



5. Hislop TG, Clarke HF, Deschamps M, Joseph R, Band PR, Smith J, et al. Cervical cytology screening: How can we improve rates among First Nations women in urban British Columbia? *Can Fam Physician* 1996;42:1701-8.

[One of the authors responds:]

I thank Dr. Clark for reiterating the points I made in the editorial:

- certain high-risk subgroups of women are underscreened;
- special strategies are needed to engage these women in screening;
- primary care practitioners are important for the success of a screening program; and
- formal screening programs provide quality assurance and efficient systems for gathering and collating data not possible with ad hoc screening.

It was encouraging to read of the work of the CCPN and the special efforts that will be made to screen hard-to-reach groups of women.

The suggestion that my reference to the article by Hislop and associates¹ is misleading is itself misleading. The points still stand that rates of death from cervical cancer are higher among native women and that culturally sensitive initiatives are needed to engage these women in cervical cancer screening programs.

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Reference

1. Hislop TG, Clarke HF, Deschamps M, Joseph R, Band PR, Smith J, et al. Cervical cytology screening: How can we improve rates among First Nations women in urban British Columbia? *Can Fam Physician* 1996;42:1701-8.

A measuring stick for health care

The article "Inappropriate hospital use by patients receiving care for medical conditions: targeting uti-

lization review" (*Can Med Assoc J* 1997;157[7]:889-96), by Carolyn DeCoster and colleagues, and the accompanying editorial, "Measuring the appropriateness of hospital use" (*Can Med Assoc J* 1997;157[7]:901-2), by Dr. Duncan J.W. Hunter, confirm many of the trends and practice patterns we have uncovered at our acute care facility.

Concurrent review of every patient admitted to hospital can be resource intensive when using previously described tools such as the appropriateness evaluation protocol¹ or the ISD-A review system.² At our hospital, a multidisciplinary team developed objective, accurate, easy-to-use criteria that were based on intensity of service and that could be applied quickly by the bedside nurse. Our "ACTIV index" allows concurrent assessment of the need for days of care in the hospital and barriers to care or discharge.^{3,4} The database that has evolved over the past 4 years represents patient-specific data focusing on the patients' condition, not their diagnosis, acknowledges nonphysician elements and identifies interruptions to care plans.

We suggest that patients who have been "inactive" for 2 hospital days should be targeted for attention. Over 2 years, our own 2-day non-ACTIV project has reduced the number of never-ACTIV hospital days from 17.2% to 5.3% of total hospital days, for a saving in resources of \$2.43 million. We have linked our review data to records from the Canadian Institute for Health Information, which allows us to analyse the practice patterns of specific diagnostic groups as well as physician characteristics related to those groups. This information shows variations in care delivery and can be used for physician education.

We too experienced the unexpected phenomenon of reduced nonacute admissions on weekends and evenings. We feel that the emergency department screens these pa-

tients well and makes good use of our on-call home care.

The health care process *can* be measured and managed. Identifying inpatients who are receiving inappropriate levels of care has given us an opportunity to direct patient care processes in a manner that has improved quality and resource use. With the bedside nurse as the reviewer who identifies every patient, every day, many of the barriers to care are identified immediately and broken down almost as fast. We believe that our CONTINUUM project, which uses the "ACTIV index," is a simple, objective, reliable and inexpensive tool for utilization review and could be adapted to suit the needs of hospitals of any size.

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References

1. Gertman PM, Restuccia JD. The appropriateness evaluation protocol: a technique for assessing unnecessary days of hospital care. *Med Care* 1981;19:855-71.
2. *The ISD-A review system with adult criteria*. Westborough (MA): Inter Qual Inc; 1978.
3. Atkinson DI, Collins P, Skafel JR. Concurrent review in a community hospital: the "ACTIV" index. *Ont Med Rev* 1994;61(12):23-8.
4. Collins PE, Skafel JR, Atkinson DI, Jenkins S. CONTINUUM: measuring and managing the patient care process. *Health Manage Forum* 1994;7(3):27-40.

BSE, variant CJD and infectious proteins

The Nov. 15, 1997, issue of *CMAJ* featured 4 articles on Creutzfeldt-Jakob disease (CJD), but none of the articles mentioned related work on "protein-like previral infectious particles." I would like to take this opportunity to correct that omission.

In 1982, at the same time that Dr. Stanley Prusiner published his paper on prions,¹ a similar mechanism for replication of the infectious proteins of scrapie was proposed,² and the