

## **2005 Medical Directors' Institute Final Report—Measures to Action: Implementing a Cardiovascular Pay-for-Performance Program (DRAFT)**

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The American College of Cardiology held its fourth annual Medical Director's Institute (MDI) on October 5-7, 2005 in Atlanta, Georgia. The MDI continued the tradition of bringing together ACC physicians, health plan medical leadership and other stakeholders within the industry to engage in action-oriented discussions to overcome common challenges in providing high quality cardiovascular care. This year, participants addressed the complex issue of ambulatory cardiovascular Pay-for-Performance (P4P) programs. Over the course of the two-day meeting, participants worked together to identify and address some of the most critical barriers that inhibit the successful implementation of ambulatory cardiovascular P4P programs. This report describes the work and the recommendations of MDI 2005.

### **Firsts for This Year's MDI**

This year's MDI was developed in partnership with its first ever Advisory Committee. The committee was co-chaired by Janet Wright, MD, FACC and Mike Valentine, MD, FACC, who were joined by ACC members, medical leadership from national health plans, some of the nation's largest employers, and non-profit groups that represent large employers. This was also the first year that employers were invited to participate in MDI.

The committee's purpose was to surface the most important issues the MDI should address. They identified P4P as crucial, believing that the MDI could make a significant contribution to the emerging national dialogue about specialty care P4P. In addition, the health plans and employers called for ACC-endorsed cardiovascular care measures that could be used as the foundation for P4P programs. They also put a call out to the ACC to help them better understand "appropriate" cardiovascular imaging.

The Advisory Committee's input was invaluable in shaping the agenda for MDI 2005, so much so that a committee of this nature will be formally embedded into the MDI governance structure.

### **Overview**

Each year, MDI participants report that the discussions between ACC members and health plan leaders improve. This year was no exception. Participants' willingness to partner around important issues was evident, and their ability to talk freely and express their views allowed a set of well-developed recommendations to result.

### ***Participants***

Thirty-two Medical Directors and staff from national and regional health plans and thirty-seven ACC members, including the President, attended MDI 2005 (Attachment A). Among the ACC members were key leaders from the Board of Governors, the Board of Trustees, the Advocacy Committee, and the Quality and Strategic Directions Committee. Also in attendance were representatives from the National Committee for Quality Assurance, American Health Insurance Plans, as well as other key accreditation organizations, subspecialty societies, and healthcare agencies.

### ***Performance Measures***

In response to the Advisory Committee and work that came out of last year's MDI, ACC presented a set of ambulatory cardiovascular care measures (Attachment B) that participants had an opportunity to weigh in on. These measures, developed by ACC in collaboration with the Physician Consortium for Performance Improvement (PCPI) and endorsed by the National Quality Forum (NQF), will be presented to the Ambulatory Care Quality Alliance (AQA) later this year as a part of a larger discussion between specialty societies and this national group. A tiered methodology, based on ease of data collection, was used to present the measures: the "core" measures (Level One) are those that the Center for Medicare and Medicaid Services (CMS) is creating G-codes for, Level Two measures are those that are reasonably quantifiable through administrative data, and Level Three measures are more difficult to quantify.

Participants received the measures with great enthusiasm. They were also asked to discuss the following questions about the measures:

- *In what ways do the core measures meet your needs as a "good enough" place to start?*—There was a general consensus that the core measures provide a good starting place for getting a set of cardiovascular measures into the field for testing, ongoing review and updating.
- *Which of the measures in Level Two and Level Three might you move up to Level One?*—Participants agreed that lipid measurements should move into Level One, along with support for weight measurement and administration of Warafin. Some participants suggested that all of the Level Two measures be moved up into Level One. Overall, participants believed that all of the measures should be tested.
- *What is your number one concern about collecting this data?*—Participants liked that the measures included data not commonly captured in claims. However, this will make it much more difficult to collect the information they need. It is unclear what infrastructure will best support non-claims data. Participants agreed that it will be important to solve this issue going forward. Participants also offered up alternative ways to think about future measures and patient attribution related to data collection. Measures could be disease-centric, rather than stand-alone. Patients could also be attributed to groups of physicians rather than individual physicians.

