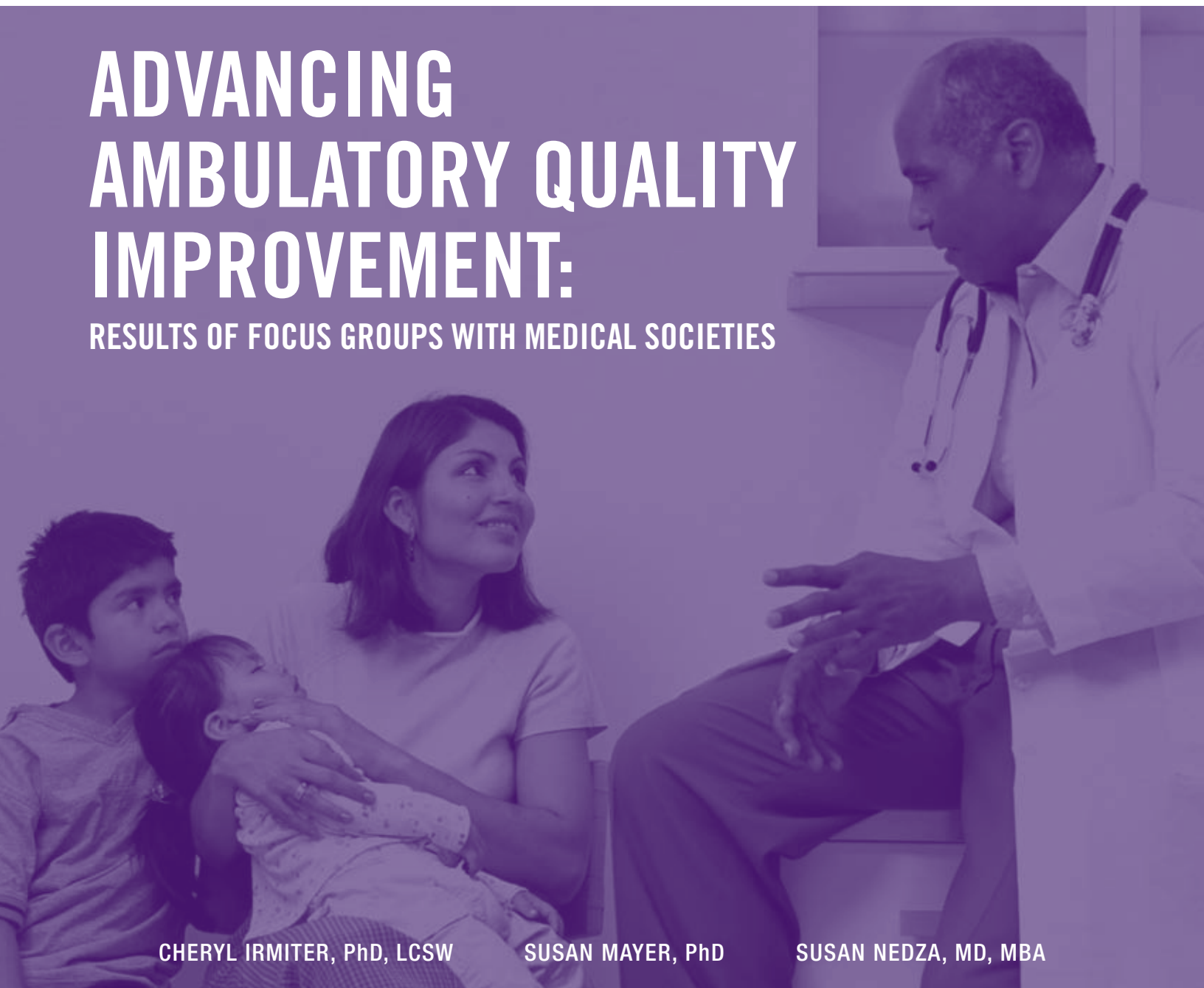


ADVANCING AMBULATORY QUALITY IMPROVEMENT:

RESULTS OF FOCUS GROUPS WITH MEDICAL SOCIETIES



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Introduction

This study sought to answer the question of how medical societies can build upon their success and expertise to support physicians, with the goal of advancing quality improvement collaboratives in the ambulatory care setting. In the current health care environment, physicians struggle to communicate with their peers about patient care and about “best practices” to improve the quality of care they are striving to deliver. Increased concern also exists about the number of primary care physicians available to serve the United States population¹; physicians must consider how this affects the quality of care in the ambulatory setting, where most patient care is delivered.²

At the present time, multiple initiatives are being undertaken within the ambulatory health care setting to improve quality of care. Three issues that directly affect physicians in this setting and that subsequently may affect the quality of care are: 1) physician isolation from their peers; 2) the local practice context; and 3) the role of professional organizations in supporting physicians. As a leading professional organization, the American Medical Association (AMA) is working with state and county medical societies to assist physicians at the local level to help them collaborate with their peers to improve and sustain quality of care.

A. Physician Isolation

Physician members at the ambulatory setting identify how isolation and lack of peer support are a consequence of the current fragmented care delivery models.^{3,4,5} The results of this study/environmental scan highlight organized medicine’s perspective of what physicians want and need to engage and sustain ambulatory care quality improvement.

One of the great accomplishments of modern medicine is that the health care provided to individual patients has led to their experiencing a better quality of life for longer periods of time. While physicians have the skills and resources to help people delay morbidity/mortality, especially those with

chronic illnesses, it is often a challenge to do so in our current health care system. For example, with 20 percent of Medicare beneficiaries having five or more chronic conditions, accounting for over two-thirds of Medicare spending, seeing 14 different physicians and having 40 office visits/year, the chances for hospitalizations—for conditions that can and should be managed effectively on an outpatient basis—increase from 13 percent for a beneficiary with five conditions to about 27 percent for a person with eight chronic conditions.^{6,7} The search for methods and empirical evidence to improve the care and decrease unnecessary risks for these patients continues.

Quality collaboratives and initiatives in the hospital care setting have been widely implemented. The hospital setting provides structural support (collaboration) and preceptor (educational) opportunities, which are not available, for the most part, in the ambulatory care setting. Traditionally, the hospital-based “doctor’s lounge” was an effective milieu for discussing clinical care, considering best practices, building relationships, and strengthening shared commitments to meeting challenges in medical practice or in the community. But with the growth of hospitalist programs over the past decade and a half, many primary care physicians no longer visit the hospital or engage in similar informal learning experiences. In addition, the expansion of outpatient settings means that many specialists provide most, if not all, of their services outside of the hospital setting. As a result, physicians who primarily are involved with ambulatory care have fewer opportunities to work collaboratively, benefit from the advice and support of peers, and join together to advance the cause of quality health care.

As the emphasis increasingly shifts to community health, prevention, and the management of chronic disease, the challenge is to develop sustainable quality improvement collaboratives in the ambulatory setting in which the atmosphere, knowledge, and free exchange of best practices can be brought back, thus lessening physician isolation. Physician leadership and participation will be critical if these efforts are to succeed and effectively address quality of care.

1 Institute of Medicine (2008). *Retooling for an Aging America: Building the Health Care Workforce*. The National Academies Press, Washington, DC.

2 Irmiter, CA, Ko, EJ, Shah J (2009). *Diversifying Practice Due to the Next Generation*. Manuscript in revision. Manuscript submitted for publication.

3 Wright, DB (2009). *Care in the Country: A Historical Case Study of Long-term Sustainability in 4 Rural Health Centers*.

4 Jackson-Bowers, E and Holmwood, C. (2008). *General Practitioners’ peer support needs in managing consumer’s mental health problems*. Primary Mental Health Care Australian Resource Centre, Available at: <http://som/flinders.edu.au/FUSA/PARC/Publications.htm>. Accessed 2/2010

5 Goderis, G, Borgermans, L, Mathieu, C, Van Den Broeke, C, Hannes, K., Heyrman, J., Grol, R. (2009). *Barriers and facilitators to evidence based care of type 2 diabetes patients: Experiences of general practitioners participating to a quality improvement program*. *Implementation Science*. 4-41

6 U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions National Center for Health Workforce Analysis. *Estimated % of physician time spent providing care, by age of patient*. 2003

7 Berenson R. *The Medicare chronic care improvement program*. Urban Institute, Washington, DC: 2004. Available from: <http://www.urban.org/publications/900714.html>. accessed 2/2010

B. Local Practice Context

A major factor that impinges on the physician’s ability to provide quality of care is health care funding and the availability of physicians in the community to provide health care. Understanding the local practice context, insurance coverage use, and physician availability within the states is important because access and cost of health care are affected by payer mix and physician availability.

Insurance Coverage

Patients’ ability to access and pay for health care influences

whether or not they will seek care and can impact the quality of care that they receive. Physicians understand that their partnership with patients to provide quality care will be affected if patients cannot afford that quality of care. Even among insured patients, those holding individual policies purchased directly from insurers—as opposed to employer-provided group coverage—may have high deductibles or limited coverage. Table 1 shows the percentages of insured and uninsured patients, and the type of coverage held by those who have insurance, for each of the 13 states with Aligning Forces for Quality (AF4Q) initiatives and, for comparison, the rates for the United States as a whole.

Table 1. Health Insurance Coverage by State - 2008⁸

	Percent: Uninsured	Percent Insured	Private: Employment Based	Private: Direct Purchase	Government- provided Insurance
CA	18.6%	81.4%	53.8%	9.2%	28.0%
ME	10.4%	89.6%	57.9%	11.2%	37.9%
MI	11.7%	88.3%	64.9%	7.4%	29.0%
MN	8.7%	91.3%	64.2%	13.6%	27.1%
MO	12.6%	87.4%	59.1%	10.8%	30.5%
NM	23.7%	76.3%	46.6%	7.5%	33.0%
NY	14.1%	85.9%	58.7%	6.5%	32.0%
OH	11.5%	88.5%	63.9%	8.7%	28.5%
OR	16.3%	83.7%	59.4%	12.5%	26.4%
PA	9.9%	90.1%	63.2%	10.8%	29.5%
TN	15.1%	84.9%	52.8%	8.0%	35.1%
WA	12.4%	87.6%	60.5%	9.9%	30.4%
WI	9.6%	90.4%	63.8%	11.4%	29.3%
US	15.4%	84.6%	58.5%	8.9%	29.0%

Note: The sum of the percentages in columns for employment-based, direct purchase, and government-provided insurance equals more than the total percent insured because some individuals have more than one type of insurance; i.e., an older person may have Medicare plus a private supplemental plan.

Insurance coverage among the AF4Q states varies, as both Table 1 and discussion with focus group participants suggest. Maine has the lowest proportion of uninsured residents, just under 9 percent. In contrast, nearly one-quarter of New Mexico residents lack insurance. Although a comparatively high proportion of individuals have government health insurance (Medicare, Medicaid, and plans for veterans and members of the military), fewer than half of New Mexico’s

residents have health insurance through their employers. Tennessee’s overall percentages of insured and uninsured residents are close to those of the nation as a whole, but the proportion of Tennesseans with employer-provided insurance is low. The gap is made up by a comparatively large proportion of Tennessee residents with government health insurance, although Maine residents are even more likely to have public insurance.

⁸ Source: US Census Bureau, “Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008,” Current Population Survey 2009 Annual Social and Economic Supplement, http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm

Table 2. HMO Penetration by State⁹

CA	ME	MI	MN	MO	NM	NY
42.9%	9.4%	27.7%	21.3%	13.2%	26.6%	27.7%
OH	OR	PA	TN	WA	WI	US
17.9%	27.1%	28.0%	25.5%	18.6%	24.8%	21.4%

Table 2 shows the percentage of state residents covered by a health maintenance organization (HMO) for the states participating in AF4Q and, for comparison, for the United States as a whole. More than a four-fold difference exists between the state with the lowest HMO penetration—Maine, at 9.4 percent—versus California, where more than four in ten residents are enrolled in an HMO. The median proportion among the 13 AF4Q states is 25.5 percent (Tennessee), more than four points higher than the average for the United States as a whole. As managed care organizations, HMOs have led the way in identifying measures, collecting data, and implementing health information technology (HIT); they may also have more robust claims data than do other payers.

