Quality First

Dipti Itchhaporia, MD, FACC

Director of Disease Management, Hoag Memorial Presbyterian, Newport Beach, CA, The Robert and Georgia Roth Chair for Excellence in Cardiac Care, Hoag Hospital; President, California Chapter of the American College of Cardiology

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Quality has been become the new buzz word in medicine. Everyone is talking about quality—Centers for Medicare & Medicaid Services (CMS), hospitals, and payors. Most doctors feel that they provide quality care. Doctors want to do to the right thing, and they want to do well by their patients. They are competitive by nature and want to perform well. So, in general, feedback via performance data is actually something doctors like. They use the data to improve their performance; for example, physicians strive for better door-to-balloon time if they are given feedback, and there is higher utilization of β-blockers and angiotensin-converting enzyme inhibitors when individual physicians are given feedback on their performance. But inherently, they are suspicious of the data—who collected them, why they collected them, and, ultimately, what are the goals of all these data?

Hospitals and payor groups are becoming more and more interested in collecting individual physician performance data. In 2006, the California Physician Performance Initiative (CPPI) was launched. They stated that they wanted to develop a system to measure and report the quality of patient care that is provided by individual physicians in California. CPPI's stated goal is "to improve patient care and its affordability by: reporting results to physicians to help them gauge how well care for their patients meets national standards of care; secondly, applying performance results so as to help consumers and purchasers get better value for choosing health care; and lastly, adopting performance measures and reporting methods using the best available science to set performance standards."

A CPPI advisory group was organized and provided clinical review and guidance related to the design of the program, selection of measures, review of findings, and presentation of results of physicians. Sixteen quality measures that were initially specified by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set 2008 (HEDIS) and the Physician Consortium for Performance Improvement (PCPI) were chosen. Eight of these are relevant for the cardiologist and were used as the quality measures in the 2009 Physician Performance report (Table 1).

Data collection utilized combined commercial PPO and HMO claims/encounter data from 3 California health plans—Anthem Blue Cross, Blue Shield of California, and United Healthcare. Performance scores for each measure were calculated as a ratio, in which the denominator represents all patients who should have received a particular service and the numerator represents the number of the denominator-qualifying patients who received the service, based on the information found in the claims data maintained by each health plan.

The California Physician Performance Initiative clinical quality results

Table 1
California Physician Performance Initiative (CPPI): Clinical Quality Measures 2009

	Measure Name	Measure Description	Relevance Specialties for Measure	Measure Source	Exclusion
1	Diabetes Case LDL Screening	Diabetics, aged 18-75, who had an LDL-C screening during 10/01/07 to 9/30/08	Family practice, internal medicine, endocrinology, and cardiology	HEDIS	Polycystic ovaries, gestational or steroid induced diabetes
2	Cardiovascular Care: LDL Monitoring for Cardiovascular Disease Patients	Patients, aged 18-75, who were hospitalized during 10/01/06 to 9/30/06 for an AMI, CABG, or PTCA, or were diagnosed with IVD during 10/01/08 to 9/30/08, and who had an LDL test during 10/01/07 to 9/30/08	Family practice, internal medicine, and cardiology	HEDIS	None
3	Cardiovascular Care: β-Blocker Therapy at 6 Months After a Heart Attack	Patients, aged 35+, who were hospitalized during 4/01/07 to 3/31/08 for an AMI and received beta-blocker therapy for the 6 months after discharge	Family practice, internal medicine, and cardiology	PCPI	Contraindication to β-blocker therapy
4	Coronary Artery Disease: LDL Drug Therapy	Coronary artery disease patients, aged 18+ on 10/01/07, who were prescribed a lipid-lowering therapy	Family practice, internal medicine, cardiology, and endocrinology	PCPI	None
5	Coronary Artery Disease: LDL Drug Therapy for CAD Patients Who Also Have Diabetes	Coronary artery disease patients, aged 18+ on 10/01/07, who also have diabetes, who were prescribed ACE inhibitor or ARB therapy	Family practice, internal medicine, cardiology, and endocrinology	HEDIS	Contraindications to ACE/ARB therapy
6	Heart Failure Patients: Left Ventricular Ejection Fraction Testing	Heart failure patients, aged 18+ who were hospitalized 10/01/07 to 9/30/08 and had a LVEF test	Family practice, internal medicine, and cardiology	PCPI	None
7	Heart Failure Patients: Warfarin Therapy for Patients with Atrial Fibrillation	Heart failure patients, aged 18+, who were hospitalized with paroxysmal or chronic atrial fibirilation during 10/01/07 to 9/30/08 and were prescribed warfarin therapy	Family practice, internal medicine, and cardiology	PCPI	Contraindication to warfarin therapy
8	Monitoring Patients on Persistent Medications	Combined rate for patients, aged 18+ who were prescribed at least a 180-days supply of ambulatory medication therapy for (1) ACE inhibitors or ARBs, (2) digoxin, or (3) diuretics during 10/01/07 to 9/30/08	Family practice, internal medicine, and cardiology	HEDIS	None

