



## Medical Directors Institute 2004:

The Judicious Use of Cardiovascular Services: Physicians and Plans  
Working to Address Quality, Value and Affordability

October 21-23, 2004 Dallas, Texas

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## **Executive Summary MDI 2004 Report**

### **The Judicious Use of Cardiovascular Services: Physicians and Plans Working to Address Quality, Value and Affordability**

The American College of Cardiology (ACC) held its third Medical Director's Institute (MDI) on October 21-23, 2004 in Dallas, Texas. The purpose of the MDI is to provide a unique opportunity for medical directors of managed care organizations and cardiovascular specialists to identify common challenges in providing high quality health care. The two-day meeting focused on fully examining issues related to value and affordability in the evolving healthcare delivery system.

The intended outcome of MDI 2004 was to promote the collaborative work of the profession with payers in establishing solutions and recommendations to address quality and affordability. It is also hoped that a collaborative research agenda could be established including the identification of potential pilot projects.

Seventeen Medical Directors from national and regional managed care companies were in attendance as well as representatives from the National Committee for Quality Assurance, Blue Cross Blue Shield Association, American Health Insurance Plans, Agency for Healthcare Research and Quality and the Centers for Medicaid and Medicare Services. Members of the ACC Board of Governors, Board of Trustees, Advocacy Committee and Quality and Strategic Oversight Committee were also in attendance.

Of particular note, the MDI has developed a comfort level and ease with which both ACC members and Medical Directors were able to converse and share concepts. MDI participants marveled at the improved participation and ease of dialogue. The two prior meetings were spent identifying problems and beginning a dialogue respectively. This year moved the group more closely to health plan Medical Directors hearing ACC positions and ACC members really listening to health plan concerns. There was a feeling of cooperation and cohesiveness that did not exist at prior meetings.

#### **MDI 2004 Recommendations:**

MDI has proven to be successful in forging new relationships between cardiovascular specialists and health plans. MDI has reached a pivotal point and must clarify its future as a national level "think-tank" of collaborative ideas. The major issues addressed during MDI's final discussions were 1) Information Technology/Electronic Medical Records and, 2) Imaging and Appropriateness Criteria. These items must be acted upon in a thoughtful but timely manner.

To meet these expectations, the MDI Steering Committee is meeting with the ACC Executive Committee to discuss an expedited process within the College for creating cohesive work groups in Imaging Appropriateness Criteria and IT/EMR. With a fast track approach, MDI liaisons will be placed on the two core work groups pulled from all College activities surrounding the topics to produce deliverables during 2005. Health Plan medical directors from MDI will be consulted on an advisory basis. As needed, additional MDI members will be asked to participate.

MDI participants have come to realize that they are working at the national level to create change at the local level. Originally a stronger connection was needed between local and national activities that were created via the Regional Quality Cardiovascular Partnership. The Regional Partnership has now been folded into the Managed Care Network (MCN). Therefore, MCN will work jointly with MDI to oversee all private payer activities at the local level. Of note, the MCN has five areas of concentration: 1) Pilot Program Database; 2) Quality; 3) Payment Issues; 4) Communications and 5) Development of solid link to the Medical Directors' Institute. Further, the MDI encourages specific proposed pilots including the Physician Recognition /Gold Star Cardiologist Program and Disease Management. In order to allow local chapters and health plans to begin the pilots, a specified pilot plan must be written to ensure that all parties are following the parameters addressed in MDI presentations. ACC is already arranging meetings with national payers who are interested in the Physician Recognition Program.

The following are highlights of each work group and pilot programs with expected outcomes:

### **Information Technology/Electronic Medical Records**

The purpose of this work group will be to stimulate the ACC to promote a set of data elements of usage and ability for IT standards. The IT/EMR group shall be responsible for researching and producing a working document for publication. The document shall be an interim finding of necessary data elements for cardiovascular specialists to refer to when considering an Electronic Medical Database.