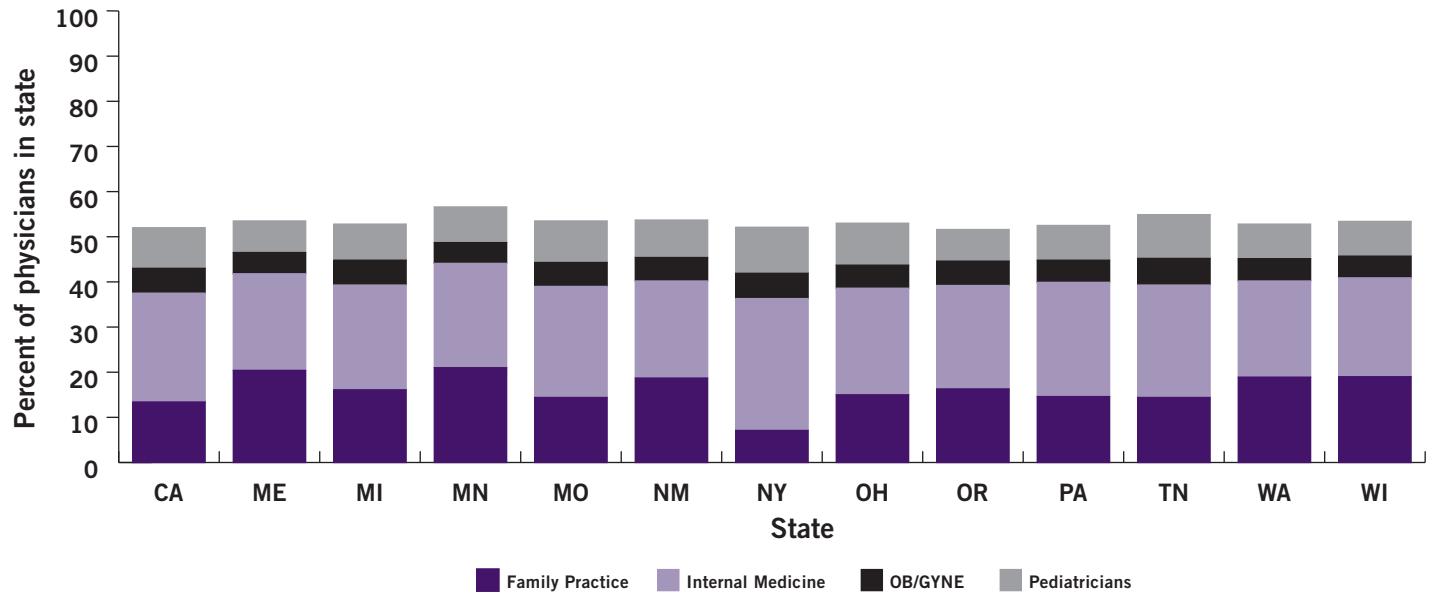
Physician Distribution

The Institute of Medicine has reported on the concerns about having enough physicians to care for the U.S. population, especially our aging population. Another concern regarding

physicians are the concerns about the distribution of physicians across the county, which has implications for the type and success of ambulatory care quality initiatives. Figure 1 provides a snapshot of community physician availability, broken out by four specialties: family practice, internal medicine, pediatrics, and obstetrics and gynecology.¹⁰ These physicians comprise over half of all physicians in each state, with family practice and internal medicine physicians most numerous and together representing approximately 40 percent of all physicians in each state. However, the variation among states is greater in the proportion of family practitioners than it is among any of the other three practice areas. New York has the smallest proportion of family practitioners at 7.1 percent, while Minnesota has the largest at 21 percent—nearly a three-fold difference.

Internists comprise just over 21 percent of physicians in Maine, New Mexico, Tennessee and Wisconsin. New York’s proportion of internists (29.2%) is the largest among the AF4Q states. The percentage of pediatricians ranges from a low of 7 percent in Maine and Oregon, to a high of 10.2 percent in New York. Tennessee has the second-largest proportion of pediatricians (9.7%); Ohio and Missouri come next with 9.3 and 9.2 percent, respectively. Tennessee has the largest proportion of obstetrician/gynecologists (5.9%) compared with other AF4Q states; Maine, at 4.7 percent has the smallest.

Figure 1. Physician Distribution by State and Specialty



Source: American Medical Association

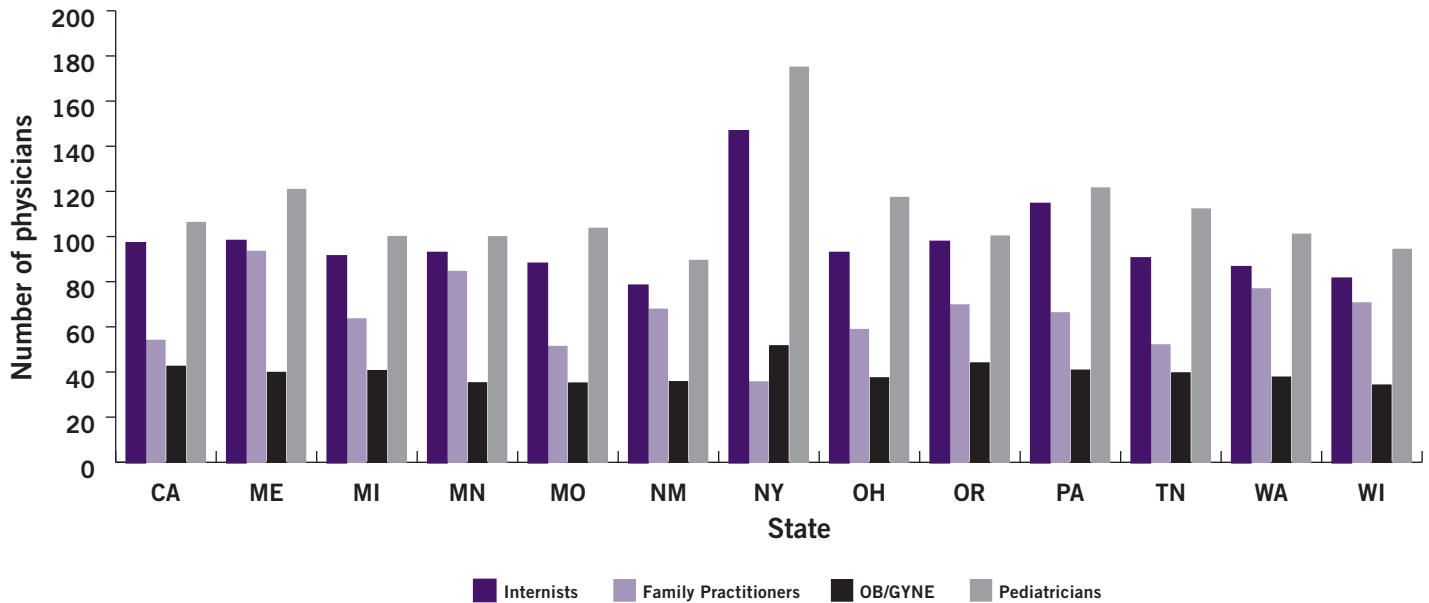
Note: The physician totals include all licensed physicians in the state, excluding medical students and residents. Figures are for 2009.

⁹ Source: Kaiser Family Foundation State Health Facts, <http://statehealthfacts.org/index.jsp>.

¹⁰ American Medical Association. Customer Relation Management System. Obtained December, 2009.

Figure 2 shows the number of physicians in each specialty per 100,000 of the state residents who may be expected to comprise that specialty's target population. Using 2008 U.S. Census estimates, we calculated the number of internists and family practitioners per 100,000 adult residents (i.e., aged 18 years and over), the number of obstetricians/gynecologists per 100,000 female residents aged 16 years and over, and the number of pediatricians per 100,000 children under 18 years of age.

Figure 2. Physicians per 100,000 residents by state and specialty



Sources: Physician data from the American Medical Association. Census data: Annual Estimates of the Resident Population by Sex and Age; U.S. Census Bureau, Population Division; release date 14 May 2009.

New York has the greatest variation among physicians per 100,000 residents across specialties: The state has the highest proportions of internists and pediatricians, but the lowest of family practitioners and obstetricians/gynecologists of all the AF4Q states. New Mexico has the smallest proportions of internists and pediatricians, and Wisconsin has the second lowest proportion of physicians in these specialties.

The median number (across the 13 AF4Q states) of physicians per 100,000 residents is 92.7, 66.2, 39.6 and 103.6 for internal medicine, family practice, obstetrics/gynecology, and pediatrics, respectively. Only Pennsylvania and Maine have physician/population ratios at or above the median in all four specialties. New York and California have above average proportions of physicians in every specialty except family practitioners. Five states have below-median proportions of physicians in all but one specialty: Missouri has an average proportion of pediatricians, relative to its population of children, but below average proportions of physicians in the other three specialties. New Mexico, Washington, and Wisconsin have above average proportions of family practitioners, but lag other AF4Q states in the availability of physicians in the other three specialties. Similarly, Michigan has a comparatively large number of obstetricians/gynecologists relative to its population of females aged 16 years and

over, but lags the other 12 states in the availability of internists, family practitioners and pediatricians.

C. Structure of the AMA

One strategy for engaging physicians is through membership in a professional organization. The mission of the AMA is to promote the art and science of medicine and the betterment of public health. It accomplishes this mission by bringing physicians together to work on the most important professional and public health issues of the day.

The AMA Board of Trustees guides the organization in implementing the policies in partnership with its professional staff in diverse medical practice, medical education, science, public health, ethics, and quality improvement initiatives. The AMA House of Delegates is the Association's principal policy-making body and is comprised of 500 delegates that represent 169 organizations including state medical societies and specialty societies. These affiliated state medical societies and national physician specialty societies are apportioned delegates based on the number of AMA members within their respective associations. The House of Delegates meets twice annually.

D. Medical Society Structure

Medical societies affiliated with the AMA are membership organizations and can be defined by both their members and their governance models. In the majority of cases, membership is defined at the individual level, but models exist to foster the participation of group practices. In addition, membership can be defined by type of practice (hospital-based, academic or independent) or stage of career (medical student, resident, practicing, or retired.) It is important to recognize that in many cases physicians will fit into multiple categories simultaneously, thus reflecting the reality of physician experience.

Medical societies are inherently grassroots organizations that are organized locally (county, regional). The governance structure of state professional organizations provides an opportunity for these independent local organizations to define a shared agenda and implement efforts related to their shared mission at the local level.

E. Advancing Ambulatory Quality Improvement

This environmental scan of medical societies was undertaken to assess more specifically the current and future roles that medical societies can play in advancing quality initiatives and how AMA can help them. The AMA worked with state and local medical societies in several communities participating in the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative, to explore the roles of medical societies in multi-stakeholder initiatives in ambulatory care quality improvement. Aligning Forces is the Foundation's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform. The questions that guided the investigators' inquiry are:

- How are professional medical organizations supporting physicians in adopting quality initiatives? Specifically, what quality-related activities have these organizations undertaken in the areas of health information technology (HIT), education, and collaboration?
- What are the challenges they see in forwarding the quality agenda?
- What lessons have they learned from their efforts thus far?

Following is a brief description of the methods used to evaluate 13 state medical societies, which were joined by county medical societies and quality collaborators; a description of the participants' description of the local practice contexts; a description of what quality improvement is in these communities (defining, supporting, and working on quality); and what roles the participants see for themselves and the AMA.

Methods

This study explored medical societies' roles in sustaining quality improvement. The purpose of this environmental scan was to engage state and county medical societies in focus groups in order to understand the current challenges and opportunities in local communities, determine the involvement of physician leadership in local quality improvement efforts, and identify the infrastructure needed to support physicians, practice managers, and others as they undertake quality improvement efforts. A qualitative methodology was used to gather and analyze the data.

A. Objective

The objective of this study was to complete an environmental scan of medical societies and their current methods assisting ambulatory health care physicians and their staff to support and sustain quality improvement. Attention focused on the following:

- Definition of quality and quality improvement
- Quality improvement efforts
- Collaboration
- Physician and staff leadership
- Health information technology
- Practice management
- Education

The topic areas were determined *a priori* based on the study team's understanding of the medical societies' current and past roles and activities.

B. Sample

The states that were associated with each of the Aligning Forces for Quality (AF4Q) sites were chosen for study based on the recommendation of Robert Wood Johnson Foundation (see Appendix A). In addition, we identified that these states and counties were probably leaders for quality improvement activities, because they were involved in the AF4Q project. All state medical societies (N=13) agreed to participate, and the states determined the involvement of the counties, except for the Academy of Medicine of Cleveland and the Northern Ohio (AMCNO). AMCNO was the only local medical society not affiliated with a state medical society and they were

asked to participate because of their involvement with Better Health Greater Cleveland (the AF4Q project in Cleveland). Oregon, Washington, Pennsylvania, and Maine participants were from the state level only.

Each medical society was asked to determine the best location (state or county headquarters) to gather a representative group of physicians and leaders who could describe the needs of local physicians in ambulatory care and the role of quality improvement projects to assist them. In some cases, organizations and groups collaborating on quality initiatives were invited by the society to participate. Those participants also were able to present the physician's perspective on ambulatory care quality and safety.

Because of the hierarchical relationship between the AMA and the state and county medical societies, the medical societies affiliated with the AMA turn to the AMA as the "parent company," while the state medical societies have a parental relationship with the county medical societies. To ensure participant engagement and open expression of opinions, we assured the medical society participants' affiliated with the AMA and AMCNO anonymity in regard to their participation. The study protocol was approved by the Institutional Review Board (IRB) of the University of Illinois, Chicago, the AMA's contracted IRB.

C. Procedure

To engage county and state medical society executives, the study team took multiple steps. They include:

- 1st Sent emails and letters introducing the project objective and team to state and county medical societies.
- 2nd Scheduled short telephone conversations (15 to 30 minutes) with each state and county medical society to answer any questions about the project.
- 3rd Scheduled two webinars (each medical society chose one) to review the objective and process, and field questions regarding the study.
- 4th Sent focus group guides prior to the meetings for each site to prepare for the focus group visit (see Appendix B).
- 5th Arranged focus group site visits.
- 6th Conducted focus groups that lasted 2 to 3 hours.

D. Site Visits

Because of the hierarchical relationship between the state and county medical societies affiliated with the AMA, the team made initial contact with the state medical societies in each of the states in which AF4Q programs were established. It was at the state society's discretion if and which county societies should be contacted to participate in our inquiry. The one exception to the hierarchical discretion was the Academy of Medicine of Cleveland and the Northern Ohio. They are not related to the state medical society or AMA; however, the medical society is involved with Better Health Greater Cleveland (the AF4Q project in Cleveland), and was invited to participate.

As noted above, focus group sessions were 2 to 3 hours long. They were held at various times of the day, depending on the medical society and its participants. The host site provided in-kind refreshments and food for the participants. Participants included a minimum of at least one physician and medical society staff member. Focus group size ranged from 2 to 18. The majority had 4 or more participants. As stated above, to ensure confidentiality no names or positions were recorded or transcribed. Meetings were audio taped with consent from all participants, then transcribed for analysis. Both directors of the project led the focus groups. Each director has expertise in gathering information on the topic of quality and patient safety (Dr. Nedza) and running focus groups and having knowledge about ambulatory care (Dr. Irmiter). This allowed us to use our time gathering as much information as possible in a rigorous manner.

