Letters continued

promoting the quality improvement effort are perceived to be most interested in reducing the costs of care.

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Response

Your comments are well taken. As mentioned in the article, stroke was chosen as a diagnosis for the development of a critical pathway for two reasons. One, stroke is a high-volume diagnosis and two, a potential cost reduction was apparent. Once the decision was made that stroke would be the diagnosis for the pathway initiative, then patient care became the main focus.

During the development of the pathway, cost was not discussed. We assumed that focused patient care is cost effective and that length of stay is the primary cost determinant for stroke patients. Also, as you mentioned, improvements in processes of care can improve patient outcomes.

You commented that the "measures" chosen in the article may not reflect quality of care. Ongoing "outcomes measurements" take place within the hospital independent of the variance measures set up specifically to monitor pathway utiliza-

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tion. Mortality and readmissions are monitored for all diagnoses by the various quality assurance committees. No changes occurred in mortality or readmission statistics, as mentioned in the article.

The variances monitored were used as surrogate markers to good patient care as defined by the pathway. The pathway guidelines were based on the current literature and the consensus of expert opinion.

You mentioned that the increased use of ultrasound and computed tomography with regard to patient outcomes has no documentation in the literature. As such, the physicians who developed the pathway guidelines based the decision to include these parameters on their expertise. Our study did not evaluate whether such inclusion was a good decision based on patient outcomes.

The argument for increasing the utilization of carotid ultrasonography was based on the need to identify critical stenosis as soon as possible, thereby, intervening with endarterectomy *prior to* a future cardiovascular event. During the pathway development phase, a retrospective chart review of stroke patients was performed to see the percentage of patients thought to have carotid disease which would suggest the need for an ultrasound. The results were discussed with the neurologists who agreed that approximately 90% of our patients had indications to undergo carotid ultrasonography. For efficiency, the task force suggested all patients admitted for acute cerebrovascular accident (CVA) should undergo carotid ultrasonography. The standing orders were not included in our article; however, if a carotid ultrasound was performed within 3 months, it is not repeated. Instead, the patient's ultrasound report is placed in his chart.

The scan may not show changes of cerebral infarction for 24 to 48 hours from the time of the ischemia. The first scan was taken primarily to rule out a hemorrhage. The second one was taken to assist in a diagnosis—if the first scan was negative. This second scan was also used to see if there was extension of the stroke. As such, it was used to define a patient with "progression of CVA."

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UNITED STATES POSTAL SERVICE™

Statement of Ownership, Management, and Circulation
(Required by 39 USC 3685)

1. Publication Title	2. Publication Number	3. Filing Date
JAOA-JOURNAL OF THE AMERICAN OSTEOPATHIC ASSN	0 0 9 8 _ 6 1 5 1	10/01/97
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
MONTHLY	12	$55.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*: AMERICAN OSTEOPATHIC ASSOCIATION, 142 E ONTARIO ST, CHICAGO, COOK IL 60611-2864 — Contact Person: SUSAN BAIRD; Telephone: 312/280-5880

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*: AMERICAN OSTEOPATHIC ASSOCIATION, 142 E ONTARIO ST, CHICAGO, IL 60611-2864

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*: SANDRA WILLIAMSON, AMERICAN OSTEOPATHIC ASSOCIATION, 142 E ONTARIO ST, CHICAGO, IL 60611-2864

Editor *(Name and complete mailing address)*: THOMAS W ALLEN, DO, AMERICAN OSTEOPATHIC ASSOCIATION, 142 E ONTARIO ST, CHICAGO, IL 60611-2864

Managing Editor *(Name and complete mailing address)*: KAREN STIPP, AMERICAN OSTEOPATHIC ASSOCIATION, 142 E ONTARIO ST, CHICAGO, IL 60611-2864

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Full Name	Complete Mailing Address
AMERICAN OSTEOPATHIC ASSOCIATION (A NON PROFIT ORIGANIZATION)	142 E ONTARIO ST, CHICAGO, IL 60611-2864

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

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12. Tax Status *(For completion by nonprofit organizations authorized to mail at special rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☒ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1995 *(See Instructions on Reverse)*

13. Publication Title	14. Issue Date for Circulation Data Below
JAOA-JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOC	SEPTEMBER, 1997

