have a hotline or consultation service available to outside resources.

Discussion and Recommendations

There were many reasons for conducting this multi-site investigation. Most cancer patients in Hawaii receive their primary and secondary care on Oahu where they may access a variety of different

agencies depending on physician privileges, bed availability and services needed. To date, there has been no aggregate data available to use to evaluate cancer pain management in Hawaii. This study is a starting point for assessing whether professional guidelines regarding pain and its management are being translated into practice.

As the chart review and institutional audit show, prescriptive practices, assessment and documentation vary between settings and practitioners. This is reflected in the fact that patients are not able to identify health care team members other than their physician and nurse as helpful with pain, except where a pain team was available. The majority of those surveyed were also unable to name the medications they were taking for pain. This may have been a phenomena of admission to a facility, where one expects professionals to take the responsibility for the knowledge and management of one's needs. However, the AHCPR and APS guidelines recommend that responsibility for pain management be assigned to "clinicians most knowledgeable, experienced, interested and able to respond to patients' needs in a timely fashion."[2,6] The AHCPR and APS guidelines also state that patients be informed of the importance of their pain management, participate in their pain management plan of care and that pain be addressed in a collaborative and interdisciplinary manner. Therefore, a strong recommendation is made that institutions designate a person or team that will be responsible for educating patients and staff, as well as designing and evaluating programs that will ensure optimal pain management.

The findings of this study indicate that use of current cancer pain guidelines is inconsistent, as the data shows that patients had orders for multiple opioids and adjuvants in insufficient quantities or by multiple routes. Many participants had multiple medications prescribed from the same "step" of the WHO Analgesic Ladder, i.e., fentanyl patches, PCA and oral morphine. This may be a reflection of inconsistent assessment and feedback or that practitioners are hesitant to order opioids in a large enough dose to control pain. However, it may also be that multiple modalities, including radiation and chemotherapy, were necessary to control cancer pain, which by its evolving nature presents a challenge.

This may account for the fact that one-fourth of the patients surveyed were on IV PCA, one was on subcutaneous PCA and one on intrathecal morphine. This is an interesting finding when one considers that 90% of all patients surveyed were also on oral medications. While it is difficult to quantify the benefit of any given pain control regimen compared with pain relief, all of the current guidelines suggest using the oral route whenever possible with the subcutaneous route as the next alternative. Hospices have used this concept for years in the home setting, with 90% of all patients maintained on oral medications with a high degree of relief and satisfaction.[16,17] It may be that PCA was being used to determine the appropriate oral dose or patients were being weaned off PCA to other routes. The data is insufficient to determine the reasons for using PCA, however, one questions whether the use of PCA in the hospital was necessary in every case.

Only two of the respondents were admitted solely for pain control so respondents' reports of severe pain in the week prior to the survey leads to many questions. Although 57% of those surveyed experienced pain beginning one to twelve months prior to the survey, the scope of this study could not examine how their pain was being managed during that time. One can only assume that there may be inconsistencies betwen outpatient and inpatient pain management related to many variables, including access to services, such as home care or hospice, or reimbursement issues. Further studies are needed in Hawaii to determine how pain is being managed in the outpatient setting. The survey results do indicate that patients are concerned about costs, addiction and side effects and having enough medications "for later" should their pain become worse. The costs of pain management can be quite high, so respondents' anxiety about cost is appropriate, especially for patients on fixed incomes or whose illness may result in a loss of employee health insurance due to an inability to work. A patient in the hospital may have insurance coverage for multiple medications but if these same medications are prescribed on discharge, even the wholesale cost (without a pharmacy markup) can be prohibitive. The major determinants in prescribing pain medicines are a patient's condition, disease status, past pain/drug history, side effects and current response. If there is no physiologic basis for prescribing one drug over another, then costs, availability, cultural biases and other factors should be considered. Professional and community education is needed to extinguish fears of addiction and to increase knowledge about the variety of pain management routes, medications and resources that are available.

The use of PCA and the high incidence of polypharmacy may have influenced patients' responses to the statement "Cancer pain can be relieved." The responses indicate that although pain management experts believe cancer pain can be relieved, this belief is not shared by all of the respondents in this study. The AHCPR and APS guidelines propose that pain be assessed individually, with "relief" defined by the patient's ability to function, sleep, work and otherwise continue their activities of daily living. In other words, achieving a pain rating of "0" may not be the primary goal. One questions whether the inconsistent use of guidelines and apparent lack of participation by patients influenced their responses. Standardizing assessment tools and practices and using easily understood algorithms for prescribing would help clinicians and patients manage pain more effectively.

Anxiety about costs, fear of addiction and undesirable opiate side effects may also influence the responses that show many patients would opt to use alternatives. A mainland study showed patients made "425 million visits to unconventional providers compared with 338 million visits to primary care physicians."[21] In Hawaii, there are many cultural practices that professionals view as questionable alternatives to Western medicine but that patients consider acceptable. Of interest is the finding that respondents consider prayer an alternative therapy. The impact of spirituality on pain and the use of nondrug interventions would make an interesting subject for further research, particularly in a multi-cultural environment. The use of cold, heat, relaxation, imagery, Healing Touch, distraction and massage may be widespread because they incorporate the "human touch" that contributes to patient satisfaction. Many of these therapies are free or cost no more than $25, making them cost-effective and attractive to patients. More studies are needed to determine how these therapies can be incorporated into existing health care delivery systems and their impact on the overall cost of pain management.

The factor that was most often identified as interfering with pain control was "having to wait too long for medications." This first relates directly to nursing practices as well as patient education.

Figure 1.—Ethnicity of Respondents

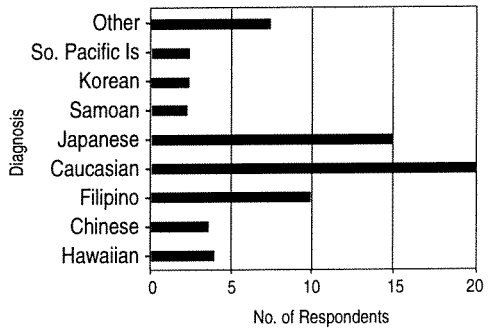


Figure 2.—Respondents by Diagnosis

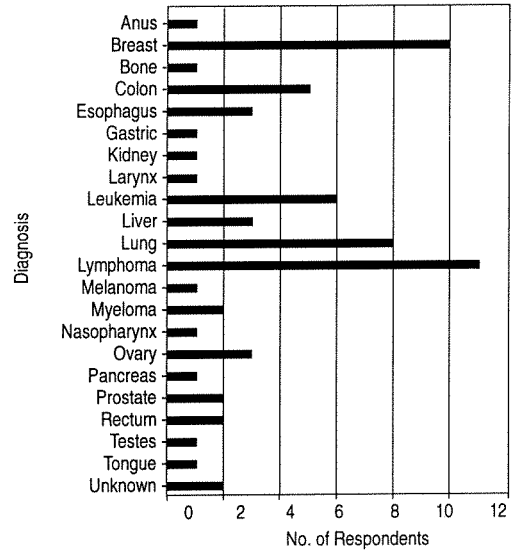


Figure 3.—Patients' Pain Experience in Week Prior to Study

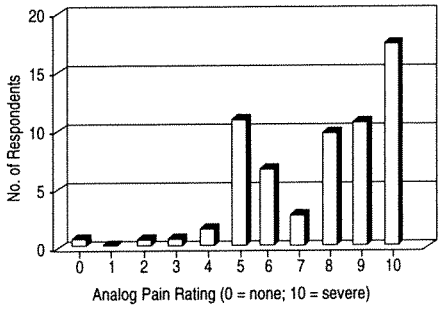


Figure 4.—Pain Experience in 24 Hours Prior to Study

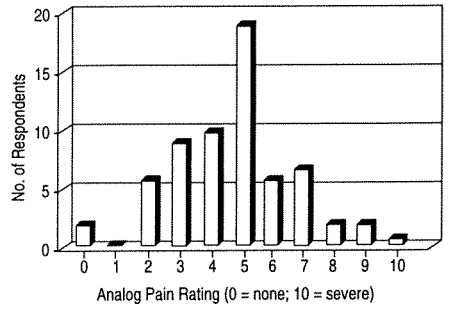


Figure 5.—Patients' Pain Experience at Time of Survey

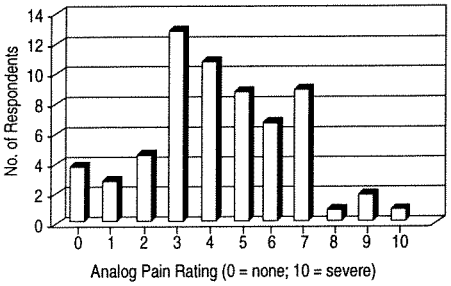


Figure 6.—Documentation of Pain Assessments

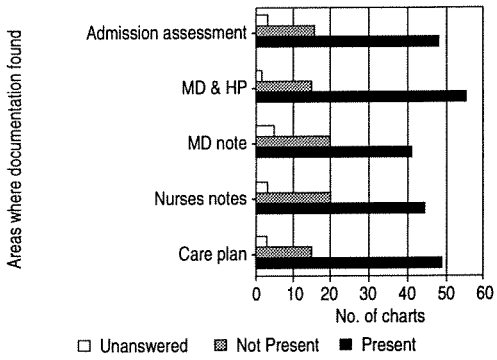


Figure 7.—Patient-Identified Barriers to Pain Control

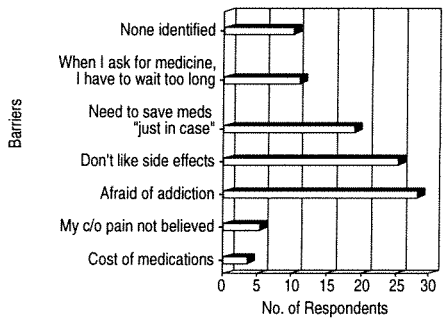


Figure 8.—Alternate Pain Relief Therapies Patients Are Using

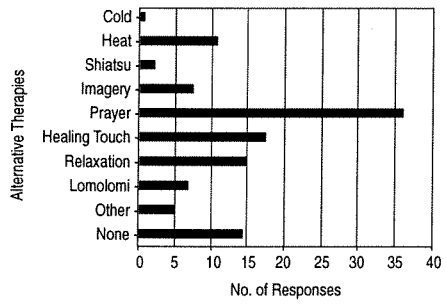
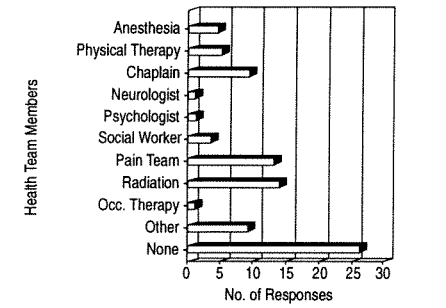


Figure 9.—Healthcare Team Members Identified as Helpful With Pain control



While patients remain on PRN medications, they will still have to ask for their medications. They may also be reluctant to "bother the nurse" or may be uneducated about the need to ask for medication before the pain escalates. This complaint may also be the reason for the use of a PCA pump. One study affirms that the average time it takes for a nurse to deliver an analgesic, including documentation, is 18.42 minutes while others show a waiting time of up to 30 minutes.[8] This may be due to variables such as staffing shortages that mean a patient's call light is not answered in a timely manner. While this seems to be a minor problem, it does show that ongoing institutional and professional assessment is necessary to define a standard of practice with regard to pain management.