E. Data Analysis

Our method of analyzing the data was based on Boyatzis' thematic analysis for a data-driven approach.¹¹ Information from the focus groups, focus guide responses, and hard copy materials was triangulated to present the findings of this study. Initially, the research team (a non-AMA employee and Dr. Irmiter) identified key domains, as each member of the analysis team reviewed transcripts from the focus groups. Independence of judgments¹² was used to measure the degree of agreement before reconciliation discussions. The team then met and arrived at a consensus on tentative themes/domains, read additional transcripts, and met again to refine these themes/domains into codes.

A codebook (see Appendix C) was developed by the analysis team based on the research objectives and interview guide. Verbatim transcripts of the focus groups were digitized and entered into a Word document. A subset of three interviews was coded by multiple team members and then shared so that inter-rater reliability could be measured. Inter-rater reliability was high, with 90.8 percent agreement. All interviews were then coded by the study research analyst using Atlas.ti qualitative analysis software. Once coding was complete, the analysis team clustered the sub-themes into domains for the report.

11 Boyatzis RE. *Transforming Qualitative Information*. Thousand Oaks: Sage Publication; 1998.

12 Ibid.

Findings

Findings highlighted the importance of the insurers, physicians, and patients at the local practice level; how organizations define quality improvement; the projects and staff involved with quality improvement; the challenges encountered; and the role of the medical society and the AMA in helping sustain quality improvement. The domain areas included: local practice context, medical societies' role in quality improvement, and medical societies' role and the AMA's role in sustaining quality improvement. From these domains, themes were identified and quotes from participants are shared to emphasize key findings.

A. Local Practice Context

Participants recognized the effect insurance coverage and availability of physicians for patient care in ambulatory settings has on quality of care. While we did focus on the percentages, participants stressed the importance that health care reform can have on quality improvement.

Insurance

Of course, the state picture as described above (Table 1) does not tell the whole story: Regions within the state may vary, as an participant from Humboldt County, CA, remarked: *"That's the other thing: probably our private insurance population is ... only 20 to 30 percent. We got a huge Medicare, MediCal, uninsured population up here."* States with high rates of uninsured or publicly insured residents are concerned about retaining physicians, as a New Mexico participant observed:

Because we lose three out of four medical students and/or residents. It's been consistent over the last ten years.... When you have one of the lowest per capita incomes, one of the highest rated uninsured... I believe if we [had] 97 percent of our population insured rather than having 23 percent uninsured that that would fix a lot of our recruitment and retention issues....

Overall, the nation has experienced a decrease in the number of medical students, which has led to shortages of primary care physicians and specialists. This in turn has a direct impact on the number of physicians available to assume leadership positions and on the amount of time physicians have for non-clinical activities.¹³

13 Yarnall KSH, Østbye T, Krause KM, Pollak KI, Gradison M, Michener JL. Family physicians as team leaders: "time" to share the care. *Prev Chronic Dis.* 2009;6(2). http://www.cdc.gov/pcd/issues/2009/apr/08_0023.htm

Physician Distribution

Participants expressed concerns about having enough physicians to care for the U.S. population, as well as concerns about the distribution of physicians across the county. Physician availability is expected to affect the type and success of ambulatory care quality initiatives. Many participants described areas within their state in which there were *"not enough physicians."* In fact, critical-access hospitals may have only *"one or two specialists"* for urban and rural areas.

B. Ambulatory Quality Improvement and Medical Societies

Recognizing that local level practice varies, the team inquired if the definition of quality varied, and what kind of medical society staffing is available to support quality and quality improvement initiatives. It was clear that the medical societies and collaborators recognize that quality is associated with the care of the patient. Moreover, the medical societies are involved in quality because it is foundational to the physician.

How Medical Societies and Physicians Define Quality Improvement

Working to defining quality in the context of a complex human endeavor quickly gives rise to two conflicting ideas. One is an understanding that intervening in human lives, each with its own unique characteristics, requires a holistic and individualized approach that necessitates informed and nuanced professional judgment. The second idea is that the health care community should define what a good approach consists of so as to devise standardized measures. These measures should be based upon robust practice guidelines to assess how well physicians are doing. The health care community is hardly alone (e.g., automotive industry, education, etc) in its efforts to define, implement, and measure quality in its work. Nor is it alone in wrestling with the tension between standardization and meeting individuals' needs; between complexity and the need for simple, concrete measures; and between focusing on process or on outcomes.

Our focus group participants also must contend with these issues, and their struggles are reflected in their responses to questions asking them to define quality and quality improvement in ambulatory health care. At the most fundamental level, participants sometimes questioned whether we yet have a good definition at all. Although quality is believed to be

recognizable—and more than one participant drew a parallel between quality and pornography (i.e., we know it when we see it) putting a definition into words was difficult for them. A major problem is finding consistent and agreed-upon terminology that captures the range of criteria each participant's experiences suggest are most central to the idea of quality.

[E]verybody's probably read that little book, "Quality: I Know it When I See it," and the problem with that is everybody sees it with their own eyes, so there's a lot of variability.

It seems like our language around quality is still pretty primitive....and sometimes we think we're speaking the same words and have the same interpretation of those words, but it's very different.

Note that participants attributed the lack of a good definition to the lack of consistency among responses to the definitional question. Sometimes, participants look to organizations involved in improving health care quality and simply adopt their definitions. Often, they cited the definitions of state- and local-level quality improvement organizations or collaboratives; payers' definitions were also mentioned. However, the quality definitions most often referenced are the Institute of Medicine's (IOM) six quality domains. In identifying standardized measures, the National Committee for Quality Assurance's (NCQA) HEDIS measures were often cited. Some local groups, such as the Kansas City Quality Improvement Consortium, have formally adopted the HEDIS measures for their activities.

Of course, the scope, specificity, and purpose of the IOM quality domains and the HEDIS measures are quite different. The former are domains that define the components that demonstrate quality of all care; the latter, are a set of highly specific operationalized measures that are used to rate health plans and set reimbursement rates for practitioners. Neither is better than the other, nor do participants make such judgments. The point is that the components of the definition focus group participants wrestle with—general principles of good practice and concrete, measurable criteria—are reflected in the definitions put forth by leading quality improvement organizations. These in turn reflect the nature of the work: translating what practitioners understand at a holistic level as quality patient care into specific measurable standards and guidelines.

Quality and best practices. Participants often invoked the idea of clinical best practices or good patient care when asked for a definition of quality; less often mentioned were non-clinical issues such as cost-effectiveness. Furthermore, most participants place best practices at the nexus of the care the physician provides and what the individual patient needs. One participant stated the definition succinctly as the "right

care for the right patient at the right time." Others echoed similar ideas:

And I think if you had to define quality, you would define it as following what is generally accepted as best practices.

[S]ervice quality is one aspect, and it is about needs and expectations and how you're delivering on those to the individual.

Although there is little disagreement that good practice and quality are linked, determining what constitutes best practice is less clear. Some participants stated explicitly that science-based (or evidence-based) practice standards are part of the quality definition.

And that's based on looking at best practices, establishing gold standards, and then adhering to them.... So, reducing the variability and establishing gold standards.

Others, while not necessarily in disagreement, nonetheless express discomfort with the over-application of the guidelines that may emanate from an evidence-based approach. Patients' needs and situations vary, and "one size does not fit all," said one participant, emphasizing that appropriate care must be individually tailored. Another participant took issue with the idea of best practices resting on standardized care:

When someone says "standards," that's a problem for me because standards is one thing, best practices is another.... Standard of care can only be set at the time, at the place, and under certain circumstances. These are best practices.

In the background of efforts to articulate the definition of quality is the recognition that definitions do not exist in a vacuum. Rather, they establish the framework for setting guidelines, developing measures, and rating physicians' work. In focus group discussions, efforts to define quality and quality improvement quickly move beyond generalities and begin to grapple with explicating best practices criteria and measures.

Formulating standards and measures. Standards and measures, in and of themselves, may not be definitional, but they are currently the operative proxy on which ratings, report cards, and reimbursements are based. Health care quality measures have real-world implications for the practice and business of medicine, and professionals involved with quality improvement understand them as a way to begin discussions on quality.

But when you ask, "What's quality?" I haven't the slightest idea. Can I define it? Absolutely not. But I think that right now, the best representative or phantom we have representing that are sort of the established measures...they don't really define quality, but they're sort of the first step to having a common ground to discuss it for the time being.

A pragmatic acceptance of the need to formulate quality standards and measures does not, however, resolve two central questions: 1) whether to measure processes or outcomes, and 2) if it is appropriate to apply universal care standards to assess the quality of care delivered to individuals. No other aspects of defining quality generated as much focus group discussion as these two questions. As a result, the discussion of quality moved from standards to guidelines for quality of care.

Process vs. outcomes. Process measures capture what physicians do, whether they have followed specific standards of care or benchmarks. One participant stated plainly that “quality is a measure of health care delivery and not a clinical outcome necessarily.” Another participant explicitly linked process with the practice of medicine (by contrast, relegating outcomes to the “business of health care”) and argued that just getting the right outcome does not necessarily indicate the presence of good practice and sound clinical judgment.

The process is “Should we do it?” not “Can we do it?” And that’s why you send someone to a specialist—to determine whether or not it’s appropriate to do that surgery. Some people practice health care and just do the procedure because you sent them for that procedure, and they may get the right outcome. But as an example ... you send someone to me for a headache, and I get rid of it with a cervical epidural, you would say I was great, but two aspirin might’ve worked just as well.

However, process measures present their own set of problems. One problem is that links have not been established between the full range of processes and their presumed outcomes, which may cast doubt on how well at least some process measures capture quality. Some process standards’ impact on outcomes may be well established; others less so. One participant contended that process measures like mammogram or pap test rates are “crude” indicators that reveal little about the quality of care, and that insisting on their application regardless of the individual patient’s needs is contrary to best practice. Often, participants simply regard outcomes as the central criterion in health care quality.

But isn’t that the bottom line? It’s outcomes. How does the patient end up? ... If they come out with a great outcome, we presume that’s good quality. On the other hand, if they have a less-than-optimal outcome, we presume that that wasn’t great.

Well, I think we have to look at outcomes of care, and defining outcomes is a hard thing to do in terms of a measurement. We know that if your [patients with diabetes] are under better control, hopefully they’ll have fewer amputations and fewer MRIs and things like that. But it’s a little harder to define with any objective measure.

Outcome measures were regarded by participants, even those who emphasize their importance, as difficult to formulate and even more difficult to apply. The main area of concern was that outcome measures often are influenced by factors beyond the physician’s control such as patient compliance or poverty or co-morbid conditions.

If I go to a healthy population as a health care provider and do nothing, then my measures show that I do good quality. If I go to a needy population and work and do miraculous things, until I can push that population up to the healthy population, I’m not doing a very good job.

Moreover, some fear that focusing on outcomes may result in doctors not wanting to treat patients who are deemed likely to have poorer outcomes, such as those who are obese, noncompliant, or too poor to follow up with recommended care. Finally, one participant questioned whether good patient outcomes can be achieved solely by a focus on the type of measures upon which we typically rely.

And the person who is not at the right target for glycosylated hemoglobin but can’t afford to eat, trying to say, “Well, we have to add meds” is not the right thing to do. We have to figure out other ways to help them reach their numbers and not be so harsh that we say, “You’re a bad person because we can’t get you to quality.” That’s why I’m saying quality is, from a primary care perspective, yes we have targets. At the same time, they have to be interpreted on a very relationship-longitudinal basis. Does that make sense?

Applying universal standards to caring for individuals.

The above statement again highlights the tension between universality and providing health care to individuals. Participants’ concerns about care standards surfaced in the discussion about best practices as well. In regard to standards and measurement, two themes emerge: 1) participants, to varying degrees, accept the value of having standards, although some prefer that these be framed as guidelines that recognize the limits of evidence or the need for appropriate variation from standardized recommendations; and 2) participants expressed deep concern that even what may start out as discretionary guidelines eventually turn into rigidly applied standards that disregard the needs of individual patients.

But guidelines are guidelines, and rules are rules. And what’s happened too many times is that guidelines become a rule. And the rule is very, very constrictive. It’s very onerous. And, unfortunately, medicine is not perfect; each patient is different.

As in the discussion about best practices, participants were concerned that efforts to dictate care according to universal standards will not result in quality improvement. One

participant framed the problem as “applying the concepts of population medicine and evidence-based care at the micro-level of the individual patient.” Other concerns address physicians treating at-risk populations, which can lead to unfair labeling because their patients will not look good on the measures. One participant, who practices mainly with older nursing home residents, stated flatly that although he agreed in general with guidelines for his patient population, they sometimes were “absurd.” Another participant offered this:

You have to be careful how you measure quality because—give you an example: A friend of mine’s a very prominent orthopedic surgeon in town, and he sees all of the complicated cases of joints, and if another [surgeon’s patient] gets a wound infection, they send their patients to this surgeon. Okay? So he takes care of all the disasters in town. Well, he got a call a few years ago from one of the insurance companies here, stating that he was considered a poor quality physician. They were going to nail him on his reimbursements because he had too many wound infections, and he said, “What are you talking about? I’m the guy they send the wound infections[to].”

Disagreements over particulars aside, there is broad agreement on the importance of defining quality improvement in ambulatory care and some preference for a definition that is broadly applicable. The challenges arise primarily with implementing a definition, with the nuts and bolts of formulating standardized quality criteria and measures—and with applying them to the work of treating individual patients. One participant emphasized the amount of work and time needed for such an endeavor:

Quality improvement is a long, drawn-out process. It takes strong leadership, physician leadership, to drive quality improvement. It’s not something you get in 20 hours. It takes long-term dedication, public, complete dedication.... It’s about working with people, building relationships, getting

people to buy into the quality concept, getting physicians to buy into it, ...buying the concept of future worth through an organization.

