

## Medical Affairs/Physician Relations Team Recommendations

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The Medical Affairs/Physician Relations Team was tasked with the following case scenario and critical assumptions:

*Menopause and other women's health issues have been identified as a focus of clinical attention by your managed care organization. Tell us how the Medical Affairs and Physician Relations departments should work within the provider network to assist in meeting the National Committee for Quality Assurance*

*Health Plan Employer Data and Information Set 2000 Management of Menopause measure.*

Other questions the team was asked to consider centered around forming and managing a medical advisory committee to oversee the process of implementing menopause counseling guidelines, training and education, measures of success, and strategies to overcome any perceived barriers to success.

The Medical Affairs/Physicians Relations Team began by outlining who should participate on the medical advisory committee. They recognized that this committee would be plan specific, with fewer or more participants depending on how broadly the managed care organization (MCO) wished to work within the provider network. These committee members and their roles are summarized in Table 1.

### Qualifications and Responsibilities

Qualifications of medical advisory committee members were then considered. Physicians who control the largest number of patients within the plan should be included. The team pointed out that the 20/80 assumption as it relates to health-

care (ie, 20% of patients accounting for 80% of the allocated resources) no longer holds true; sometimes it is 1% to 5% of patients that cost the plan the most. Other members of the committee should include champions with a passion for what is being communicated; ie, those who do not consider their role a duty but believe in what the plan is trying to accomplish for women; medical directors; and people within the MCO who are best at intervention.

Responsibilities of the medical advisory team included identification of resources, including vendors; planning interventions; anticipating barriers; controlling information given to physicians to ensure consistency; and deciding how the information is disseminated.

An National Committee for Quality Assurance (NCQA)-certified independent vendor must perform the survey for the HEDIS 2000 Management of Menopause measure. It is important that a vendor with a good track record is selected to collect and ensure accuracy of the data. This will help circumvent physicians who may have experienced problems with data collection/accuracy in the past and thus refuse to accept data as measured by the survey, resulting in “push back” from within the MCO and, most likely, unchanged behavior. In supplying information to physicians in a consistent manner, protocols are necessary not only regarding counseling of patients but for recommending and disseminating treatment.

After the Medical Affairs Team reaches a consensus, it transfers these recommendations to an implementation committee (the multidisciplinary work group described earlier), which would include representatives from quality assurance/improvement, physician relations, marketing, and education. This work group would

communicate with senior management within the corporate structure. Understanding how the corporate entity works with a multidisciplinary work group (and vice versa) is important to achieving long-term goals. For example, although some health plans have corporate mandates to implement and enforce certain programs, other health plans take a different approach and recognize that it is not possible to have a standard program, especially when plans operate across states. In these cases, plan, cultural, and participant needs differ, as does the way in which physicians and members interact with the health plan. In these instances, the corporate entity assumes more of a facilitator role.

**Other Related Education**

The Medical Affairs/Physician Relations Team next addressed the importance of educating physicians within the physician network. Providing financial incentives for physicians to ensure their interest in attending a meeting in which the business case for women’s health could be made was seen as important to the success of the program. Some plans pay \$100 per hour with a cap of 2 hours; others pay \$150 per committee meeting (with a 2-hour limit). Meetings that include a meal (vs “snacks”) will also ensure higher attendance. Timing of the meeting during the day (morning, lunch, evening) is also important and specific to the market and physician specialty. In attempting to attain the greatest interest and attendance, the convenience of the meeting location should also be considered, eg, off site or centralized.

The team noted that successful implementation of a program designed to meet the Management of Menopause measure included changing physician behavior, which would be resource intensive. This could be achieved in several ways: targeted academic detailing, pre- and postsur-

**Table 1.** Medical Advisory Committee Members

Member	Role
Academic	Consultative/key opinion leader
Physicians (community)	Control largest number of patients
Local experts (obstetricians/gynecologists/nurse practitioners)	Champions/passion for goal
Office managers*	Resource
Member*	Help committee understand needs and how best to communicate about those needs
Health educator	Communicating with members
Pharmacy	
Local celebrity*	Champion the cause

\*Plan specific.

veys, continuing medical education (CME), profiling (including physician recognition), internal communications, partnering with external groups (pharmaceutical companies, health departments, societies), and other related education.

*Academic detailing.* Academic detailing involves sending a physician to speak with either another physician responsible for a large group of patients or to a group of physicians within the physician network. One MCO reported reviewing whether primary care physicians responsible for large groups of patients within the network were prescribing an angiotensin-converting enzyme (ACE) inhibitor to those who had experienced a myocardial infarction (MI). Physicians who replied they were not prescribing ACE inhibitors were called by a plan cardiologist, who discussed any ambivalence physicians may have prescribing these drugs, and provided education. After this interaction, the rate of members who were identified as needing an ACE inhibitor after an MI increased dramatically.

*Pre- and Postsurveys.* Surveys conducted before and after program implementation can also help identify potential problems areas in which to target additional resources. For example, if physicians are asked whether they believe in hormone replacement therapy (HRT) and are going to offer it to their patients, those who reply no to either question can be targeted for specific educational efforts and would also be surveyed after the program is in place to gauge behavioral change.

*Continuing medical education.* CME related specifically to behavioral changes that are identified as important, especially among primary care physicians, included the following programs: Web-based, workbooks, telelectures, on-site dinner grand rounds, and symposia with HRT-related content that included patient management, understanding risk-benefits, and counseling.