It appears that some of the guidelines are used part of the time in various ways. While this study cannot show the reasons for inconsistent use of the guidelines, the data does support the fact that there needs to be standardization and further research in a number of areas. The Hawaii Cancer Pain Initiative strongly recommends devising a standardized pain assessment tool and flow sheet that will be used by all medical centers and outpatient agencies. Adopting algorithms that utilize methods of determining efficacy and cost-effectiveness for use when prescribing medications should be considered for use along with the WHO analgesic ladder. All institutions providing inpatient care to cancer patients should have a pain management team or service. If this is outside the resource capability of the agency, then a mechanism for referring to or accessing a pain management resource should be defined. Basic pain management education should be required for graduation from Hawaii's nursing and medical schools. Acute medical centers providing care to oncology patients should mandate competency in cancer pain management for all clinicians working in this area. Recognizing that patients themselves often present many barriers to pain control, research into the educational needs of the Island's various cultural groups, especially validating the use of pain rating tools in other languages, may define culture-specific barriers to pain management. A study comparing outpatient pain management to this inpatient study is needed to provide important information about the needs of cancer patients across the continuum of care. As with any endeavor, these recommendations will require ongoing energy, interaction and commitment from individuals and institutions alike but the benefit to our Island community will be worth the effort.

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An Assessment of Hawaii QUEST Medical Plans Performance Using Medicaid HEDIS Measures, 1996-1997

Lynette Honbo MD* and Matthew Loke PhD*

MEDICAID HEDIS Quality of Care Performance Measurements

What is Medicaid HEDIS?

HEDIS (Health Plan Employer Data and Information Set) is the performance measurement system for health plans developed by the National Committee for Quality Assurance (NCQA). The NCQA is an organization which accredits health plans as well as other types of health care organizations. The number of NCQA accredited managed care plans now exceeds 330, covering three quarters of all HMO enrollees or roughly 45 million Americans. HEDIS data is collected by more than 90 percent of all health plans. *Medicaid HEDIS* is an adaptation of *HEDIS 2.0/2.5* for use by health plans with Medicaid managed care programs. In 1997, *Medicaid HEDIS* was incorporated into *HEDIS 3.0.* Therefore, QUEST plans will report their HEDIS data for the 1998 fiscal year in *HEDIS* 3.0 format.

What is measured in Medicaid HEDIS?

Health plan performance related to the following seven (7) areas is measured:

- Membership;
- Utilization;
- Quality of Care;
- Access to Care;
- General Plan Management;
- Financial Performance; and
- Satisfaction with Care.

Health plan performance for membership, utilization, quality of care, and access measures are reported as tables. Membership and utilization measures relate to all members. Generally, quality of care measures apply to members continuously enrolled for 12 months with a maximum lapse in coverage of 30 days. Access to care measurements relate to the availability of services. Most general plan management measures require health plans to describe specific services.

*Department of Human Services
Med-QUEST Division
Medial Standards Branch and
Health Care Management Branch
Acknowledgement: We thank Alan Matsunami for helpful comments

What measures are the QUEST plans required to report?

The QUEST medical plans are required to report measures related to membership, utilization, quality of care, access to care, and general plan management. Since all QUEST plans are required to submit financial statements, and an annual customer satisfaction survey is performed by the Med-QUEST Division (MQD), plans are not required to report financial performance and satisfaction with care as part of their *Medicaid HEDIS* report.

Why is the DHS requiring QUEST plans to report Medicaid HEDIS data?

Medicaid HEDIS has standardized data collecting and reporting requirements and its measures are clearly defined. It allows the evaluation of a plan's performance over time, identification of areas which should be improved, quantitative measurement of strategies a plan uses to improve outcomes, and comparison of similar elements across plans.

What should be considered in reviewing the QUEST Medicaid HEDIS report?

The data presented is an aggregate of data submitted by individual QUEST medical plans. Since *Medicaid HEDIS* specifications allow for data collection using various specified methodologies, the QUEST plans may select alternative methodologies to report the same measure. Therefore, differences in data sources and data collecting methodologies may affect the validity of the aggregate data presented. Additionally, while the QUEST plans reviewed their individual reports and verified the data prior to submission, the Department does not audit each plan's data (NCQA does not require it either). However, the Department executes a protocol to examine the contents for accuracy and consistency.

Medicaid HEDIS specifications require 12 continuous months of enrollment with one lapse in coverage not to exceed 30 days for most of the quality of care measures. Therefore, the quality of care measures do not reflect the experience of a plan's total membership, only that of members who met the definition of "continuously enrolled."

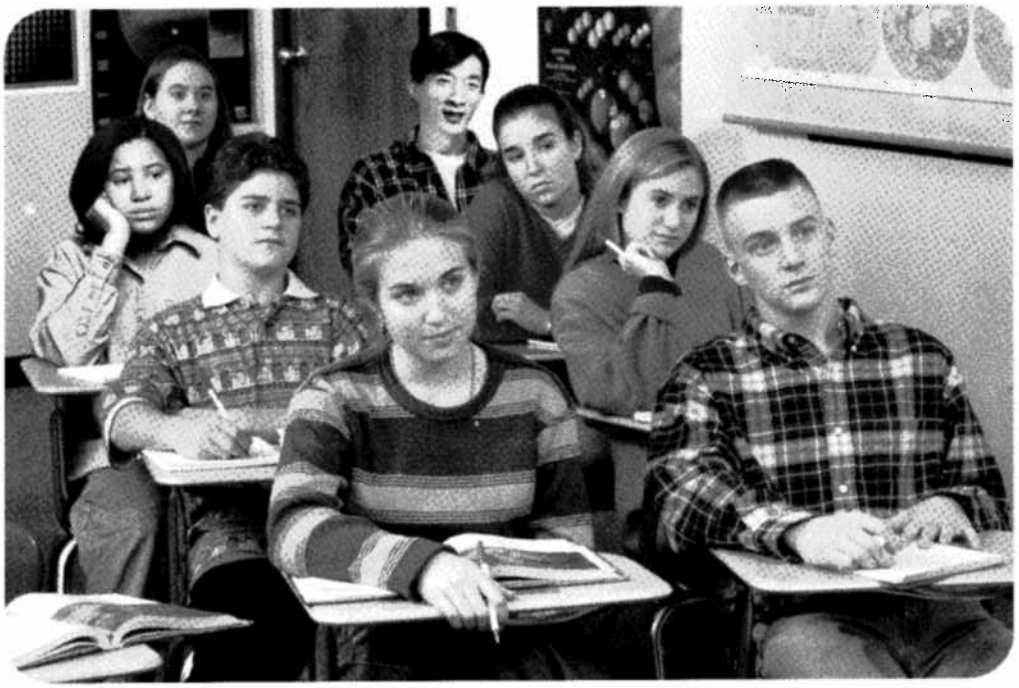
Medicaid HEDIS cautions that data from health plans with "small numbers" for a measure may be of questionable statistical validity.

What are the Medicaid HEDIS measures being reported?

The QUEST plans reported a total of 37 mandatory measures. The collection of these measures is available from the Med-QUEST Division. This report will focus on the following twelve (12)

Teenagers.
Parent problems. Math problems.

ACNE Problems



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"[Benzamycin Gel] ... produced a significantly better response in therapy of moderate acne than did either component alone."[1]

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Adverse reactions infrequently reported include dryness, erythema and pruritus.

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measures which are key to assessing QUEST's performance in providing quality care:

- Membership by Age and Sex;
- Childhood Immunization;
- Cervical Cancer Screening;
- Cesarean Section;
- Diabetic Retinal Exam;
- Inpatient Acute Hospital Care;
- Emergency Room Visits;
- Live Births;
- Mental Health and Chemical Dependency Services;
- Outpatient Drug Utilization;
- Low Birthweight; and
- Care Access: Utilization of Primary Care Providers by Children.

In addition, a description of how managed care is being provided by the QUEST medical plans is presented. The description includes four key programs in the delivery of managed care services:

- Case Management;
- Utilization Management;
- New Member Orientation/Education; and
- Standards for Waiting Times.

Overall, this report focuses primarily on data submitted by QUEST medical plans for fiscal 1997. However, *Medicaid HEDIS* data for fiscal 1996 is included, when available, to note changes in QUEST performance over time. HEDIS measures were reported in fiscal 1995 but have been excluded for comparison in most instances due to the following reasons:

- QUEST began on August 1, 1994. Therefore, fiscal 1995 for QUEST was only 11 months in duration;
- In the initial months of QUEST, there were many plan changes and significant confusion among providers as to which plan should be receiving and reporting a patient's encounter data;
- *Medicaid HEDIS* measures were not available. Hence, the plans reported a combination of *HEDIS 2.0/2.5* and specific state measures, which in many cases, were not directly comparable with *Medicaid HEDIS* measures.

Membership by Age and Sex

Why is this important?

This measure answers general questions about the people who are receiving their health care services through QUEST.

