



POLICY IN ACTION



COURTESY/BELINDA BYRNES

CHILDREN OF TERRA SANTE crowd the local clinic waiting room looking for stickers from volunteers. Terra Sante is one of a network of 17 villages in the area surrounding the town of San Lucas Toliman created by community health promoters and core faculty member Paul Wise. §

Care Coordination Lacking for Children Report Finds Inconsistencies in Health Outcomes for Children in Managed Care Settings

“A Critical Analysis of Care Coordination Strategies for Children with Special Health Care Needs” (CSHCN) is one of the most recent technical reports to be released by the Agency for Healthcare Research and Quality (AHRQ) that aims to improve understanding of how different models of care delivery—particularly Medicare managed care—affect the health and well being of children with chronic illnesses.

CHP/PCOR core faculty member **Paul H. Wise** led the two-stage approach to analyzing the issue: first, to examine the evidence of what programs have been evaluated and have shown improvements in care coordination; and second, to determine whether Medicare managed care has been conducive to care coordination. The overarching theme and finding from the systematic review is that there is “not a lot of evidence on anything” and

that care coordination for CSHCNs is “very poorly studied.”

With a focus on poor children with serious chronic illnesses in California, Wise and two colleagues—Lynne C. Huffman and Gabriel Brat—began by looking at the history of the definition of “chronic illness” for insight into how CSHCNs are dealt with in the health care system.

“[CSHCNs] were considered crippled children back in the 20s and 30s. We still have programs that, in their names, have mention of ‘crippled children,’” Wise explained. “Then came a phase when people were looking at children with significant conditions—cerebral palsy, cystic fibrosis—things that really physically affected children chronically.”

More recently, the definition of CSHCNs has developed to include children

Children’s Care, continued on page 5

REVAMPING MEDICARE Controlling Costs, Limiting Expenditures

Medicare, a bastion of health care for 44 million elderly and disabled, has been facing financial hardships especially in the past few years. As baby boomers approach the age of Medicare eligibility, there are rising concerns about how to manage Medicare expenditures and ensure adequate financing.

CHP/PCOR director and core faculty member **Alan M. Garber** has played a major role in evaluating reform options for Medicare and serving in an advisory capacity to the federal health program. Garber and three other lead investigators, including CHP/PCOR core faculty member **Victor R. Fuchs**, serve as expert consultants on one project that examines key topics in Medicare reform.

The investigators have evaluated the major functions of Medicare, as well as missing parts in its current capacity to serve the target population. Through

Medicare, continued on page 2

INSIDE THIS ISSUE

Media Mentions.....	2
Disability and Obesity.....	4
Care Coordination Report.....	6
International Health.....	8
Research in Brief.....	9
Staff Spotlight: Allison Gienger.....	10
Staff Spotlight: Ellen Schultz.....	11
Publications.....	12
Announcements.....	13
Presentations & Grants.....	14
Patient Safety Annual Meeting.....	15
Research in Progress Seminars.....	16

Medicare, continued from page 1

the project, they aim to design an “efficient future Medicare program to be implemented in a 5- to 10-year time horizon,” according to Garber.

With the backdrop of demographic changes and financial challenges, their project hones in on key questions such as: Should Medicare reform be tied to broader reform of health care financing and delivery for Americans? How much variation in plan designs should be encouraged? How should Medicare eligibility be changed or restricted?

“The major challenge for Medicare is not just financing,” Garber observed. “You can think of it as finding a way to control expenditures so that financing and expenditures are in line with each other. There will be a huge increase in the number of Medicare beneficiaries in the coming years, and the number of working Americans [who are contributing to Medicare through the payroll tax] will shrink in relative terms. The solutions to this are going to have to be many-fold.”

As life expectancy rates have increased and disability rates have declined, eligibility has remained steadfast at 65 years of age.

“Medicare is a very popular program. At a time when growing numbers of Americans aren’t insured, it is the one insurance program that provides universal coverage for the elderly, and has become the bedrock of health care for many of them,” Garber said. “To many people, raising the age of eligibility or shrinking eligibility based on income or other criteria is off the table as a policy option.”

Tightening eligibility might be acceptable, however, in the coming years, if it is done in a way that is perceived as fair and does not weaken political support for the program. In addition, benefits might be selectively reduced.

“A way to achieve the same aim is to require people who have a high enough income to pay for a share of the ‘premium’ costs of Medicare directly,” Garber explained. “Just as with employment-based insurance, the employer pays a share and the employee pays a share, so you could have Medicare beneficiaries paying a share of Medicare Part A (hospital coverage)—and perhaps, Part B (outpatient care).”

Modifying eligibility could also involve changes to the benefits structure. Medicare could pay for a lower fraction of high-income beneficiaries’ costs, versus that of low-income individuals.

“These are only possibilities; we are not committed to any one of them,” Garber said. “Some of them will be very unpopular politically, but we’re going to have to consider a range of choices and strategies to deal with Medicare costs, none of which will make everybody happy.”

Garber continued, “There are a few things we’d like to see happen. One is to improve the process by which services and products are selected for Medicare coverage. We’d also like to see more innovative structures to benefits.”

GETTING QUALITY HEALTH CARE

Since the vast majority of beneficiaries have supplemental insurance to pay for all or part of the fees that Medicare imposes through co-payments and deductibles, this results in less cost-sharing than in a conventional health insurance plan.

“It might be feasible to use cost-sharing to promote the use of high-value services,” Garber explained. “And Medicare could do a better job of deterring the use of low-value services.”

In order to measure the value of services though, there would need to be a governing body that determines which services are

Medicare, continued on page 3

PEOPLE OF CHP/PCOR

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SUMMER MEDIA MENTIONS

Media Mentions are a compilation of select CHP/PCOR-relevant daily media reports produced by the Stanford School of Medicine’s Office of Communication & Public Affairs. Media Mentions are edited by CHP/PCOR editor Amber Hsiao.

Associated Press of 57 programs aimed at nutrition education. The story also appeared in numerous other media outlets, including ABCNews.com, CBSNews.com, Forbes.com, FOXNews.com, Salon.com, the New York Times, Newsday, San Francisco Chronicle, and San Jose Mercury News.

CHP/PCOR associate **Thomas N. Robinson** is quoted in this USA Today (July 4) article that discusses a review by the

CHP/PCOR associate **Keith N. Humphreys** provides comments in an Oakland Tribune (July 10) article that discusses new research that shows that the anti-smoking drug Chantix may also help patients curb drinking. Humphreys states that while the drug appears to be effective in rats, human efficacy is still unknown. The research was also covered in the Contra Costa Times.

CHP/PCOR director and core faculty member **Alan M. Garber** provides comments in a New York Times (July 12) article with regards to a new Harvard study. The study shows that when uninsured adults with common chronic

Media Mentions, continued on page 10

Medicare, continued from page 2

indeed high quality. And, while such a list could be compiled today, new information and new technologies would continually be introduced.

“We would like to see physicians receive stronger incentives to provide high-quality, high-value care. The Centers for Medicare and Medicaid Services (CMS) is already taking steps in this direction,” Garber said. “They are trying to implement pay for performance. For example, CMS recently announced that they would not reward hospitals or reimburse for care of conditions that are the result of medical errors or substandard care. Now, some of these provisions are bound to be controversial, but the idea that Medicare should not pay more when hospitals and doctors make mistakes is a really appealing one.”

If the public can identify low-value providers, individuals will not have an incentive to pay a visit to them, as is the case with the airline industry where prices, accidents, and on-time performance are transparent.

“If you want to boost quality, it’s not simply a matter of paying for better outcomes—although that’s certainly something that should be of concern. It’s a matter of letting patients know who provides great care and who provides inferior care,” he said. “Now, measuring that in a fair and accurate way is difficult. I don’t mean to underplay the difficulty or challenges involved, but it’s clear that patients have a right to know if their doctor is practicing state-of-the-art medicine.”

Garber predicts that there will be an attempt to promote greater transparency in the future, though how far reaching it will be and how quickly it will be implemented remain to be seen. And as far as current reforms go, they are rather limited.

“I don’t think Congress is currently considering any major Medicare reform; that could change, but as far as I know, there aren’t fundamental reform proposals on the table yet, but they will be considering some kind of change over the next decade or so,” Garber said. “They’re going to be forced to because of the difficulty of sustaining its financial base.”

EXCHANGING LESSONS INTERNATIONALLY

In looking to other countries for ideas about health reform, Garber notes that there is a lot we can learn. However, the United States has been successful in at least some ways with respect to health care.

