Standards of Care: Who is Determining How We Practice

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2008 Nephrology Conference
March 20, 2008
Outline

• Learn about the national quality agenda
• Describe some of the challenges in assessing physician performance
• Recommendations for national and local action
Trends in Bridging the Quality Gap

• Growing interest in measuring quality and cost of care/efficiency
• A focus on P4P and public reporting
• Shift in focus from measuring performance of health plans and hospitals to the physician
• NQF adopts multiple measurement sets for physicians level performance assessment
• CMS implementing reporting program, to be followed by a P4P program
• Three IOM reports focused on accelerating improvement
• Continued commitment to EBM, system re-design and payment re-alignment
IOM Recommendations: New Principles and Rules for Design of Care

• An overview:
  – Evidence based care
  – Patient centered care
  – Systems-based care

AND

  – Realigning incentives
  – Transparency

Ref: IOM Report: Crossing the Quality Chasm
IOM Reports “Accelerating Improvement”

• This report is the 3rd part of a 3-part series entitled “Accelerating Improvement”
• The first – “Performance Measurement”
• The second – “Restructuring the QIO program”
• The third – “Aligning Incentives for Providers” (P4P)
Key Messages of the P4P IOM Report

- The payment system is broken and with few disincentives for overuse, underuse and misuse – fundamental change is required
- P4P is a key but not the only component to transform the system
- Evidence is not available about the effectiveness of these programs, but P4P does offer promise
- Payment should encourage providers to assume shared accountability
- Implement P4P within a learning system, assess early experience and adjust for unintended consequences
- Implement programs for hospitals immediately, but delay for physicians
Physician Performance Assessment – Some Challenges and Controversies

- Level and changing evidence
- Measurement “system” chaotic
- Data collection
- Impact of patient preference and behavior
- Measurement in patients with co-morbid conditions
- Accountability assignment
- How to measure cost of care and efficiency
- Measure characteristics (structural vs. process vs. outcome, all or none, competency vs. high performance)
- Measurement and maintenance of certification
- Funding for various activities
Clinical Expertise

A Model for Evidence-Based Clinical Decisions

- Research Evidence
- Patient Preferences

Clinical Expertise

Ref: ACP J Nov/Dec 96.
Changing Evidence

washingtonpost.com
April 3, 2007
Benefits of Mammograms For Women in 40s Challenged

WSJ -- April 4, 2007

MATTER OF TIMING
New Study Reassures
Most Users of Hormones

For Newly Menopausal,
There's No Heart Risk; A Reversal of Findings

WSJ -- April 4, 2007

Study Shows Flaw
In Mammography Tool
Performance Measurement and Quality Improvement “System”

Measure Development
PCPI & Specialty Assoc.  
NCQA  
CMS

Measure Adoption
NQF

Measure Implementation
AQA, HQA, QA  
Physician & Hospitals, etc.  
Health Plans and CMS  
HIT vendors

Evidence and CPG Generation

Evaluation
CME  
HIT
## CKD Performance Measures

<table>
<thead>
<tr>
<th>Development</th>
<th>NQF Adoptions</th>
<th>AQA Selection</th>
<th>PQRI 08</th>
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<tbody>
<tr>
<td>BP management</td>
<td>NA</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>ACE and ARB</td>
<td>NA</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Lab (Ca, P, PTH, and lipids)</td>
<td>NA</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>HB receiving EPO</td>
<td>NA</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Flu shots</td>
<td>NA</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Referral AV fistula</td>
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## ESRD Performance Measures

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<th>Development</th>
<th>NQF Adoption</th>
<th>AQA Selection</th>
<th>PQRI 08</th>
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<tbody>
<tr>
<td>URR and plan (HD)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>URR (PD)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Referral vascular</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seen by surgeon</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Flu shots</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Plan of Care - Anemia</td>
<td>no</td>
<td>Yes</td>
<td>yes</td>
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AQA – Partial 08 Agenda

• Competency vs. high performance measurement – raising the bar
• Measure “types” – structural, composite and appropriateness
• HIT to support measures – mapping exercises
• Registries as an HIT tool
• Physician group-team level measures
HQA – 08 Agenda (Partial Wish List)

• Display of information and consumer focus group reviews
• Risk adjustment for mortality data – add clinical data
• Composite measures
• Usefulness of reports to hospitals
• A measures pipeline
• Readiness to implement
• Episodes of care issue
Convergence of Various Tools

- Physician Performance Measurement
- Continuing Medical Education
- Evidence Based Medicine
- Maintenance of Certification

CME Credits
Physician Performance Assessment: Data Collection Challenges and Options