### **Appropriateness Criteria for Imaging**

Aims to produce interim appropriateness criteria for specific modalities based on data provided by MDI medical director participants.

### **Pilot projects on recognition/Gold Star Cardiologist**

The ACC is already meeting with national payers to discuss the possibility of a recognition program whereby physicians and their offices would meet certain agreed upon criteria for clinical care and electronic solutions and be recognized for that achievement.

### **Disease Management**

A pilot project to highlight the value of a team based approach to care.

### **Next Steps**

MDI is in the process of developing a structured schedule to ensure that there are deliverables during 2005.

Next steps include:

1. Confirmation by the ACC Executive Committee for the expedited action plan
2. Coordination of all groups within the ACC working on Imaging/Appropriateness and IT/EMR to ensure MDI goals are achieved including deliverables in a timely manner
3. Create a suitable pilot program plan
4. Reorganizing the MDI Steering Committee to create the Advisory Panel including ACC members and medical directors

This paper serves as a summation of the key points from the MDI meeting including keynote address, recommendations by the 2003 workgroup, comments of four speakers, recommendations of the 2004 breakout sessions and the MDI final recommendations.

## **I. Keynote Address: Value, Quality and Affordability: How can Health and Physicians Collaboratively Address Employer Issues**

Marianne Fazen, Ph.D., Executive Director of the Greater Dallas/Fort Worth Business Group on Health (DFWBGH) presented the keynote address. Her role was to ignite dialogue between medical directors and physicians with her presentation that focused on the implementation of the DFWBGH's Cardiac Network of Excellence and the Outpatient Cardiac Care Improvement Program. Both programs focus on improving quality and reducing the cost of health care services to employers.

The DFWBGH represents 115 employers, with more than 200,000 employees. The coalition members spend \$1.3 billion /year on health care in Dallas/Fort Worth. Their mission is to: Promote health care quality, accountability and cost effectiveness and to empower employers to make informed health care purchaser decisions.

Dallas area employers have cited their top three health benefit concerns including uneven quality and patient safety, 50 percent higher premiums in the past five years and increasing retiree medical costs. Previous remedies included cost absorption, reduction of benefits, increased cost sharing or removal of coverage. However, with the development of cost-saving alternatives i.e. employee health assessments, consumer directed health plans, disease management, and "Tiered" provider networks, employers in Dallas are taking a more pro-active measure to ensure future health benefits.

### Cardiac Network of Excellence

DFWBGH has created a Cardiac Network of Excellence Demonstration Project. The project is a collaborative, community-wide quality improvement initiative that uses evidence based processes and outcomes measures to identify and recognize providers that demonstrate superior performance. Focus areas include AMI, CABG and PCTA using evidenced based processes and outcomes. AMI measures are taken from JCAHO Core Measures and based on volume. The program takes into account risk-adjusted mortality rates and length of stay that are consistent with Leapfrog patient safety goals. The qualification criteria are: "as expected" or "better than expected" risk adjusted ratings. The information is already being reported out on hospitals.

### Outpatient Cardiac Care Improvement

The Outpatient Cardiac Care Improvement project, still in development, aims to give employers and physicians the opportunity to collaborate. The DFWBGH is conducting the project directly with the cardiovascular specialists and not the plans.

Distrust of the health plans by the cardiovascular specialists and DFWBGH's desire to move forward account for the decision to exclude the plans. The Project has a joint leadership committee made up of DFWBGH board members and cardiovascular specialists. The joint leadership committee is responsible for recruiting cardiovascular participants, identifying champions and control groups, defining the scope, data collection and reporting criteria, and determining incentives. The physician's task force identifies evidence based performance measures and is developing criteria for superior performance and defining superior physicians' qualifications.

The project includes three additional phases: 1) performance measurement assessment whereby they will conduct medical record reviews of 10 practices and 30 charts per participating physicians, 2) performance improvement including patient and physician's toolkits, and physician's forums, 3) rewards and incentives by cardiac specialty groups, health plans and employers. The final product is designed to be a Pay for Performance Program. The DFWBGH sees this partnership as a way to improve patient outcomes, build stronger physicians patient relationships, satisfied and more compliant patients, healthy employees and lower health care costs.