“What’s not as widely appreciated by some critics of the U.S. health care system is that there’s a lot that can be learned from the United States,” Garber said. “For one thing, we manage to promote innovation in a way that few other countries can approach. One of the challenges will be to cut away at the inefficiencies in the U.S. health care system, and improve Medicare and the commercial health insurance market to make sure we don’t at the same time kill off innovation. Reforms should not consist merely of lowering prices; they should also promote the use of high-value care.” §

Figure 2-4. National Personal Health Care Spending, 1992-2003

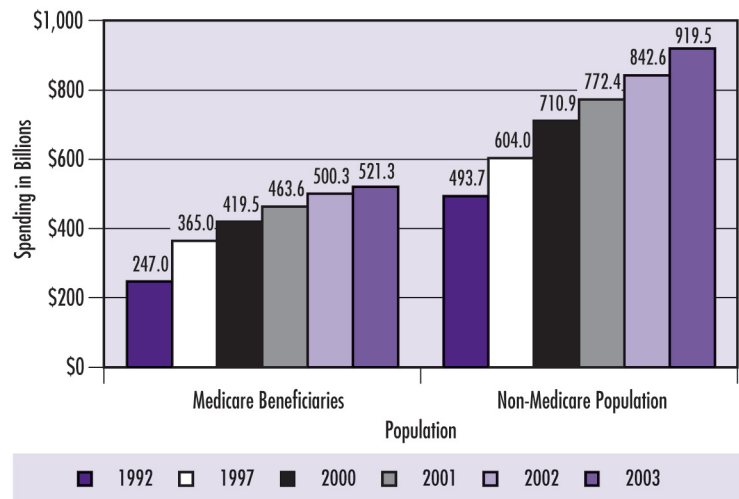
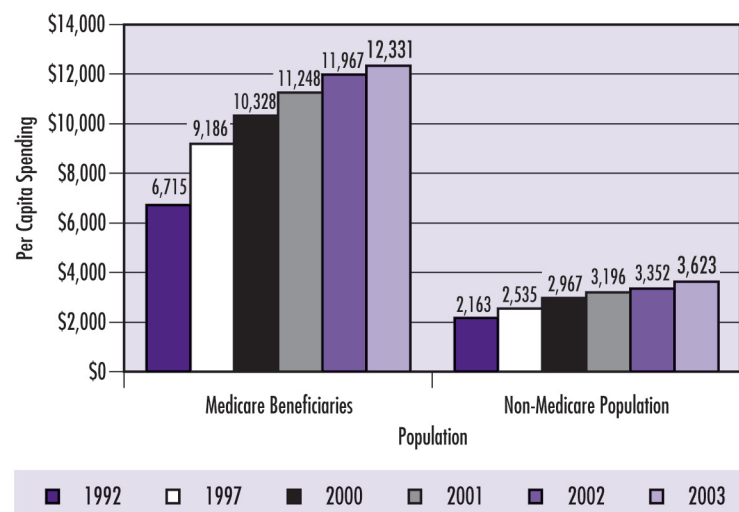


Figure 2-5. Per Capita Spending on Personal Health Care, 1992-2003



SOURCE: CENTERS FOR MEDICARE & MEDICAID SERVICES

Disability Rates on the Rise for Near-Elderly Population, Researchers Say

A number of factors have contributed to the increase in life expectancy. While most of these factors can be attributed to positive economic growth, the consequences of prosperity and wealth are being reflected in various health outcome measures. New research shows how these health trends are affecting disability rates.

While disability rates in the U.S. population have declined in the past 20 years, these trends may not be looking so good for the near-elderly population. CHP/PCOR core faculty member **Jay Bhattacharya**, and colleagues at Harvard and RAND have been investigating why this is the case and what its policy implications are.

The goal of their paper, “Chronic Disease and Severe Disability Among Working-Age Populations,” was to examine whether chronic disease plays a role in the increasing disability in the near-elderly population, defined as individuals aged 50 to 65.

“The good news from previous research is that older people have been getting less disabled over time,” Bhattacharya said. “In the United States, some of the people who have discovered this have extrapolated it to say that this might even solve Medicare’s financing problems, because disabled people spend a lot more [on medical care] than non-disabled people.”

To the surprise of the researchers, obesity turned up as the most prominent chronic condition that may lead to disability.

“The one big story that pops out from the paper is that obesity is responsible for a large part of increasing disability in the population,” Bhattacharya said. “So the increasing

prevalence of obesity in the near-elderly population has a huge effect on the number of people with disabilities. If you’re obese, you are more likely to develop a disability than if you are not.”

Even major chronic conditions such as hypertension, heart disease, diabetes, and arthritis are overshadowed by the effect of obesity as a chronic condition that may cause disability.

Disability is broadly defined as activity limitations, or the “inability to perform mechanical activities of daily living (ADLs) such as dressing, eating, and bathing, as well as instrumental activities of daily living (IADLs) such as grocery shopping, managing money, and preparing meals.”

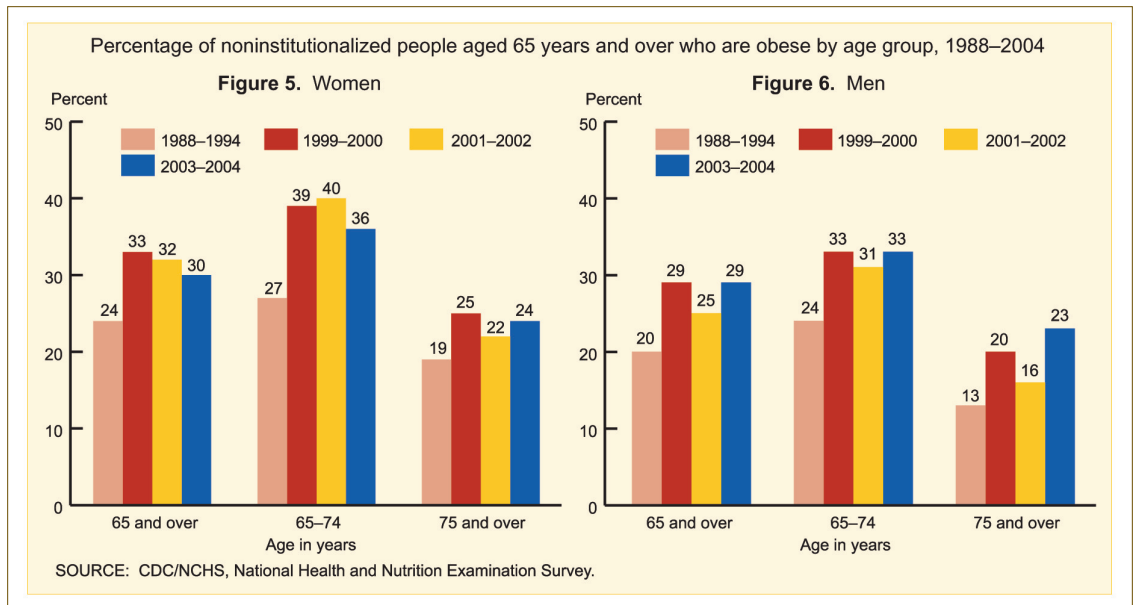
The researchers used the National Health Interview Survey (collected by the Centers for Disease Control and Prevention), which asks a nationally-representative

sample of Americans about whether each has various health conditions, as well as questions to determine whether one is disabled.

The researchers looked to the disability trends in the near-elderly populations to see if the decreases in disability in elderly populations translate to the near-elderly. In elderly populations, reduced stroke rates, improved rehabilitation after stroke, and new technologies to support disabled elderly populations are all partly responsible for declining disability.

“You might expect that some of those same things would be true in the near-elderly population as well,” Bhattacharya explained. “It turns out that the good trends that you see in older populations are not the same in the near-elderly population. There have actually been increases in disability among the near-elderly.”

Disability, continued on page 7



Children's Care, continued from page 1

with developmental problems including learning and social disorders that require significant care coordination.

The researchers also looked at how medical homes fit into the definition of care coordination, finding that there is somewhat of a tension between the definitions depending on where care is delivered.

“For many parents and advocates for children with special health care needs, the medical home is actually the home,” Wise said. “The parents assume a lot of the responsibility of the children. In the pediatric world, it’s the pediatrician who takes on the lead coordinator role.”

The way these definitions are conceived affects how health care is delivered, supported, and reimbursed. For example, one of the main problems with the medical home approach is that pediatricians and other health personnel are not always adequately reimbursed for services they might render in the home versus in a medical setting.

“Most pediatricians do not schedule extra time for a kid with a serious chronic illness even though they require enormous resources and time,” Wise explained, “and the reason is that they don’t get reimbursed for any more than they would if a kid came in for a shot—that has a devastating effect on care coordination for children.”

In contrast, reimbursement policies for care coordination in adult populations are more responsive to the requirements of individual patients, especially because adults consume the majority of health care dollars.

“Right now, children are not on anybody’s radar screen in terms of reimbursement, since they don’t cost [the system] a lot of money,” Wise said. “Because children consume a very small amount of our health dollar, it’s not really a large area of concern for policymakers. What we’re trying to say is that there needs to be a pretty fundamental rethinking of funding for children with chronic illness.”