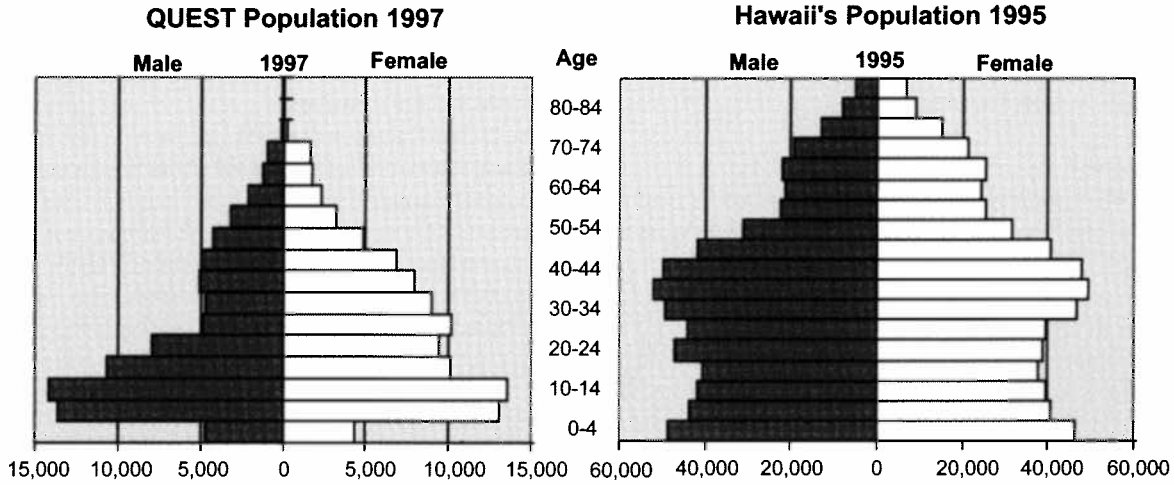
What was measured?

The total number of unduplicated QUEST enrollees by age and sex, enrolled during any part of the report year from July 1, 1996 to June 30, 1997 was recorded.

How did QUEST perform?

Enrollment in QUEST decreased from an average monthly membership of 155,420 in fiscal 1996 to 134,830 in fiscal 1997. The QUEST population in fiscal 1997 was also younger. The mean age of QUEST members dropped to 20.1 years in fiscal 1997 from 21.3 years in fiscal 1996. QUEST members remain predominantly children and adult females. Approximately 56 percent of total membership were children under 20 years of age.

Chart 1



Source: Med-QUEST and DBEDT.

The age and sex distribution of a population for a given fiscal year can be summarized graphically by a "population pyramid." A population pyramid displays the distribution of male and female members in different age-groups. Chart 1 shows QUEST's population structure in fiscal 1997, as compared to Hawaii's resident population in 1995. The QUEST population displays a skewed, classic "pyramid", with a large proportion of younger people, fewer middle-aged people, and far fewer elderly people. There is also a disproportionate number of middle-aged women.

In contrast, the Hawaii resident population structure resembled a bulging "pillar." This is a more mature population, with proportionately fewer young people (ages 0-24) contributing to the total. The middle-aged group (ages 25-54) is the dominant segment of this population structure while the near-elderly (ages 55-64) and elderly (ages 65 and over) appear rather significant before tapering off. The average age of Hawaii's resident population in 1995 was 34.5 years of age. Additionally, there were 102 males per 100 females in the same population. In comparison, there were only 95.6 males per 100 females in the QUEST population in fiscal 1997.

Childhood Immunization

Why is this important?

Immunization in the first two years of life is accepted as one of the most effective public health measures in preventing serious illnesses such as whooping cough, polio, measles, and hepatitis B. Unfortunately, studies have shown that low-income children are less likely to receive timely and adequate immunizations. In 1990, the Centers for Disease Control (CDC) reported that less than 50% of low-income inner city children were fully immunized by age two.

What was measured?

The childhood immunization rate is the percentage of QUEST two-year olds who were enrolled in one plan for 12 months, and who had received appropriate immunizations by their second birthdays (A break in enrollment not to exceed 30 days was allowed).

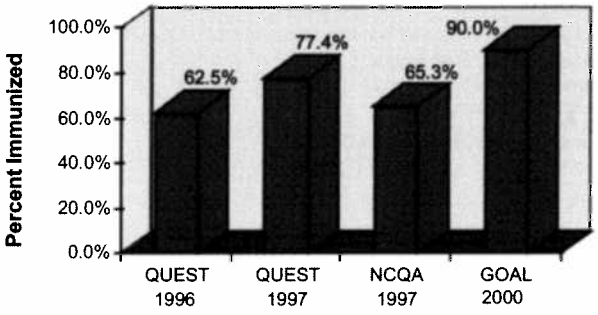
How did QUEST perform?

QUEST did very well compared to the previous fiscal year and to rates reported in other studies. The Childhood Immunization Rate improved to 77.4 percent in fiscal 1997 from 62.5% in fiscal 1996. At this rate of improvement, QUEST should realize the "Healthy People 2000" goal of 90 percent Childhood Immunization Rate.

Recently, the NCQA released its first annual report on HEDIS measures, "The State of Managed Care Quality." This report collected information, voluntarily submitted by over 330 health plans throughout the United States, which participated in the NCQA's accreditation program. The NCQA reported that the national average rate of children who had received 4 DTP/DTaP (diptheria-tetanus-pertussis), 3 polio (OPV/IPV), 1 MMR (measles-mumps-rubella), 1 Hib (H influenza type b), and 2 HepB (Hepatitis B) was 65.3% for the health plans which submitted data. Retrospective studies done in Hawaii on children entering kindergarten have shown that between 58-63% received the basic series by age 2.

Chart 2

Childhood Immunization Rates



Source: Med-QUEST and NCQA.

Cervical Cancer Screening

Why is this important?

Nationally, more than 13,000 new cases of cervical cancer are diagnosed each year, and 4,800 women die of the disease annually.

Additionally, the rate of cervical cancer is typically higher among poor women and they are more likely to be diagnosed when the cancer is in advanced stages. Fortunately, cervical cancer is curable if detected early by regular check-ups and the use of the Papanicolaou (Pap) smear test. Thus, for Medicaid women, cervical cancer screening is very important and saves lives.

What was measured?

The cervical cancer screening rate is the percentage of women aged 16 to 64, enrolled in a medical plan for 12 months, who had at least one Pap smear during the past three years.

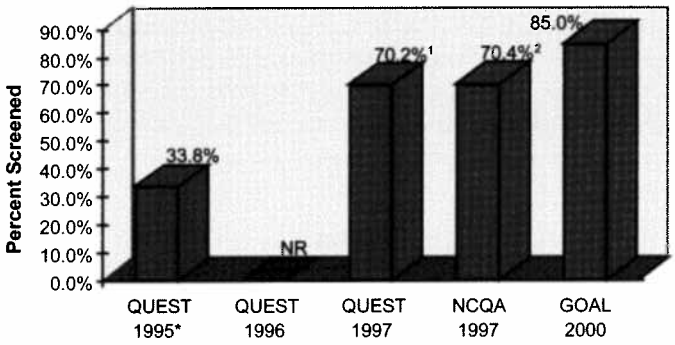
How did QUEST perform?

The QUEST medical plans did not report this measure in fiscal 1996. In fiscal 1995, the reported rate was 33.8 percent. This rate was for the first eleven (11) months of QUEST program and was reported by four (4) of the five (5) plans. Another shortcoming of the 1995 QUEST data was the plans did not have three years worth of data as required by the measure.

In fiscal 1997, the QUEST screening rate reported was 70.2 percent (women aged 16 to 64). This screening rate is compatible with a recently released NCQA study which reported a 70.4 percent national average for women aged 21 to 64 in participating health plans. The "Healthy People 2000" goal is to have 85 percent of all women receive a Pap smear every one to three years.

Chart 3

Cervical Cancer Screening Rates



*Rate for 11 months and reported by 4 out of 5 QUEST plans.
[1]Women aged 16-64 years.
[2]Women aged 21-64 years.
NR: Not Reported.

Source: Med-QUEST and NCQA.

Cesarean Section

Why is this important?

Cesarean (C)-sections are among the most frequent surgical procedures performed in the United States and both mother and neonate have a greater chance of complications than with vaginal birth. A C-section is normally unnecessary if vaginal delivery of the baby does not pose a serious health risk to the infant or mother. Hospital and physician services associated with C-section deliveries are more costly than vaginal deliveries. Therefore, the rate of C-section deliveries is an indicator of appropriate clinical management and quality of care.

What was measured?

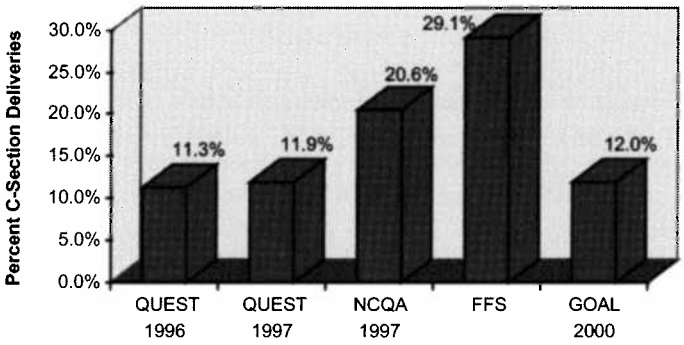
The C-section rate is the percentage of total QUEST deliveries resulting in live newborns which were C-section delivered in fiscal 1997.

How did QUEST perform?

The QUEST plans performed very well in this measure. In fiscal 1996 and fiscal 1997, the QUEST C-section rates were essentially unchanged at about 11 percent (see Chart 4). This rate is far lower than the NCQA's national average of 20.6 percent, and the national fee-for-service (FFS) rate of 29.1 percent. QUEST's fiscal 1996 and fiscal 1997 rates have actually exceeded the national health's established C-section rate of 12-15 percent by the year 2000.

Chart 4

Cesarean Section Rates



Source: Med-QUEST and NCQA.

Diabetic Retinal Exam

Why is this important?

Diabetes mellitus affects about 6.5 percent of Hawaii's population, and it is the leading cause of severe eye damage and adult blindness in the United States. However, blindness can be prevented if retinal changes are detected early, and treated appropriately with laser. Therefore, early intervention through effective screening is crucial in preserving the eye sight of individuals with diabetes.

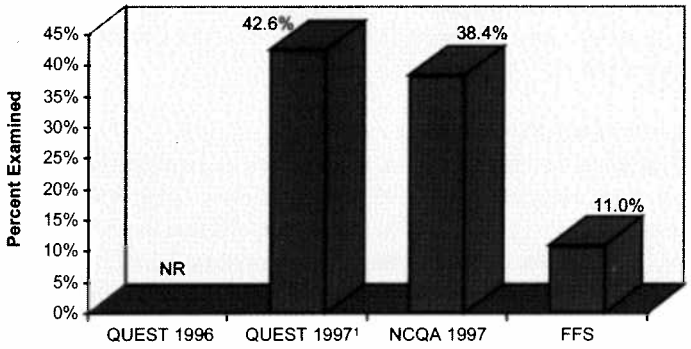
What was measured?

This was an optional measure for QUEST plans. However, two of the larger medical plans submitted data on this measure for fiscal 1997. The diabetic eye exam rate is the percentage of plan members with diabetes aged 31 to 64 years who received an ophthalmoscopic eye exam in fiscal 1997. Members in the plan must be enrolled continuously during the reporting period (allowing for one break in service, not to exceed 30 days).

