

## Implementing the 1997 Asthma Guidelines

*After Dr. Stoloff completed his presentation, the panel discussed physician response to the 1997 asthma guidelines from the National Heart, Lung, and Blood Institute.*

**Dr. Turk:** Dr. Stoloff, do you have a feeling of how well accepted the guidelines are? If it's not 100%, what is the primary reason that they are not used in all areas? A number of studies over the last few years have demonstrated that asthma patients treated according to the guidelines have enormous improvement in terms of clinical parameters such as hospitalization and emergency department visits.<sup>1-4</sup> If the guidelines work so well, why are we not seeing them used on a more extensive basis?

**Dr. Stoloff:** Many physicians believe that it takes too long to educate a patient and to provide the amount of information necessary to provide care in a comprehensive fashion for this disease. In actuality, a recent study showed it takes anywhere from 5 to 7 minutes less time to educate a patient and provide optimal care than when care is provided in the normal, customary fashion.<sup>5</sup>

Physicians, especially in primary care, feel overwhelmed with the amount of material that they're supposed to accomplish in a visit. They often decide that the easiest management is to provide the patient with something that's easy to take, that they don't have to educate them about, and leave that responsibility, many times, to other people. Also, physicians perceive the disease as episodic. The only time the patient actually shows up in the office is during an illness, and the physician gives the patient rescue medication. A follow-up visit may or may not be sched-

uled, depending on the time commitments of both the physician and the patient. No formal process is in place to identify what's going to happen to that patient after that event transpires, partly because the physician feels that may be too much to do.

Many physicians are not aware of the types of ancillary support systems available in their community to assist them in the education. For instance, in diabetes, a tremendous effort that's been very successful is with diabetic educators. These people introduce how to use insulin and provide the patient with information, then schedule follow-up appointments with the patient. That process is not available in most communities for physicians involved in dealing with asthma.

Many physicians also do not determine disease severity. If the patient's disease severity is not categorized at the first office visit, then the physician is really ill equipped in determining how to administer medications, what medications to provide, or what information and additional education or laboratory evaluation will be needed.

### Education Issues

**Dr. Turk:** How much is physician education lacking?

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**Dr. Stoloff:** Actually, physician and patient education are both lacking. Most physicians have not had any training in how to provide patients with information about their disease, especially with chronic diseases. Most

people don't know what asthma is because many times they don't feel it. And when they feel it, they take their treatment. When they stop feeling it, they think they don't have it anymore. Physicians perceive the same process. If the patient is not feeling the symptoms, they don't have it; it isn't hurting them.

With these guidelines, we're trying to educate people that this is a continuum, that the process is ongoing, and that we need to treat this process whether the patient feels the process or not. The patient will be at significant risk for other problems if we don't treat the process over time.

*Ms. Stump:* I think the recent *JAMA* [*Journal of the American Medical Association*] article on lack of shared patient decision making affirms this communication deficiency.<sup>6</sup> Many of the providers that I've spoken to cite the fact that education isn't reimbursed, that only procedures are paid for, as a deterrent to spending time on education. The problem and solutions are complex and multifactorial. Specifically for asthma, keeping up to date on asthma-related issues is typically a priority with asthma subspecialists. Other providers—family practice, pediatrics, and general internal medicine—have patient mixes that are more varied. In gatekeeper systems, primary care providers are often expected to manage asthma and refer harder-to-manage cases to the specialist. A one-size-fits-all solution does not exist. Optimal outcomes come from a best-fit patient/provider team.

*Dr. Turk:* One of the things about patient education that's come up in surveys on why physicians don't follow the guidelines is that they don't have enough lectures and they don't have enough education. On the other hand, when opportunities are offered, they are not taken advantage of because so many lectures are avail-

able on so many topics. And a common statement is, "Well, we don't want to go to a lecture that is sponsored by pharmaceutical companies because pharmaceutical companies tend to shift the emphasis." And that may or may not be true.

In some of the coalitions that have formed in states and among states, one idea is to have a joint pool of funds provided by the pharmaceutical companies. With this money, absolutely impartial lecturers could give the lectures.

*Dr. Eisenberg:* I think that is an excellent idea. To a large extent, physicians have a definite reluctance to get involved with the drug companies because of the perceived or real opportunity for marketing. That's certainly true, not only at the practicing physician level but at the health plan and other levels within our industry. And some of the companies do so much more marketing than others do.

Also, it's not just the asthma guidelines that don't work across the board, and I don't think we can put that solely on physicians. If we expect physicians or other care providers to do this independently of anything else, I think it's doomed to failure. The key to success is to put into place processes within the delivery of care to help physicians do what you expect them to do. I don't think we spent any real time and effort looking at what we can do along those lines—using technology or other means.

A good example of those processes is how Pap smears are scheduled. We implemented simple things like revolving card files to remind patients to come in and get their Pap smear. The patient gets a card in the mail reminding her to schedule a Pap smear, and the physician gets a reminder on the chart that this person has not had an annual Pap smear.

*Ms. Hardin:* We do a variety of interventions to assist and advise physi-

cians with implementing guidelines. For asthma, we send chart stickers to the physicians of members enrolled in our program. The stickers, which act as a reminder, list specific guidelines for treating the disease. We also send physicians lists of their patients who are not being treated in accordance with the recommended guidelines. We send them a letter and a copy of the Expert Panel Report.