### ***Appropriateness Criteria***

ACC also unveiled Appropriateness Criteria for Single-Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT-MPI) (Attachment C). Four participants, representing a microcosm of MDI attendees, were asked to react to the presentation. The panel consisted of Dr. Gregg Allen of MedSolutions, Dr. Andrea Gelzer of Cigna Healthcare, Dr. Lee Newcomer of United Healthcare and Dr. Andrew Van Tosh of Beth Israel Medical Center. Panel members applauded the swift work of the Appropriateness Criteria Working Group, a group that emerged as a result of MDI 2004. The panel's view on the Appropriateness Criteria was mainly positive, praising the responsible approach taken to try to control imaging utilization. Some highlights from the conversation are included here.

#### *Value of Appropriateness Criteria*

- “There is a need for clear pathways related to optimal use of imaging to manage conditions. I'd like to see a package of Appropriateness Criteria (AC) for all cardiovascular testing modalities.”
- “By comparing efficacies of different modalities, this will only add to value that has already been accomplished.”

#### *Education and Dissemination*

- “How do you disseminate the document? It must flow. It must be simple and straight forward, one-page maximum.”
- “It would be interesting for the College to put into place educational programs for membership to somehow help them police themselves.”
- “We must educate consumers so they know the test is not always needed. Patients walk in expecting to receive the test. Consumer needs to be involved.”

#### *Credible Process*

- “I was impressed with the process.”
- “It was a good thing that there was a mixed, multi-disciplinary panel that did not demand consensus. This leads to credibility.”
- “Remember that in the 1400's, eight of ten would have agreed that the world was flat... and in the early 1990's, eight of ten would have agreed that bone marrow transplant was an appropriate treatment for Stage 3 and Stage 4 breast cancer. We need to continue to evaluate appropriateness.”

#### *Inappropriate Referrals*

- “There is huge variability and issues of inappropriate referrals. People managing health care want to see a definitive process—what is the right sequence of diagnostic studies that lead to the answer at the lowest economical cost?”
- “Just because a patient is referred to me for SPECT doesn't mean I have to do it. We need to do a better job to educate primary care physicians.”
- “AC go a long way to help plans understand appropriateness and what they can do to help give feedback to physicians and groups.”

#### *High Utilization*

- “I wouldn’t use this routinely with cardiologists. Look at high utilizers of SPECT and speak with them. Focus on high utilizers.”

#### *Data Collection*

- “The right time to collect appropriateness data is at the time of the procedure. Pay a premium for collecting data.”
- “The justification for the data collection infrastructure is complex. To go retrospectively to collect data would be onerous. Payers should be prepared to pay to engage in bi-directional sharing.”

#### *Missing*

- “I was surprised that the question of segregation between men and women was not addresses in the AC.”
- “It was interesting that there was no limitation or comment on post intervention and MPI imaging was not mentioned. According to this, it looks like it would be appropriate.”
- “Underutilization is not included in the AC, but that feels appropriate. This is an issue better addressed in guidelines.”

### ***Ambulatory Cardiovascular Pay-for-Performance Programs***

The focus of this year’s MDI was to explore the issues and challenges related to Pay-for-Performance. ACC values pay-for-performance programs that are designed to support and facilitate the quality improvement process and to strengthen the patient-physician relationship, rather than solely for quality assurance purposes.

#### *ACC Pay-for-Performance Principles*

The ACC Pay for Performance Principles (Attachment D) were presented at the start of the P4P work, and participants were encouraged to use them as a framework for their discussions. Participants were asked to think about the principles they felt would be the most challenging to implement going forward, and why they thought that would be the case. Their discussions raised the following issues:

- *Trust is a major issue*—Who holds the data, and are the data credible?
- *Investments and Return*—There are cost issues and concerns about the return on investment for establishing systems.
- *Applying Credit*—It will be challenging to credit the appropriate physician (e.g., the primary doctor vs. the specialist) in ambulatory P4P programs.
- *Information Technology*—What can realistically be done in the interim before EMRs are widely adopted?