How did QUEST perform?

In this measure, QUEST out-performed both the NCQA's national average and FFS rates (see Chart 5). The QUEST rate of 42.6 percent in fiscal 1997 indicates that the QUEST performance compares favorably with that of managed care in the private sector. QUEST plans did not report this measure in fiscal 1996.

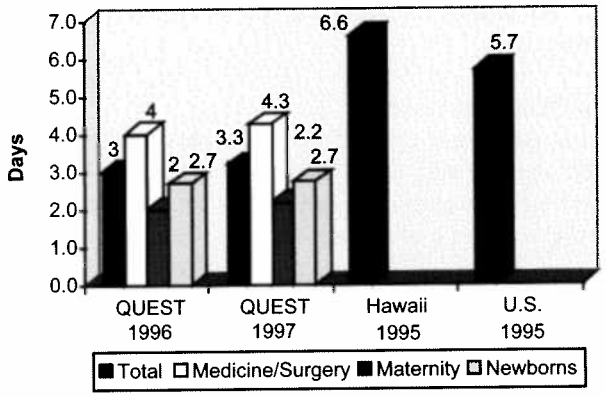
Chart 5
Diabetic Retinal Exam



¹Optional Measure: Two primary plans reporting.
NR: Not Reported.

Source: Med-QUEST and NCQA.

Chart 6
Inpatient Average Length of Stay



Source: Med-QUEST.

Inpatient Acute Hospital Care

Why is this important?

Inpatient acute hospital care is one of the most costly expenses of a health plan. It is a measure of a plan's performance in managing patient care.

What was measured?

The total number of QUEST enrollees who received inpatient hospital care and the category of care they received (medical/surgical; maternity; and newborns) by age were measured. The total number of hospital days, days by category of care, and the average length of stay (ALOS) were also reported.

How did QUEST perform?

Compared with the previous fiscal year, there were fewer total days and fewer inpatient discharges. This was consistent with the decrease in enrollment. However, the total ALOS and the ALOS for each category of care remained essentially the same (see Chart 6). The QUEST ALOS for total acute inpatients was 3.3 days in fiscal 1997. In contrast, the latest available statewide and national ALOS reported by the Healthcare Association of Hawaii for acute care hospitals in 1995 were 6.5 days and 5.7 days respectively.

Emergency Room Visits

Why is this important?

The emergency room rate is a critical measure of appropriate utilization of health care because a visit to the emergency room is largely member initiated, and emergency room costs for non-emergency care are much higher than visits to PCPs. Historically, the higher emergency room utilization of Medicaid populations compared with the general public has been attributed to the inadequate access by Medicaid enrollees to other primary care options. By providing education to patients so that they will utilize emergency room services more appropriately and by improving access to primary care, managed care plans should be able to bring down emergency room rates.

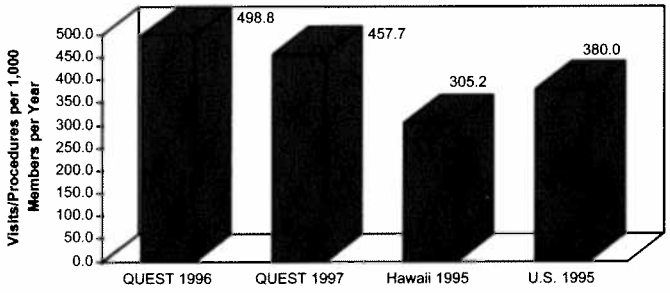
What was measured?

This HEDIS measurement reports the total number of QUEST emergency room visits which did not result in inpatient stays. Each visit is counted once, regardless of the intensity of care required or the length of time spent.

How did QUEST perform?

Compared with the previous fiscal year, QUEST showed improvement. The total number of emergency room visits and the rate of emergency room utilization had both decreased. In fiscal 1997, the QUEST emergency room rate was 457.7 per 1,000 members. This rate is higher than the last available 1995 rates of 305.2 per 1,000 population statewide and the national rate of 380 per 1,000 population. We believe the emergency room rate for QUEST will decrease further in future as QUEST members become better educated on appropriate use of emergency room services and how to better access services through PCPs.

Chart 7
Emergency Room Visits



Source: Med-QUEST and AARP.

Live Births

Why is this important?

Medicaid has traditionally been a major payer for deliveries and newborn care. In the late 1980s, the federal government encouraged states to expand income eligibility for pregnant women and newborns because of studies which demonstrated savings of at least $3 in direct care for each dollar spent on care given to pregnant women. Thus, this HEDIS measure is important because it enumerates the deliveries covered by QUEST and the general health of the newborns after delivery.

What was measured?

The total number of live births (including separate counts of well newborns and complex newborns), the number of inpatient hospital days, and the average length of stay for women of different ages were reported.

How did QUEST perform?

The total number of QUEST deliveries resulting in live births decreased from 4,916 in fiscal 1996 to 4,065 in fiscal 1997. However, the average length of hospital stays for well newborns increased slightly from 1.44 days to 1.74 days, while that for complex cases decreased from 16.46 days to 15.46 days. We feel that the decrease in births can be explained by the decrease in QUEST enrollment. The increase in average length of stay for well newborns is consistent with the QUEST policy of allowing physicians and families to determine how long a healthy newborn and mother should remain in hospital.

Mental Health and Chemical Dependency Services

Why is this important?

Utilization of mental health and chemical dependency services is important because it is an indirect measure of a QUEST member's ability to access these services. Beyond that, it measures the adequacy of the provider network established by a QUEST plan to provide appropriate mental health and chemical dependency services.

What was measured?

The utilization of mental health/chemical dependency services by age and sex was measured. The services are grouped into the following general categories—(1) members receiving any service; (2) inpatient hospital services; (3) day/night services, and (4) ambulatory services.

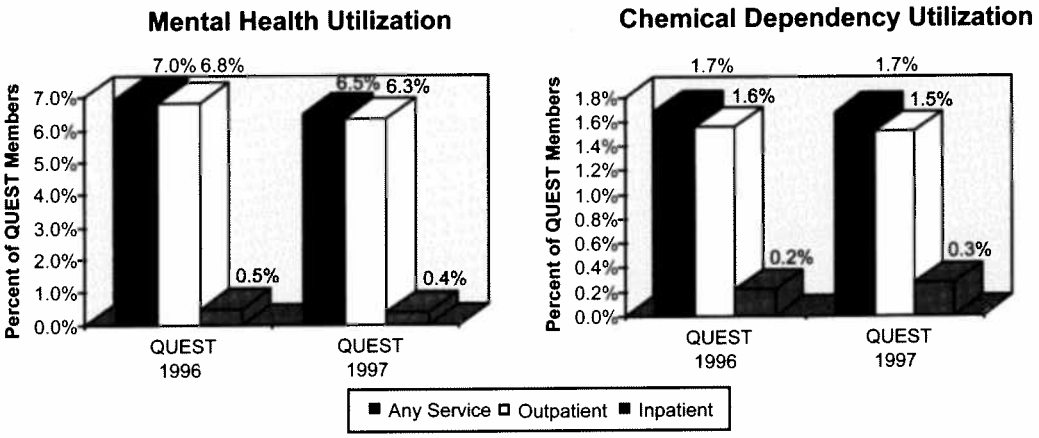
How did QUEST perform?

The actual number of mental health services provided decreased 9.6 percent between fiscal 1996 and fiscal 1997. Chart 8 shows the decrease was less significant as a percentage of members receiving services across the different categories of services. This is consistent with the decrease in overall QUEST enrollment count of six (6) percent. For chemical dependency services, the actual number of services dropped four (4) percent but the percentage of members who had received these services by different categories remained essentially unchanged.

In addition to the decrease in QUEST membership, the following factors should be considered in evaluating the decline in actual number of mental health and chemical dependency services:

- The benefit package for mental health and chemical dependency services was unlimited for the first eight (8) months of fiscal 1996 but limited to 30 inpatient hospital days and 24 hours of outpatient services in fiscal 1997;
- One QUEST plan reported encounters for 11 months instead of 12 months for fiscal 1997, thus the actual number of services provided should be higher;

Chart 8



Source: Med-QUEST.

- The processing of enrollment into the behavioral managed care plan for the seriously mentally ill (SMI) adults improved. Therefore, mental health services used by QUEST members in most need of mental health services were not being provided and reported by the QUEST plans. Instead, these services were being provided by the QUEST behavioral managed care plan for SMI adults.

Outpatient Drug Utilization

Why is this important?

This measure assists health plans and the Department to assess how cost effective the QUEST drug benefit is being administered.

What is being measured?

The total cost of prescription drugs, the average cost per member per month, the total number of prescriptions filled, and the average number of prescriptions filled per year for QUEST members of different ages are measured.

How did QUEST perform?

The total costs of QUEST drug benefits decreased by more than $6 million in fiscal 1997 compared with fiscal 1996. Cost per member per month decreased by 13.6 percent from $13.92 to $12.03. The total number and average number of prescriptions filled also decreased. Studies have shown that decreases in drug benefits, if done inappropriately, may be accompanied by increases in emergency room visits, mental health services, and inpatient hospital utilization. This did not happen in the QUEST program and thus, we feel the decreases in the drug benefit did not affect access to care, nor did it promote overutilization of more costly care. The inference is that the imposition of managed care provided needed control on drug utilization without denying access.

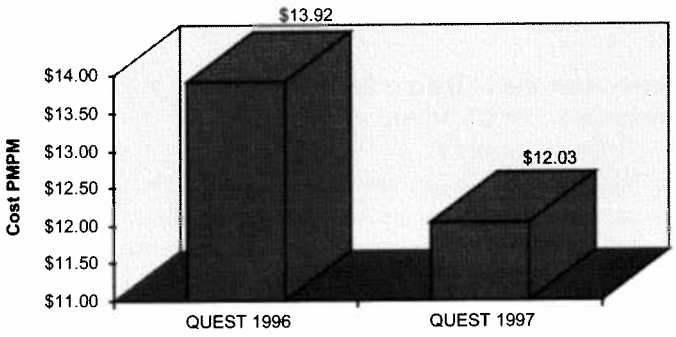
Low Birthweight

Why is this important?

In the United States, 263,000 low birthweight infants (weight less than 2,500 grams) are born annually. Low birthweight infants face higher risk for chronic and permanent disabilities, serious medical complications and illnesses, and death in infancy. Low-income women are typically at higher risk for having low birthweight infants. There are many factors which increase a woman's risk of having a low birthweight infant. Some of the more common factors include smoking, poor nutrition, and chronic medical conditions. It is widely felt by the medical profession that the incidence of low birthweight can be decreased by improving access to appropriate prenatal care.