MDI 2004 Feedback: The medical directors were very surprised that the coalition did not work through the plans to implement the new initiatives. The responses echoed concern about the ability of the program to be accepted by health plans since they were initially excluded from the development.

The "take away messages" from this talk were referenced several times throughout the conference in terms of: the rapid advances in employer and physician collaboration, the need for immediate and timely action on performance and cost issues by the ACC and cardiologists and the recognition of the value of cardiologists being willing and ready to engage in the dialogue.

## II. MDI 2003 Work Group Recommendations/ 2004 MDI Comments

MDI 2003 resulted in the creation of four work groups, identified as prevalent areas for exploration:

- Measuring Quality
- Paying for Quality
- Disease Management Processes
- Imaging.

The Work Groups were charged to develop recommendations and goals originally identified by a question posed during the breakout session at MDI 2003. To foster communication between medical directors and ACC members, the work groups were created with a combination of participants.

### Measuring Quality

Co-Chairs: David Hale, M.D., F.A.C.C. and Peter Goldbach, M.D., Medical Director BCBS MA

MDI 2003 Question: As key stakeholders, how can cardiologist play a central role in establishing and adjusting cardiovascular performance measures to evaluate quality?

Task: Develop valid performance measures, including definitions and terminology that agreed upon by both plans and ACC.

Agree to Definitions of Data/Metrics of Performance Measures/Terminology  
Develop Valid Measures

Recommendation: The consensus was a need to raise the standard of care across outpatient cardiovascular practices. The benefits of electronic medical records (EMR) were highlighted for ease of data extraction. The idea was to recognize and reward practices actively measuring their own performance and meeting metrics that were easily identifiable including adoption of electronic solutions.

It was proposed that the ACC in collaboration with interested health plans create a National Quality Reporting and Recognition Program. The program would establish a unique set of evidence based practice metrics-- using existing, national recognized, evidence – based guidelines and electronic solutions, -- which would be used to recognize excellence, to assist in improving quality and safety in cardiology practices, and which may be adopted by participating health plans to report on and reward participating physicians. Participation would be voluntary.

### Pay for Quality

Co-chairs: Linda Gillam, M.D., F.A.C.C. and John Gillespie, M.D., Medical Director, BCBS Western New York

MDI 2003 Question: Can new models be developed that pay for quality based on adherence to guidelines while continuously improving quality of care?

Task: Collaborate to develop effective Pay-for-Quality models related to cardiovascular care

Proposal: “Gold Star Cardiologist” Program

To be a Gold star Cardiologist, a cardiovascular practice would be required to meet five broad criteria including 1) Measure own Performance/ Practice Evidence based medicine, 2) Commitment to needs-based continuing professional development, 3) Patient Satisfaction 4) Information Systems and 5) Appropriateness. These criteria were determined based on consensus. The consensus was reached through a combination of findings of health plan survey responses regarding medical directors’ top concerns and ACC members feedback based on those findings. The ACC members and the medical director’s have differing perspectives on some of the components of the criteria. (See grid for Pay for Quality)

### Recommendations:

1. Health plans should vigorously start to support the NCDR to monitor outcomes.
2. Adoption and use of performance measures for Atrial Fibrillations, CHF and CAD.
3. Appropriateness of Care- The workgroup did

not specify an area – although they did emphasize the importance of non-invasive testing and evaluating those procedures.

### Disease Management

Co-Chairs: Janet Wright, M.D., F.A.C.C., and Donald R. Fischer, M.D, F.A.C.C., Medical Director  
Highmark BCBS

MDI 2003 Question: What are the paradigms, tools and information necessary to develop an ongoing and successful disease management process?