The focus groups provided a breadth of information about the definition of quality improvement, but most noteworthy is that the discussions provided a forum for multiple stakeholders to grapple with this complex issue and to seek a shared understanding within the context of the local area. At the end of each site visit, participants noted the benefits of discussing what quality is and hearing about all the work that is occurring. In this endeavor, focus group participants see a role for physician organizations—medical societies and the AMA. These professionals are aware of the importance of arriving at a good definition and see their organizations as well positioned to address the problem.

What’s the purpose of being organized, representative, [and] available is that we still have to look at setting standards, and where I think the medical groups are very important is paving the road and bridging the gaps between those.

Medical Society Staffing to Support Quality Improvement for Physicians

The medical societies reported that they are involved with a number of projects that attend to quality improvement. To participate in these efforts, state and county medical societies utilize staff and physician volunteers (leaders in quality improvement in the community or their organizations, group practice, hospital, etc.). State and medical society staff range from 4 to 100, and the number of individuals dedicated to quality improvement ranges from 1 to 10 (see Table 3). Thus, we estimated from these aforementioned numbers that 10 to 25 percent of medical society staff are supporting quality improvement for physicians at the local level. It should be noted that this does not include the numerous physician volunteers who are often champions and leaders in quality improvement.

Table 3. Medical Society Staffing for Quality Improvement

State	Medical Society	Total Staff	Number of Staff Supporting Quality Improvement
California	California Medical Association	60	5
Maine	Maine Medical Association	12	2
Michigan	Michigan State Medical Society	100	10
Minnesota	Minnesota Medical Association	35	1
Missouri	Missouri State Medical Association	12	<1.0 FTE
	Metropolitan Medical Society of Greater Kansas City	7	2
New Mexico	New Mexico Medical Society	8	<1.5 FTE
New York	Medical Society of the County of Erie New York	4	1 ¹
Ohio	Academy of Medicine of Cincinnati	9	4
	Academy of Medicine of Cleveland and Northern Ohio	4	1
Oregon	Oregon Medical Association	24	3
Pennsylvania	Pennsylvania Medical Society	98	7-9 ¹
Tennessee (Memphis)	Memphis Medical Society	4.5	2 ¹
Washington	Washington State Medical Association	14	3
Wisconsin	Wisconsin Medical Society	61 full- and part-time, and 6 LTE	8 ²

1—Number of staff supporting quality improvement may include those whose duties also encompass other areas of responsibility.

2—In addition to number of staff shown in the table, the Wisconsin Medical Society has field staff who work to create awareness of quality improvement activities and opportunities

C. Medical Societies' Quality Improvement Projects

Medical societies engage in a variety of activities to promote and sustain health care quality improvement, including projects to educate physicians and consumers, encourage and support the adoption of health information technology (HIT), and promote patient safety. Some of these projects are conducted by the medical societies themselves; often they are undertaken collaboratively with other groups. This section of the report describes some of these projects. We begin by discussing collaborative projects, which span a variety of content areas. Next we discuss educational efforts, HIT, health information exchanges (HIE), performance measure development, and patient safety projects.

The information presented in this section was compiled from focus group discussions, focus group guide responses, and other material provided to AMA staff. It is important to emphasize that the projects depicted in tables and/or discussed in the text in no way reflect all the quality improvement projects

medical societies are engaged in; such projects are many, and to describe them all would be burdensome. Rather, we have presented those that were highlighted by focus group participants and that we believe provide a useful profile of the depth and breadth of medical societies' involvement with quality improvement efforts.

Collaborative Projects

Medical societies collaborate with a wide range of stakeholders—insurers, foundations, health systems, local employers, and government agencies—on a variety of quality-related projects. These efforts bring stakeholders together and endeavor to engage all in improving health care in their local communities. In focus group discussions, state and county medical societies highlighted these collaborative relationships that support quality improvement. Table 4 illustrates the diversity of the collaborations and the methods by which partnerships are formed. Some groups are formalized with clear missions; others are administrative partnerships.

Table 4. Medical Societies' Collaborative Projects

Medical Society	Description of Collaborative Efforts
Maine	Maine Health Management Coalition —a group of employers doctors, health plans, and hospitals working together to improve the safety and quality of health care with an interactive website allowing patients and doctors to review doctors, hospitals, and best methods to achieve “quality care.”
Michigan	Michigan Quality Improvement Consortium —comprised of physicians and personnel representing health plans in the state of Michigan; provides consultative services, medical and utilization review, and data analysis to federal agencies, state Medicaid and public health agencies, health care facilities, and private health plans and other third party payers.
Ohio	Ohio Committee on Trauma —comprised of surgeons and health care professionals dedicated to improving care of the injured patient. It is dedicated to improving trauma care along the continuum through a focus on public and professional education, advocacy, injury, prevention, trauma system development, standards of care, quality of patient care, and financial assessment of care
Ohio, Cincinnati	Diabetes Footprints Campaign —a project of AF4Q's Health Improvement Collaborative of Greater Cincinnati, this collaborative project works with large employers to provide diabetes education, and a campaign staff member tracks how many employees are participating in the courses. The campaign partners include the Academy of Medicine of Cincinnati and other health care providers, insurance companies, employers, and community organizations, including the American Diabetes Association.
Oregon	<p>Health Leadership Task Force—created in 2008 by Oregon business groups, this collaboration between physician organizations, hospital and health systems, and health plans is working to hold down health care costs through administrative simplification, promoting evidence-based practice, and exploring payment options such as bundled services and medical homes.</p> <p>Oregon Health Reform Collaborative—convened in 2006 by the Northwest Health Foundation and the Oregon Health Policy Commission, this broad-based group works to advance comprehensive health care reform.</p>
Pennsylvania	<p>Pennsylvania Coalition to Save Antibiotic Strength (PaCSAS)—the collaborative partners for the project—which included the Pennsylvania Medical Society and other physician organizations, state government, and the insurance industry—worked to reduce the overuse of antibiotics.</p> <p>Pennsylvania eHealth Initiative—a collaboration that includes the Pennsylvania Medical Society, other physician and professional organizations, major health systems, payers, employers, and consultants. Created in 2005, the initiative's focus is to encourage the use of electronic medical records and HIE.</p>

The PaCSAS (Pennsylvania Coalition to Save Antibiotic Strength) project was aimed both at physicians and the general public. Its work involved bringing evidence-based antibiotic-use information to physicians, creating informational materials for physicians and the general public, and conducting extensive outreach to day care centers and school nurses, and even conducting programs at the Philadelphia Zoo to educate consumers about appropriate antibiotic use.

And, so, we created all these programs. We work with our alliance. They did some programs at the Philadelphia Zoo, again to address kids and younger parents, smaller kids. We also had something called the “Hand Me a Hand Project.” Really innovative things we tried to do. By including all the insurance companies, especially the Blues because the Blues in this state are the market-dominant payers... so, their market basically includes almost every area of the state and almost every family in the state.

The medical society evaluated outcomes from the project. By collaborating with Blue Cross/Blue Shield, the project was able to mine claims data to assess the program's impact. The collaborators hired a contractor to collect health plan data from before and after the intervention. The latter data

showed a decrease in antibiotic use. A recent infusion of new money will allow the group to replicate the approach in three additional health initiatives; the first will be colorectal screening.

Oregon's Health Leadership Task Force arose out of a challenge issued by local employers hoping to “bend the cost curve” on health care. The Task Force includes physician organizations, health and hospital systems, and the insurance industry. Through the work of this collaborative project, Oregon has joined payment reform with evidence-based medicine in a statewide effort to implement systemic reform.

Educational Projects

State and local medical societies engage in a wide variety of educational activities around quality improvement. For the purpose of this report, we have defined “educational” activities to include not only formal continuing medical education (CME) programs, but any quality improvement-related activities that collect data, develop and disseminate information (via newsletters, reports, conferences, listservs, or newsletters), provide expert review and consultation to medical practices, develop resources and tools, and provide

other educational programs that aim to inform physicians, payers, and consumers about health care quality and quality improvement. We included educational projects aimed at physicians as well as those directed at the general public. Table 5 gives examples of medical societies' educational activities. Some of these are part of AF4Q; others are focused on assisting the physician with various office practice management and professional development skills.

Table 5. Medical Societies' Educational Projects

Medical Society	Description of Educational Projects
Maine	<p>Voluntary Practice Assessment Initiative—a project of the Maine Medical Association and Maine Osteopathic Association, funded by the Maine Quality Forum, that offers confidential practice assessments and focuses on small primary care practices.</p> <p>Maine Independent Clinical Information Service (MICIS)—MICIS is the state's academic detailing program, a quality improvement initiative that provides physicians and other medication prescribers with independent (i.e., not pharmaceutical industry-provided), evidence-based clinical information.</p>
Michigan	<p>Health Literacy Grant Project—this project of the Michigan State Medical Society received a “Pillar of Excellence” award in 2004; the project is now part of the ETHOS (Enhancing Traditional Health Outreach Strategies) project, which works to reduce health disparities.</p>
Pennsylvania	<p>Counter Details—this is a publication of the Pennsylvania Medical Society providing evidence-based treatment information on a variety of topics, including colorectal screening and pediatric asthma. Each is written by leading specialists in the related field.</p> <p>Physician Education: PQRI—the Pennsylvania Medical Society offers webinars on the Physician Quality Reporting Initiative.</p>
Washington	<p>Practice Management Seminars/Continuing Education Units—offered by the Washington State Medical Society to assist physicians with purchasing and successfully implementing electronic health records, and understanding state medical quality assurance requirements and other topics.</p>

Performance Improvement Continuing Medical Education (PI-CME). Although we have not specifically listed these in the table, many medical societies are involved with CME. In addition to their traditional role with CME, a few medical societies we spoke with (Greater Albuquerque Medical Association [GAMA], Pennsylvania Medical Society, and Wisconsin Medical Society) have begun to offer Performance Improvement Continuing Medical Education (PI-CME), although these efforts are still in the formative stages (see Appendix D). GAMA plans to use its newly formed group of emeritus physicians who “*have the time and the effort to go in and do it*” to take the lead. The Pennsylvania Medical Society convened a task force a year ago to make recommendations about CME activities, and PI-CME was among these. The medical society is also working to develop a toolkit for physicians and practices that want to implement a PI-CME process, is planning to make PI-CME a topic at its annual Provider CME Accreditation Conference in 2010, and is considering the use of technology—social networking, videos, podcasts—to disseminate information to physicians about “*the new paradigm of CME, tying it into quality and performance measurement.*”

The Wisconsin Medical Society recognized the opportunity presented by PI-CME to assess its CME activities in the state, and is now engaged in several areas of activity in PI-CME. One is to provide coaching to accredited providers “*that are ready to move into PI-CME but don't quite know how to get*

their arms around it.” The Wisconsin Medical Society is also developing performance improvement modules for specific programs such as the substance abuse-oriented Screening, Brief Intervention and Referral to Treatment (SBIRT) program and the Wisconsin Health Information Exchange (WHIE). Finally, it is providing PI-CME implementation assistance to provider organizations that request it.

However, medical societies in other areas have yet to add PI-CME activities to their portfolios. Some sites visited seemed unfamiliar with the term PI-CME. Others, such as those in Maine and Michigan, were aware of PI-CME but not directly involved in related efforts. Still others expressed interest in the topic:

I would say if it were something that the OSMA [Ohio State Medical Association] would take on, we would combine our efforts with the local levels, the Academies of Medicine around the state, because it just makes sense.

This comment, along with praise from participants in another state for the AMA's “*fabulous job of promoting performance improvement CME,*” suggests local physician organizations may be more likely to become involved with PI-CME if a larger organization takes the lead.

Research and data collection. In addition to efforts to disseminate information, participants discussed their engagement in research or data collection efforts around

quality improvement. Two of these—in Pennsylvania and Cincinnati—are evaluations of quality improvement education efforts. The Cincinnati project is evaluating the diabetes education program offered through area employers. In addition to the participation tracking that is part of the program, they are trying to evaluate the impact of the Diabetes Footprints Campaign, specifically how being given the same message from their doctors, pharmacies, employers, health plans, etc. affects patients' knowledge and behavior.

We did a study with the [medical group] physicians and were able to show that the consumer, their knowledge of guidelines increased. It did not, however, affect their interaction with their physician like we'd hoped, and we think that's a training issue - that the educators weren't trained to actually tell patients to take the tool with them and talk with their doctor about it, one-on-one.

The participant recognized that a study of behavioral impact, however, would be well beyond the financial resources of the group and added that it “drives me crazy that we don't have data on a lot of this.”

The Pennsylvania Medical Society also plans to survey members who have participated in online CME courses to assess the impact of those programs. The Wisconsin Medical Society has surveyed its members about their interest in information on the Physician Quality Reporting Initiative (PQRI) registry reporting. Two years ago, GAMA undertook research to prepare report cards on managed care organizations. It developed and fielded a 20-item survey, administering it twice, two years apart, to managed care organizations providing care under Medicare and Medicaid. GAMA also disseminated the findings through a series of meetings with the managed care organizations and the state.

Health Information Technology (HIT) Projects

Focus group participants discussed HIT from a systems perspective, and utilization beginning at the micro (physician level), moving to the macro (organizational level), and on to the meso (national/federal and integrating all levels). Furthermore, discussion of HIT led to additional discussions on health information exchanges (HIE), Health Extension Centers (HECs) and Regional Health Information Organizations (RHIOs). Participants' discussions of HIT progressed naturally from a micro level (i.e., the use of electronic medical records [EMRs] in individual practices) to regional or state-wide HIEs at the macro level. The medical societies' involvement depended on the level of acceptance of technology at the ambulatory care practice level, primarily for groups of one or two physicians, and the amount of time they have been involved in assisting the physicians.

Medical societies recognize the importance of HIT, although there is variability in the length of their involvement in this area and, consequently, in the extent of their involvement and knowledge. However, all recognize that they must collaborate and that HIT is a priority that overlaps with quality.