While there are virtually no studies analyzing the impact of care coordination on costs, Wise expects that if care coordination is done well, it would reduce costs.

However, treating chronic illness in children is distinctively different from chronic illness in adults, since children must rely on their caretakers and social institutions for their needs. Especially in light of cutbacks in funding for health and education, many schools are unable to

keep school nurses and health centers on board.

“There really has been a reduction in our capacity to deal with CSHCNs in schools,” Wise explained. “Due to cuts in education and also restrictions in how reimbursements can be used, it doesn’t support the enormous amount of work that the physician or physician staff would have to really do to coordinate care in a school setting.”

While managed care is supposed to be a way of organizing delivery of care, the researchers found mixed results for care of CSHCNs enrolled in Medicare. The impact of managed care is further complicated by the fact that it is not disease-specific; the more complicated the disease, and the more interaction one has with outside agencies, the larger the challenge for care coordination.

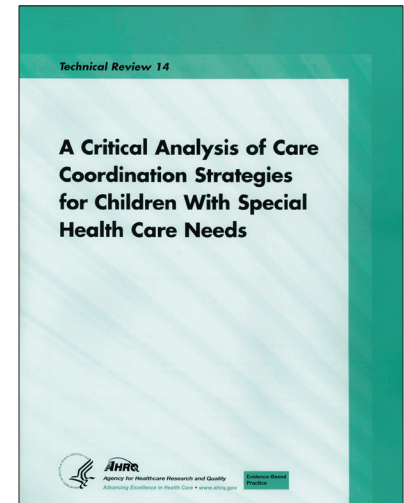
In general, improvements for care coordination were observed when there was new money invested for care coordination. Nonetheless, Wise is hopeful that the report will continue to call attention to the need for major change in the way pediatric care is structured in the United States.

“The report has slowed down enthusiasm for throwing kids with special health care needs into managed care—which people were attempting to do,” Wise said.

He continues, “We basically were trying to say that we need to be far more cautious about how policies are developed and place greater care in developing systems that will take care of these kids. The worst scenario would be to just throw CSHCNs into a managed care setting that has no special capacity to take care of them—that would be a disaster.” §

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—Paul H. Wise



REPORT SERIES

Report Tackles Current Issues and Evidence in Improving Care Coordination

In the final volume of the series “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies,” the Stanford-UCSF Evidence-based Practice Center (EPC) conducted a systematic review of care coordination practices to pinpoint strategies for improving how such practices are administered in multifarious settings. Health care management can be complicated when patients have conditions that require multiple evaluations, treatments, and follow-ups, so proper management is paramount to good health.

As one of the most comprehensive and broad studies of evidence about ways to improve care coordination, the report is setting the stage for progress in strategies to advance care. The EPC team led by CHP/PCOR executive director **Kathryn M. McDonald** identified 75 systematic review publications on care coordination interventions, and from these, 20 coordination interventions covering 12 clinical populations in various clinical settings were noted.

Of the many findings, the analysis revealed the complexity of the care coordination issue and how difficult it is to get all health care stakeholders on the same page with regards to even the definition of care coordination and similar terminology—over 40 such definitions were discovered in the process of review.

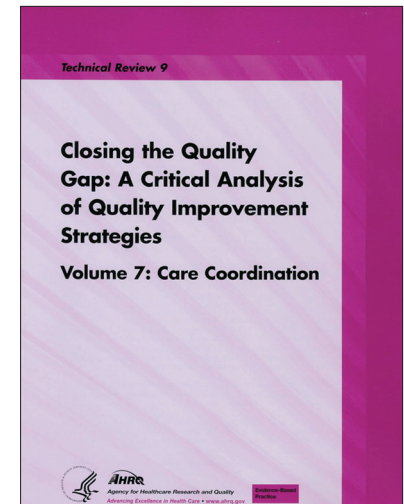
“I think the various definitions reflect the disciplinary or organization perspective of those defining it,” McDonald explained. “For example, a social scientist specializing in organizational behavior notes the relational aspects of coordination—that the nature of interprofessional relationships and

education might influence coordination. Meanwhile, a health system such as the VA has a definition that reflects what they are trying to do as an organization—getting the right care to the right patient at the right time. It’s purpose-oriented, and actually quite patient-centered.”

Based on the systematic review of relevant literature, the EPC team came up with a definition of their own to combine the various perspectives and common elements, part of which states: *Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.* The definition was meant to serve as a basis for conducting the systematic review.

The review found that current care coordination strategies exhibit benefits for conditions, such as congestive heart failure, diabetes, and mental illness. There was evidence that multidisciplinary teams that engage in a more collaborative method of care—whether through shared primary-specialty care, case management, or disease management—displayed reduced mortality and dependency rates in stroke patients.

“It is likely that this reflects a higher density of primary intervention studies in these conditions,” McDonald said, “and in turn, researchers have been more likely to design and implement care coordination interventions for these clinical situations because the risks of uncoordinated care have graver consequences, and the opportunities for making an improvement may be greater than other conditions.”



Research efforts and dollars tend to favor conditions that affect more patients—it is estimated that 20.8 million have diabetes, 5 million have heart failure, and 57.7 million suffer from a mental illness.

In spite of benefits to care coordination, however, the literature review did not reveal any single model of care coordination that yielded the most beneficial results. Much of this is due to the difficulty of comparing the value of different coordination strategies, with varied definitions afloat.

Furthermore, little evidence was found about the specifics of what types of barriers might need to be overcome, or even considered, in order for care coordination to be beneficial in dealing with any one condition.

“There are two levels of thinking about barriers—those that might impede an implementation of a specific care coordination intervention and those that might be considered while an intervention is designed,” McDonald said. “I think the most effective interventions have been developed with some forethought about how to reduce barriers, though this is speculation.”

Care Coordination, continued on page 7

Care Coordination, continued from page 6

Organizations such as the American Board of Internal Medicine have been receptive to the study.

In March, McDonald was invited to participate in work by a group called “Stepping Up to the Plate” where initial findings were presented to make ground on an effort to “bring professional clinical organizations together in coming up with tools for primary care practices,” according to McDonald.

She spoke about the EPC’s research at a consensus conference on care transitions, hosted earlier in the summer by the American College of Physicians.

CHP/PCOR assistant director of research and project manager **Vandana**

Research efforts and dollars tend to favor conditions that affect more patients—it is estimated that 20.8 million have diabetes, 5 million have heart failure, and 57.7 million suffer from a mental illness.

Sundaram—also an investigator involved in the review—presented the findings on a care coordination panel at a recent Agency for Healthcare Research and Quality conference.

“Some of the theoretical and conceptual work that we had done helped the discussion, and the evidence base we’ve developed gave the participants an understanding that there are strategies that work at the level of clinical outcomes,” McDonald explained, “but that we are limited in terms of knowing what components are most crucial to measure or standardize.”

Ultimately, effectiveness depends upon matching individuals appropriately with an intervention or care coordination type. Until then, though, the EPC team will continue to disseminate the findings, in hopes that health care organizations will use the report as a resource in improving care coordination and in determining what is worth trying. §

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The CHP/PCOR EPC investigators who were involved in this systematic review also include: senior scholar **Dena M. Bravata**, former staff members **Robyn Lewis** and **Helen Paguntalan**, former trainees **Nancy Lin** and **Sally A. Kraft**, CADMA/CDEHA project manager **Moirra McKinnon**, and core faculty member **Douglas K. Owens**.

Disability, continued from page 4

While it is hard to pinpoint the exact reasons as to why this is happening, Bhattacharya observes that if disability is often permanent in the near-elderly, then the idea that the Medicare expenditures would not be as high and that disability will continue to decline as the population ages might not hold true.

In the analysis, the researchers framed the role of chronic disease in two ways: one is that the prevalence of chronic disease has gone up in the near-elderly population, so an individual taken at random is more likely to have a disability. The second way of framing the issue is to view prevalence of chronic disease as fixed, but the probability of being disabled given that an individual has a chronic disease could be going up.

“Either of these scenarios is possible, and they are not mutually exclusive. I tried to think about the extent to which these chronic diseases are responsible or associated with the increasing disability,” Bhattacharya said.

On the insurance end, Bhattacharya also explains that changes in state policies

may have led to changes in disability qualifications. “[In many states during the 1990s], income thresholds [to qualify for state disability insurance coverage] fell and the amount of time you have to spend disabled [to qualify for coverage] has decreased,” he explained.

“Another possibility,” Bhattacharya said, “is that we are getting better at treating chronic disease so that people who otherwise would have died stay alive and in a stable state.”

While the reasons are not completely clear, Bhattacharya does believe that the rising rates of obesity in relation to rising rates of disability are a “consequence of the things we like rather than the things we don’t like.”