#### Task:

- Patient: Develop tools and mechanisms to educate and motivate patients
- Providers: Develop a mechanism to identify accountable physicians. Develop an effective two way communications process for the timely exchange of information and data between disease management entity and physician office
- System: Create a set of agreed upon quality indicators; Define successful outcomes and support best practices; align incentives; Optimize pharmaceutical utilization; Risk stratify and ID patients

Definition: Disease Management is a system of *coordinated health care intervention* and communication for populations with conditions in which patient self-care efforts are significant. Disease Management:  
1) *supports the physician or practitioner/patient relationship and plan of care* 2) *emphasizes prevention of exacerbations and complications utilizing evidence based practice guidelines and patient empowerment strategies* and 3) *evaluates clinical, humanistic, and economic outcomes on an on-going basis with goals of improving overall health*

#### Recommendations:

There is a need to optimize team-based care as a method to improve patient outcomes. Best approach is a pilot project that will test various mechanisms to optimize team-based care and focus on clinical outcomes as well as costs. Resulting activities will support these goals and address outcomes. (See Activity Summary and Recommendations from Disease Management Workgroup and Top Ten Principles for Physicians to effectively work with Health Plans on Disease Management)

Please note: The purpose of the recommendations was not to evaluate disease management but to point out that they would recommend to the ACC the value in practices looking at population management- something most physicians are not trained in and the value of team based care. Who conducts it is not as relevant as plans and physicians coming together to look at population management and team based approaches to care.

### Imaging Utilization

Co-Chairs: Ben D. McCallister, Jr, M.D., F.A.C.C. and

MDI 2003 Question: As it relates to cardiovascular imaging, what mechanisms, tools and processes can be developed to ensure that access to imaging services is based on analysis of quality data?

Task: Define and support appropriate accreditation process by credentialing of imaging laboratories, performers, and interpreters that will be the basis for access to imaging services.  
-Base access (choice of physician) on quality and appropriateness

Recommendation: Based on 1) review of lab accreditation practices and requirements ( e.g. Intersocietal Commission, the American Institute of Ultrasound Medicine, and the American College of Radiology) \*, 2) an assessment of the value of accreditation\* and a discussion on appropriateness, and the 3) development of elements of a Physician Transition Plan \* for accreditation, the groups recommendations include: Continuing work toward developing a collaborative approach to **lab accreditation** including:

1) Guideline development for appropriate use of cardiac advanced imaging, 2) Development of consumer education regarding risk/benefits of new technologies (perhaps sponsored/developed by the ACC)

- 3) Development of framework for agreement on controlling self-referral in the use of existing and new technologies.
  - 4) Development of standards for training and expertise of professionals interpreting new imaging studies
- \* =See “Imaging Utilization Workgroup Activity Summary and Recommendations paper” and its references.

### **III. Panel Discussion: Current Efforts Underway to Address Value Quality and Affordability: Measuring Physician Performance and Efficiency and Appropriateness – Why? Lessons Learned, New Initiatives and Exploring Collaboration**

*These notes highlight three speakers who targeted their topics on efficiency and appropriateness for cardiology practices.*

#### Ray Hirschman -- Mercer Consulting-- Physician Efficiency Measurement

Health care spending continues to rise, though studies conducted by Rand and others demonstrate that patients receive enormous variations in care. “What we know works is not always what is actually done”. This phenomenon is challenging health plans and their consultants to look more closely at Quality and Efficiency Measurement. It is also encouraging large Employers to tailor health plan options that target consumer selection of high quality, low cost providers.

Efficiency measurement according to Bridges to Excellence and Leapfrog White Paper is defined as “a relative level of resource consumption, and associated costs, in the production of health care services”- cost efficiency. The opportunities in this arena are: 1) to carefully examine the variability of like providers who provide care for like conditions (studies like Wennberg and Dartmouth Health Atlas), 2) to explore analytically how patients move through the delivery system and 3) how consumers with incentives for cost/quality make their decision based on given information.

