

Spreading the message –
Can we achieve better
implementation of privacy
requirements?

PRESENTATION TO PRAIRIE HEALTH
INFORMATION PRIVACY DAY
Monday, April 16, 2007

Bryan Salte

Institutional vs. Individual Implementation of Privacy Requirements

Institutional Settings

- Hierarchical
- Large
- Specific Resources
- Allocated to privacy

Physicians' Offices

- Generally small (1 to 5 physicians)
- Entrepreneurial
- No specific resources allocated to privacy

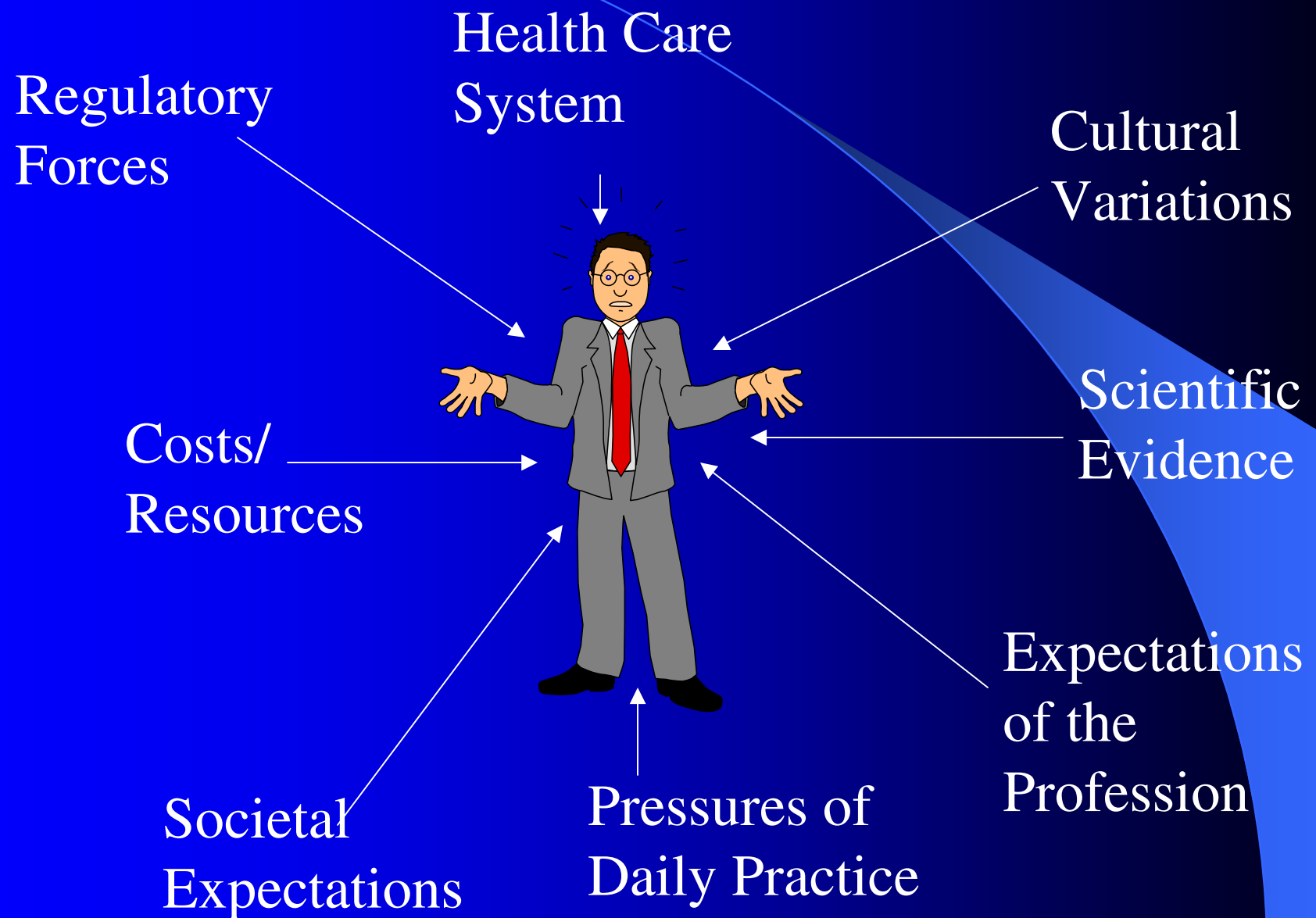
My perspective on dealing with the challenge

- Physicians generally want to do as well as they can;
- Generally, physicians remain patient focussed and matters they regard as not related to patient care are viewed as distractions;
- Frequently, physicians have a distrust of “bureaucracy” and “paperwork”.