According to Bhattacharya, changes in technology are a major driving force in the rising obesity rates. Changes in technology of agriculture allow food to be produced at cheaper prices and in greater quantities. Changes in the work place have led to less physical activity. Finally, the technology of food production allows for speedier

food preparation, leading to increases in opportunities for women in the workplace, as their time spent on home production has now decreased.

The nature of the obesity problem then, is particularly difficult to address, even though there have been vast improvements in treatment of diseases—the cost of having a chronic illness these days are much lower than they were 20 years ago.

“I don’t know what we can do about eliminating obesity, but what you can do is to focus on the other side: the probability of being disabled given that you do have a chronic disease,” Bhattacharya expressed. “What this research suggests is that we have to have more focused policies aimed at disability prevention among the chronically ill and doctors need to be aware of the chronically ill patients that are much more likely to be disabled than they used to be. Clinically, we need better ways of screening the chronically ill to identify those who are most likely to become disabled.” §

INTERNATIONAL HEALTH

The Impact of Governance On Health Improvement

In the 1980s, UNICEF launched the GOBI initiative, an effort to bring the benefits of relatively simple, low-technology health-improving interventions to developing countries.

The campaign emphasized a set of interventions designed to reduce infant and child mortality—**G**rowth monitoring, **O**ral rehydration therapy, **B**reastfeeding, and **I**mmunization—and provided technical and financial support to governments in the developing world to put these GOBI-endorsed strategies into practice.

Technological and medical progress placed these low-tech interventions within the reach of all countries, and UNICEF pledged to raise funds for implementation and provide technical support. However, the availability of inexpensive health-improving technologies was insufficient to generate significant improvements in infant and child mortality across the developing world.

Why did some governments embrace the GOBI-campaign and successfully improve public health for their citizens? Why did other governments fail to take advantage of these widely available technologies and public health interventions?

The CHP/PCOR members of the Health and Governance Project team are examining the case of GOBI on three

POLICY IN ACTION



COURTESY/BELINDA BYRNES

PAUL & JANICE WISE (left), both pediatricians and medical volunteers visiting rural south-western Guatemala, are joined by a University of Wisconsin medical student and Stanford pediatric resident as they bring a donated wheelchair from the United States to a child with cerebral palsy in the town of San Lucas Toliman. §

fronts: (1) identify components of governance associated with more intensive program implementation and relatively better child health indicators, (2) use secondary microdata from the Demographic and Health Surveys (DHS) for empirical research on health measures of children and women that allows for analyses of sharp trend breaks that coincide with launch of GOBI, and (3) analyze detailed information about specific interventions and outcomes—such as vaccine coverage, breastfeeding, and child morbidity—linked to GOBI that may address concerns about confounding influences beyond the strengths of analyzing precisely-timed trend breaks.

Health Governance, continued on page 13

As part of his work on children’s issues, CHP/PCOR core faculty member **Paul H. Wise** recently established the Children’s Project at Stanford University.

“The idea is to use the Children’s Project to engage expertise at Stanford in the real world of real kids in the real world,” explained Wise, who is leading the project.

The project marks the establishment of the first academic base dedicated to analytically explore and ultimately address the most urgent threats to the health and well-being of children throughout the world. “The effort would create an infrastructure of collaboration at Stanford that would bring together faculty and students from a variety of relevant disciplines, including from the medical, legal, social science, and educational arenas to engage issues that have not been well addressed by any single discipline alone,” writes Wise.

Many existing programs focus on specific issues such as children orphaned by AIDS, sex worker trafficking, child labor, and young child survivor. Unlike these narrowly-focused programs, however, the Children’s Project attacks these issues in a more integrated way.

“The idea isn’t to focus on one specific issues,” Wise explained. “For example, children orphaned by AIDS face huge issues with child labor; they have huge issues with prostitution and drug use. The idea here is to bring together all the disciplines in a more integrated way, and this hasn’t been done anywhere else.”

The primary elements of the Children’s Project are to support collaborative faculty and student research on major children’s issues, particularly in overseas field settings; a visiting scholar program that would bring to Stanford a small number of influential scholars or advocates from around the world who are dedicated to children’s issues; and a series of speaker or other events at Stanford that would elevate children’s issues for faculty, students, and the local community.

The Children’s Project is housed within the Center for Health Policy at the Freeman Spogli Institute of International Studies and the Stanford University Department of Pediatrics. The group is currently securing funding sources and in the early stages of developing projects in Africa. §

THE CHILDREN’S PROJECT
a collaborative initiative

RESEARCH IN BRIEF

PAY FOR PERFORMANCE IN ESRD CARE

In a recent clinical commentary piece published in the *Clinical Journal of the American Society of Nephrology*, CHP/PCOR adjunct associate (and former fellow) **Amar A. Desai** analyzes the effect of pay for performance (P4P), or value-based purchasing, initiatives to raise the quality of care.

Desai and co-authors **Alan M. Garber**—CHP/PCOR director and core faculty member—and **Glenn M. Chertow** examine P4P in light of its affects on chronic kidney disease and end-stage renal disease (ESRD).

ESRD is a stage at which the kidneys fail and patients either require dialysis or a transplant. While transplant is the best option, there are organ shortages and other issues that prevent many patients from getting a transplant, according to Desai.

Since the adoption of the Medicare ESRD program in 1973, there has been increasing demand of patients requiring dialysis. The paper, “Rise of pay for performance: Implications for care of people with chronic kidney disease,” describes the evolution of the dialysis market—-independent dialysis facilities have now become more consolidated and dominated by for-profit large dialysis organizations.

While the dialysis market has been marked by such shifts, reimbursement and payment methods have not changed much until recently.

“One of the major difficulties with implementing P4P for ESRD is that there are a variety of providers that care for ESRD patients,” Desai described. “It is a challenge to direct incentives in a way that ensures fairness and accountability.”

The Medicare ESRD program reimburses dialysis providers for a specified bundle of services, called a composite rate. The payment structure is a flat fee charged on a per-service basis, which means that dialysis providers are reimbursed on volume rather than efficiency and effectiveness.

With the introduction of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the structure of the ESRD financing system was changed: it required a basic case-mix-adjusted prospective payment system for dialysis, and it mandated a demonstration project for broader bundled payment systems.

“Prior to the case-mix-adjustment, there was very little difference in the payment for different types of patients,” Desai said. “Case mix adjustment attempts to adjust payment by accounting for underlying differences

in patients. Unfortunately, important comorbidity variables, such as information about other illnesses, are not included in the current case-mix-adjustment, which may limit the predictive ability of the system.”

The case-mix-adjustment prospective payment system is based on age and body composition, since treatment for younger and older adults, and larger and smaller adults based on body mass index can affect how treatment is administered.

While previous studies have shown mixed results when it comes to P4P for ESRD care, Desai emphasizes the need for the right quality metrics to really get at the heart of process measures that are associated with outcomes such as mortality.

A number of previous projects have developed metrics to evaluate quality in ESRD care, such as ESRD Clinical Performance Measures Project, the National Vascular Access Improvement Initiative, and the ESRD Managed Care Demonstration Project.

Reimbursement policy in ESRD is especially important in the dialysis industry, as it has affects on provider behavior and quality.

The authors write, “Reimbursement policies that do not adequately fund the provision of

Pay for Performance, continued on page 13

OBESITY AND WAGES

Obesity has become a major concern in the past few years, especially as obesity rates have climbed even outside of the United States.

CHP/PCOR adjunct associate **Vincenzo Atella**, **Noemi Pace**—who finished her stay as a visiting scholar at CHP/PCOR in August—and their colleague **Daniela Vuri** are investigators from the University of Rome Tor Vergata who have examined the link between obesity and wages in Europe.

Unlike past studies on the topic, their paper, “Wages and weight in Europe: Evidence using quantile regression model,” uses the quantile regression approach that attempts to parse out the wage distribution and examine it in fourths, rather than taking the average of all wages, and trying to find a link to obesity.

Data were taken from the European Community Household Panel over the period of 1998 to

2001, which contained information on wages and obesity from nine European countries.

“Past studies have not considered different kinds of jobs where being obese or not may cause all kinds of problems,” Atella explained. “If you are obese and your job requires a lot of physical activity, it may be that this is not your kind of job.”

In their analyses, Atella, Pace, and Vuri controlled for various effects and socioeconomic determinants of wages, including job type, level of education, income, health status, productivity, and so, they were able to identify the “pure” relationship between obesity and wages.

For example, in some cases, a single country may exhibit high discrimination in the low-wage quantile, versus low discrimination in the high-wage quantile. Averaged, the differences in quantiles as masked, as they will compensate for each other and a discriminatory effect does not seem to exist.