Efficiency rankings of physicians as well as hospitals are possible through the use of efficiency software. The data is then shared with providers and often leads to further discussions and a willingness and interest by physicians to understand the data and attempt to consider ways in which to improve care delivery. Ideally, the specialty being reviewed will have input into the construction of the elements reviewed. ( See Tufts Health Plan talk for example)

Of note, Health plans are beginning to change payment structures - from unit price contracting – (percentage off of RBRVS) to using Efficiency data to make payment determinations. Further employers feel employees should be made aware of the data by way of “tiered” networks whereby high quality low cost hospitals and physicians are given corresponding co-pays that incent behavior to those hospitals. This arrangement also encourages change in the lower ranking hospitals.

The “take away messages” from Mr. Hirschman’s presentation are to understand: 1) that the external world is gearing up to measure your efficiency performance- including carriers, CMS, accreditation agencies, state and local business coalitions; 2) the need to reconcile how practices measure and incent practice performance with how “health plans and others” are evaluating your performance; 3) the need to assess internal data capture and decision support capabilities to measure and improve performance over time; 4) the change in payer reimbursement contracting strategies from unit cost to a “longitudinal” efficiency and quality focus.

#### Ralph Brindis, M.D. F.A.C.C. The Physician Perspective: Efficiency Measurement and Appropriateness Criteria

Appropriateness Criteria are defined by “what to do” “when to do it” and” how often to do it.” The ACC has been asked and needs to address misuse, overuse and underuse and the connection of those to ACC guideline content. Dr. Brindis noted that if we [MDI] does not lead this effort, those in need of appropriateness criteria will lack the voice of the profession in setting them and go else were. The ACC must be good stewards of the gifts and the responsibilities that have been entrusted to us.” He identified several initiatives underway.

Nine attributes of appropriateness criteria were outlined 1) being consistent with existing guidelines and performance measures; 2) focusing on diagnostic and therapeutic procedures; 3) being applicable to different care

environments; 4) taking into account patient and family values, preferences and goals; 5) being mindful of the most cost effective choice among available alternatives; 6) performed or provided by properly trained and certified professionals in properly equipped and accredited facilities; 7) account for co-morbid conditions; 8) benefit versus risk analysis of available care alternatives. These measures – and this is the hard part- 9) they need to be simple, reliable, valid, and transparent.

To clarify critical features of an appropriateness measures, there must be: 1) Strong validity – Clearly aligned with the indication for the procedure; 2) Implementable- capable of being used in routine clinical practice; 3) Reproducible- can be replicated across sites and clinical indications and 4) Interpretable- variations in performance are actionable. The pros and cons to the approaches to appropriateness are:

1. Use physician assessment of need Pro: Able to integrate multiple characters Con: Highly variable across MDs
2. ACC believes that we should use guidelines to quantify indications Pro: Evidence based  
Cons: Very complex to implement; Derived from clinical trials where strong selection bias may occur and irreproducibility of source data

Using the Lucien Leape's study on angiography and a review of an alternative study of appropriateness from the patient perspective embodied in the ACC Seattle Angina program, Dr. Brindis offered a conclusion that extrapolating guidelines to appropriateness measures may be challenging and that more work needs to be done to further develop such appropriateness measures.

#### Current ACC Actions on Appropriateness

-The Quality Strategic Directions Committee has proposed a \$750,000 business plan to form working groups to work with payers and ACC experts on defining, developing and guiding use of appropriate criteria.

-An Imaging collaborative has assembled nearly 700 recommendations on imaging with hopes to have an appropriateness pilot by 2006.

-NCDR recently developed an auditing strategy to accurately judge outcomes. Items under review at NCDR: to look at longitudinal study of Catheter and Angioplasty to help determine appropriateness.

#### John Freedman, M.D., Tufts Health Plans- Lessons Learned in Developing a Tiered Network

Dr. Freedman was instrumental in implementing the tiered network for Tufts Health Plan in Massachusetts. Tufts decision to adopt a tiered system was in synch with Arnie Milstein's grid which states that the more comparative hospital and physician information in the health system, the more pressure there is to realign the health system to improve processes of care and that in turn will create more value for consumers.