Chart 9

Outpatient Drug Utilization



Source: Med-QUEST.

What was measured?

The percentage of low birthweight (less than 2,500 grams) infants born during the fiscal year was measured using hospital discharge data or birth certificate data.

How did QUEST perform?

Although the number of low birthweight babies crept up slightly from fiscal 1996 to fiscal 1997, the QUEST rate is still very good and do not indicate that QUEST pregnant women have a higher rate of low birthweight infants compared to their peers in the state. Chart 10 shows that QUEST's low birthweight rate of 5.8 percent in fiscal 1997 is lower than the overall state's rate of 6.7 percent in 1996. We

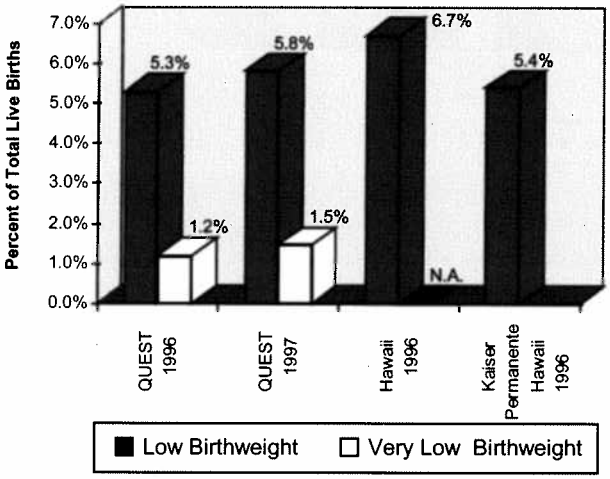
believe QUEST is doing well in this measure and will continue to do so in the future with better monitoring and pre-natal care for members.

The QUEST low birthweight rate of 5.3% in fiscal 1996 was actually better than Kaiser Permanente Hawaii's commercial plan rate of 5.4 percent[1] in calendar year 1996.

Kaiser Permanente Hawaii is ranked as one of the best managed care plans in the United States.

Chart 10

Low Birthweight Babies



Source: Med-QUEST & DOH.

Care Access: Utilization of Primary Care Providers by Children

Why is this important?

Traditionally, under the fee-for-service Medicaid Program, access to non-emergency care was difficult to obtain. One of the primary reasons Hawaii turned to managed care was to improve access to non-urgent, preventive care. By requiring that each QUEST member have his/her own primary care provider (PCP), the State felt that access to medical care and the general health of Medicaid recipients would be improved. Children comprise about 56 percent of total QUEST membership. Therefore, children's utilization of primary care services through PCPs is an important measure of access.

What was measured?

The rates of utilization of primary care providers by children are the rates of QUEST children enrolled in one plan for 12 months by the following age categories:

- children aged 12 to 24 months who had at least one visit to a primary care provider (PCP) during the past 12 months;
- children 25 months to 6 years who had at least one visit to a primary care provider (PCP) during the past 12 months; and
- children aged 7 years to 11 years, enrolled in one plan for two years, who had at least one visit to a PCP in the past 12 to 24 months.

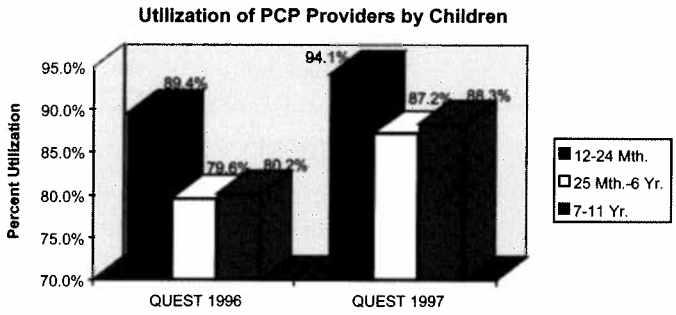
[1]See Kaiser Permanente Hawaii's 1997 Quality Report (page 11). Kaiser Permanente Hawaii recently received a four-star rating, and was ranked as the sixth best plan in the U.S. News & World Report's annual appraisal of "America s Top HMOs."

How did QUEST perform?

In fiscal 1997, the utilization of PCPs by QUEST children continued to improve. In fiscal 1996, QUEST's rates for the different age categories exceeded 80 percent. The average utilization rate for all three age categories was about 83 percent (see Chart 11). In fiscal 1997, rates for the different age categories jumped to the high 80s and the average utilization for all three age groups jumped to 90 percent. The inference here is that QUEST children have excellent access to their PCPs.

Chart 11

Utilization of PCP Providers by Children



Source: Med-QUEST.

Managed Care in Hawaii QUEST

In fiscal 1997, QUEST eligible persons were able to choose from five (5) QUEST medical plans. These QUEST plans are unique with five (5) different approaches to the delivery of medical care and five (5) different structures and organizational experiences. A summary description of the QUEST medical plans is as follows:

- **AlohaCare** is a plan formed by community health centers, and QUEST is its single line of business;
- **HMSA-QUEST** is a plan by a local, non-profit, mutual benefit society associated with Blue Cross/Blue Shield — with many commercial lines of business;
- **Kaiser Permanente QUEST** is a plan by a large, nationally affiliated, non-profit Health Maintenance Organization (HMO);
- **Queen's Hawaii Care** is a plan by a local, non-profit health care system; and
- **Straub Care Quantum** is a plan by a local, for-profit health care system.

Kaiser Permanente QUEST and **Straub Care Quantum** can be described as "closed panel" health plans because the care they provide is largely performed by their staff physicians in their own clinics and facilities. **AlohaCare, HMSA-QUEST,** and **Queen's Hawaii Care** are "open panel" health plans which contract with health care providers to provide care at various sites, largely, the providers' offices and facilities.

Although each QUEST health plan operates differently, all of the plans utilize managed care concepts in the provision of health care to QUEST members. Four (4) key components which are critical to the delivery of care in managed care and how these programs are used by QUEST health plans will be briefly described.

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- Normalization of keratinization.
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*The exact mechanism of action is unknown.

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AZELEX® has been shown in vitro to possess antimicrobial activity against *Propionibacterium acnes* and *Staphylococcus epidermidis*; the clinical significance is unknown.
†Double-blind, comparative clinical studies have not been conducted to evaluate comparative efficacy.

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Case Management

What is it?

Case Management is a process to identify and assist members with complex or chronic conditions. This includes helping members who have difficulties in obtaining needed medical care to gain access and to obtain the appropriate care.

How do QUEST plans perform case management?

All of the plans have systems which identify members who may need case management/care coordination. Although plans are free to determine which recipients need case management, generally, plans priorities for case management are similar, and include high risk pregnancies, lengthy hospitalizations, and chronic diseases such as asthma or diabetes.

The two closed panel plans perform case management services using plan staff. The three open panel plans also perform most case management activities using plan staff. In addition, **AlohaCare** uses case management services of the community health centers. **HMSA-QUEST** contracts with the community health centers and other community agencies for specific outreach services such as transportation, translation and non-compliance counseling. **Queen's Hawaii Care** has contracted for patient education and case management to assist providers on a neighbor island in an Asthma Management Program.

Utilization Management

What is it?

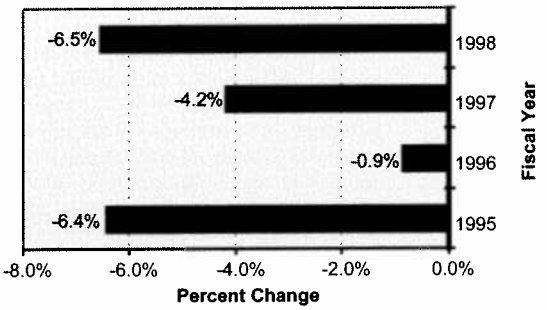
Utilization management is the process which plans use to determine the appropriateness and need for medical care. Plans evaluate utilization patterns (including under-utilization and over-utilization) through data analysis and provider profiling. Among the specific programs used to make decisions of appropriateness and need are prior authorization, concurrent review, and retrospective review.

How do QUEST plans perform utilization management?

Although plans differ in the specific services/situations which require prior authorization, all plans utilize prior authorization in some form. For inpatient hospital, concurrent and retrospective reviews, all five (5) plans employ national standard criteria such as InterQual Severity of Illness/Intensity of Service, Milliman and Robertson's Length of Stay Guidelines and/or Medical Care Appropriateness Protocol (MCAP) as part of their utilization review protocols.

Chart 12

Change in Per Capita QUEST Cost*



*TANF and GA Categories Only. Costs include projected costs for adult dental care after February 1996.

Source: Med-QUEST.

New Member Orientation/Education

What is it?

New member orientation/education are the activities performed by plans to educate and orient new members on the types of covered services and how to access those care services.

How do QUEST plans do this?

All QUEST plans send welcome packets of information including a member handbook, list of providers, summary of plan benefits, how a member can access care, and member rights and responsibilities. In addition, **HMSA-QUEST** conducts optional member orientation sessions; **Kaiser Permanente QUEST** has case management assistants and visiting nurses who work directly with new enrollees; **Straub Care Quantum** includes in its welcome packet the (800) number of its HMO Services personnel who can answer questions and assist members in obtaining services; **Queen's Hawaii Care** issues quarterly member newsletters which features educational material as well as updated plan member services; **AlohaCare** uses its Member Services department to reinforce the programs in the Member Handbook. Also, all plans send out Early and Periodic Screening, Diagnosis and Treatment (EPSDT) information. (Under Federal EPSDT rules children are entitled to a broader range of Medicaid services than adults and it is required that parents receive information explaining EPSDT benefits).

Standards for Waiting Times

What are these?

Each plan sets its own standards for acceptable waiting times for the following:

1. **Emergency care**;
2. **Urgent routine illness**; and
3. **Preventive and non-urgent routine care**.

What are the standards used by the plans and how are they being monitored?

Although each plan sets its own standards for waiting times, all plans are generally in agreement that the standard waiting time are as follows:

1. **Emergency care** is immediately (within the same day);
2. **Urgent routine illness** is from 24 to 48 hours; and
3. **Preventive and non-urgent routine care** is from 24-48 hours to 6 weeks.

Plans monitor these standards by on-site visits to providers (**Queen's Hawaii Care and HMSA-QUEST**), member surveys and appointment accessibility surveys (**HMSA-QUEST**), waiting time surveys (**Straub Care Quantum**), actual measurements (**Kaiser Permanente QUEST**), and member education on appropriate use of services (**AlohaCare**).