Well, I think the Society now for a number of years has made HIT a priority in their strategic plan, number one. And my sense among the leadership in the positions is that there's really no disagreement that technology plays an important role in that. Ultimately, everything we do in HIT is about quality.

Beginning at the micro level, the medical societies recognize that the physician must have access to the basics, such as registries and EMRs, and that smaller physician practices generally do not have such access. The medical societies have made efforts to assist physicians in ambulatory care settings to adopt EMRs. However, adoption of EMRs is a challenge in terms of costs, including staff and physician time, and the need to revamp office procedures and workflow. As a result, small practices have been slow to integrate EMRs. In addition, rural area practices struggle with basic electronic issues such as high-speed access. State medical societies are trying to expand physicians' access to broadband connections or just “help physicians' offices get wired.”

We actually applied for and received two grants now from our Department of Community and Economic Development called BOAF: Broadband Outreach and Aggregation Fund grants. And the purpose of that's to get broadband in every physician's practice. Ultimately, that would be our goal. To get broadband access in every physician's practice in Pennsylvania.

In contrast, in states such as Minnesota “90 percent of physicians ... use and have [EMRs] for the past four years.” These two examples demonstrate the degree of variability in local practice adoption of HIT, which dictates the amount and focus of involvement for the medical societies.

Health Information Exchanges (HIE) Projects

A majority of the state medical societies recognize the importance of health information exchanges (HIE) to quality improvement. They indicated that registries are thought to help local areas address specific diseases and quality of care.

Part of HIE is the use of registries to get information on a particular disease or on ... how many people are getting vaccinated or whatever. These registries are an important component of providing that information to some such repository.

Medical societies are working with physicians, organizations, and government agencies to enhance opportunities (collaborations, legislation) for all physicians to be involved in HIE.

We're currently exploring our relationship with other health care provider organizations with all this high-tech funding coming down for what's called a health information exchange and to see how we might be able to insert ourselves in a governance role in creation of an HIE. So, when opportunities like this present themselves, we'd like to figure out a way that we can have a seat at the table for a long time.

At this point, we're working with the governor's office of health care reform on their fixed initiative for statewide HIE, so we're working at that level, and right now everybody's grants are due

The focus of HIT attention by physician organizations varies across states. As mentioned above, one medical society may be focusing on EMRs “getting wired,” while others are involved in HIEs or registries. States such as Minnesota and Maine, where practice-level adoption of HIT is more advanced than in other areas, are moving away from simple data collection toward determining what to do with the data.

One is the interface, in which you [physicians] collect information, and the other is how you store it. That is how the data systems are set up, store it. What you need to have is some agreement on how we're going to store data at top level. If you do that, you're going to be able to access it in many different ways.

Our health information technology plan... is going to be forthcoming in the next 60 days or so, will be interlocked with the health information exchange

Maine's five-year effort with HIEs has worked with public reporting to foster quality improvement. In Pennsylvania the medical society has been involved with HIE for many years and has “done a lot of things over the last year and a half with connect-the-docs,” at the micro system level.

Five years ago—four years ago, we started the Pennsylvania eHealth Initiative as an effort. This was a statewide RHIO—as an effort to work at that high level.

In contrast, the Missouri Medical Society is at a much earlier stage, because of sustainable funding opportunities driven by the health care reform initiatives. Concern about long-term involvement includes securing sustainable funding.

The HIE is still in the speculation stage. It's not even in the planning stage, because the great question is, “How do you create a sustainable business model within this HIE after the fed funds dry up?”

Other state medical societies, such as New Mexico's, are participating in the development of HIEs that have been mandated by state legislation, but which are not yet fully operational

Thus, on a meso systems level, medical societies have been connected to some extent with HIEs or HECs. Appendix E lists the Regional Extension Centers (REC) for each participating Advancing Ambulatory Quality Improvement (AAQI) or AF4Q state. While not all the HECs are connected to the medical society, this illustrates the number that are available at a local level.

D. Performance Measurement

In focus group discussions participants spoke about many quality improvement projects with which the medical societies were involved. Performance measurement projects were largely driven by payers seeking to compare providers for given processes or outcomes. The stated purpose is often to ensure that patients are achieving the goals that the physician and patient have agreed upon. The performance measurement projects were clustered into two groups: 1) projects driven by payers; and 2) projects driven by reimbursement chosen by the practitioners.

Projects Driven by Payer

Focus group participants highlighted projects that were payer-driven. Table 6 lists payer-driven projects designed to focus on measurement that is linked to financial rewards for submitting or evaluating patient outcomes data. These projects reflect a motive from payers to attend to outcomes data. Two payer-driven project schemas were uncovered: 1) outcomes-driven and 2) model-drive (medical home).

Outcomes-driven. It was apparent in our conversations with participants that the medical societies' collaborations with various organizations present an opportunity for payers to engage physicians through the medical societies to evaluate health care outcomes. This provided opportunities to determine the cost-effectiveness of “best practices.” As shown in Table 6, the Michigan State Medical Society is working with the Greater Detroit Area Health Council, which convened a group of committed stakeholders representing employers, physicians, health systems, health plans, health care providers, and unions, to use core measures with assessment tools.

Oregon and Accumentra Health, CareOregon, the Oregon Association of Hospital and Health Systems, the Oregon Nurses Association, the Oregon Patient Safety Commission, and the Oregon Rural Healthcare Quality network initiated the 5 Million Lives Campaign in hospitals across the county. The targeted interventions address preventing deaths from heart attacks, medication reconciliation, central line infections, surgical site infections, and ventilator-associated pneumonia among other things.

Table 6. Payer-Driven Projects

Medical Society	Projects Driven by Payers to Sustain Quality Improvement and Impact Cost Driven by Outcomes
Michigan	<p>At Your Service—quality assessment tool using core measures etc.</p> <p>Save Lives Save Dollars—Wayne State County Medical Society is part of a collaborative multi-year initiative of coordinated, immediate- and long-term actions to drive quality improvement (save lives) and derive cost reductions (save dollars) in southeastern Michigan. Program implementation began October 2005.</p>
Minnesota	<p>Quality Improvement Organization (QIO) Collaboration—partnering with Stratus</p> <p>Community Measurement Specification—“50 plus medical groups, 500 plus clinical site reporting on two measures.”</p>
Oregon	<p>Quality Management Internal System Auditor (QIAs)—staff and physician volunteers are participating with four state-based health insurers, a hospital system and workers’ compensation to address chronic non-malignant pain management.</p> <p>Ambulatory Record Certification program (ARC)—the Oregon Medical Association (OMA) conducted a single review of records for compliance with quality standards.</p> <p>Five Million Lives Campaign—Accumentra Health, Oregon’s QIO, OMA, CareOregon, Oregon Nurses Association, and the Oregon IHI Network are implementing the World Health Organization Surgical Checklist in every hospital.</p>

Model-driven. As reported in the “Building an Infrastructure for Ambulatory Care Quality Improvement in AF4Q Communities” report prepared by the Center for Health Care Quality at the George Washington University Medical Center School of Public Health and Health Services, eight AF4Q sites have medical home projects. Four of our medical society focus groups reported on the initiatives associated with medical homes.

The Maine medical society indicates that it has a “*multi-stakeholder working group that helps to guide the [medical home] pilot.*” Stakeholders include those involved with the AF4Q project, as well as many others. Cincinnati has a multi-payer pilot project on medical homes.

There are many pilot projects for medical homes; some are “*trying to arrive at a uniform definition of [the] patient-centered medical home.*” In fact, a Minnesota medical society staff member asserted, “*Well, I think we identified a medical home for every Minnesotan back in 2004 as part of our reform.*” Michigan and a few other states have had significant support from insurers;

“The Blues...[are] putting 60 plus million dollars this year into physician reimbursements specifically directed towards creating the elements of a medical home.”

Other state medical societies are working with their state legislators to address medical homes. In New Mexico:

Last year, one of the bills we prioritized was a medical homes bill for [the] Medicaid [Children’s Health Insurance Program] and state-coverage insurance. It’s a waiver program that’s kind of a public-private partnership. It has about 40,000 individuals enrolled. So this program is to really set up a series of pilots.

Projects using Physician Consortium for Performance Improvement (PCPI) Measures

As noted above, physicians recognize the importance of measures and are choosing measures for both their own practice evaluation and for accountability. One of the measurement sources for the PQRI is the AMA-Physician Consortium for Performance Improvement (PCPI) measures. The majority of state medical societies participate in the PCPI.

The PCPI is comprised of over 100 national medical specialty and state medical societies, the Council of Medical Specialty Societies, the American Board of Medical Specialties and its member boards, experts in methodology and data collection, the Agency for Healthcare Research and Quality (AHRQ); and the Centers for Medicare & Medicaid Services (CMS) (see Appendix F). Membership is open to any organization or individual committed to health care quality improvement and/or patient safety, and which participates in the development, review, dissemination, or implementation of performance measures and measurement resources

The PCPI is committed to improving patient health and safety by:

1. Identifying and developing evidence-based clinical performance measures and measurement resources that enhance quality of patient care and foster accountability
2. Promoting the implementation of effective and relevant clinical performance improvement activities
3. Advancing the science of clinical performance measurement and improvement

The PCPI focus also includes:

- Actively identifying quality improvement initiatives
- Informing measure development— incorporating that which has been proven in practice
- Determining how to encourage widespread use of best practices/strategies
- Supporting overall patient care delivery, including physicians in solo/small group practices
- Integrating measures into EHRS

Patient Safety Models

All focus groups agreed that quality is connected to patient safety. As a result, the medical societies' commitment to quality improvement has led them to become involved with patient safety. One clear differentiation is that quality is focused on the individual patient, whereas patient safety is focused on all patients in systems in which they receive care.

Patient Safety Organizations (PSOs). The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the creation of PSOs to improve quality and safety by reducing the incidence of events that adversely affect patients. While physicians can argue about “good” quality measures that may not apply in individual situations, as discussed above, no one doubts that a medical error is bad quality as defined by the IOM.¹⁴ To implement the Patient Safety Act, the AHRQ published the Patient Safety and Quality Improvement Final Rule (Patient Safety Rule), which became effective on January 19, 2009.¹⁵

A PSO is an entity that is recognized by the Secretary of Health and Human Services and listed by AHRQ based on a self-attestation by the entity or component organization that it meets the criteria established in the Patient Safety Rule.

The primary activity of an entity seeking to be listed as a PSO must be to conduct activities to improve patient safety and health care quality. A PSO's workforce must have expertise in analyzing patient safety events, such as the identification, analysis, prevention, and reduction or elimination of the risks and hazards associated with the delivery of patient care, and provide timely feedback.¹⁶

Most noteworthy is that medical education has established that quality improvement and patient safety go hand-in-hand. As our participants noted:

Within the medical school, they're ... expanding their curricula around quality improvement and patient safety.

[H]opefully the younger generation will be embracing the concept of quality and patient safety early in their careers,

Medical society executives often sit on PSO boards and are involved with related local or state patient safety coalitions.

We're involved in patient safety efforts. We are a founding member at the Patient Safety Coalition.

Several other physician members of this committee either sit on that council now or have sat on that council in the past, working together on patient safety initiatives.

Table 7 highlights the local and state medical societies that are currently involved in PSOs or their safety coalitions. Included are those projects for which the organizations were involved (current or future) with peer-reviewed activity. Participation in PSOs and coalitions gives medical society executives an understanding of how hospital or larger group organizations are addressing quality. This allows the executives to understand how to assist ambulatory care quality improvement efforts.

14 Six Domains that define quality: Safe, Timely, Effective, Equitable, and Patient Centered. IOM Crossing the Quality Chasm.

15 Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21—b-26 (Patient Safety Act).

16 <http://www.pso.ahrq.gov/index.html>.

Table 7. Patient Safety Organization (PSO) Involvement

State	Medical Societies Linked with PSOs to Enable Voluntary Reporting	Medical Societies Focused on Payer Activities
California		Focus of state and local societies: physician ratings driven by payers.
Maine		Maine Medical Association
		There are no PSOs located in Maine; focus is on peer review, which is utilized more in the hospital environment, both unit and individual focused, and Individual practice improvement
Michigan	Michigan State Medical Society	
	PSO: Michigan Hospital Association; MSMS on PSO Board	
Missouri	Missouri State Medical Association	
	PSO: Missouri Center for Patient Safety; MSMA on PSO Board	
	Metropolitan Medical Society of Greater Kansas	
	PSO: Missouri Center for Patient Safety; highly involved with the PSO; additional focus on Kansas City ambulatory surgical center	
Minnesota	Minnesota Medical Association	
	There are no PSOs located in Minnesota	
New Mexico	New Mexico Medical Society	
	There are no PSOs located in New Mexico	
New York	Medical Society of Erie County	
Ohio	Academy of Cincinnati	
	Academy of Medicine of Cleveland & Northern Ohio	
	PSO: Ohio Patient Safety Institute; PSO a subsidiary of Ohio Patient Safety Institute- Ohio State Medical Association, founding member of the Institute	
Oregon	Oregon Medical Association	
	PSO: Oregon Patient Safety Commission; PSO is a component of statutorily formed Oregon Patient Safety Commission; OMA participates in the Commission	
Pennsylvania	Pennsylvania Medical Society	
	Unable to determine if PMS has a contract(s) with listed PA PSOs	
Tennessee		Memphis Medical Society
		Focus: mandatory reporting requirements
Washington	Washington State Medical Association	
	WSMA is coalition member of Washington Pt Safety Coalition and sits on their steering committee	
Wisconsin	Wisconsin Medical Society	
	No PSOs are located in this state	

E. Challenges to Quality Improvement

In discussing medical societies' efforts to implement and sustain quality improvement initiatives focus group participants told us about barriers they have dealt with along the way. One of these will be familiar to AF4Q project participants: engaging and retaining the involvement of physicians, particularly practicing physicians.