Talks of the program initiated because the Commonwealth of Mass., the largest employer in the state representing 10 percent of Tufts' business, was experiencing four years of double digit increases in premium. The state wanted an alternative and they were ready to proceed on the Milstein continuum.

In response, Tufts developed the Navigator system that is a PPO plan design. Navigator does tiering and it will be phased in over three years. In July 2004, they tiered inpatient hospital care, July 2005, they will tier PCP's and in July 2006 they will tier specialty care. The tiering is based on cost and quality. Co-payments are assigned depending on ranking. Patients are encouraged to visit hospitals with the best quality, better-cost and lowest co-payment.

Tufts spent a large amount of time developing the quality and cost metrics. The quality metrics included Mortality, Complications (AHRQ), Volume, Leapfrog (CPOE and ICU staffing), credentialing status, and were case-mix and severity adjusted. The cost effectiveness metrics were adjusted for the average cost per case, length of stay, contracted rate, service mix and were case mix and severity adjusted.

Based on outcomes by Tufts when comparing the Eastern Pediatric Quality Measures vs. Efficiency in Massachusetts Community Hospitals, a majority appeared in the right quadrant (the preferred quadrant) but many were in other, unfavorable quadrants. Tufts implemented their Navigator tiered program, starting with hospitals, within a four month period. This was an enormously labor intensive effort.

Tufts's process was done very introspectively and not with the input from outside parties and caused challenges with the hospitals who felt the measures were inadequate and that they should have been at the table to discuss the measures. In this second round, hospitals are engaged in the metrics process. Right now the entire physician network and 10 quality experts are working on the physician's assessments.

Lessons learned: 1) The current payment system does not incent doctors to deliver quality care. Rather, per unit of service is solely rewarded. 2) The marketplace is moving and changing. Other competitors in Massachusetts have the Commonwealth as a client and also will be developing these models. Other states are developing these types of models. 3) Success of the product is not only about the metric set but also about offering real value over the existing PPO. This puts more pressure on plans. This gives opportunity for providers to come forward and help. 4) Where patients do not have health information, insurers will provide information with the theory of "not letting the perfect be the enemy of the good." The Boomers will also demand this information. To the extent the providers step up and create those metrics and make them available will be very welcome. 5) Collaboration with network representatives helps ensure best metrics and methods used- tufts created their own metrics and now in round 2 are working with their network and have found the collaboration useful and timely with very positive metric improvements coming out of it.

Dr. Freedman's experience with the tiered system has resulted in more meaningful conversations about quality in these last few months during the Navigator implementation than all his three and a half years as Medical Director of Clinical Quality at Tufts. For better or worse, it got people's attention and it got people invested in having the program work well.

Comments from MDI 2004:

A majority of participants were intrigued by Tufts implementation and turned to Dr. Freedman to answer questions regarding cost, capacity and physician efficiency

The discussion continued to flow freely and the plans and the physicians concurred that there was a role for ACC to continue to educate and inform its members that these kinds of activities were underway and how ACC hopes to help them.

#### **IV. Addressing Imaging Concerns: The Role of the ACC in Addressing Utilization, Quality and Access**

*Ben D. McCallister, Jr., M.D., F.A.C.C., Director, Non-invasive Cardiology Michigan Heart and Vascular Institute St. Joseph Mercy Hospital Ann Arbor, MI*

Data from the Blue Cross Blue Shield Association Technology Assessment Center (BCBS TEC) on diagnostic imaging shows that diagnostic imaging was the largest category of medical technology costs in 2000 at \$65 million to \$75 million and that the rate of growth of imaging is not likely to slow. It is noted that refinement of these technologies and development of new uses for diagnostic imaging will spur demand for both new and replacement machines, thus increasing the demand for more radiologists. Spending is expected to grow by 38 percent by 2005 and BCBS points out that GE expects all growth in MRI sales from 2001-2005 to occur outside the hospital setting.