Previous papers have also found differences in wages to be due to cultural and institutional factors, but Atella, Pace, and Vuri find that this is also not the case.

Atella also points to the faultiness of the two models previous research has formulated: the northern-central model and the southern model.

The northern-central model purports that—due to geography, climate, culture, and stage of life—the population in northern and central Europe in countries such as Denmark, Finland, Austria, and Belgium, have higher protein intake of animal fats.

This is in contrast to the southern model that asserts that the southern culture of Europe is more urban with lower levels of physical activity and the population in these countries—including Portugal, Spain, Italy, and Greece—intake less animal fat and more vitamins.

Obesity and Wages, continued on page 12

STAFF SPOTLIGHT: Allison Gienger



Allison Gienger always had a strong interest in the sciences, and more specifically health, as it was fascinating for her to see how people's bodies worked, what made them sick, and what made them well. "I think everybody has somebody who has been touched by the health care system very deeply, so it's a common experience," Allison explained.

Her interest in health guided her in selecting Molecular and Cell Biology as her major while an undergraduate at the University of California, Berkeley, where she also took public health and statistics courses that allowed her to be involved in various health- and medical-oriented campus activities.

Allison worked with the medical journal, *Berkeley Medical Journal* as an editor for two years, taught a molecular and cell biology course for two-and-a-half years, and was editor-in-chief of the journal her last year at Berkeley. In her senior year she also worked as a lay healthcare worker at a free clinic in the hepatitis division.

"We did a lot of patient education and outreach with different groups, mainly among the homeless community and injection drug users," Allison said. "They are the most at risk, especially in the Bay Area. We didn't do treatment but we did testing and vaccinations and gave people referrals to different agencies."

Throughout college, she also worked with libraries, including the Health Sciences and Optometry library at Berkeley, where she gained plenty of experience working with the optometry students and undergraduates in the health sciences.

Allison taught them how to run the databases and how to do research. Outside of school and during school breaks, she continued to work for a public library.

While it would seem that Allison was on the track to be a librarian, she explains that her love for libraries came from her mother, who works at a library.

Even so, when it came time to graduate, she did continue to work for various libraries, including the Martin Luther King, Jr. Library, where she had the opportunity to teach many San Jose State University students how to use different databases.

"I actually did that for a few months before coming to Stanford. With an undergraduate degree in biology, I wasn't quite sure what to do—it's not quite the pharmacy track or the biotech track," Allison said.

When a research assistant position opened at CHP/PCOR, it was a natural fit, given her academic background and strong database searching and EndNote skills, a proficiency she gained from working in the many libraries. She has now been at CHP/PCOR for nearly one-and-a-half years.

At CHP/PCOR, Allison is currently working on a number of projects with faculty fellow and VA researcher **Paul A. Heidenreich** and assistant director of research **Vandana Sundaram** on a heart failure quality indicators project. She is also working with Sundaram and executive director **Kathryn M. McDonald** on an elective induction of labor project.

She explained that while she had entertained thoughts of becoming a doctor eventually, "After meeting doctors and understanding very clearly what medical school and residency entails, it definitely made me feel like it isn't what I want to do. There are a lot of ways that you can interact with people and work in the health field without needing to go to the medical school route."

Allison is also heavily involved in the community outside of work. She volunteers in science departments at the Palo Alto Unified School District, as well as with the Humane Society.

She explained, "I feel a lot more grounded and linked to the community when I'm volunteering. I think it's a great way for people to feel like they are a part of where they live, and it's a nice break from hectic daily life." §

Media Mentions, continued from page 2

illnesses become eligible for Medicare, they saw doctors and were hospitalized more often and reported greater medical expenses than people who had had insurance before Medicare. The study also reported that the increased use of medical services continued until at least age 72, according to the *New York Times*.

CHP/PCOR fellow **Kanaka Shetty** and core faculty member **Jay Bhattacharya** conducted a study that examined the effect of limited work hours for all residency programs in the United States. Shetty was quoted in the *Chronicle of Higher Education* (July 12) and *KQED-FM* (July 17).

CHP/PCOR core faculty member **Alain C. Enthoven** was featured in a *Milwaukee Journal Sentinel* article (July 12) that discusses his talk about sweeping reform in Wisconsin's universal health proposal. Enthoven was in Wisconsin to discuss sweeping reform of health care in Wisconsin, calling for a proposal that would provide universal health coverage to nearly everyone in the state.

Some employers are penalizing workers who are overweight or do not meet health guidelines in order to hold down medical costs. A *Los Angeles Times* (July 29) article referenced a study from 2005 conducted by CHP/PCOR core faculty member **Jay Bhattacharya** and faculty fellow **M. Kate Bundorf** that found that obese people with health coverage may already be punished on the job through decreases in wages.

The work of CHP/PCOR core faculty member **Victor R. Fuchs** is mentioned in a *Ogden Standard-Examiner* (Ogden, Utah) (Aug. 17) article on single-payer health insurance. The article gives an analysis of Fuchs and colleague **Ezekiel Emanuel's** voucher-based system proposal.

CHP/PCOR director and core faculty member **Alan M. Garber** was featured during the segment on *National Public Radio* (Aug. 17) about the FDA-issued advisory to physicians and nursing mothers with regards to codeine, a painkiller that is widely prescribed and used after childbirth.

CHP/PCOR associate **Keith N. Humphreys** wrote in a *San Francisco Chronicle* (Sept. 2) Op/Ed of the importance of getting enough sleep. Humphreys gives an overview of leptin and ghrelin in regulating appetite and the effect of these levels on other important daily activities, such as working out and immune system health.

CHP/PCOR faculty fellow **M. Kate Bundorf** and adjunct associate **Mark V. Pauly** are

Media Mentions, continued on page 11

Media Mentions, continued from page 10

referenced in a *USA Today* (Sept. 5) article on the costs of health care. This piece analyzes the recent Census Bureau estimate of how many people in the United States lack health insurance—47 million—and gives an overview of reasons for the uninsurance rate. Bundorf and Pauly estimate that as many as 75 percent of the uninsured can afford to buy insurance.

CHP/PCOR core faculty member **Alain C. Enthoven** provided comments in a *Wall Street Journal* (Sept. 6) article that discusses the health care system in the Netherlands. Following a “managed competition” system first proposed by Enthoven, the Netherlands began to overhaul its health system in 1987.

CHP/PCOR core faculty member **Jay Bhattacharya** provides comments in a *San Francisco Chronicle* (Sept. 12) article on the reasons why the age of the labor force is increasing. Bhattacharya notes that older Americans are healthier, allowing them to stay in the labor force.

CHP/PCOR associate **Julie Parsonnet** is quoted in a *Columbia Journalism Review* (Sept. 19) article about a recent *New York Times Magazine* piece focused on the limitations of observational studies and the fact that these studies provide fodder for much of the health news that appears in the media.

CHP/PCOR faculty fellow **Randall S. Stafford** is quoted in a *Washington Post* (Sept. 21) article about a study he led on hormone replacement therapy. Despite the huge publicity generated by a 2002 study on the potential dangers of hormone therapy for postmenopausal women, new research has found that only 29 percent of women surveyed knew about the study two years later.

CHP/PCOR core faculty member **Douglas K. Owens**, who chairs the subcommittee of the American College of Physicians, provides comments in a *CBS News* (Sept. 24) article. According to a new study published in the Sept. 24 issue of the *Archives of Internal Medicine*, the annual physical exam may not always be necessary. The study was covered by various media outlets, including the *Centre Daily Times* (Centre, Pa.) (Sept. 30), *USA Today* (Sept. 30), and *WebMD* (Sept. 24).

As a part of the World Contraception Day coverage, the *BBC World Service* (Sept. 26) featured a segment in which CHP/PCOR core faculty member **Grant Miller** discussed the impact of contraceptives and family planning in Colombia, an area that he has conducted research. §

STAFF SPOTLIGHT: Ellen Schultz



PHOTO/AMBER HSIAO

Research assistant **Ellen Schultz's** background in science writing is fitting for a research center like CHP/PCOR. As an undergraduate student at Washington University in St. Louis, Ellen's focus was biology and genetics—the genetics component more a result of the university's strong genetics program than a strong personal interest in the topic.

“Over the course of my senior year, I got really interested in science writing and I figured out by then that lab work wasn't what I wanted to do,” Ellen explained.

Before heading to University of Wisconsin-Madison (UW-Madison) for graduate school, however, Ellen continued to work in a genetics lab at Washington University's School of Medicine, all the while preparing for a science writing program. Once she secured a spot as a graduate student in the Life Science Communications department at UW-Madison—previously the Agricultural Journalism program—Ellen had an opportunity to gain exposure to communications research and applied science writing.