Quest Capitation History

When QUEST was initiated in August 1994, the premium savings associated with each enrolled member was approximately 6.4 percent lower than payments under the previous fee-for-service system. Chart 12 shows that more premium savings have been realized subsequently in fiscal 1996, fiscal 1997 and fiscal 1998, without compromising quality health care services to the QUEST population. Selected clinical measures reported under HEDIS guidelines have supported this contention. We believe much of the success is attributable to productivity gains and continuous quality improvements in both clinical and administrative areas of participating QUEST plans.

Towards the Millenium

The member's freedom to choose a health plan has always been an important consideration in QUEST. As participating QUEST plans continue to mature in utilizing managed care concepts in the provision of services to the Medicaid population, they are continuously driven to improving and upgrading their services. The plans are fully aware of their similar product offerings, and that quality of service is the key determinant to winning consumer confidence. QUEST members are the primary beneficiaries of this competitive structure established by the State. The DHS, through its Med-QUEST Division will continue in its efforts to monitor the quality of services offered by participating plans. The MQD is also exploring innovative ways to improve the delivery of health care services to the Medicaid population in Hawaii, currently not in QUEST.

As we move closer to the millennium, QUEST is working diligently to extend managed care services to more Medicaid recipients. We believe that managed care can effectively deliver to the Medicaid population, greater access to non-urgent and preventive health care services, and improvement in their general health status. The offering of long-term care services through a managed care setting is currently under consideration. Certain segments of Hawaii's community view this as a viable, "high-value" alternative to the existing fee-for-service system. With each existing, and potential service offering, consumer protection will continue to remain a key pillar of QUEST's efforts. And towards achieving this goal, QUEST will continue to use HEDIS measures to define quality of care services in a tangible, quantitative, and meaningful manner.

News and Notes Henry N. Yokoyama MD

Life in These Parts

Waipahu GP 73-year-old ***R.J. Maffei*** retired in July after 40 years. A Waipahu resident related how the "plantation doctor" made house calls and constantly provided medical services and medicine at no cost to dying, elderly or low income patients. "He was always on-call 24-hours a day and it was never about money. I've never known a more compassionate doctor who cared for the well being of his patients."

Maffei says, "I'm not going to stay home and be idle, that's for sure." Re retirement: "Retirement? I hate it!" He plans to volunteer at an Iwilei drug rehab center and periodically check on long time patients who are seriously ill.

When asked for a business card, urologist ***Steven Chinn*** reached into his pocket and pulled out a packet of Viagra pills.

(Eddie Sherman MidWeek, July 22)

Hawaii patients are among the few in the nation with a law protecting them against managed care abuses. ***Governor Ben Cayetano*** signed a patients' rights bill in July to ensure that managed care plans emphasize "quality care rather than deny treatment based solely on profit." The AMA and some state medical societies launched a national campaign in July to fight "unfair, onerous and one-sided physician contracting practices."

Locally, ***Arleen Jouxson-Meyers***, president of the patient-advocacy Hawaii Coalition for Health had worked hard for the bill and says, "For the first time ever in Hawaii, all entities that provide health insurance came under the jurisdiction of the insurance commissioner."

Freeze Dried Sperm

Acclaimed world authority on fertilization, UH researcher ***Ryuzo Yanagimachi*** has shown that freeze-dried mouse sperm can fertilize eggs. He will next work with rabbit sperm. "If it works for rabbits, I think it will work on every species of mammals." Ryuzo's freeze dry technique may replace the expensive technique of storing cattle and human sperm in liquid nitrogen at minus 385°F. The technique involves sperm freeze dried in vacumn sealed vials and then rehydrated to inject in eggs (thus far, his experiment has been for 3 week periods).

Vincent DeFeo, chairman of the Anatomy & Reproductive Biology Department explains that in the liquid nitrogen technique, the sperm are still alive while in the freeze dry technique the sperms are dead and the sperm's DNA triggers the whole response.

Physician Moves

July: New neurosurgeon in town, ***Eric Oshiro*** opened at Kuakini Medical Plaza, Ste 711.

Elected, Appointed, & Honored

Kuakini Medical Center elected pulmonologist ***Stuart Sugihara*** chief of staff in the wake of outgoing chief ***Tad Iwanuma*** who had served several terms efficiently.

Pediatric surgeon ***Walton Shim*** was elected chief of staff at Kapiolani Medical Center. Walton said, "In the face of the changing medical economy, it is important—despite the external pressures like decreasing physicians' fees and increasing regulatory controls—to keep quality care and keep being the patients' advocate and acting solely in the patient's best interests."

Potpourri

A college physics professor was explaining a particularly complicated concept to his class when a premed student interrupted him. "Why do we have to learn this stuff?" the young man blurted. "To save lives," the professor responded before continuing.

A few minutes later the student spoke up again, "So how does physics save lives?" he said.

The professor stared at the student for a long moment. "Physics saves lives," he said, "because it keeps the idiots out of medical school."

A chicken and an egg were lying in bed. The chicken smoked a cigarette with a satisfied smile on its face while the egg frowned, looking put out. The egg muttered to no one in particular, "Well, I guess we answered that question."

Playboy Party Jokes, Sept '98

(Contributions by Mike Ishioka)

A nature lover took his new car for a spin in the country. A rabbit ran in front. He tried to avoid it, but too late. He stopped and found a limp dead body. He felt so bad, he started to cry. A car stopped and a sympathetic lady surmised the situation. "Never fear. The Avon Lady is here." She pulled out a spray can and sprayed the dead carcass. The rabbit sprung to life and went hopping down the road. Every few hops he would stop, turn and wave. The man was curious. He asked to see the spray can. The directions said, "This restores life to hair and gives it a permanent wave."

Five surgeons were having lunch. First surgeon: "Accountants make the best patients. When you open them up, everything is numbered inside."

Second surgeon: "Nah, librarians are the best. Everything inside is in alphabetical order."

The 3rd surgeon responded: "You can't beat electricians, man! Everything inside is color coded."

The 4th surgeon interrupted, "I prefer lawyers. They're heartless, spineless, gutless and their heads and butts are interchangeable."

Finally the 5th surgeon quietly commented, "By far the engineers are the best patients. They always understand when you have a few parts left over after surgery."

HMSA Mail-out Survey

Len Howard, HMA President says:

"Our association has received much negative reaction from our physicians and their patients to the recent HMSA member satisfaction survey. In October, 1997, HMA adopted a policy that HMSA stop linking bonus payments to survey results. We believe that such an incentive plan poses the danger of creating a conflict of interest between the patient's needs and the desires of the insurance company.

Despite the letter attached to the survey, many patients still assumed that their doctors were under investigation. Obviously, this survey has had a damaging effect on the doctor-patient relationship.

All of us want to improve our quality of service in any possible way. However, unstated in HMSA's letter was that this survey will result in some physicians receiving bonus payments. Our members do not want bounty payments or bribes. We object to HMSA's offering them."

HMSA's Client Priorities are Wrong. Hypocritical

"It is ironic that HMSA would collect quality-of-care data for its patient customers, while at the same time increasingly undermine the patient's ability to use that information by restricting the patient's free choice of physicians.

In free markets, consumers obtain information about quality through neutral parties (e.g. "Consumer Reports") and make their own purchasing choices. If HMSA and state government would work together to offer Medical Savings Accounts, patients would have a much greater choice, and quality rating systems would naturally evolve as a result of customer demand.

The result would be a marketplace more responsive to the consumer's needs, without the expense, complexity and uncertainty of an unproven reward system."

Dan Helinga (Via the Internet)

National News

When physicians complained about falling fees in Florida, Texas and Ohio, Aetna cancelled meetings with state and local medical associations arguing that anti-trust laws barred these groups from discussing their complaints. The AMA urged the doctors to rebuff the insurers' demands.

Aetna's chief executive, ***Richard Huber*** wrote to the AMA president that "The company's limits on coverage are determined by the employers who purchase our products. Without these limitations, our products would be unaffordable."

Dr Arthur Leibowitz, Aetna chief medical officer explained that the doctors's complaints were part of business discussions. "We have successful contracts with our 200,000 physicians. We cannot unilaterally change a provision of a contract. If you don't like them, you can quit or better, negotiate with us."

A United Healthcare VP, ***Dr Kaveh Safori*** said, "United runs on a fixed total budget. It's not just a United Healthcare issue—It's the medical system."

Conference Notes

"New Approaches To and Current Management of Heart Failure" *VP Barry Greenburg,* Professor of Medicine UC SD, QMC, May 5, 1998, Fri. a.m.

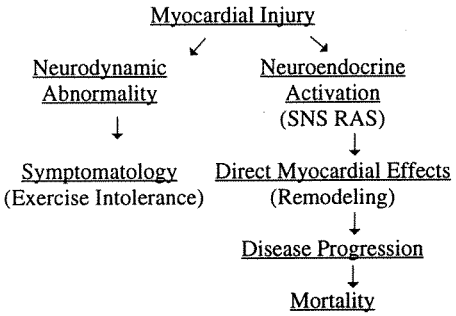
Burden of CHF

Five million new cases/yr; 6-10% over age 65; 800[3] hosp discharges; 1/4 million deaths/yr; cost $40 billion/yr (Hosp cost=2/3)

Goals of CHF Therapy

- Slow the disease progression
- Reduce risk of mortality & morbidity
- Improve quality of life and clinical status by alleviating sy's

Pathophysiology of CHF



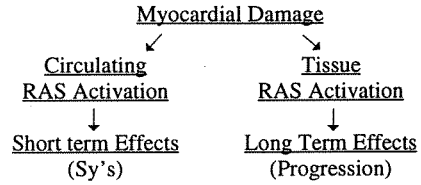
Neurohormonal Changes:

Asymptomatic Pts:	Activation of sympathetics
Symptomatic Pts:	Early activation even preceding sy's

Ventricular Remodeling:

- Dilation, ventricle
- Hypertrophy
- Increased globular shape
- Mitral & tricuspid regurgitation

Renin-Angiotensin System (RAS)



Therapy CHS

Survival Effect of ACE:

Trials	ACE	Outcome
CONSENSUS	Enalapril	Increased overall survival
SOLID	Enalapril	"
SAVE	Captopril	"

***ACE is underutilized in pts with CHF.

High Catacholamine Levels

- Direct Effect: cardiac myositis
- Down regulation of beta receptors
- Arrhythmogenic (40% of pts die)
- Renin-angiotensins sy's

Beta Blockers in CHF

(Historically contraindicated)

- Improves cardiac function (Sweden report)
- Experience with most BB limited
- CARVEDILOL (New BB)

U.S. Carvedilol HF Trials:

CHF x 2 mos: LVEF ≤ 35%
Overall Survival: 65% reduction overall mortality
Hospitalization: 27% reduction

Carvedilol Mild HF Trial:

50% reduction in events
(death, hospitalization, CHF)