Participants had an opportunity to explore these and other issues related to ambulatory cardiovascular P4P programs throughout the event. The results from those conversations can be found later in this report in the section entitled, “Recommendations to Advance Quality-driven Ambulatory Cardiovascular Pay-for-Performance Programs.”

### *Learning from the Success of Inpatient Pay-for-Performance Programs*

Inpatient P4P programs have made some great progress in recent years, as evidenced in a presentation about Anthem Blue Cross and Blue Shield’s Quality-In-Sights Hospital Incentive Program (Q-HIP) need a couple of bulleted process and outcomes or an Attachment E. Participants were asked to think about the lessons they might apply to the ambulatory P4P experience. They addressed several questions related to this issue.

- *What do you think are the top 2-3 most important lessons that inpatient programs can teach us about how to approach ambulatory P4P programs? Why?* Participants reported that “new money” financial incentives would be helpful. In addition, it will be important for the different players to trust one another. Everyone must buy-in and work together to create a shared belief that they are playing fair with each other. There is also a need for champions, both on the national and local level, to advance credible P4P programs. This would be helped if payers can begin to establish some uniformity across the programs.
- *Based on your own experience, what do you believe is the biggest pitfall to avoid?* The biggest pitfall would be allowing “lack of perfection” to impede these programs from getting off the ground. Other pitfalls mentioned included the difficulties family physicians face in attempting to keep up with disease management, an imbalance between payers and providers in terms of covering administrative costs, and caution about raising the bar and excluding those who are not achieving. Avoidance of creating more access-to-care problems was stressed.

Participants took with them the P4P Principles and the lessons they learned from the inpatient experience as they began to explore the complex task of developing ambulatory cardiovascular P4P programs.

## Recommendations to Advance Quality-driven Ambulatory Cardiovascular Pay-for-Performance Programs

Earlier in the event, participants were asked to identify the top two or three things they hoped would come out of this year's MDI, as well as their biggest fears for the event.

- *Hopes*—Participants' expectations were modest. They unanimously reported that they hoped "something" would develop, especially on the local level. They articulated a need to figure out how to use the structure of the ACC to give local leadership the proper tools and guidance they need to advance complex initiatives, like P4P. In addition, a white paper or some other mechanism could be used disseminate the best practices nationally.
- *Fears*—Without a doubt, participants' greatest fear was that "nothing" would happen coming out of the event. They also cautioned that the P4P process could become overly burdensome, and feared that participants would not be able to agree upon the measures that serve as the foundation for P4P programs. Not including the practice community would also negatively impact the potential success of broadly acceptable P4P programs.

It was clear that participants were committed to advancing their hopes and moving beyond their fears. As was stated earlier, participants were able to agree on the core measures ACC presented. With this as a foundation, they worked to address the complex topic of designing and implementing successful P4P. This is a subject wrought with numerous challenges, so participants were asked to focus their efforts on six primary barriers to ambulatory cardiovascular P4P programs. The barriers were identified through a survey of MDI 2005 participants, discussions with national quality leaders, and the literature. They included:

- Attribution
- Consideration of Cardiovascular Subspecialties and Small Sample Size
- Data Collection
- IT Infrastructure
- Recognition
- Data Reporting

Multiple levels of complexity characterize each of these barriers, so participants were asked to explore the layers. They worked to identify restraining forces, and prioritized the forces that they considered relevant, yet practical, in terms of believing that people in the room (e.g., physicians, health plans, and quality organizations) could actually do something about them.

MDI endeavors to align physicians, payers and employers at the national level to develop solutions that can be delivered on the local level. This was certainly the case with P4P. With a short list of prioritized issues, participants worked together to develop solutions to overcome each of the most important barriers, and to identify the types of stakeholders

(namely ACC, physicians, payers, employers and other specialty societies or quality organizations) who they expect will have the greatest impact on each barrier.

Participants were asked to refrain from a “one size fits all” mindset, and to consider generating multiple—perhaps even philosophically different—approaches to address the barriers. As a result, they successfully presented numerous solutions that are feasible for designing and testing ambulatory cardiovascular P4P programs.