Well, I think the tough piece is going to be getting physician buy-in to do just exactly what [name] is talking about, for physicians to continue to come to the table and be part of working that project. . . . [Our local medical society] been supportive of it, but there's only a few physicians. . . . but they're not practicing physicians, and so I think we just need a way to encourage more physicians to be part of this.

The remainder of this section presents focus group findings that suggest why physicians have been difficult to engage in quality improvement work and describes some specific barriers to their involvement: time constraints, financial constraints, and concerns about how quality measures are formulated and applied. In some cases, medical societies have learned how to transcend these barriers, and we offer their insights on that as well.

Time Constraints

Two subgroups of physicians were identified as finding it particularly difficult to devote time to quality improvement work—or even be involved with their medical society at any level: solo practitioners or those in small practices and younger physicians.

But if you're talking about the family medicine doctor, who's sitting in his office, who's barely getting by, he can't or she can't take the time to get together and do that [participate in meetings] because the only thing they're getting paid for is opening and closing doors, and generating RVUs [relative value units]. And somewhere along the line, we've got to take that nonsense out of the equation.

Another participant observed that physicians in larger groups may also be unable to take time off for meetings, but for a different reason.

Well, I do think we have to deal with the group practice where people are looking to their group for being involved, rather than looking to the [state medical society] for being involved. We hear that all the time: "My group doesn't give me time off to do [state medical society work], but it'll give me time off to do [work] within my group."

This same participant went on to emphasize that the medical association needs to make it clear to physicians in groups that organized medicine “*enhances what your group is doing.*”

Younger physicians face other challenges. Residency requirements may preclude meeting attendance, prompting one participant to emphasize that “*we need to get the residency directors to say it's important*” and persuade them to encourage participation. Both this speaker and another participant noted that younger physicians just starting out in practice are “*stressed*” or may be focused on getting out of debt.

One thing we've learned within the last couple of years is that our focused efforts on getting younger physicians involved in the organization is affected by a process we really hadn't realized, and that is physicians coming out of training are in debt, and the first step they take is to unburden themselves. So we anticipate that our future members will not necessarily be people who are immediately transitioning into practice. . . . We would rather have the interaction at [age] 28 to 35, but we may not get them 'til they're 40.

Despite the barriers younger physicians may face, participants expressed optimism about the coming generation's commitment to quality. Unlike their older counterparts, who have seen many things come and go and wonder if quality will be just “*another fad,*” physicians in training today are “*growing up with that culture*” of engagement and quality improvement. Another participant put it succinctly:

I just wouldn't worry about how we get the young people in quality. Just make sure you get the young people involved, and they'll tell you quality is the thing they should be involved in.

Financial Challenges

To the degree that physicians believe participating in quality improvement requires implementing health information technology (HIT) at the practice level, they are concerned that they simply cannot afford to participate. Although this concern was expressed most often by physicians in smaller practices, participants opined that larger practices, too, may find this an obstacle.

[H]ow do you really make it something that's doable for most physicians? I think a lot of people, you know, both in small practices and large practices struggle with the fact that there's some parts of the [inaudible] that are incredibly onerous: . . . the HIT and all the financial implications of getting it in place are practically overwhelming. And I'm not sure if we're going to be there anytime soon.

For example, everybody predicts that with the use of information technology, electronic medical records, electronic prescribing, you know, quality of care is going to increase.

That's a fairly large expansion for any physician to embark on, especially these one-, two-, three-practitioner practices. The [large groups] of the world are well-advanced in EMRs. University of Pittsburgh: well-advanced in EMR. ... But these smaller practices, which comprise most of our membership, are not information technology savvy at all.

The second speaker noted that the state medical society was applying for a federal Regional Extension Center (REC) grant to help smaller practices implement the HIT they need to implement quality improvement activities. However, participants suggested that physicians' "sense that I need an EMR in order to do it [quality] right," was not correct. As participants talked about practice re-engineering to support quality, they made similar observations, noting that changing workflow and office procedures were the key changes, and that HIT simply supports those. But for physicians in rural areas, the infrastructure for HIT may not be in place, even if the practice can afford to implement it. Speaking of the so-called "T-bone" area in Pennsylvania—the regions of the state outside the Philadelphia and Pittsburgh metropolitan areas—one participant described the problem:

'Cause there's parts of Pennsylvania right now that's not serviced by broadband. They may have dial-up. Or they may have DSL, which by definition is not broadband. And without building that basic backbone, there's a lot of quality initiatives that can't be initiated.

In the above situation, the speaker added, telemedicine and telehealth systems, some of which use ordinary phone lines, could be implemented to provide care in remote areas, particularly for patients, such as women with complicated pregnancies, who cannot travel long distances to receive care from a specialist.

Finally, one participant described a non-HIT related financial barrier (perverse incentive) that was successfully resolved by persuading a state agency to revise its payment policies. The initiative was to combat the over-use of antibiotics; the problem was that physicians were not always conducting the appropriate tests to determine if the drugs actually were needed because they were not always reimbursed for doing so:

It was clear that doctors weren't doing rapid strep tests on kids before they made a determination as to whether they needed an antibiotic or not. Which, as you know, [is] something we should do, because the pressure the parents put on doctors, especially pediatricians and family doctors, to get an antibiotic is overwhelming. And a lot of physicians fold and say, "All right, I'll give it to you," because they say, "If you don't give it to me, I'm going down the street. You're going to lose me as a patient." But what we found out from the Medicaid population was our Department of Public Welfare through our Medicaid

program did not pay for rapid strep tests [at] our physicians' offices, so as a result of this we got our Department of Public Welfare to start paying for that service, so then doctors were willing to do it, because they get paid for it. They weren't willing to do it if they didn't get paid for it. Why should they have to provide a test on a loss? So more testing was done and less antibiotics were given.

Physician Concerns With Quality Standards and Measures

Being held to nationally formulated quality measures that do not take local populations into account was criticized by several participants. For physicians working in areas with above-average rates of obesity, for example, or where many patients lack insurance, achieving good health care outcomes may be difficult no matter what the physician does. Some express concerns about the perverse incentives that may be created to treat only healthy populations in order to maximize good quality scores. Understandably, practicing physicians are wary of quality goals established by government officials (especially from the federal government), national organizations, or health insurance companies. Instead, physicians suggest that quality standards be clinically appropriate for specific local populations and that physicians practicing in these areas must be involved in setting those standards. There were several comments in this vein:

The thing that really concerns me is that if physicians are not actively engaged, truly actively engaged in trying to prove or identify their own quality—if it's left up to the regulators, like the people from the Dartmouth Atlas [who] look at things from the 30,000-foot view, look at general data, that may or may not be risk-adjusted even though they claim it is risk-adjusted, but you wonder if it is. I just worry about these measures being dictated to us from a regulatory-standpoint by CMS or the government, and then that leads to changes in reimbursement or shuffling of reimbursement based upon these bureaucratic concepts of quality.

And we don't have a lot of health providers in the legislature to translate some of these difficult and complex issues. You know, we used to, but we don't now. So now it becomes even more important. They go to [medical society leaders]... and really ask for, what does this really mean? How should we really stand on it?

Our [California Physician Performance Initiative] project—I'm very proud of what docs have done. We've nixed a lot of national indicators, because they didn't fit clinically and were not rational. They were actually political appeasements for some group. Which was not appropriate.

The above concerns go back to how quality is defined and physicians' concerns with definitions built around outcome measures. Despite recognizing that outcomes matter, physicians are wary of being held to standards influenced by local factors beyond their control such as populations with a high rate of co-morbid conditions or who lack insurance, or a scarcity of supportive services in the community.

[If] they're going to be paid in a different way than everybody getting paid now ... and they're going to be held accountable for outcomes, and they have no other array of services to depend on, there may be nothing else in the community. How are we going to array the services so it happens? How are we going to finance that? ... We're going to hold ourselves accountable for what we control in the variables.

Not everyone agrees. A participant in another state suggested that process measures were the way to get physicians on board initially, but that with time, outcome measures may become more acceptable.

To go back to your question about process versus outcome measures, I think it talks about the infancy or the adolescent stage or the maturity of the system. When we were first starting to do it, all we could get our physicians to accept within our organization was process measurement data, because they didn't trust the outcome measurement data, and process was something they could say, "You know what? Hold me accountable for supplying this." That process was the way we got the buy-in, and as we got more success with process, we're able then to add outcome measurement. And now we do very little process, because process is in some respects easy.... But we couldn't have started out with outcome measurements, five or six years ago.

Finally, some focus group participants questioned whether or not the measures currently in use accurately reflect what they believe constitutes quality health care. One participant observed that different health plans all have different measures of quality. Another noted that any given physician or practice may show a range of scores across a set of metrics, opining that such wide variation indicates that such an assessment "really is not assessing quality." Another took issue with how meaningful some physician ratings are:

But when you jump into the medical arena, it's not that simple.... [We are] not measuring quality like how well your refrigerator runs here. I mean, quality is different. ... [You are] not going to put a yellow sticker on their lab coats to say they're a 93-rated doctor or an 85-rated doctor.

A More Fundamental Concern: Is All This Really About Quality?

Certainly, physicians are wary of being rated on standardized measures devised by non-physician groups such as insurers and government. However, at a more fundamental level, they wonder if the forces driving performance measurement and quality improvement initiatives—and the way these initiatives ultimately are implemented—really will result in quality health care for patients and communities.

I think physicians have this feeling that they're doing that for the benefit of the [insurance companies], not for the benefit of the community.

And I think that docs—I mean, I hear over and over—that the docs feel that the whole quality movement's been hijacked, and it's not really about—kind of what we were talking about earlier: it's not about being a better doctor; it's about meeting whatever this measure is so that you can get an A, and it's not exactly what it's been intended to be.

At the same time, physicians recognize that quality improvement is inevitable and that "we need enough physicians to come to the table" to lead and participate in those efforts. Focus group participants express interest in the process and a willingness to become involved. Furthermore, they see physician organizations as a mechanism for engaging in the work.

Right now, I think we've sort of been behind the 8-ball on this process. Everybody else has beaten us to the punch, both politically as well as from the PR standpoint, so I think we really need to get at it.

I agree the individuals can't do it on their own for the reasons [that have been stated], and I agree that grassroots physicians don't wake up in the morning, thinking, "How can I create an effective, organized system of care?" but when given an opportunity to join together to create systems of care that they can influence, that they can control, that they can lead, they resonate to that, because they see that a more effective system of care that they lead can actually be responsive to their personal and professional values and goals.

F. Medicals Societies Role in Sustaining Quality Improvement

As a result of the medical societies' experience in the aforementioned projects, the medical society staff have the expertise to guide, advise, consult, design, and structure physician practices to sustain ambulatory care quality improvement efforts.

My goal ... was to make sure that there wasn't anything happening for physician quality in the state that didn't have some involvement through the medical association, either in helping form and develop that or at least having a discussion about what it is, what it means, and making our members aware of that. Provide a lot of information to our member practices about PQRI, how to participate and what that means.

Medical society staff has been informing physicians with education, plan design, and templates to ensure that their practices can measure quality, whether through process or outcomes. In fact, the medical society executives recognize that:

Trying to get the message to our members that value-based purchasing is where things are going...and if [they] don't pay attention ... they will be behind the times.

Historically, the role of the medical society has been about influencing data reporting and collection.

[As a medical society] to influence [quality health care]... a lot of interest emerged around data reporting and data collection and what are the parameters around physician reporting and data collection. And a lot of it, I think, was directed at state agencies that were doing the data collection, so it [medical society] was working with the Health Department.

Ultimately, medical societies individually and collectively can:

Help [physicians] get to the use of best practices without having them feel like we're walking away with their data that we might share with our funders. That's a real sensitive boundary we want to make sure we respect.

Currently, it's voluntary, but our thought was, as a society, whether we can support that and help to roll that out or at least encourage it on a community-wide basis, and give support to it in that regard, rather than just individual physicians and practices here or there across the country participating in that. Roll that program out as a regionally focused effort.

We can make those templates available to practices and for a very reasonable enrollment fee and annual fee for continuation practices can enroll their practice, their program with us. And they get some guidance and advice about what ought to be in the plan, what might not need to be in the plan, get some feedback on what they're doing.

Medical society executives recognize the role of organized medicine in sustaining ambulatory care quality improvement through leading, educating, and collaborating to assist physicians and physician practices.

Leadership

In our focus group discussions, participants suggested that medical societies should be leaders and take a position while “leveraging our credibility.”

I think the best use to us is to leverage our credibility. Dr. J_____ [is] very proud about his local medical society, and you trust those, and I think we have a built-in ability—these are organizations of doctors for doctors, and they listen to each other. We sat in here last night and listened to all the physicians talking about a variety of subjects. I mean, there are shared experiences you have to build on. I think bringing best practices together. I think building mentorships. How do you figure out what you want to use... [E]veryone of you all probably bought the cell phone that you have based on what someone in your group's using. 'Cause you're ... walking down the hallway, and “Hey, let me see your thing.” Well, it's going to be the same way with EMRs and prescribing-

Respondents suggested that medical societies can uniformly emphasize that physicians “must have informational technology.” It is clear that the medical societies have significant experience and recognize the importance of their roles in ensuring that physicians not only support health care quality, but take a leading role to sustain health care quality.

A majority of participants felt that the medical society should take a position, “against reporting on individual physicians.” Overall, the thought was that as care is team based, physicians do not support reporting data at an individual level, but do support collecting and using data to improve individual performance.

[T]here are certain principles that are reasonable principles: that the communications, the information technology, the financial support of the transition to that process are going to take some bold leadership moves, and we cannot wither when we stand forward and say that, and it's going to alienate some people, but leadership [has] to say, “Okay. You're going to have a lot of dissent, and but somebody's still got to lead and say, ‘What's the big principle here?’” The big principle is our patients can get good care. Our physicians cannot duplicate services, and we can have a faster, more economical way to make sure that patients all over this country know what their medical history is. And it's not going to be from 50 different systems and from 300 different systems and from two states battling over each other.