SG2 consulting group states that "demand for imaging services will grow by over 200 percent during the next decade. SG2 also notes that general cardiology growth has grown at 8 percent over five years (1998-2000) Imaging has out distanced general cardiology and nuclear cardiology. Echocardiography in general and in the hospital (93307) in particular has seen a dramatic rise from 1996-2003 for Medicare patients. Nuclear Cardiology and Echocardiography is moving outpatient and increasing. Conversely, Cath volumes in Medicare decreased 3 percent in 2003.

Some of the reasons for increased volume include: guidelines and protocols calling for testing; an aging population; safer and less invasive testing; other specialties and patients being inclined to use them. Also testing can beget testing. Interestingly, even if new technologies decrease the costs per case, total costs grow as volume grows. Costs increase due to: volume increase; behavior patterns not changing even when evidence of ineffectiveness becomes available; poor education of ordering physicians.

The American College of Radiology (ACR) goal of only having radiologists be paid to perform and interpret diagnostic imaging studies was discussed. The cons of directing and limiting cardiac testing to radiologists include the growing shortage of radiologists and their limited understanding of cardiac function. The message was clear that there needs to be dialogue among health plans and cardiologists to ensure appropriate steps in contending with the increase demand for imaging. In terms of collaborating solutions Dr. McCallister concurred that accreditation was a likely first step and provided a summary side-by-side review of the Inter-Societal Commission of Accreditation and the ACR accreditation process.

Support for appropriateness criteria for imaging was discussed as a key measure to strengthen the quality of diagnostic imaging performance. Participants express their support for accreditation and an acknowledgement that the Intersocietal Commission Accreditation process is more costly and time consuming and therefore difficult for practices, however more reputable because of its high standards for quality. There is also a need for some financial support and transition time for groups to comply with accreditation.

## **V. Breakout Groups**

Breakout groups were tasked to prioritize their groups findings based on a key question(s) posed. These findings were to be used to determine MDI's next steps.

### Group 1: Pilot Implementation from MDI 2003 work groups

What steps are required to initiate pilot programs based on MDI workgroup recommendations?

#### Recommendations:

*A series of key attributes to be considered to launch a pilot project are:*

1. Share data with people involved in project
2. Project champion
3. Define quality/outcome measures
4. Need to improve communication to better understand practice (combine and align strengths/common language)
5. Need infrastructure –funding,
6. Need to have goals (new/existing)
7. Clear definition of the compelling problem (internal)

*A set of key attributes that contribute to pilot projects:*

1. Scalable/applicable to other parts of country – life beyond the pilot,
2. Committed resources,
3. Description of current state,
4. Business Plan – Financing,
5. Education at all levels –all stakeholders
6. Synergy - unique opportunity of collaboration and incentives are aligned,
7. Finite time-line
8. Education at all levels –all stakeholders

### Group 2: Quality and Utilization in Imaging

What can be done to assure patient-centered care addressing the usage of all imaging modalities?

Note: Modalities include Nuclear, Magnetic Resonance, CT, PET, and Peripheral Vascular

Key discussion points: The discussion centered on steps that need to be taken to assure quality of physician services including credentialing of physicians, quality of test interpretation, quality of equipment, and quality of the imaging procedures.

Other important topics include the use of clinical guidelines, the development of appropriateness criteria to help guide imaging utilization, addressing the value of the procedure to the patient both in terms of the cost effectiveness and the quality of imaging performed.

Discussion also included the increasing concern about the growth in imaging being partially driven by defensive medicine and the importance of addressing this in the context of patient-centered care

Recommendations:

1. Insure clinical quality of imaging modalities;
2. Coordinating test results with clinical picture
3. Assure longitudinal access to the imaging results so that providers determine what tests have been done and assure redundant testing is not done;
4. Determine physician credentials for each imaging modality
5. Assuring clinical quality of imaging procedure;
6. Address use of defensive test ordering
7. Developing/following clinical guidelines;
8. Communication among the various providers of clinical care for a particular patient;
9. Assure value to patient (cost effective and quality);
10. Assure appropriateness of imaging modalities for a specific problem

Group 3: Information Technology Implementation in physician practice

What key action steps must occur to increase use of information technology in physicians' practices?