Each group’s work is summarized below. They focused on what they believed to be the primary challenge to overcoming their barrier. Each group reported the goal that they were working towards, as well as the primary challenge, proposed action steps, the players involved, a recommended time frame and potential support needed.

***Attribution—Patients are fairly attributed to the appropriate physician.***

<b>Primary Challenge</b>	The lack of standardized measures and an approach/methodology for assigning accountability.
<b>Proposed Action Steps</b>	<ul style="list-style-type: none"> <li>▪ Establish a group to identify the range of attribution models are currently available and in use from both payers and providers. Need to identify what is practical and what the best representation should be.</li> <li>▪ Work towards developing a realistic method of appropriately assigning accountability for clinical outcomes.</li> <li>▪ Create one group to look at lack of measures, lack of data chain and look at how the group can make it better.</li> </ul>
<b>Players Involved</b>	Payers, purchasers, data collection people, clinical, cardiology and subspecialty, primary care physicians
<b>Time Frame</b>	Preliminary recommendations are made within three months, a pilot starts within six months, and a status report is given at MDI 2006.
<b>Support Needed</b>	Funding, commitment from stakeholders, and a project manager

***Subspecialties—We will be able to measure subspecialty quality.***

<b>Primary Challenge</b>	There is a limitation in available measures and access to data.
<b>Proposed Action Steps</b>	<ul style="list-style-type: none"> <li>▪ ACC to develop a subspecialty with specific measures with other national organizations (e.g. PCI, imaging) and then health plans could test the measures.</li> <li>▪ ACC should develop multi-modality imaging appropriateness criteria.</li> <li>▪ For better access to data, health plans should invest in data collection (nurse data abstractors) and establish an incentive payment program for</li> </ul>

	<p>participation in clinical data registry.</p> <ul style="list-style-type: none"> <li>Try to consider the reliance on existing data registries as a focal point to bring cardiologists together and then share best practices and catalyze quality improvement.</li> </ul>
<b>Players Involved</b>	ACC, subspecialty organizations, national measure development organizations, health plans
<b>Time Frame</b>	ASAP
<b>Support Needed</b>	Collaboration among all the parties involved.

*Data Collection—Develop feasible data collection alternatives to current systems.*

<b>Primary Challenge</b>	The ability to leverage available clinical information.
<b>Proposed Action Steps</b>	<p>Need to leverage the available clinical information. Share data already available in physician office (problem list and schedule) and claims (medication and labs). In addition to payers receiving the information, payers need to give back data as to what prescription has actually been filled. This data could be held by a third-party such as QIO. There needs to be a two-way communication around data. With all of this data collection, there needs to be an audit system in place as well.</p> <ul style="list-style-type: none"> <li>Short-term solution—Develop a checklist that a physician can fill out in 20 seconds and send it off to the payer without using paper system.</li> <li>Long-term solution—create a new system of data collection such as a web-based or kiosk that potentially relies on the patient to enter data. In addition, need to work at prioritizing clinical information and engage the physician in collecting data. Work towards a common data element—define the terms and definitions for data. Develop a “problem list” so everyone can agree a patient had a certain type of disease.</li> </ul>
<b>Players Involved</b>	Physicians and payers, third party data holder such as QIO.
<b>Time Frame</b>	12 to 18 months
<b>Support Needed</b>	Auditing (cross checking data sources), development of a checklist for physicians, data transmission (QIOs, fax-based form system). For creation of a new data collection system, there needs to be development of data repositories.

***IT Adoption—Accelerate adoption of an IT infrastructure to support ambulatory cardiovascular performance measurement.***

<b>Primary Challenge</b>	Data standardization, prohibitive costs, the implementation process and resistance to adoption.
<b>Proposed Action Steps</b>	<ul style="list-style-type: none"> <li>▪ Investigate a web-based IT solution to EMR and develop a vendor comparison tool. In the meantime, ACC should help with the transition between digital and paper data records.</li> <li>▪ In order to keep down costs for IT adoption, health plans should leverage their strengths regionally and negotiate with IT vendors.</li> <li>▪ Define viable financial incentives for physicians through either additional assistance or practice costs that are dropped as a result of adopting IT.</li> <li>▪ Work collaboratively to support the development of uniform data collection form that all payers would use.</li> <li>▪ Get other players involved such as the NCQA and the AQA.</li> </ul>
<b>Players Involved</b>	Physicians, health plans, IT vendors NCQA, AQA, National Quality Forum
<b>Time Frame</b>	ASAP, with development of uniform data implemented by 2007
<b>Support Needed</b>	Staff and financial resources from health plans and ACC