Moreover, the participants recognized how many layers are involved and the potential for various leaders in quality at a national and local level:

You kind of have the two levels in the quality [area]—you've got the leadership or the front people who are working at the national level, and you've got national standards and you've

got pushback from the payers, and so you've got those that are leading the registries to submit measures—so that's one tier.

Education

Education at various meetings and venues is an integral part of what medical societies provide.

We've been doing practice informatics presentations at the [state medical society's] annual meeting.

Physicians and medical society administrators emphasize that measurement for measurement's sake is not the goal. They have a desire to learn and participate in measurement. They want to have a concrete link of what they are learning with best practices and measurement to improve their practice of health care, while gaining knowledge.

I've only been to three Alliance meetings, and at each one I pounded my shoe on the table and said, "What are we going to do to support physicians? We've been doing these reports. We've been putting them on the web. You know, we've been flashing these results for everyone to see..."

G. AMA's Recommended Future Role

Medical societies and quality collaborators strongly believe that the AMA can assist them and their physician members in the mutual goal of improving the quality of health care in the ambulatory care setting. The medical societies and quality collaborators recommend that the AMA take a leadership role to ensure that physicians, the medical societies, and national funders are working together to support a cohesive quality improvement effort at both local and national levels. The participants highlighted seven areas in which the AMA could help sustain quality improvement: 1) Advance Team-Based Care at a Local and National Level; 2) Clearly Define Quality; 3) Ensure Measurement Supports Quality Improvement; 4) Ensure Focus on the Physician/Patient Relationship; 5) Encourage Use of Performance Improvement Continuing Medical Education (PI-CME); 6) Promote Models and Advance Ambulatory Care Quality Improvement; 7) Work Towards Comprehensive Standardized Performance Measures to be Incorporated for Reimbursement and Payment Reform.

While participants recognize they have strength in advocacy, they acknowledged that they, as well as the AMA need to do more regarding quality.

Yes, we have other interests from the medical society, which may be advocacy and politics and stuff, but we [have] to create a wing in the medical society, in AMA, which is as strong and as powerful on the quality front.

We should be wanting to be better at quality next year than we are this year, and maintaining the status quo is not going to be good enough.

Below are the seven areas in which the AMA could help sustain quality improvement, and participants' supporting comments.

1. Advance Team-Based Care at a Local and National Level

Participants stressed the need to focus on care coordination and teamwork by giving others the ability to work as a team.

I'd love to see a better care coordination panel or care coordination model developed through organized medicine that would filter down to local communities.

Another key role that the AMA was encouraged to play is as a convener of key stakeholders on quality and reimbursement. For example, participants recommended the following:

[I]n terms of quality ... I think the AMA should do whatever we can to help ... with reaching out to organizations, to our own institutions, and trying to cross the borders between us, and it's very difficult, because these are very strong organizations and very strong political basis, and they're run very tightly and centrally.

[I]f you guys [AMA] have any influence or impact to encourage CMS and ONC [Office of the National Coordinator for Health Information Technology] to speak to each other [the AMA should do so].

2. Clearly Define Quality

One area of focus is to foster acceptance of a clear definition of quality and quality improvement, and then to decide how to measure quality.

[W]hat will be very helpful for the state medical societies and the AMA [to do] would be to first define what we mean by ambulatory quality. I don't think we have a really good definition for ambulatory quality.

So what can organized medicine do? They can help us figure out what quality is and how to measure it.

3. Ensure Measurement Supports Quality Improvement

Participants recommended that the focus on metrics and how they are used should be clarified on both the individual practice and public health levels. However, it is important to know what the question is and for which audience the data are being used. Medical societies at the county and state level see the AMA helping ensure that quality of care for all of our society (public health) is a top priority. This can be the impetus to embody quality of care for preventive services as well as acute and chronic care needs.

I would say that from the AMA down, if you just start pecking away at those metrics that we use to measure health care in the world... You know: beta blockers when you need them, etc. every community should be able to document 75 percent of their citizens or 80 percent. The current status is 58 percent. We want to go up 18 percent, and if you're above it, great, see if you can go higher, but we want to get everybody to a certain level.

Moreover, the results support the AMA's decision to focus on using clinical data rather than claims data to ensure ambulatory care quality improvement. It was emphasized that clinical "[m]easurement[s] are valid and reliable information" and there is:

Direct [clinical] data submission. They [physicians] are "so proud of the direct data submission that the [physician] groups are doing, because originally it was health plan claims stuff. Nobody puts in a claims for quality. They all put in a claims for payment.

4. Ensure Focus on the Physician/Patient Relationship

Participants further explained the need to clarify guidelines and best practices, with the AMA taking a leadership role. Discussion of how the AMA could assist to clarify what is being measured often focused on the best interests of the physician, the patient, and public health. That is, participants discussed the importance of organized medicine's leadership role to sustain quality improvement by physicians.

The goal of a big group then in a leadership role is to be bold enough and courageous enough to come forward and take a stand and say, We represent the best interests of both the patients and the public and of our members, which are our physicians, and take a bigger view, just the way the president has to do it.

The best delineators of quality of care in this country are quality physicians living by good codes of ethics: that's what it [the AMA] should be saying.

5. Encourage Use of Performance Improvement Continuing Medical Education (PI-CME)

The AMA was encouraged to assist physicians with using PI-CME in combination with Physician Consortium for Performance Improvement (PCPI) measures.

I can see where that model would work for PI-CME. You've got all the specialty societies there [in the PCPI], who have given their time and talent to developing measures. [Combining] the nationally endorsed measures that everyone is kind of leaning toward in their states and with their own regional [education] initiatives [would work].

6. Promote Models and Advance Ambulatory Care Quality Improvement

The AMA takes advantage of what other have learned.

[I think] why not take advantage of what we've learned? We take advantage of what others have learned, and with the help of the AMA in a few key areas, I think we have a great opportunity to really, really help practices.

Many medical society participants recommended that some organization needs to take a lead to help the medical societies ensure that ambulatory health care quality improvement can be sustained.

[B]ut somebody's still got to lead and say, What's the big principle here? The big principle is our patients can get good care. Our physicians cannot duplicate services, and we can have a faster, more economical way to make sure that patients all over this country know what their medical history is. And it's not going to be from 50 different systems and from 300 different systems and from two states battling over each other.

[T]he only way the state medical societies will be able to influence ambulatory quality is when physicians come seeking out assistance. They won't be able to impose it. So you [AMA] create the push, and you have the open arms once the push comes. So to the extent that we can start to define this, measure it, and incentivize, you'll then be able to create a need for the medical society [to assist in sustaining quality improvement].

[T]he goal of a big group, and even if you extend to something like the AMA, the goal of a big group then in [a] leadership role is to be bold enough and courageous enough to come forward and take a stand

7. Work Towards Comprehensive Standardized Performance Measures to be Incorporated for Reimbursement and Payment Reform

The medical societies and the AMA seek opportunities to work towards a comprehensive measurement to support physicians. The medical societies felt the AMA should address quality by helping physicians and medical societies deal with reimbursement and payment reform. Many participants recognize that there are: [M]ultiple yardsticks and ... you reach a point where it gets hard to compare.

Several participants stated that they would rather address guidelines than measures.

I think that the one thing the [state medical society] needs to do is figure out how we enhance survival of primary care in the current situation, which is going to require payment reform. And that has to happen at the national level, not at the state level. We can no longer have geographic discrepancies like we have right now with Medicare.

[T]he advocacy of the AMA on the national level on the payment reforms is the absolute critical part.

Summary. Focus group participants' ideas about the role that the medical societies and the AMA can play to advance quality improvement reflect the significance of creating an environment built on relationships. The seven recommendations are a natural fit with the AMA's traditional relationship with the medical societies. They can be put into action steps to advance and sustain quality improvement in the ambulatory care setting not just for acute care needs, but for preventive services as well.

Recommendations for Organized Medicine's Role in Quality Improvement

How do you make this [quality improvement] relevant to the physicians, and how do you really make it something that's doable for most physicians?

This quote from one participant emphasizes what medical societies, those involved in quality improvement, and this study have sought to answer. As described in the findings, site visit participants indicated that this question can be answered in more than a few ways, but primarily through collaboration. Whether ambulatory or hospital-based, it is imperative that all stakeholders understand what quality is and how to sustain it. Because physicians and medical societies believe that quality standards should be clinically appropriate for specific local populations, physicians practicing in these areas want to and must be involved in setting those standards.

Quality collaboratives affect the success and sustainability of quality improvement efforts. As reported above, there are multiple aspects of health care that drive quality. These include: 1) the availability and type of insurance coverage; 2) the number of family practice physicians in ambulatory care settings; 3) the access to health systems (i.e., insurance, resources, coordination); and 4) the economic challenges faced by physicians in maintaining their solo or small practices. These concerns along with the lack of a consistent definition of quality have challenged physicians with embracing and leading quality improvement activities that could lessen the burden of disease and enhance disease prevention, while improving the health of our communities

Participants in this investigation supported the importance of three things needed to sustain quality: 1) shared focus—ambulatory quality improvement should be focused on the relationship between the physician and the patient at the local community level, yet impact public health; 2) shared best practices—there are practices in which medical societies are involved that could be replicated; and 3) shared resources—the medical societies and the AMA can help physicians understand, implement and sustain quality initiatives.

Within the AF4Q communities, it is clear that state and/or county medical society staff and other quality improvement leaders are actively involved or have shown significant interest in understanding what is needed to ensure and sustain quality. They have separately and together developed practice models through their projects in education, collaboration, HIT, measurement, and patient safety. The work the medical societies have undertaken in these areas have engaged physicians to collaborate with organized medicine. If this is to be successful, peers with expertise in quality initiatives need to be engaged and nurtured.

What might the role of the AMA be? The AMA's strength has been as a convener and educator. As a convener, the AMA can support the following: a) augment the state and local medical societies' work to find and engage leaders in quality improvement; b) assist in the meaningful implementation of Health IT that rapidly enables quality improvement projects; and c) establish the national goals and measurement needed to improve quality at a local level. As an educator, the AMA can leverage its expertise to facilitate and guide organized medicine in developing an infrastructure that helps physicians apply measurement to enable practice evaluation and redesign. Thus, the physician can ensure that professional development and licensure requirements are fulfilled as he/she strives to improve the quality of patient care.

The results of this investigation underscore the reality that current medical education is embracing continuous learning for physicians to ensure that they meet maintenance of certification and licensure requirements. When physicians are engaged and supported in continuous learning about clinical care and patient outcomes, and measurement becomes a by-product of the care process, quality will no longer be a goal but a given.

Conclusion

Advancing ambulatory care quality improvement to promote patient health care with chronic diseases and disease prevention is critical for patients and physicians. From this investigation, it is clear that the engagement of the AMA and medical societies to may help advance and sustain quality improvement is essential to engaging physicians in ambulatory care settings. As one participant emphasized:

I agree the individuals [physicians] can't do it on their own for the reasons [that have been stated], and I agree that grassroots physicians don't wake up in the morning, thinking, "How can I create an effective, organized system of care?" but when given an opportunity to join together to create systems of care that they can influence, that they can control, that they can lead, they resonate to that, because they see that a more effective system of care that they lead can actually be responsive to their personal and professional values and goals.

Site Grid

RWJF AF4Q Site	State and County Medical Societies
Eureka, California	California Medical Association Ste 200 1201 J Street Sacramento, CA 95814-2906 Humboldt-Del Norte County Medical Society PO Box 6457 Eureka, CA 95502 Alameda-Contra Costa Medical Association (ACCMA)
Brunswick, Maine	Maine Medical Association PO Box 190 Manchester, ME 04351
Detroit, Michigan	Michigan State Medical Society 120 W Saginaw St East Lansing, MI 48823 Wayne County Medical Society of SE Michigan 3031 W Grand Blvd #645 Detroit, MI 48202
Grand Rapids, Michigan	Michigan State Medical Society 120 W Saginaw St East Lansing, MI 48823 Mason County Medical Society 907 E. Tinkham Avenue Ludington, MI 49431-1464 Ottawa County Medical Society 59 Forest Hills Drive Holland, MI 49424 Kent County Medical Society 234 Division Ave North Suite 300 Grand Rapids, MI 49503 Allegan County Medical Society 300 36th St SW General Motors Metal Center Grand Rapids, MI 49548
Minneapolis, Minnesota	Minnesota Medical Association Ste 2500 1300 Godward St NE Minneapolis, MN 55413
Kansas City, Missouri	Missouri State Medical Association 113 Madison St PO Box 1028 Metropolitan Medical Society of Greater KC Kansas City, MO 64112

Albuquerque, New Mexico	<p>New Mexico Medical Society 7770 Jefferson NE Ste 400 Albuquerque, NM 87109</p> <p>Greater Albuquerque Medical Association 7770 Jefferson NE Ste 420 Albuquerque, NM 87109</p>
Williamsville, New York	<p>Medical Society of the State of New York 865 Merrick Ave Westbury, NY 11590</p> <p>Medical Society of the County of Erie 1317 Harlem Road Buffalo, NY 14206</p>
Cincinnati, Ohio	<p>Ohio State Medical Association 3401 Mill Run Dr Hilliard, OH 43026</p> <p>Academy of Medicine of Cincinnati 2300 Wall Street Ste F Cincinnati, OH 45212</p>
Cleveland, Ohio	<p>The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) 6100 Oak Tree Blvd. Ste. 440 Independence, Ohio 44131</p>
Portland, Oregon	<p>Oregon Medical Association 11740 SW 68th Parkway Ste 100 Portland, OR 97223-9038</p>
York, Pennsylvania	<p>Pennsylvania Medical Society 777 E Park Drive PO Box 8820 Harrisburg, PA 17105-8820</p> <p>York County Medical Society 1001 S. George St. York, PA 17405-3676</p>
Memphis, Tennessee	<p>Tennessee Medical Association 2301 21st Ave S PO Box 120909 Nashville, TN 37212-0909</p> <p>Memphis Medical Society 1067 Cresthaven Rd Memphis, TN 38119-3833</p>
Seattle, Washington	<p>Washington State Medical Association 2033 6th Ave Ste 1100 Seattle, WA 98121</p>
Middleton, Wisconsin	<p>Wisconsin Medical Society 330 E Lakeside St Madison, WI 53701-1109</p>

Focus Guide for the Site Visit

Prior to the visit we are requesting the following: an organization chart, mission statement, and any other information that would provide information about your organization, quality initiatives, health information technology, and educational programs.