- Administrative data (claims data)
  - From practice management system
  - With CPT-2 codes
  - Merged across health plans

- Plus a disease registry

- Plus drug and lab data

- Plus from an EMR/EHR
Recommended PQRI Quality Measures Based on Qualifying Patient Counts for Respective Measures

<table>
<thead>
<tr>
<th>PQRI Measure Number and Name</th>
<th>Patient Count</th>
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<tbody>
<tr>
<td>6: Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease (CAD)</td>
<td>162</td>
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<tr>
<td>7: Beta-Blocker Therapy for Coronary Artery Disease (CAD) Patients with Prior Myocardial Infarction (MI)</td>
<td>162</td>
</tr>
<tr>
<td>5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>80</td>
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<tr>
<td>8: Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction</td>
<td>73</td>
</tr>
<tr>
<td>1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus</td>
<td>60</td>
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</table>
Performance Measurement and the Complex Patient

- 78 female-osteoporosis, diabetes, hypertension and COPD
- 10 meds, potentially taken at 7 times during the day, plus in excess of 10 additional instructions
- Physician tasks during a visit-7 types of tasks, including 3 with 4/5 subtasks
- Contradictory guidelines
- Guidelines with varying levels of evidence, no prioritization, no balance, practicality and feasibility not addressed

Ref: Boyd and Wu JAMA 10/Aug/05
Payment for Reporting (P4R) and Payment for Performance (P4P)

• Current programs are interim

• What measures to use?
  – Cost/efficiency and quality
  – Composite measures
  – All or none
  – Structural (e.g. use of ePrescribing and registries)

• Achieving thresholds vs. improvement
Patterns of Care and “Assignment” of “Accountability”

- 66% had a traditional primary care physician, 22% a specialist and 12% a surgeon
- Many had 2 primary care physicians in a calendar year
- The “assigned” physician billed 53% E and Ms and 35% of total visits
- 33% changed “assigned” physicians in a year

creates problems for the current “accountability” “system”
cooordination of care difficult absent CHANGE

Ref: Hoagngmai and Bach New Eng J Med 15/March/07
Obesity Trends* Among U.S. Adults:

(*BMI ≥30, or about 30 lbs overweight for 5’4” person)

Source: Centers for Disease Control and Prevention
Hospital Performance Based rankings: Some Issues

- Identifying preferred hospitals yield different results using different strategies of combining quality and cost data
- Tradeoffs will have to be made between quality and cost measures
- Quality varies by department and condition (Jha New Eng J Med 2005)
- Cost to charge ratios imperfect proxies for costs and payments
- Improved data sources, e.g. clinical, and accurate financial data needed

Ref: Rosenthal et al. HSR 42;6, Dec 2007.
Physician Effectiveness Profile

- CAD w/Lipid Lowering Therapy: 69%
- Heart Failure w/LVF Assessment: 73%
- CAD w/Antiplatelet Therapy: 64%
- Warfarin Therapy Patients w/ Atrial Fibrillation: 39%
- Partial Compliance (weighted by measure): 47%
- Heart Failure & LVSD w/Ace /ARB Therapy: 60%
- Lipid Profile after AMI, CABG or PTCA: 58%
- CAD & Diabetes w/ ACE / ARB Therapy: 18%
- % Patients w/Total Compliance: 58%
Percentage of Patients Receiving Recommended Care

**DIABETES**
- Hemoglobin A1c management
- Cholesterol management
- Eye exam
- Urine protein screening
- Received all
- Received none

**CORONARY ARTERY DISEASE**
- Lipid profile
- Cholesterol management
- Cholesterol drug therapy
- Received all
- Received none

**HEART FAILURE**
- LV function
- Beta blocker therapy
- ACE/ARB therapy
- Received all
- Received none (unavailable)

**CANCER SCREENING**
- Breast cancer
- Cervical cancer
- Colorectal cancer

Source: Thomson Healthcare analysis. All data is from 2004.
AQA Definitions of Cost of Care and Efficiency

• “Cost of care”¹ is a measure of the total health care spending, including total resource use and unit price(s), by payor or consumer, for a health care service or group of health care services, associated with a specified patient population, time period, and unit(s) of clinical accountability.

• “Efficiency of care”² is a measure of cost of care associated with a specified level of quality of care. “Efficiency of care” is a measure of the relationship of the cost of care associated with a specific level of performance measured with respect to the other five IOM aims of quality.

• “Value of care” is a measure of specified stakeholder’s (such as an individual patient’s, consumer organization’s, payor’s, provider’s, government’s, or society’s) preference-weighted assessment of a particular combination of quality and cost of care performance.