***Carvedilol is well tolerated in mild to moderate HF

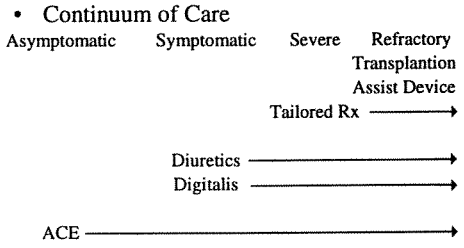
Standard Therapies CHF

- Digitalis (Pts with NSR)
  When digitalis is discontinued, CHF rate rises

***Therefore, digitalis + diuretics + ACE = Best therapy**

- Diuretic
  - Only in pts with volume overload
  - Stimulates: renin and catecholamines
  - Enhances ACE and dig effects

- Continuum of Care



- Refractory CHF (reversible Causes)
  - Comorbidity (fever, thyrotoxicosis, anemia)
  - Ischemia
  - Arrhythmias or heart block
  - Drugs which depress cardiac function
  - Non-compliance (poor comprehension of rationale of therapy; how & when to take drugs, ie education; unable to purchase drugs; failure to continue after sy's subside; willful non-compliance)

Calcium Channel Blockers

- First generation CaCB increases neurohormonal activity → worsening CHF
- Negative inotropic effects
- New CCB: **MIBEFRADIL**: Unique: blocks L & T channels
  - ± ↓ HR
  - Coronary and peripheral vasodilator;
  - No negative inotropic effect
  - Neurohormonal: No reflex↑ S Node
  - T channel regulator
  - Survival data: (Mark I Study Report in Aug)

Angiotensin II Receptor Blockers
(May be better than ACE?)
(Losartin Study: 1/2 - 2 yrs hence)

Cardiac Transplants
**UC SD Survival data c Class II & IV patients:
Overall 88% Survival rate: 93% survival at 1 yr
87% survival at 3 yr
83% survival at 5 yr

Lt Ventricular Assist Device
(with portable battery = bridge to transplant)

Other Therapies CHF

- Gene therapy (normalizes altered Ca handling; therapeutic angiogenes etc)
- Non-Gene Therapy: (molecular approach to CHF)
- Growth Hormones (Normalize ejection fraction)

The Only Good H. Pylori Is a Dead H. Pylori

Nimish Vakil, Professor of Medicine

Disease Management

Explicit, population based approach to identify patients with a disease; intervene with specific programs of care and monitor clinical and economic outcomes.

H. Pylori Infection

Causal role in peptic ulcer and eradication of infection prevents relapse.

California Medicare pts: Only 39% of Medicare pts c̄ peptic ulcer disease were tested for H. Pylori; and less than 1/2 who tested positive received AB Rx.

Dyspepsia

- Persistent or recurrent abdominal pain or discomfort in upper abdomen
- Population based surveys show 20 to 30% of population have dyspepsia. 1987 Stats: 1.5 million outpt visits and 0.8 million ER visits 2° dyspepsia.

New Guidelines in Dyspepsia Therapy

Non-invasive testing and H. Pylori treatment if tests positive.

Recent data: High rate metronidazole resistance and rising rate of Clarithromycin resisitance.

*H. Pylori a/c CAD, CVA, urticaria and other diseases. Questionable beneficial role of H. Pylori in preventing: NSAID gastropathy & GERD.

Miscellany

"Your driver's license says you should be wearing glasses," the traffic cop said to the speedster. "Why aren't you wearing them?"

"I have contacts," the speedster said.

"I don't care who you know," the cop said, "You're getting a ticket anyway."

"Doctor, how long will my arm be in this cast?"

"At least six weeks."

"When you remove it, will I be able to play the violin?"

"Of course."

"That's great! I could never play it before."

Classified Notices

To place a classified notice:

HMA members.—Please send a signed and typewritten ad to the HMA office. As a benefit of membership, HMA members may place a complimentary one-time classified ad in HMJ as space is available.

Nonmembers.—Please call 536-7702 for a nonmember form. Rates are $1.50 a word with a minimum of 20 words or $30. Not commissionable. Payment must accompany written order.

For Sale

For Sale.—Brand new HP Desk Jet 670 Color Printer. $150/offer. Call Nelson (808) 536-7702 ext. 2220.

For Sale.—One four (4) panel X-ray viewer. Used, good condition . $200. One Omniclave steam sterilizer, 22" x 17" x 14". Sterilizing chamber 18-1/2" long, 9-1/2" diameter. Non-computerized. Good condition. $550. (New computerized, same size sells for $4,000. For more information call (808) 737-9066.

Locum Tenens

Board Certified family practitioner.—Available for short term practice coverage. Liability insurance provided. Please contact: V. Braslavsky, MD (913) 383-3285. http://www.concentric.net/~locumdr/1.htm.

Locum Tenens available.—Board-certified Family Practice, 14 yrs clinical experience in Hawaii. Office coverage, Deborah C. Love MD: home Oahu: (808) 637-8611; cel ph: (808) 295-2770.

Office Space

Pearl City Business Plaza.—Tenant Improvement Allowances for Long Leases; 680+ sq ft; 24-hr security; free tenant/customer pkg; Gifford Chang 581-8853 DP, 593-9776, 531-3526.

Office Space for Rent.—Kaneohe Atrium, located 1 block from Windward Mall. Call 247-0067, 222-7707.

Looking for physician(s).—to share spacious, 1700 sq ft clinic complete with experienced staff. We're located in the Pan Am Building, within walking distance of major bus routes, banks, Ala Moana and the Convention Center. Call Bonnie at 943-6001.

Misc.

Mask & Glove Relief.—Sensitivity barrier gel reduces irritation from latex, nitrile, polyethylene face masks & gloves. Free evaluation sample to USA physicians (1 per office). Sahara Cosmetics Oahu 808-735-8081, USA toll free 1-877-280-2020, record complete delivery address.

Announcement

Office Relocation.—Dr Leonard Y.H. Kiehm, Maui Clinic, 53 Puunene Ave., Kahului, Maui, Hawaii 96732, ph: (808) 877-2023, Fax: (808) 871-6701.

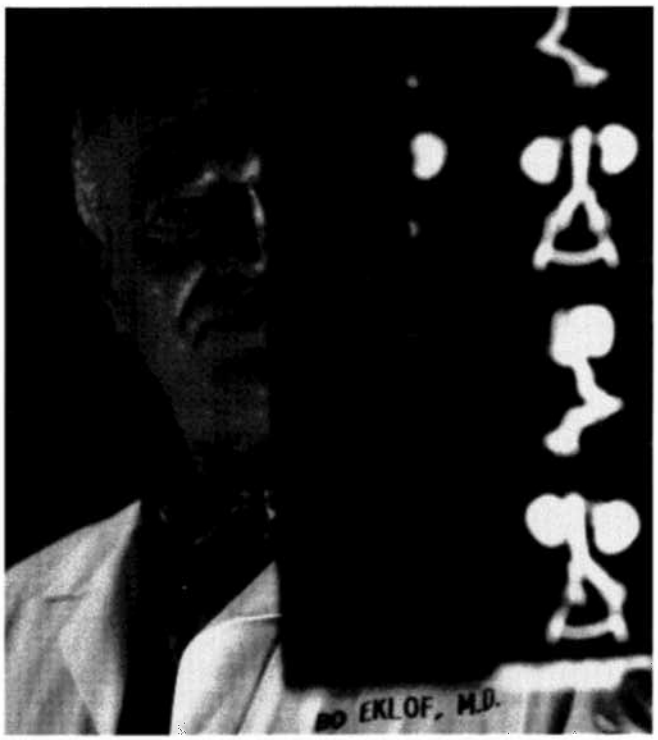
For Sale.—Established, thriving general practice in Kailua-Kona. Completely equipped. TURNKEY OPERATION. Three exam rooms, B/R. Modern building, good parking, access. Flexible arrangements possible. Call 329-6682.

Practice Opportunity.—Busy Pracitioner desires transfer of substantial number of patients to physician with an interest in chronic illness within their office. Part-time to full-time practice opportunity with full support staff. Located near the Queens Medical Center. To start immediately. Call Traci at 545-7159.

Psychiatrist/Psychologist.—Seeking qualified practitioner to transfer substantial number of counseling patients for treatment at our office. Space lease/service arrangement. Enough case load for a busy part-time practice with full staff support. To start immediately. Call Traci at 545-7159.

Hawaii Permanente Medical Group.—Hawaii's most established multi-specialty group 300 physicians recruiting BC/BE internist busy outpatient internal medicine clinic largest Kaiser Maui facility, Wailuku. Position immediately available. Call 3-4 times monthly, affiliated Maui Memorial Hospital. For more information, call 834-9111. Send CV: Physician Recruitment, HPMG, 3288 Moanalua Rd., Honolulu, HI 96819. Fax (808) 834-3994. EOE.

Join us in the quest for continued medical excellence.



Join your Straub colleagues as we strive for continuing medical excellence.

Straub Clinic & Hospital, Inc. is accredited by the Hawaii Medical Association to sponsor continuing medical education for physicians.

Straub designates this educational activity for a maximum of one credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Straub
When it really matters
Visit Straub's homepage at http://www.straubhealth.com

You are invited to attend...

– Friday Noon Conference –
Luncheon
Vascular Disease and Stroke: New Therapies
Leo Maher, MD
October 2, 1998, 12:30 – 1:30 p.m.
Doctor's Dining Room

Learning Objectives
At the conclusion, participants will be able to:
- Describe role of antiplatelets in stroke prevention.
- Understand basic classification of stroke.
- Summarize the concept of acute stroke care.

We would like to acknowledge the generous Educational Grant from Sanofi Pharmaceuticals, Inc.

– Tumor Board Conference –
Luncheon
Management of Intractable Neuropathic Pain
Stuart DuPen, MD
October 5, 1998, 12:30 - 1:30 p.m.
Doctors Dining Room

Learning Objectives
At the conclusion, participants will be able to:
- Describe pathophysiology of neuropathic pain.
- Discuss limitations of common neuropathic pain treatment strategies.
- Understand new techniques for managing intractable neuropathic pain.

We would like to acknowledge the generous Educational Grant from Knoll Pharmaceuticals Company

– Friday Noon Conference –
Breast Conservation for Early Stage Breast Cancer
Laeton J. Pang, MD
October 16, 1998, 12:30 - 1:30 p.m.
Doctors Dining Room

Learning Objectives
At the conclusion, participants will be able to:
- Understand the basic surgical and radiation principles for optimal outcome.
- Interpret the results of the major prospective randomized trials on breast conservation vs. mastectomy.
- Summarize the criteria for patients not eligible for breast conservation.