***Recognition—Adequate incentive for investments in structure, best practices and tools that can lead to improvement and high quality care.***

<b>Primary Challenge</b>	Adequate incentive for the value of all parties and ROI
<b>Proposed Action Steps</b>	ACC and health plans develop templates for P4P, and ACC communicates the best practices. Practices might be recognized for some type of participation in data collection/EMR. Look for an economic engine and cost savings in pharmacy and appropriate imaging/revenue stream.
<b>Players Involved</b>	Physician perspective, health plans
<b>Time Frame</b>	Template to be completed by March 2006 and implemented in 2007.
<b>Support Needed</b>	Physician and health plan support

***Data Reporting—Develop a clinically meaningful assessment tool (“report card”), which has quantitative and qualitative performance measures that all interested parties (e.g., patients, physicians, payors, consumers, health plans, hospitals, CMS, IPAs) will agree are important and worth reporting and rewarding pay-for-performance dollars.***

<b>Primary Challenge</b>	Concern over the control, use, and ownership of data
<b>Proposed Action Steps</b>	<ul style="list-style-type: none"> <li>▪ Begin a pilot program of sharing clinical data where interim reports are sent to the physician from the health plan. This will allow for educational opportunities to not only provide information on outcomes but also how to change outcomes.</li> <li>▪ Data registries such as NCDR would receive interim reports with possible data sharing between physicians. Take the NCDR tool as a model to create an ambulatory data collection tool.</li> <li>▪ The ACC should be the third-party aggregator and facilitate sharing of information by disseminating reports. ACC currently has a data repository and that could be used as a model to develop a program to collect ambulatory clinical data. Need to compare claims data from the health plan to the clinical data provided by the physician.</li> <li>▪ Evaluate the MD Datacorp model</li> </ul>
<b>Players Involved</b>	Health plans, hospitals, physicians, CMS, MD Datacorp
<b>Time Frame</b>	6 to 12 months
<b>Support Needed</b>	ACC, payor incentives, physician voluntary participation

## Next Steps

This year’s participants generated a wealth of important ideas that will help cardiovascular specialists, health plans and employers find ways to work together to launch successful ambulatory P4P programs. The following next steps will support the advancement of these efforts.

- **MDI Governance Model (Attachment F)**—The ACC will continue to sponsor the MDI. The Advisory Committee will be comprised of volunteer representatives from health plans, accreditation organizations, subspecialty societies, employer groups, and other stakeholder agencies. Individuals interested in serving on the MDI Advisory Committee should contact Eileen Hagan at [ehagan@acc.org](mailto:ehagan@acc.org).
- **Call to Action**—MDI leadership will be following up with you regarding the projects you expressed an interest in testing either during the MDI or through the Requests For Information (Attachments G and H) that were distributed with the MDI Executive Summary Report. These projects include, but are not limited to:

- ◆ Cardiovascular care measures and specialist recognition
- ◆ Appropriateness criteria for SPECT-MPI
- In addition, the MDI Steering Committee is proposing the formation of two distinct workgroups to address the P4P barriers of attribution and information technology (IT) infrastructure.
  - ◆ The *Attribution Work Group* will identify and assess current attribution models and recommend a method of appropriately assigning accountability for clinical outcomes.
  - ◆ The *IT Work Group* will identify/ develop a model RFP, explore the feasibility of a vendor comparison tool, investigate web-based IT alternatives, and recommend system solutions for implementation at the practice level.

Anyone who is interested in participating in these groups should contact Eileen Hagan at [ehagan@acc.org](mailto:ehagan@acc.org).

We thank you for your participation. We look forward to working with you in the future as the MDI continues to serve as a venue for physicians, health plans and others in the health care landscape to improve the delivery of quality of cardiovascular care.