Demographics

Number of staff? _____ Number of executive staff members? _____

Foundation

Do you have a Foundation? Yes No

If yes, what is the name? _____

What role does your organization's Foundation play, overall? _____

What role does the Foundation play with quality? _____

What role does the Foundation play with education? _____

What role does the Foundation play with practice management? _____

Collaboration

Can you describe your engagement/awareness of the AF4Q? _____

How does your organization assist doctors (feasible and sustainable)? _____

Does your organization have the ability to build on what you have now to deal with the members needs? (please explain)

How does your organization interact with the county medical society or state medical society? _____

Regarding Networking/Learning? _____

With advocacy in quality _____

With education? _____

With infrastructure? _____

With practice management? _____

Quality Improvement

How do you define quality or quality improvement? _____

How does quality fit in your organization (e.g., top priority, legislation is priority)? _____

How many staff members are dedicated to quality? _____

How many staff members support quality? _____

How many other quality improvement projects/programs (e.g., AF4Q) are you involved in? _____

Who within the you organization are actively participating in quality/quality collaboratives? _____

How does your organization show doctors how to adopt ambulatory care quality improvement strategies to participate in quality improvement (feasible and sustainable)?

With education _____

With infrastructure (human resources, physical space) _____

With leadership _____

With communication/networking _____

Are any quality improvement activities sponsored by a health plan?

QIO? Specialty board? Other? _____

Education

How active is your organization with physician education? _____

Are you aware of performance improvement continuing medical education (PI-CME)?

Yes No

If yes, which PI CME programs for your members are you aware of? _____

How many primary care physicians are engaged in PI CME? _____

What types of education around quality do you provide to your members? _____

Practice Management

What does the organization do to assist physicians with practice management? _____

Can you describe your involvement with practice management regarding:

Regulatory changes? _____

Coding (PQRI)? _____

Health information technology? _____

Leadership

Who are the leaders for quality?

Staff: _____

Members: _____

How did they evolve as leaders?

Staff: _____

Members: _____

Resources

What kind of financial resources do you have to support quality initiatives? _____

What kind of internal resources do you provide (financial; health IT)? _____

What kind of external resources do you provide (financial; health IT)? _____

Outcomes

What are the lessons learned about any work you are undertaking with regarding to the following:

A leadership role? _____

Advancing quality? _____

Infrastructure? _____

Education? _____

Communication? _____

Are you aware of any practices to implement registries? Yes No

Do they review the performance data? Yes No

Do they share the data with colleagues for purposes of improvement? Yes No

If so, who sponsors this? _____

How do physicians in the community's responses to this? _____

We would like to learn from all your success and failures:

What initiatives have you tried, and failed? _____

Have you shared them? Yes No

If yes, can you explain? _____

How can the American Medical Association (AMA) be of assistance to you to promote ambulatory care quality improvement?

How can the AMA be of assistance to you to promote practice improvement continuing education? _____

How can the AMA be of assistance to you to promote practice management? _____

Coding Scheme Outline

Main codes	
LP Context	Local practice context
LP Context-QI	Local practice context—quality improvement (QI)-specific
QI def	How informants define QI
MS role	Medical society role—general
MS role-QI	Medical society role—QI-specific
MS structure	Medical society structure
MS structure-QI	Medical society structure—QI-specific
QI barrier	QI barriers/challenges
MS future-QI	Medical society future role in QI
AMA role	Role for the AMA in QI

Role Subcodes

Note: Most of the time, the Role subcodes should be used to refine information about the medical societies' activities. However, there may be instances where these codes may also be paired with the local practice context codes.

- **PMgmt**—Practice management
- **Ed**—Education
- **DataSys**—Data Systems
- **LeadershipDvlp**—Leadership development
- **Collab**—Convening/participating in collaborations
- **PAdvocacy**—Policy advocacy

Performance Improvement— Continuing Medical Education Description

Performance improvement (PI) activities describe structured, long-term processes by which a physician or group of physicians can learn about specific performance measures,¹ retrospectively assess their practice, apply these measures prospectively over a useful interval, and re-evaluate their performance. To award AMA PRA *Category 1 Credit*TM for PI activities, providers must:

- Establish an oversight mechanism that assures content integrity of the selected performance measures. These measures must be evidence based² and well designed (e.g., clearly specify required data elements, data collection is feasible). PI activities may address any facet (structure, process or outcome) of a physician's practice with direct implications for patient care.
- Provide clear instructions to the learner that define the educational process of the PI activity (documentation, timelines, etc.) and establish how they can claim credit.
- Validate the depth of physician participation by a review of submitted PI activity documentation. Providers may award credit to physicians for completing defined stages of the PI activity. When requested, supply specific documentation of such credit to participating physicians.
- Provide adequate background information so that physicians can identify and understand the performance measures that will guide their PI activity, and the evidence base behind those measures. Providers may deliver this education through live activities, enduring materials or other means. Providers must ensure that participating physicians integrate all three stages described below to develop a complete, structured performance improvement activity.

Stage A: Learning from current practice performance assessment

Assess current practice using identified performance measures, either through chart reviews or some other appropriate mechanism. Participating physicians should be actively involved in data collection and analysis.

Stage B: Learning from the application of PI to patient care

Implement an intervention based on the performance measures selected in Stage A, using suitable tracking tools (e.g., flow sheets). Participating physicians should receive guidance on appropriate parameters for applying an intervention and assessing performance change, specific to the performance measure and the physician's patient base (e.g., how many patients with a given condition, seen for how long, will produce a valid assessment?).

Stage C: Learning from the evaluation of the PI effort

Re-evaluate and reflect on performance in practice (Stage B), by comparing to the assessment done in stage A. Summarize any practice, process and/or outcome changes that resulted from conducting the PI activity.

Assigning credit for PI activities

Physicians may be awarded incremental AMA PRA *Category 1 Credit* for completing each successive stage of a PI activity. Incremental credit for PI activities should be awarded as follows:

- Five (5) AMA PRA *Category 1 Credits* can be awarded for the completion of each of the three stages (A, B and C). Completion of the full PI cycle is not required.
- Providers may design PI activities so that physicians can enter at any of the three stages. Providers that do so must design a mechanism by which physicians who enter after Stage A can document their completion of work equivalent to that described for the earlier stages.

Physicians completing, in sequence, all three stages (A–C) of a structured PI activity may receive an additional five (5) AMA PRA *Category 1 Credits*, for a maximum of twenty (20) AMA PRA *Category 1 Credits*. This credit allocation acknowledges the best learning is associated with completing a well conceived PI activity.

Health Information Technology Extension Program/ Regional Extension Centers (RECs)

Alaska eHealth Network
Anchorage, Alaska

Altarum Institute
Michigan

Arizona Health-e Connection
Phoenix, Arizona

Arkansas Foundation For Medical Care

Chesapeake Regional Information System for our Patients
Baltimore, Maryland

CIMRO of Nebraska

Colorado RHIO

Community Health Centers Alliance, Inc,
St. Petersburg, Florida

Dakota State University
Madison, South Dakota

Dallas- Fort Worth Hospital Council Education
and Research Foundation
Irving, Texas

District of Columbia Primary Care Association

eHealthConnecticut, Inc.
Rocky Hill, Connecticut

eQHealth Solutions, Inc.
Baton Rouge, Louisiana

Fund for Public Health New York

Greater Cincinnati HealthBridge
(Ohio-Kentucky-Indiana)

Hawaii Health Information Exchange, Honolulu, Hawaii

Health Choice Network, Inc.
Florida

HealthInfoNet
Manchester, Maine

HealthInsight
Utah-Nevada

Iowa Foundation for Medical Care (IFMC)
Des Moines, Iowa

Kansas Foundation for Medical Care Inc.

Key Health Alliance (Stratis Health) Minnesota—North
Dakota

LCF Research
New Mexico

Local Initiative Health Authority for Los Angeles County
Los Angeles, California

Louisiana Health Care Quality Forum
Baton Rouge, Louisiana

Massachusetts Technology Park Cooperation

MetaStar, Inc, Wisconsin

Morehouse School of Medicine, Inc. Georgia

Mountain-Pacific Quality Health Foundation
Helena, Montana

National Indian Health Board
Washington, D.C.

New Jersey Institute of Technology
Newark, New Jersey

New York eHealth Collaborative (NYeC)

Northern California Regional Extension Center

Northern Illinois University

Northwestern University

OCHIN Inc. (Primary)
Oregon

Ohio Health Information Partnership

Oklahoma Foundation for Medical Quality, Inc.

Ponce School of Medicine
Puerto Rico

Purdue University

Qualis Health
Washington - Idaho

Quality Insights of Delaware, Inc.
Wilmington, Delaware

Quality Insights of Pennsylvania, Inc. (Eastern)
King of Prussia, Pennsylvania

Quality Insights of Pennsylvania, Inc. (Western)
King of Prussia, Pennsylvania

Qsource (Tennessee)

Rhode Island Quality Institute

Southern California Regional Extension Center

South Carolina Research Foundation
Columbia, South Carolina

Texas Tech University Health Sciences Center
Lubbock, Texas

The Curators of the University of Missouri
Columbia, Missouri

The TAMUS Health Science Center Research Foundation
College Station, Texas

University of Central Florida
Orlando, Florida

University of Kentucky Research Foundation
Lexington, Kentucky

University of North Carolina
Chapel Hill, North Carolina

University of South Alabama
Mobile, Alabama

University of South Florida
Tampa, Florida

University of Texas Health Science Center at Houston
Houston, Texas

Vermont Information Technology Leaders, Inc.

VHQC and the Center for Innovative Technology,
for The Virginia Consortium

West Virginia Health Improvement Institute Inc.

Physician Consortium for Performance Improvement Members

Society/Association Name

American Medical Directors Association
 American Society of Plastic Surgeons
 American Society of Retina Specialists
 National Medical Association
 American Society for Aesthetic Plastic Surgery
 American Society for Clinical Pathology
 American Urological Association
California Medical Association
 American Heart Association
 American Association of Gynecologic Laparoscopists
 American Physical Therapy Association
 Accreditation Association for Ambulatory Health Care
 American Medical Directors Association
 American Society of Neuroradiology
 American Society for Therapeutic Radiology and Oncology
 College of American Pathologists
 American Society of Clinical Oncology
 American Society of Colon and Rectal Surgeons
 American College of Surgeons
 American College of Cardiology
 American College of Surgeons
 American Society of Anesthesiologists
 American Academy of Audiology
 American Academy of Ophthalmology
 American Academy of Physical Medicine and Rehabilitation
 American College of Rheumatology
 American College of Radiology
 American Urological Association
 American Society of Plastic Surgeons
Michigan State Medical Society
 American College of Radiology
 American Geriatrics Society
 American Geriatrics Society
 American Society for Therapeutic Radiology and Oncology
 American Society for Therapeutic Radiology and Oncology
 American Urological Association
 American Society for Clinical Pathology

Infectious Diseases Society of America
 College of American Pathologists
 American Gastroenterological Association Institute
 Minnesota Medical Association
 American Academy of Physical Medicine and Rehabilitation
 American Association of Electrodiagnostic Medicine
 American Society for Gastrointestinal Endoscopy
 American Society of Hematology
 American Medical Directors Association
 American Academy of Neurology
 American College of Cardiology
 American College of Cardiology
 American Heart Association
 American Academy of Family Physicians
Ohio State Medical Association
 American Academy of Allergy, Asthma, and Immunology
 American Society of Clinical Oncology
 Endocrine Society (The)
 American Society of Clinical Oncology
 American Psychiatric Association
 American Society of Anesthesiologists
 College of American Pathologists
 American Chiropractic Association
 American Thoracic Society
 American Gastroenterological Association Institute
 American Society for Gastrointestinal Endoscopy
 American Academy of Allergy, Asthma, and Immunology
 American Academy of Facial Plastic and Reconstructive Surgery
 American Academy of Otolaryngology-Head and Neck Surgery
 American Academy of Dermatology Association
Pennsylvania Medical Society
 American Board of Internal Medicine
 American College of Cardiology
 American College of Medical Genetics
 American Geriatrics Society
 American Institute of Ultrasound in Medicine
 American Society of Transplant Surgeons
 Society of Nuclear Medicine

Society for the Advancement of Blood Management
American College of Radiology
American Academy of Pediatrics
American College of Physicians
American College of Radiology
American Society for Therapeutic Radiology and Oncology
American Board of Internal Medicine Foundation
Society of Critical Care Medicine
American Academy of Sleep Medicine
American Society of Anesthesiologists

Tennessee Medical Association

Society of Interventional Radiology

Wisconsin Medical Society

American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
Council of Medical Specialty Societies
American Academy of Family Physicians
American Association of Neurological Surgeons/
Congress of Neurological Surgeons
American Society of Addiction Medicine
National Association of Social Workers
American Academy of Physical Medicine and Rehabilitation
American Academy of Allergy, Asthma, and Immunology
American Academy of Pediatrics
American College of Allergy, Asthma and Immunology
American College of Radiology
American College of Chest Physicians
American Society for Therapeutic Radiology and Oncology

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