*Profiling.* Physician profiling is another way behavior can be modified. Profiling is a quantitative tool used to measure physician performance. In addition to longitudinal outcome studies, profiling can be used to demonstrate that what a particular physician is doing is not only effective but is provided in a cost-effective manner.

Use of *International Classification of Diseases, Ninth Revision* (ICD-9) codes may serve to measure changes in physician behavior. For example, to monitor and encourage physicians to identify women early (ie, before the age of 45 years; the HEDIS measure is targeting women aged 47 to 55 years who may have been counseled during the past 2 years or ever), they would be offered additional compensation for completing the *Perimenopausal Health Evaluation Form* published by the American College of Obstetricians and Gynecologists (ACOG). An audit would be performed to ensure that the form was being completed.

*Communications.* Internal communications can promote behavioral change among physicians. Because of the low readability levels of lengthy newsletters, a concise, 1-page, folded sheet with bold, bulleted items, including a "tip of the day" and containing the key messages would work well, especially when coupled with a customizable message to those physicians identified by the pre-implementation survey as being philosophically opposed to HRT. For MCOs that fax authorization numbers back to physicians, a simple message could be added to the bottom of the sheet to alert the office staff. These messages could also be linked to the plan's Web page. Top volume physicians can be identified as potential partners for supplying these messages.

*External partnerships.* Physician behavior can be modified by partnering with groups outside the MCO, such as pharmaceutical companies, which have resources available that range from materials that can be cus-

tomized by the plan to providing dinner grand rounds and CME symposia. A growing US alliance between local health departments and managed care plans, both on the physician side and on the managed care plan side, attests to related health issues, such as the high number of hip fractures as a result of osteoporosis and the dollar amounts involved. Managed care organizations should also consider involving medical or obstetric and gynecologic societies and local peer-review organizations in their efforts to educate and modify the behavior of their physicians.

Physicians whom women identify as not spending enough time with them or who do not communicate clearly can be offered courses on communication skills. This was viewed as especially important to conveying the complexity of information about menopause, given the limited amount of time—estimated at 7 to 11 minutes—available for most office visits. As outlined above, many physicians perceive they do not have enough time to explain all the implications surrounding menopause and the risks and benefits of available therapeutic options such as HRT. A physician who treats a woman for the primary reason for her office visit and then writes a prescription for HRT may find she does not fill the prescription because she believes she did not receive enough information.

One solution is to provide education to patients so they know what kinds of questions to ask their physicians to elicit enough information to make an informed choice. Another solution: Pay physicians separately for providing a well-woman menopausal consultation. Another educational effort for physicians includes accessibility to a plan statistician to provide perspectives on and interpretation of published studies regarding HRT and menopause.

### Challenges to Implementation

The Medical Affairs/Physician Relations Team also identified challenges to implementing a program for menopausal health within the plan. These challenges included those met by physicians, nurses and other healthcare professionals, case managers, and pharmacists.

For physicians, challenges were perceived regarding the patient's inability to understand or accept HRT, so that she may not even broach the subject. For example, women may have concerns about some of the side effects of HRT, such as bleeding, or fears of breast cancer or breast changes, and physicians may feel they do not have enough time or knowledge to convey information or allay these concerns.

Using diabetes as an analogy, if a physician provides a consultation and then hands the patient a prescription, would he or she say: "Think about it. If you want to take insulin, you can. It is up to you. You know the side effects." Some physicians are not giving their patients a strong enough indication that they should take medication for menopause, even in light of an extremely high mortality rate from osteoporotic hip fractures. The team believed that women's healthcare should be about trying to keep a woman independent as long as possible; by not counseling appropriately, ie, by not giving a clear message about HRT, women could be denied their independence.

Other challenges for physicians regarding patient management included a lack of understanding of perimenopause and choosing the most appropriate product for each patient. For example, irregular cycles associated with perimenopause can be regulated with oral contraceptives; HRT includes cyclic or continuous combined therapies and different delivery systems.

Challenges for nurses and other healthcare professionals, who play a

critical role in counseling patients, were linked to whether the physician has a clear office policy regarding menopause; if not, it can result in inconsistent recommendations or in nurses and other healthcare professionals forming and expressing their own opinions. Some may even push women away from HRT and into natural products. Therefore, they need to be educated about some of the more unique aspects of HRT; very few are discussing the long-term effects on Alzheimer's disease, macular degeneration, or dental and other tissues.

Although in most plans case managers would not be involved in a menopause program, many focus on disease management and long-term sequelae of menopause, such as cardiovascular risk reduction, Alzheimer's disease, and colon cancer, and should thus be included in the program.

The role of pharmacy in implementing a program for menopausal health was discussed in light of national mandates that pharmacists must counsel patients when they dispense medications. In some pharmacies where this is done, the team saw opportunities to provide and disseminate information about the risk-benefit ratios of a particular drug, including adverse effects and con-

traindications that can tend to decrease continuation of therapy or actually move the member/patient away from therapy.

Pharmacists should be provided with information regarding global health outcomes, so that when, for example, a woman asks about breakthrough bleeding with HRT, the focus should instead be directed at trying to help her see the advantages of therapy in terms of cardiovascular and Alzheimer's diseases and osteoporosis. This information can also be provided to members by mail or at the retail level.

### Measures of Success

Measures of success for program implementation included outcomes, as determined by focus groups of members after they have been counseled; physician profiling; prescription data; surveys of patients before and after they complete the HEDIS Management of Menopause questionnaire; and audits to ensure that physician counseling is comprehensive. The Medical Affairs/Physician Relations Team concluded that it is important to remember that rather than focusing solely on ROI, the focus should be on women, who deserve to have the best possible quality of life.