Challenges in obtaining Privacy Compliance

- “I am already compliant” - I maintain patient confidentiality;
- Limited time to deal with all of the demands;
- Referring non-clinical matters to support staff to implement - often untrained in privacy;
- Perceived complexity - “if it can’t be reduced to one sheet of paper, it is too complex.

Forces Acting on Medical Practices



Some expectations of physicians

- Meet CPD (CME) requirements for licensure
- Be familiar with practice guidelines
- Be familiar with regulatory guidelines
- Report STDs
- Report impaired drivers
- Provide reports to WCB
- Provide reports to SGI
- Provide “sick slips”
- Provide fitness to work reports
- Monitor prescribing by others to their patients
- Provide reports to insurers
- Meet the requirements of HIPA

The Medical Information System

- Journals
- Throwaways
- Monographs
- Practice Guidelines
- CME courses
(lectures)
- Clinical Experience
- Colleagues
- Textbooks
- Pharmaceutical Reps
- Computers
- Audiotapes
- Newsletters
- News Media
- Patients

Information Anxiety

Most Clinicians suffer from too much information

Maladjustment to Information Anxiety in Medical Practice

- Frustrated, lacking in confidence
- Wait for the Expert Answer
- Rigid and dogmatic attitude

Obstacles to integrating preventative care in physicians' practices

Integration of the recommendations of the Canadian Task Force on Preventive Health Care: Obstacles perceived by a group of family physicians Hudon et.al. Family Practice 21(1) 11-17

The study identified the following barriers:

- Lack of motivation;
- Lack of value placed on continuity of care;
- Lack of financial incentives;
- Work overload;
- Contradictions among the recommendations;
- Inability to acknowledge obstacles ascribed to physicians' beliefs.

Obstacles to integrating preventative care in physicians' practices (2)

Integration of the recommendations of the Canadian Task Force on Preventive Health Care: Obstacles perceived by a group of family physicians Hudon et.al. Family Practice 21(1) 11-17

The authors reached the following conclusions:

- Interventions proposed to date to improve integration of preventative care do not address the barriers identified in the study;
- CME focuses on knowledge, which does not address the communication skills and feelings of powerlessness that the authors identified as the barriers.

Obstacles to integrating preventative care in physicians' practices (3)

Integration of the recommendations of the Canadian Task Force on Preventive Health Care: Obstacles perceived by a group of family physicians Hudon et.al. Family Practice 21(1) 11-17

The authors reached the following conclusions:

- Physicians have “caved in” to the weight of responsibility that has been assigned to them;
- There is a need for more specific and concrete training on communication and counselling skills.

Lessons from Reporting of STIs in Saskatoon

- 85 % of physicians were aware that the law requires cases of Chlamydia (CT) and Gonorrhoea (GC) to be reported within 72 hours of diagnosis
- 5% of respondents stated they never reported CT or GC
- 5 % stated they rarely did so
- 5 % stated they sometimes reported
- 15% stated they often reported
- 69% stated that they always reported

Lessons from Reporting of STIs in Saskatoon (2)

- 72% of physicians felt it was important to report Chlamydia (CT) and Gonorrhoea (GC) within 72 hours of diagnosis
- 69% stated that they always reported
- 25% of physicians felt it was neither important or unimportant to report
- 15% reported sometimes or never

Physicians' suggestions for improving STI reporting

- 49% - financial compensation to complete form
- 7% Administrative changes to report
- 48% Shorter form
- 5% more skills training

Physician compliance with HIPA disclosure requirements

- In 2005, I visited 10 physicians' offices in Downtown Saskatoon. I selected them so that they would include family physicians and physicians who practiced a specialty, a walk in clinic, single practitioners, small clinics and large clinics. None of the practices had any information for patients.
- None of the receptionists I spoke to knew anything about the compliance requirements.