Throughout her stay in Wisconsin, Ellen focused on the intersection of science and media. For example, as a research assistant during her 2-year Masters program, she conducted a project that examined how media messages influence smoking adoption in adolescents. Alongside this project, Ellen also contributed several feature stories to a local newspaper, where she gained hands-on experience in understanding the way media frames science and how that framing might influence people's beliefs about science in general.

“Once you get out of high school and definitely once you get out of college, most adults don't have any information about science except for what comes from the media, unless they are in the science field,” Ellen said.

Ellen devised a project where she edited

two real newspaper articles—one about whether eating tomatoes would help prevent cancer, and another about finding another solar system in another galaxy—to change the framing of the issue.

For example, in one version of the tomato article, the headline boldly stated, “Tomatoes Reduce Cancer Risk.” In the other version, the headline was more vague, asking “Could Tomatoes Prevent Cancer?” Ellen asked undergraduate participants to share their beliefs about science and measured whether participants' responses differed based on the version of the story they received.

She found responses differed somewhat for questions like, “Do you think eating certain foods can reduce your risk of cancer?”

“This work really got me interested in social science, so when it came time to look for a job, I was a little on the fence about whether I wanted a writing job or a research job,” Ellen explained. “When looking through various job postings, I found that I was typically more interested in the research aspect, and I was really interested in being at Stanford because it's the type of academic environment I really wanted to be in.”

Since arriving at Stanford, Ellen has worked on a number of projects, primarily with CHP/PCOR faculty fellow **Michael K. Gould** and adjunct associate **Gillian D. Sanders**, on topics such as decision analysis modeling, VA quality improvement projects, and timeliness of care issues for patients with lung cancer.

When not busy with work, Ellen enjoys cooking, especially the “American style of Indian cooking,” as well as baking all sorts of treats. On most weekends, she and her husband make it a point to explore California as much as possible. At one point or another they have walked along all the beaches from New Brighton State Beach in Capitola, all the way down to Marina State Beach. The Redwoods and hiking are also on the top of their weekend “field trip” list.

“We weren't very psyched about coming out to California, but while we're here, we want to make it worth it,” Ellen expressed with laughter. “Definitely in the Midwest—where we're both from—you've got to drive a long way to go to both beach and forest in the same weekend.” §

SUMMER QUARTER PUBLICATIONS

Amruster B, **Brandeau ML**. Optimal mix of screening and contact tracing for endemic diseases. *Mathematical Biosciences* 209 (2007):386–402.

Barnato AE, Chang CC, **Saynina O**, **Garber AM**. Influence of race on inpatient treatment intensity at the end of life. *Journal of General Internal Medicine* 22 (2007):338–345.

Bravata DM, Holty JE, Wang E, Lewis R, **Wise PH**, **McDonald KM**, **Owens DK**. Inhalational, gastrointestinal, and cutaneous anthrax in children: A systematic review of cases: 1900 to 2005. *Archives of Pediatric and Adolescent Medicine* 161, no. 9 (2007):896–905.

Bravata DM, **McDonald KM**, **Gienger AL**, **Sundaram V**, Perez MV, Varghese R, Kapoor JR, Ardehali R, **McKinnon MC**, Stave CD, **Owens DK**, **Hlatky MA**. Comparative effectiveness of percutaneous coronary interventions and coronary artery bypass grafting for coronary artery disease. *Comparative Effectiveness Review No. 5*. (Prepared by Stanford-UCSF Evidence-based Practice Center under Contract No. #290-02-0017.) Rockville, MD: Agency for Healthcare Research and Quality. In Press.

Carrico AW, Gifford EV, **Moos R**. Spirituality/religiosity promotes acceptance-based responding and twelve-step involvement. *Drug and Alcohol Dependence* 89 (2007):66–73.

Cutler DM, **Miller G**, Norton DM. Evidence on early-life income and late-life health from America's Dust Bowl era. *Proceedings of the National Academy of Sciences* 104, no. 33 (2007):13244–13249.

Desai AA, **Garber AM**, Chertow GM. The rise of pay for performance (“P4P”): Implications for care of persons with chronic kidney disease. *Clinical Journal of the American Society of Nephrology* 5 (2007):1087–1095.

Durand-Zaleski I, Combe C, Lang P. International study of health care organization and financing for end-stage renal disease in France. *International Journal of Health Care Finance and Economics* (August 7, 2007).

Heidenreich PA, Gholami P, Sahay A, Massie B, **Goldstein MK**. Clinical reminders attached to echocardiography reports of patients with reduced left ventricular ejection fraction increase use of beta-blockers. A randomized trial. *Circulation* 115, no. 22 (2007):2829–34.

Ilgem M, McKellar J, **Moos R**. Personal and treatment-related predictors of abstinence self-efficacy. *Journal of Studies on Alcohol and Drugs* 68 (2007):126–132.

Kennedy BS, **Fortmann SP**, **Stafford RS**. Elective and isolated carotid endarterectomy: Health disparities in utilization and outcomes, but not readmission. *Journal of the National Medical Association* 99 (2007):480–488.

Kurian AW, Newton Thompson R, Gaw AF, Arai S, Ortiz R, **Garber AM**. A cost-effectiveness analysis of adjuvant trastuzumab regimens in early HER-2/neu-positive breast cancer. *Journal of the Clinical Oncology* 25 (2007):634–641.

Linder JA, Ma J, Bates DW, Middleton B, **Stafford RS**. Electronic health record use and the quality of ambulatory care in

the United States. *Archives of Internal Medicine* 167, no. 13 (2007):1400–1405.

McDonald KM, **Sundaram V**, **Bravata DM**, Lewis R, Lin N, Kraft S, **McKinnon M**, Paguntalan H, **Owens DK**. Care Coordination. Vol 7 of: Shojania KG, **McDonald KM**, Wachter RM, **Owens DK**, Eds. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under Contract No. 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

Moos R. Theory-based active ingredients of effective treatments for substance use disorders. *Drug and Alcohol Dependence* 88 (2007):109–121.

Moos R, Holahan CJ. “Adaptive tasks and methods of coping with illness and disability.” In E. Martz & H. Livneh (eds.), *Stress reactions to and coping with chronic illness and disability* (pp. 107–126). New York: Springer, 2007.

Owens DK, **Sundaram V**, **Lazzeroni LC**, Douglass LR, Tempio P, Holodniy M, **Sanders GD**, Shadle VM, McWhorter VC, Agoncillo T, Haren N, Chavis D, Borowsky LH, Yano EM, Jensen P, Simberkoff M, Bozzette SA. HIV testing and screening in an integrated health care system. *Journal of General Internal Medicine* 22 (2007):315–320.

Qaseem A, Snow V, Barry P, Hornbake ER, Rodnick JE, Tobolic T, Ireland B, Segal J, Bass E, Weiss KB, Green L, **Owens DK**. Current diagnosis of venous thromboembolism in primary care:

Publications, continued on page 15

Obesity and Wages, continued from page 9

Atella explains, however, that one cannot lump these “northern-central” and “southern” countries together and say that discrimination occurs all in the same way across the countries. According to the group's data, this northern-central and southern divide is far from what happens.

“In the northern countries, the wage discrimination effect disappears when you average things,” Atella said. “In our case, we are able to understand the specific countries and specific problems in certain parts of the wage distribution. When you look at the whole picture, you don't see any common factors like the presence of unions,

power of unions, and so on. The cultural effects—like being in a northern or southern country—are not present, so it is impossible to say that in Europe, there are cultural distributions of factors that determine wage discrimination.”

On the whole, the researchers have found that there is no single country in Europe where the wage discrimination effect is not being detected. However, where in the wage distribution the effect has been detected does vary across different countries.

“The main point of the paper is that, by looking at averages, people may make a big

mistake because they tell you a completely different story,” Atella said. “We need to look at the differences within countries and across countries using quantiles instead of averages. Caution should be taken when interpreting the relationship between obesity and wages through averages.” §

Vincenzo Atella is a CHP/PCOR adjunct associate who is also an associate professor of economics at the University of Rome Tor Vergata. His research deals with the introduction of new technologies into the health sector and health-related income inequalities, among other topics.

SUMMER QUARTER ANNOUNCEMENTS

CHP/PCOR faculty fellow **Laurence C. Baker** was promoted to full professor of health research and policy.

Margaret L. Brandeau has been granted the designation as a CHP/PCOR faculty fellow given her high level of involvement and collaboration with CHP/PCOR researchers previously as an associate of the centers.

Karyn Skultety, associate director for education and evaluation at GRECC at VA Palo Alto Health Care System, and former CHP/PCOR trainee **Amar Desai** join the centers as adjunct affiliates.

CHP/PCOR adjunct associate **Hau Liu**, who was previously a trainee at the centers, was appointed to Clinical Assistant Professor (Affiliated) of Medicine.

Alain C. Enthoven is serving as project director for the Committee for Economic Development Health Reform Project. The committee plan to issue their report on October 15, 2007.