### Time Issues

**Dr. Nathan:** Is the time that primary care physicians have with the patients really an issue? We always hear that 7 to 12 minutes is probably all the time they have with a patient. How much can be done during that period of time when it comes to patient education? As allergists, we tend to schedule half-hour appointments for most of our patients, then we follow up. I spend an inordinate amount of time trying to educate. After I do it, my nurse comes in and does exactly what you're talking about—going over metered-dose inhaler technique, peak flow meters education, and those kinds of things. If you say this process takes only 5 to 7 minutes but you only have 7 to 12 minutes, can you get everything done, including the history, the physical, and writing out the prescriptions?

**Dr. Stoloff:** I believe this is a major issue for a lot of physicians. It may not be real for some of them, but it is definitely perceived as a factor. Even for the physicians that actually have more time, they perceive that they only have 7 to 10 minutes.

The amount of other responsibilities that they have during the workday, the amount of other material and different forms of communication that they are held responsible for, especially if they deal with patients in the hospital, precludes the educational process that they see as important. For hypertension, you give them a

pill, you check their blood pressure, you ask them if they're feeling fine, and you wing it at that point. In diabetes, you look at what their blood hemoglobin or their blood glucose levels may be, and you may ask a few questions. In asthma, we're asking the physicians to ask more questions and show they have some level of skill. And physicians, with the time they have, feel that is not possible.

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—Robert A. Nathan, MD

Also, physicians don't see how much fun it is to treat asthma patients, how much better they get. They don't perceive the disease as chronic, but they see their loss of time as a chronic issue. In many ways they perceive this almost like dealing with someone who has depression, thinking, “Oh, well, this is going to take a lot longer than I want to spend.”

**Dr. Miller:** No one says that the physicians only have 7 to 12 minutes. Unless you work in a staff model, where the plan schedules your patients for you, primary care physicians make a determination of their panel size in relation to the number of HMO [health maintenance organization] contracts they have, which medical group or IPA [independent practice association] they work for, how much money they want to make, and what their capitation is. They can easily schedule 15-minute visits and see half as many patients as doing a 7 1/2-minute visit. So the decision is up to the individual physician on how

much time is available unless they're an employed physician in a staff model or a group situation.

I think that physicians know the guidelines. They know that asthmatics need to be on controller medications. When we do statistically valid random samples to monitor against clinical practice guidelines, for the charts that we review, we see 70% to 80% of our CIGNA members who have moderate to severe asthma on controller medications.

The focus, for me, would be on the tracking and reminders—for example, a flowsheet on every asthma patient's chart, questionnaires that patients can answer while they're in the waiting room. Those are the types of things that can help to avoid having patient care be time consuming during the examination time.

Most of the research has shown that education alone is one of the poorest ways to change physician behavior. Education can be achieved by attending lectures, whether they're sponsored by pharmaceutical companies or not or going to a CME [continuing medical education] talk or a brown-bag lunch. But physicians need to live it; they need to feel it. You need to make their life easier.

*Ms. Hopper:* Our experience is that physicians will use materials that can save time and be easily integrated into their routine. We've had positive feedback from physicians regarding tools that assist them in tracking member care and the member education tools that help members take a more active role in the management of their disease.

*Dr. Miller:* And they need to have experience with their patients on these particular medications or see changes that will make them change their behavior. They will have a little bit more of an incentive because they have better patient satisfaction; the patients have better quality of life,

functional status, clinical outcomes, or other positive outcomes.

### Using Ancillary Healthcare Personnel

*Dr. Berney:* I think we've identified some very critical factors at this point. One is that we've perfected the guidelines. But I'm quite surprised that when studies are done in my home state, which is Tennessee, that the implementation of the guidelines totally fails. So I think we've created just a wonderful product, but no one is buying it. The next critical factor that we've identified is the fact that primary care physicians are incredibly busy. And yes, the amount of time they spend is up to them. But the situation is that managed care has got them running on a treadmill where they have patients scheduled every 5 to 10 minutes.

In a lot of primary care offices, patients are not considered to actually be affected by this disease; it fluctuates and gets worse at night, but it is probably pretty good by the afternoon, when most physicians see them. And with children, I believe asthma is the number-1 chronic disease of childhood. Most of these children have insurance, and we're still not seeing a lot being done.

The next critical point we've identified is that ancillary healthcare personnel can take over when the physician is extremely busy, unwilling to work with the disease, or simply is seeing a patient for an acute symptom and is not treating a chronic problem. In Tennessee, we've had quite a bit of experience using outreach workers, who are ancillary healthcare personnel, and along with that, using pharmacists to help educate patients in this area. Has anyone else had experience using these ancillary models?

*Ms. Hopper:* In our plan, we provide extensive individualized patient education by a registered nurse for mem-

bers at early risk. We have case management services aimed at members with more complex healthcare needs. We also try to eliminate barriers to care, for example, by expanding healthcare benefits to include coverage of diabetic classes.

**Dr. Turk:** Several areas of the country are using ancillary personnel. The pharmacists, especially, are being pushed into helping with instruction on utilization of medication. And in many places, a particular approach has been adopted; having one nurse in charge of about 100 people, making sure they're taking their medications and going to follow-up visits and so on, which produces an enormous improvement in outcome.<sup>7</sup>

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