Lessons from Reporting of Adverse Drug Reactions

An Educational Intervention to Improve Physician Reporting of Adverse Drug Reactions Figueiras et. al. JAMA 2006;296:1086-1093

The estimated underreporting of drug reactions is 94%

Challenges to reporting:

- complacency - belief that serious drug reactions will already have been reported by the time the physician encounters it
- insecurity - was the patient's reaction really due to a drug reaction?

Lessons from Reporting of Adverse Drug Reactions (2)

An Educational Intervention to Improve Physician Reporting of Adverse Drug Reactions Figueiras et. al. JAMA 2006;296:1086-1093

Challenges to reporting:

- indifference - the single case would not contribute to medical knowledge
- ignorance - unaware of the reporting expectation
- lack of time

Lessons Learned from Reporting of Adverse Drug Reactions (3)

An Educational Intervention to Improve Physician Reporting of Adverse Drug Reactions Figueiras et. al. JAMA 2006;296:1086-1093

A targeted intervention (educational material followed by individual meeting intended to address identified knowledge and attitude issues with each physician) resulted in significant changes at 4 months, and less of an effect after 12 months.

Does CME change Physicians' Behaviour?

Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds and other Traditional Continuing Medical Education Activities Change Physician Behaviour or Health Outcomes?
Davis et. al. JAMA 1999 282(9): 867-874

- Didactic education - None of the Four interventions reviewed altered physician performance

Does CME change Physicians' Behaviour? (2)

Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds and other Traditional Continuing Medical Education Activities Change Physician Behaviour or Health Outcomes?
Davis et. al. JAMA 1999 282(9): 867-874

- Most of the interactive sessions demonstrated a positive impact on physician performance
- Multiple interventions were more effective than single interventions in changing physician performance

Does CME change Physicians' Behaviour? (3)

Impact of Formal Continuing Medical Education: Do Conferences, Workshops, Rounds and other Traditional Continuing Medical Education Activities Change Physician Behaviour or Health Outcomes?
Davis et. al. JAMA 1999 282(9): 867-874

- Successful adult education is learner-centered, active rather than passive, relevant to the learner's needs, engaging and reinforcing;
- Communication sustained over time is more effective. Changes is promoted if learning is implemented, then reinforced or discussed later.

What Changes Physicians' Behaviour?

Changing Physician Behaviour Bauchner et. al. Archives of Disease in Childhood 84(6): 459

- Traditional didactic continuing medical education and passive distribution of information (mailing) does little to change physician behaviour;
- CME that included interactive interventions, such as small group discussion, is effective in changing physician behaviour;
- Creation, publication and passive dissemination of guidelines does not improve patient care.

What Changes Physicians' Behaviour? (2)

Changing Physician Behaviour Bauchner et. al. Archives of Disease in Childhood 84(6): 459

- Educational outreach with local opinion leaders (the champion) is effective in producing change, but it is time consuming and expensive;
- Audit and feedback are only modestly effective in changing physician behaviour;
- Financial incentives can be very effective in some circumstances.

What Changes Physicians' Behaviour? (3)

A three-part intervention to change the use of hormone replacement therapy in response to new evidence Changing Physician Behaviour
Roumie et. al. *Annals of Internal Medicine* 141(2):118-125

- The intervention was designed to improve the treatment with hormone replacement therapy to coincide with current knowledge;
- The study concluded that a multifaceted approach in an integrated health care system with standardized methods of communication is an effective way to implement patient-centered, effective, and timely care with changing medical knowledge.

Newer Models for CME

- Practice-based small group CME
- Asking focused clinical questions
- Educational prescriptions
- Just-in-time Evidence

So what has been done to try to achieve physician knowledge and compliance?

- College newsletters
- SMA newsletters
- PEP reviews
- Toolkit on the SMA website and the College website

My parting message

If privacy compliance is so important, why the disconnect between what has been demonstrated to produce change in physician behaviour, and the methods used to date in relation to privacy compliance?

Whose responsibility is it to improve compliance?



QUESTIONS OR
COMMENTS?