WELCOME NEW STAFF

Nancy Lonhart joined CHP/PCOR as the associate director and division manager. She previously worked as administrative services manager for the department of anthropological sciences and as supervisor for hospital outcomes measurement division. She provides administrative and financial oversight, strategic planning, grants/contracts management, and supervises CHP/PCOR staff.

Christina Gathmann joined CHP/PCOR as a postdoctoral fellow with the Stanford Center for Longevity. CHP/PCOR core faculty member **Jay Bhattacharya** is her primary mentor. Christina is studying the mortality crisis in Russia. She earned her PhD in economics at the University of Chicago in December of 2004. She was a postdoctoral fellow in the department of economics at Stanford and a visiting scholar at the Stanford Institute for International Development from 2004 to 2006. In 2006–2007, she held a W. Glenn Campbell and Rita Ricardo-Campbell national fellowship and the Britton fellowship at the Hoover Institution.

Walter Park joined CHP/PCOR as a trainee. Walter was an undergraduate at the School of Foreign Service, Georgetown University and graduated in 1998. He went to medical school at Johns Hopkins, graduating in 2003, and came to Stanford to complete a residency in Internal Medicine. He is currently in his second year of fellowship in the Division of Gastroenterology and Hepatology. Walter is interested in colon cancer screening, and the management of Hepatitis B and C.

Daniella Perlroth joined CHP/PCOR as a trainee in the VA Medical Informatics fellowship program. Daniella has a dual appointment with Infectious Diseases and is currently in her second year of fellowship with them. She received her MD from Stanford University in 2000 and previously worked at McKinsey & Co. as a consultant primarily for health

care companies. Daniella has worked with CHP/PCOR faculty fellow **Michael K. Gould** on evaluation of thrombolysis for submassive pulmonary embolism, and will continue her research in the area of infectious diseases at CHP/PCOR.

Jennifer Schneider joined CHP/PCOR as a VA trainee. Prior to receiving her MD in 2002 from Johns Hopkins, Jennifer conducted research in Malawi, where she examined the role that Vitamin D plays in eliminating mastitis in pregnant HIV-positive women, among other research experiences. She has worked as a hospital-based specialist and worked on faculty development for a new residency program at Kaiser Permanente since 2006. Jennifer is working closely with CHP/PCOR core faculty member **Douglas K. Owens**.

Peter Richmond joined CHP/PCOR as a research assistant who is working with core faculty members **Alan M. Garber**, **Jay Bhattacharya**, and **Grant Miller**. Peter is currently working on the “Equitable, Efficient, and Sustainable Medicare for the 21st Century” project. Prior to CHP/PCOR, He spent three years as an assistant analyst at the Congressional Budget Office where he gained experience working on a wide range of health policy issues. He earned a bachelor’s in economics and international studies from UNC-Chapel Hill.

Kristin Cox joined CHP/PCOR as an administrative associate. Kristin is a recent graduate from the University of California, Santa Barbara, where she majored in communications and law & society. She is working with faculty and carrying out administrative/operational responsibilities at the centers.

Grace Yeh joined the VISN Collaborative for Improving Hypertension Management with ATHENA-HTN—led by CHP/PCOR core faculty member **Mary K. Goldstein**—as a project coordinator. Grace received her master’s in public health from University of California, Berkeley, and her bachelor’s in psychology from University of California, Davis. Grace is located at the Geriatric Research, Education and Clinical Center (GRECC) at Veterans Affairs Palo Alto Health Care System.

Terri Huh joined the VA Palo Alto Geriatrics Research Education and Clinical Center (GRECC) team as a trainee in the Special Fellowship Program in Advanced Geriatrics (SFPAG). Terri received her PhD from the University of Massachusetts, Boston. She is working with CHP/PCOR core faculty member **Mary K. Goldstein**, and CHP/PCOR adjunct affiliate **Karyn Skultety**, PhD, and **Ruth O’Hara**, PhD assistant professor of research in department of psychiatry and behavioral sciences.

Cherisse Harden joined the VA Health Economics Resource Center team, where she will be assisting researchers with various tasks. Cherisse earned a bachelor’s in psychology and a minor in statistics from California State University, East Bay (CSUEB). At CSUEB, she gained research experience by assisting professors with projects in social and cognitive psychology. §

Health Governance, continued from page 8

The students who have worked on the project this past summer are Jennifer Brown, Jessica Herda, Evan McDonald, and Fatima Hassan. They worked on building two to three data sets for each DHS wave in each county for 75 countries—roughly 150 to 225 data sets total.

This intensive work was offset by weekly readings and seminars related to the project, each of which was led by a member of the Health and Governance project team, which includes CHP/PCOR executive director **Kathryn M.**

McDonald, core faculty members **Paul H. Wise** and **Grant Miller**, assistant professor of political science **Jeremy Weinstein**, and assistant professor of political science at Duke University, **Alberto Diaz-Cayeros**. CHP/PCOR research assistant **Nicole Miller** and CHP/PCOR project manager **Moira McKinnon** coordinate the project, and programmer **Olga Saynina** is now analyzing the data for answers to questions. §

This summary was provided by CADMA and CDEHA project manager **Moira McKinnon**.

Pay for Performance, continued from page 9

dialysis itself yet fund other therapies that are used in dialysis can have the perverse effects of limiting care for the sickest, most vulnerable patients and promoting overuse of services or drugs for which compensation is higher.... Well-designed payment systems will reward quality while maintaining appropriate accountability and fairness for providers.” §

Amar A. Desai is a CHP/PCOR adjunct associate and a former trainee. His research interests include quality measurement and improvement, chronic disease management, and the experiences of underserved communities.

SUMMER PRESENTATIONS

RUTH C. CRONKITE

CHP/PCOR associate

“2007 National Library of Medicine Informatics Training Conference”
Participant in conference held at Stanford University, June 26–27, 2007.

JOHN W. FINNEY

CHP/PCOR associate

“Regression to the Mean in Substance Use Disorder Treatment Research”
Presented at the Third Annual Pre-conference Workshop: The Search for Mechanisms of Change in Evidence-Based Behavioral Treatments for the Research Society on Alcoholism Meeting in Chicago, IL, July 10, 2007.

MARY K. GOLDSTEIN

CHP/PCOR core faculty member

“A Quality Improvement Implementation Research Project from Initial Idea to Multiple Sites: ATHENA-Hypertension Project”

Presented at the Stanford University Division of General Internal Medicine Projects in Progress Meeting at Stanford, July 16, 2007.

“History of Geriatrics”

Presented at the Geriatrics Research Education and Clinical Center (GRECC) for the VA Palo Alto Health Care System in Palo Alto, CA, August 21, 2007.

“2007 National Library of Medicine Informatics Training Conference”
Participant in conference held at Stanford University, June 26–27, 2007.

GRANT MILLER

CHP/PCOR core faculty member

“Time Vs. Money in Child Health Production: The Case of Coffee Price Fluctuations and Child Survival in Colombia”

Presented at the Cornell Conference on Infectious Diseases and the Social Sciences in Ithaca, NY, September 8, 2007. Also presented at the Yale Department of Economics on September 24, 2007.

KATHRYN M. MCDONALD

CHP/PCOR executive director

“Executive Summary AHRQ Evidence Report on Care Coordination”

Presented at the American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine Transitions of Care Consensus Conference in Philadelphia, PA, July 11–12, 2007.

RUDOLF H. MOOS

CHP/PCOR associate

“Active Ingredients of Effective Treatment and Self-Help Groups”

Dan Anderson award address presented at the National Association of Addiction Treatment Providers in San Diego, CA, May 2007.

“Creating the Environmental Context for Sustained Alcohol and Drug Recovery”

Presented at the American Psychological Association Annual Convention in San Francisco, CA, August 2007.

DOUGLAS K. OWENS

CHP/PCOR core faculty member

“Biodefense”

Presented at the Annual Continuing Medical Education Symposium at the Stanford University Medical Center Alumni Association at Stanford, May 5, 2007.

“Grading Strength of Evidence for a Body of Literature”

Presented at the Evidence-based Practice Centers Methods Meeting for the Agency for Healthcare Research and Quality in Gaithersburg, MD, June 15, 2007.

SARA J. SINGER

CHP/PCOR senior research scholar

“Relationship of Safety Climate and Safety Performance in Hospitals”

Presented at the Academy of Management Annual Meeting in Philadelphia, PA, August 6, 2007.