Please call Fran Smith at 522-4471 for more information.

The Weathervane Russell T. Stodd MD

With friends like these, who needs enemas?

Speaker Gingrich led the House of Representatives in support of the insurance lobby in refusing to halt HMO abuses. If Newt were astute he would grab this issue and side with 3/4 of voters and make managed care plans responsible. When the AMA, the unions, the trial attorneys, and 75% of the voting public are in agreement that managed care must be held liable for medical decisions, one might expect leadership to respond. "Republican leadership" is becoming an oxymoron. They have been wrong about women's rights, wrong about religious freedom, wrong about tobacco legislation, wrong about protecting patients from HMOs, and now some are even recommending that any doctor who legally prescribes drugs to assist suicide (according to Oregon law) should lose his DEA number.

If you think you did something wrong, you're right.

How many of us have had patients who blacked out briefly with minor surgery in the office, or rarely even with topical anesthetics? In a recent Indiana malpractice case, a physician was held responsible for injuries caused by his patient who had a history of blacking out after vaccinations. The patient lost consciousness while in the doctor's office, but later was allowed to drive himself home. When he blacked out again after leaving the physician's office, he collided with another car, causing serious injury to the driver. According to the courts, the doctor was liable, and had a duty to take precautions to monitor and warn the patient following the injection. The court ruled that a reasonably prudent person in the same circumstance would not have permitted the patient to drive himself from the doctor's office.

It takes most people five years to recover from a college education.

With an incredible degree of rotten taste, *Abercrombie and Fitch* in their back-to-school catalog offered a full page of recipes for campus drinking parties. On a page titled Drinking 101, ten hard core cocktails are described. "Rather than the standard beer binge, indulge in some creative drinking this semester." Deaths on campus from binge drinking, the fact that 3/4 of college students are under age 21, and that 2,315 Americans between the ages of 15 and 21 died in alcohol-related car crashes in 1996 alone, all means nothing compared to the A&F crass grubbing for profits. Abercrombie and Fitch has become hugely profitable in recent years, largely due to its success with the fickle college crowd. The share price has almost doubled since the initial public offering in 1996. Mothers Against Drunk Driving (MADD) is more than angry and has accused the corporation of placing profits ahead of health and safety for its clientele.

A free country offers what a police state denies—privacy.

The Department of Health and Human Services has some changes in mind which will effect your lives now and forever. Slipped into the health reform law two years ago was a plan for a cradle-to-grave "unique patient identifier." Moreover, the HHS's latest plan is that every doctor would apply for and be assigned a one-time eight digit alpha-numeric identifier which he/she will keep forever even with relocation or change in specialty. Another change would require all insurers to accept a standardized claim form. Get the picture? The patient is a number, the doctor is a number, the form is standard. When the Clinton people held a hearing recently, people woke up to this frightening big brother approach and flooded their lawmakers with calls. With the equivalent of a bar code stamped on everybody's forehead, medical privacy will be as dead as the Clinton presidency.

We spend money the old fashioned way. We burn it.

The story goes that AMA staffers were directed to seek non-dues mechanisms to increase revenue. Thus, a deal was prepared with Sunbeam to endorse certain of their products in order to generate income, much like the American Dental Assn. and the American Women's Medical Assn. have done with product endorsements.

John Seward, MD, the CEO, and Trustees failed to think the matter through and await discussion by the House of Delegates. Dr. Seward signed the contract took the photo-op, and the shinola hit the fan. The other shoe has dropped and the American Medical Association has reached a settlement with Sunbeam Corp. regarding the proposed endorsement fiasco. Board Chairman Randy Smoak, M.D., announced that the AMA will pay $7.9 million in damages and another $2 million in legal expenses. Very expensive, yes, but still far cheaper than going to court where the cost could have been exponential.

Don't let a pretty face turn your head.

An anecdote in the *Managed Care Interface* noted an unexpected cost item at a Maine HMO. A newlywed wife dropped off her husband for his first day of work, and flashed her left breast at him for good luck. A passing cab driver caught the display, and lost control of his cab which careened across a curb and into the Johnson Medical Building. The jarring impact caused a dental tech to slice off a piece of a patient's gum while she was cleaning his teeth. In painful reflex, the patient clamped his jaw hard enough to sever the technician's fingers. Moral: when someone else is offered an appetizer, try not to salivate.

There are trains leaving every hours, all headed for oblivion.

In Colorado an intoxicated driver went over a roadside cliff in his pickup, causing serious injuries to himself and one passenger, and another passenger was killed. Because the investigating officers smelled liquor on the driver's breath, a blood test was taken in the hospital without authorization. Subsequently, when the driver was charged with vehicular homicide and vehicular assault, the trial court determined that the blood test was improperly obtained and therefore inadmissible as evidence. The appellate court vacated the suppression order, stating that the state troopers had probable cause to arrest the man for driving while intoxicated. Congratulations to the Hawaii Legislature (Yes!) because now Hawaii state law provides that emergency room physicians have the right (and duty) in all auto crashes, to obtain blood to be tested for alcohol, and other drugs, without patient consent. As one mainland consultant said, Hawaii is 20 years ahead of the mainland on this issue.

If two wrongs don't make a right, try three.

Health Care Services Corp, aka Blue Cross Blue Shield of Illinois, pleaded guilty to eight felonies, including conspiracy to obstruct a federal audit and obstruction of that audit. Additionally, there were six instances of false statements based on actions of managers, five of whom have been indicted, and two others have pleaded guilty. Specifically they lied to auditors, destroyed documents, mishandled claims, shredded claims, deleted and manipulated files, shut down the telephone system at times of high volume, all in order to receive $1.3 million in unwarranted bonuses and incentives. The Blues will pay $144 million to settle the Medicare fraud charges, and the whistleblower will get at least $21 million for spreading the news. She first told her story to senior Blues executives after she was told to shred 10,000 unprocessed claims, but they refused to help. She filed a lawsuit under the federal *False Claims Act*, and as they say, the rest is history.

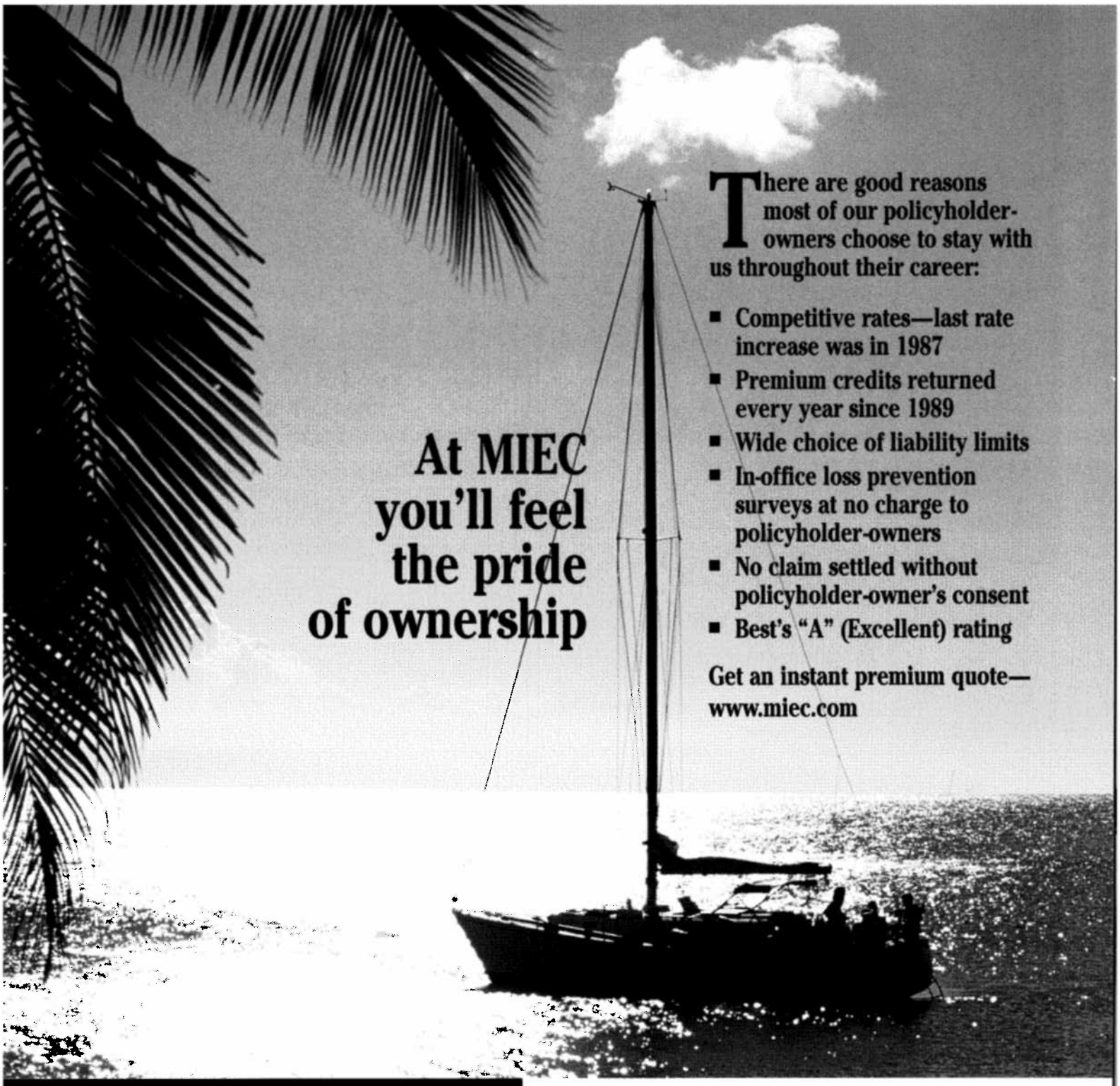
There are two kinds of people, those who finish what they start and so on.....

Numerous investigational studies have confirmed that addicts do like clean needles, and the occurrence of new HIV patients decreases with needle exchange programs. Donna Shalala, PhD, secretary of Health and Human Services has declared that the programs are an effective way to reduce HIV infection rates, but left the ban on federal finding intact. HHS now admits the program works but, for political reasons, won't provide money, and has shifted responsibility to state governments to decide on prevention strategy. Conservative lawmakers insist that the program increases drug use, but data refute that claim. Estimates are that if federal resources had been available, as many as 10,000 HIV infections could have been prevented since the beginning of the Clinton administration. What's that line about "an ounce of prevention..... ?"

Addenda

- ❖ Now here's a spokesperson you can believe. "Viagra is not an aphrodisiac," said FDA drug boss Janet Woodcock.

Aloha and keep the faith — rts ■



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