¹Commonly referred to in the marketplace as “efficiency.” ²Also referred to as “economic efficiency.”

Source: AQA Principles of Efficiency Measures, v.1, approved 01/06
## Risk Adjustment – Episode and Complexity

### Coronary Artery Disease

<table>
<thead>
<tr>
<th>Severity Stage</th>
<th>Stability</th>
<th>Complexity Levels</th>
<th>Mean Allowed Payments</th>
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<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td>Stable Angina</td>
<td>1</td>
<td>$1,080</td>
<td>$1,424</td>
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<tr>
<td>Progressive Angina</td>
<td>2</td>
<td>$5,974</td>
<td>$8,704</td>
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<tr>
<td>Acute Myocardial Infarction</td>
<td>3</td>
<td>$11,041</td>
<td>$15,041</td>
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Source: Medstat Health Plan Customer, 2003-2004
Per Use for Difference Services within Episodes, by MSA, 2002

<table>
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<tr>
<th></th>
<th>E&amp;M</th>
<th>Procs</th>
<th>Imaging</th>
<th>Tests/Other</th>
<th>Hospital</th>
<th>PAC</th>
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<tbody>
<tr>
<td>All Selected MSAs</td>
<td>21%</td>
<td>21%</td>
<td>7%</td>
<td>6%</td>
<td>34%</td>
<td>10%</td>
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<td>17</td>
<td>6</td>
<td>6</td>
<td>34</td>
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<tr>
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<td>7</td>
<td>5</td>
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<td>Miami</td>
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<td>7</td>
<td>5</td>
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<td>Phoenix</td>
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<td>25</td>
<td>8</td>
<td>6</td>
<td>33</td>
<td>7</td>
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Medpac analysis of 100% sample of Medicare claims 2001-2003
Cardiac Care by Type of Service

- Coronary Artery Disease
- Hypertension, Essential
- Cardiac Arrhythmias
- Cerebrovascular Disease
- Rheumatic Fever/Valvular Disease
- Other

Legend:
- Inpatient Facility
- Inpatient Professional
- Outpatient Professional
- Outpatient Facility
- Drugs
# Per Episode Resource Use vs. Per Capita Resource Use, by MSA, 2002

<table>
<thead>
<tr>
<th></th>
<th>Episodes per Person</th>
<th>Per Episode Costs</th>
<th>Per Capita Costs</th>
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<tbody>
<tr>
<td>All selected MSAs</td>
<td>5</td>
<td>$942</td>
<td>$4,932</td>
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<tr>
<td>Boston</td>
<td>5</td>
<td>$998</td>
<td>$5,139</td>
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<tr>
<td>Greenville</td>
<td>5</td>
<td>$914</td>
<td>$4,449</td>
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<tr>
<td>Miami</td>
<td>7</td>
<td>$950</td>
<td>$6,412</td>
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<tr>
<td>Minneapolis</td>
<td>4</td>
<td>$956</td>
<td>$4,036</td>
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<tr>
<td>Orange County</td>
<td>6</td>
<td>$913</td>
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<tr>
<td>Phoenix</td>
<td>5</td>
<td>$920</td>
<td>$4,480</td>
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Medpac analysis of 100% sample of Medicare claims 2001-2003
Coronary Artery Disease: Professional Breakout $7.7M

- Cardiac Care: 66%
- Primary Care: 11%
- Other Specialist: 2%
- Non-E2 Physician: 11%
- NonPhysician: 10%

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Societal Preference

Dollars (billions) per year

<table>
<thead>
<tr>
<th></th>
<th>Pharma</th>
<th>NIH</th>
<th>AHRQ</th>
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<tbody>
<tr>
<td>Dollars</td>
<td>32</td>
<td>28</td>
<td>0.3</td>
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Pharmacology (Pharma) vs. National Institutes of Health (NIH) vs. Agency for Healthcare Research and Quality (AHRQ)
Recommendations: National

• Agree on national priorities

• Create a national coordination of efforts to improve care and contain costs – need for a rational measurement system

• Clearly distinguish measurement purposes – improvement, public reporting/accountability, patient choice, P4P (split P4P from public reporting)

• Adopt standards for the needed HIT infrastructure

• Provide funding for guideline development, measurement development, HIT needs and for EVALUATION

• Evolve to a new accountability system for physicians and other healthcare professionals

• Conduct public information campaigns to change expectations and behaviors
Recommendations: Local

- Be knowledgeable about national trends
- Leverage national efforts by committing to small local and achievable steps
- Build coalitions and collaborative relationships with employers and patient advocacy groups
- Prepare for the information age – (all care is predominantly an information exchange)
- Prepare for continued change
Contact

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