GRACE YEH

ATHENA-HTN project coordinator

“Clinician reasons for not intensifying therapy identified using point-of-care feedback to decision support”

Presented poster at conference held at Stanford University, June 26–27, 2007. §

GRANTS AWARDED

“Women’s Empowerment and Child Survival in the Historical United States”

Funding: National Institute of Child Health & Human Development
Principal Investigator: **Grant Miller**
Project Period: June 1, 2007 to June 30, 2009

“The Causes and Behavioral Foundations of Mortality Decline in Developing Countries”
Funding: National Institutes of Health
Principal Investigator: **Grant Miller**
Project Period: June 1, 2007 to May 31, 2011

“External Costs of Obesity”

Funding: National Institutes of Health
Principal Investigator: **Jay Bhattacharya**
Project Period: July 1, 2007 to June 30, 2009

“Longitudinal Assessment of Manic Symptoms”

Funding: Case Western Reserve University
Principal Investigator: **Sarah Horwitz**
Project Period: July 1, 2007 to June 30, 2008

“Collaborative Model Addressing Mental Health in the Perinatal Period”

Funding: Child & Adolescent Services Research Center
Principal Investigator: **Sarah Horwitz**
Project Period: July 1, 2007 to June 30, 2013

“Identification/Detection of Maternal Depression in Primary Care Pediatrics”

Funding: Annie E. Casey Foundation
Principal Investigator: **Sarah Horwitz**
Project Period: July 1, 2007 to February 28, 2008

“Making Better Decisions: Policy Modeling for AIDS and Drug Abuse”
Funding: National Institute on Drug Abuse

Principal Investigator: **Douglas K. Owens**
Project Period: July 15, 2007 to June 30, 2012 §

Patient Safety Consortium Sixth Annual Meeting a Success

Hospital errors have received greater media attention since the Institute of Medicine's landmark 2000 report *To Err is Human*. Since 2001, the CHP/PCOR Patient Safety Research Group has been working with a consortium of over 150 hospitals to study patient safety and design and implement interventions to improve it.

At the Patient Safety Consortium's sixth annual meeting in July, CHP/PCOR researchers and consortium hospitals convened at Stanford University for a 2-day conference.

"We had several objectives for the meeting," said **Alyson Falwell**, CHP/PCOR project manager for the project "Improving Safety Culture and Outcomes in Healthcare."

She explained, "The first was to provide an update on our research project, in which the consortium hospitals have all been participating. Our second objective was to update them on important national programs in patient safety from organizations like the Joint Commission and the Institute for Safe Medication Practices. The third was to showcase exemplary hospital initiatives, which other participants could adopt. Finally, our fourth objective was to provide an opportunity for hospitals to network and form relationships with one another."

The group works with organizations such as the Joint Commission and the Institute for Healthcare Improvement, as well as faculty at the Harvard Business School and consultants from Convergence Consulting and the University of Utah on projects that examine safety culture and outcomes in health care.

As part of its current project, which ends in 2008, the group is investigating safety

culture in hospitals, and designing and evaluating an intervention to improve communication between senior managers and front-line staff.

This year's meeting featured talks on topics such as using simulation for learning to improve patient safety and leveraging front-line nurses to improve medication safety, among other issues.

"The meeting was very well received. Falwell explained. "What was special about this year's meeting was that we were able to discuss how hospitals might include patients and families in their safety improvement efforts. We had a speaker whose husband died as a result of a medical error. She helped to form a Family and Community Advisory Council at her hospital and talked about all the good work and positive changes that came out of this tragedy."

Since many of the hospitals that participate in the group's research and evaluation are not located near Stanford,

Falwell noted the value of the conference in bringing everyone together to discuss initiatives that improve patient safety.

"Since we work with these hospitals remotely, we see their data, and we hear about their successes and their failures. It's really nice to see them in person and hear their stories of how this project has helped them," Falwell said. "Most rewarding is that hospital safety officers have been able to use their safety culture survey results from our project as leverage to get a lot of things accomplished."

The group has several other projects on which they are working on, including a project that uses simulation to improve safety culture, and one to study safety culture and outcomes in the VA.

They are hoping to begin two new projects this winter. The first will enable investigators to work with hospitals to improve Rapid Response Teams and examine the impact on safety culture and other outcomes. The other will use simulation as a tool to improve senior managers' communication and teamwork skills. §

Publications, continued from page 12

A clinical practice guideline from the American Academy of Family Physicians and the American College of Physicians. *Annals of Family Medicine* 5 (2007):57-62. Also published in the *Annals of Internal Medicine* 146 (2007):454-458.

Rigby A, Ma J, **Stafford RS**. Women's awareness and knowledge of hormone therapy after the Women's Health Initiative. *Menopause* (April 10, 2007):EPub.

Shapiro L, Lee M, **Lee JF**, Lapasaran A, Fearon W, Kamal A, Ahmed A. The pre-operative utility of dobutamine stress echocardiography in patients undergoing liver transplantation. *The American Journal of Gastroenterology* 102, Issue S2 (September 2007):S240-241.

Singer SJ, Edmondson AC. When learning and performance are at odds: Confronting the tension. In *Learning and Performance*, Ramsey P and Kumar P (Eds.), 2007 (also available as HBS Working Paper No. 07-032).

Snow V, Qaseem A, Barry P, Hornbake ER, Rodnick JE, Tobolic T, Ireland B, Segal JB, Weiss KB, Green L, **Owens DK**. Management of venous thromboembolism: A clinical practice guideline from the American College of Physicians and the American Academy of Family Physicians. *Annals of Family Medicine* 5 (2007):74-80. Also published in the *Annals of Internal Medicine* 146 (2007):511-515.

Stafford RS, Berra K. Critical factors in case-management: Practical lessons from a cardiac case-management program. *Disease Management* 10 (2007):197-207.

Waechter A, Williams J, **Lee JF**, Shapiro L, Lee M, Kamal A, Keeffe E, Ahmed A. Sustained virological response to interferon-based antiviral therapy by viral genotype in recurrent Hepatitis C patients following liver transplantation. *The American Journal of Gastroenterology* 102, Issue S2 (September 2007):S437-438. §

RESEARCH IN PROGRESS SEMINARS

Free and open to the public, the seminars are interactive forums at which attendees may ask questions and offer input on the research being discussed.



CHP/PCOR hosts this weekly event series, at which the Centers' faculty, affiliates, and invited guests discuss their research on a relevant health policy or health services research topic.

Past Research in Progress Seminars have featured topics like the health care costs of obesity, the effects of insurance mandates on infertility treatments and outcomes, case studies of multi-drug-resistant tuberculosis, universal healthcare vouchers to pay for medical care, creating a culture of safety in U.S. hospitals, and family planning.

The fall quarter seminars will be held at 117 Encina Commons, in the first floor conference room on Wednesdays, 1:30 pm – 3:00 pm, unless otherwise noted.

Please visit the event series webpage for the most up-to-date session information.

FALL 2007 SESSIONS

September 26, 2007

"Kan Bing Nan, Kan Bing Gui": China's Healthcare System Reforms, 1980–2007
Karen Eggleston, PhD, CHP/PCOR & APARC Fellow

October 3, 2007

Do You Get What You Pay For? The Relationship Between Premiums and Benefits in Medicare Prescription Drug Plans
Kosali Simon, PhD, Cornell University

October 10, 2007

Developing and Writing Grant Applications
Alan M. Garber, MD, PhD, CHP/PCOR Director, Core Faculty

October 17, 2007

Children with Special Health Care Needs and the Disproportionate Share Hospital System in California, 1998–2004
David Krodel, Stanford University

October 24, 2007

Effects of Soft Budget Constraints and Continuity of Hospital Safety Net Services
Yu-Chu Shen, PhD, Naval Postgraduate School
Karen Eggleston, PhD, CHP/PCOR & APARC Fellow

October 31, 2007

To Be Announced
M. Kate Bundorf, MBA, MPH, PhD, CHP/PCOR Faculty Fellow
Helena Szrek, University of Pennsylvania

November 7, 2007

To Be Announced
Ciaran S. Phibbs, PhD, CHP/PCOR Associate

November 14, 2007

To Be Announced
Katherine E. Herz, MD, CHP/PCOR Trainee

November 28, 2007

To Be Announced
Paul H. Wise, MD, MPH, CHP/PCOR Core Faculty

December 5, 2007

To Be Announced
Ram Duriseti, Doctoral Candidate in Decision & Risk Analysis, Stanford University §

SUMMER 2007 SESSIONS

July 1, 2007

A Multilevel Approach to Explain Variation in Costs and Quality for Treatment After AMI Among Hospitals of the U.S. Veteran Health Administration and Germany
Jonas Schreyögg, CHP/PCOR Visiting Scholar

July 17, 2007

Wages and Weight in Europe: Evidence Using IV Quantile Treatment Effect Model
Noemi Pace, CHP/PCOR Visiting Scholar

July 18, 2007

Developing World Drug Access: A New Approach
John H. Barton, CHP/PCOR Associate

the CENTER FOR HEALTH POLICY and CENTER FOR PRIMARY CARE AND OUTCOMES RESEARCH

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

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

ABOUT