ACE, angiotensin-converting enzyme; AMI, acute myocardial infarction; ARB, angiotensin II receptor blocker; CABG, coronary artery bypass graft; CAD, coronary artery disease; HEDIS, Healthcare Effectiveness Data and Information Set; IVD, intrapulmonary vascular dilatation; LDL, low-density lipoprotein; LDL-C, low-density lipoprotein cholesterol; LVEF, left ventricular ejection fraction; PCPI, Physician Consortium for Performance Improvement; PTCA, percutaneous transluminal coronary angioplasty.

were mailed to more than 13,000 California physicians on July 24, 2009. The deadline to request a physician's patient list was September 9, 2009. The corrections provided by September 18 were applied to correct the quality results before the information was provided to the health plans. According to Ted von Glahn, the director of Performance Information and Consumer Engagement for the Pacific Business Group on Health (PBGH), who provided guidance for the CPPI project, approximately 1200 physicians provided corrections. The correction process was laborious, but provided some further process refinement. For example, if a patient refused a medication that was deemed necessary, the physician could state that the patient refused. However, starting next year, this option will no longer be available. Mr. von Glahn said that there has been a "spirited" discussion with regard to the patient adherence issue.

Mr. von Glahn also states that the CCHRI executive committee is providing guidance to health plans on how to use these data. He believes that in 2010 these plans will use the data to recognize top performers.

Many physicians were surprised by the CPPI report. The California Chapter of the American College of Cardiology (CA ACC) received many phone calls with questions, concerns, and pleas to help navigate this process. The purpose of this article was to describe the process. CPPI will be an ongoing process; after my discussions with Mr. von Glahn, the CA ACC has been invited to be on the advisory group to help refine the process.

I would like to hear from you about your experiences: Did you submit the corrections? What were the barriers you faced? Your feedback will help us better represent you in this process. This initiative, along with others looking toward collecting individual physician data, is here to stay. We need to become active participants. I look forward to hearing from you. Please feel free to contact me at drdipti@yahoo.com or Lianna Collinge, CEO, at Lianna@caacc.org. ■

Echocardiography Preauthorization Mandates From Private Insurers

Richard F. Wright, MD, FACC

Research Director & Director Heart Failure Center, Pacific Heart Institute, Santa Monica, CA; Past-President/Governor, California Chapter, American College of Cardiology; Co-Director, Medicare Contractor Advisory Committee, California

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Increasing use of advanced imaging modalities has led to widespread concern about burgeoning expenditures for these procedures. Although recent growth has been most robust for CT, PET, and MRI modalities, echocardiography remains the most utilized cardiovascular imaging test. This has led payors to institute measures that address the appropriateness and utilization of echo services.

One company, Wellpoint, Inc. (Indianapolis, IN), has already unilaterally instituted a program of pre- and postnotification for echocardiography. This program is applicable to all Anthem Blue Cross providers of outpatient echocardiography examinations, whether in a hospital, office, or free-standing facility. Notification of such requirements was mailed to 20,175 physician offices in May 2009. At present the prenotification process is voluntary and not required for payment, but Anthem has expressly stated that prior authorization will become mandated sometime in 2010. At that time, any echocardiographic service performed without an authorization number will be denied even if the service was medically necessary. The program is being administered by American Imaging Management (AIM), a wholly owned radiology benefit management subsidiary of Wellpoint. AIM's proprietary utilization guidelines cover indications and frequency of use for transthoracic, stress, and transesophageal echocardiography services and are available for review on its Web site (http://www.americanimaging.net).