15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*		30,317	32,200
b. Paid and/or Requested Circulation	(1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not mailed)*	0	0
	(2) Paid or Requested Mail Subscriptions *(Include advertiser's proof copies and exchange copies)*	15,420	17,850
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2))* ▶		15,420	17,850
d. Free Distribution by Mail *(Samples, complimentary, and other free)*		14,439	13,936
e. Free Distribution Outside the Mail *(Carriers or other means)*		0	0
f. Total Free Distribution *(Sum of 15d and 15e)* ▶		14,439	14,439
g. Total Distribution *(Sum of 15c and 15f)* ▶		29,859	31,786
h. Copies not Distributed	(1) Office Use, Leftovers, Spoiled	458	414
	(2) Returns from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2))* ▶		30,317	32,200
Percent Paid and/or Requested Circulation *(15c / 15g x 100)*		51.6%	56.2%

16. Publication of Statement of Ownership
☒ Publication required. Will be printed in the NOVEMBER, 1997 issue of this publication.
☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Susan C Baird Circ Mgr — Date: 10/01/97

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CME quiz discussion

The following answers/discussions relate to the quiz appearing in the October 1997 issue of JAOA.

1. (c) Briminodine shows an increased selectivity for α_2-adrenoceptors, and this helps in decreasing its incidence of allergic reaction.

2. (b) Latanoprost causes a darkening of the iris color by increasing the number of melanosomes in hazel or mixed-color irides.

3. (b) Fluconazole causes leukopenia.

4. (d) Decreasing the dose of fluconazole reduces gastrointestinal distress. Rarely does fluconazole need to be discontinued because of gastrointestinal distress. Instead the dose should be decreased.

5. (d) Alcohol use disorders in US elders (>65 years) are predominantly manifested by atypical physical and psychological consequences. The prevalence of alcohol use disorders in the community elders is 3% to 5%, and in the family practice setting, 5% to 33%. Elders are more likely to be adversely affected by alcohol use disorders than younger adults owing to drug interactions, limited reserve in cognitive and physical functioning, and a higher blood alcohol level for the amount consumed due to a smaller volume of distribution. Although the Alcohol Module of the Diagnostic Interview Schedule is often considered the gold standard for diagnosis of alcohol use disorders, many of its criteria may not apply to elders who are often retired, widowed, or separated from other family members. In addition, withdrawal symptoms may be difficult to assess in elders. Previous studies have shown that physicians diagnose only about 30% of elders with alcohol use disorder.

6. (e) Both the CAGE and the AUDIT may be useful in screening elders for alcohol use disorders. In addition, NIAAA criteria for excessive alcohol conumption in elders may be a useful clue to those with alcohol use disorders.

7. (c) Although transmission of the infectious form of the coccidian or microsporidian agents of intestinal disease can theoretically be transmitted via food, only *Cyclospora* has been reported as having a strong association with this mode of transmission.

8. (d) Although light microscopy coupled with other techniques, such as histologic examination (plastic-embedded sections, et cetera), touch preparations of biopsy materials, and cytospin preparations, will demonstrate the spores of a microsporidian, more refined procedures are required for identification of the species level.

9. (c) The microsporidian is unique in terms of host entry. The polar tubule everts in proximity to the host cell. On contact with the receptive host cell, an entry channel occurs, and the parasite protoplasm enters the cell to initiate the parasitic process. ◆

Letters continued

Appropriate utilization of telemetry beds affects the patients who require their use more than the outcome for the individual stroke patient. Timely referrals to rehabilitation allow patients to begin a functional improvement program that much sooner. It takes the patients off the general medical floors sooner and (theoretically) also decreases their risk for nosocomial infection, aspiration, deep vein thrombosis, and contractures.

All patients' functional status is monitored by healthcare personnel in the Department of Physical Medicine and Rehabilitation. Again, because this monitoring was not directly implemented as a result of the pathway, we did not report on it. The functional improvement measure scores did not change significantly the year before the pathway was implemented compared with the year after the implementation.

I also think that most physicians want to practice good quality care. Information can be relayed to physicians, and we generally adhere to it. The difficulty lies in getting us busy physicians to "hear" the information—and to remember it. Educating physicians requires frequent reminders. With time, change *does* take place. Many physicians still refuse to attend educational meetings; these same physicians' patients have the greatest lengths of stay and their doctors have the poorest utilization. Nevertheless, I am sure that in their minds, these physicians desire to practice good quality care.

The length of stay during our study period remained higher than was our goal because the patients stayed in the hospital while receiving no interventions. In my opinion, this is poor utilization and puts such patients at risk for further problems that can occur with prolonged length of stay. The question then becomes, "Is poor utilization poor care?" ◆

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