Key Discussion Points: There needs to be improved education and awareness that build the business case and the quality of care case for practices to expend resources on IT. There needs to be a funding mechanism -- through collaborations or otherwise -- for practices to implement this enormous expense. There also needs to be a common definition for hardware and software and finally there needs to be safeguards for privacy and security.

Recommendations:

1. Build Quality / Improvement of Care Case;
2. Building a Business Case Including time management and Return on investment;
3. Study / Address Funding Sources, a) Employers, b) Health plans, c) Industry, d) System, e) External.
4. Clarify Range of IT Options and Costs;
5. ACC and Health Plans commit to increase awareness regarding value of IT within community providers and purchasers;
6. Adopt Timeline for Committee Action

Group 4: Efficiency Paper

What are the top concerns raised by the recommendations set forth in the Efficiency white paper sponsored by The Leapfrog Group and Bridges to Excellence.

Key Discussion Points: The group agreed that the paper was not well written, it appears to be written by committee and is not easily understood. Further, the executive summary does not summarize the paper but rather is an introduction. The report provides a snap shot on the issue of physician efficiency. It is not clear how it will aid with the ongoing issues of reporting of efficiency.

Recommendations:

1. Clearly define and measure efficiency in context of Cost, Waste, Quality, Value;
2. Fairness of use/or application is important;
3. What if the Leapfrog and Bridges to Excellence recommendations are not well received – Will changes be made?;
4. Paper is not easily understood, executive summary is not adequate: need preamble, problem statement for context;
5. If data is not presented well, it will get thrown out- and not accepted

Group 5: Appropriateness Criteria Group – Had two questions

1. What are the top areas in need of appropriateness criteria?

Key Discussion Points: Economic drivers are fueling the need for appropriateness.

Recommendations

1. Nuclear
2. Angioplasty
3. Emerging technologies

2. What factors must be included in such criteria (i.e. cost effective, test efficacy, co-morbidities)

Recommendations:

1. Effective;
2. Safety;
3. Clinical indication (Need);
4. Influences care;
5. Misuse, overuse, under use;
6. Evidence-based;
7. Influences outcome

## **VI. MDI Final Recommendations:**

MDI has been successful in forging new relationships between cardiovascular specialists and health plans. MDI has reached a pivotal point and must clarify its future as a national level think-tank of collaborative ideas. The major issues addressed during MDI's final discussions were 1) Information Technology/Electronic Medical Records and, 2) Imaging and Appropriateness Criteria. These items must be acted upon in a thoughtful but timely manner.

To meet these expectations, the MDI Steering Committee is meeting with the ACC Executive Committee to discuss an expedited process within the College for creating cohesive work groups in Imaging Appropriateness Criteria and IT/EMR. With a fast track approach, MDI liaisons will be placed on the two core work groups pulled from all College activities surrounding the topics to produce deliverables during 2005. Health Plan medical directors from MDI will be consulted on an advisory basis. As needed, additional MDI members will be asked to participate.

MDI participants have come to realize that they are working at the national level to create change at the local level. Originally a stronger connection was needed between local and national activities that was created via the Regional Quality Cardiovascular Partnership. The Regional Partnership has now been folded into the Managed Care Network (MCN). Therefore, MCN will work jointly with MDI to oversee all private payer activities at the local level. Of note, the MCN has five areas of concentration: 1) Pilot Program Database; 2) Quality; 3) Payment Issues; 4) Communications and 5) Development of solid link to the Medical Directors' Institute.

Further, the MDI encourages specific proposed pilots including the Physician Recognition /Gold Star Cardiologist Program and Disease Management. In order to allow local chapters and health plans to begin the pilots, a specified pilot plan must be written to ensure that all parties are following the parameters addressed in MDI presentations. ACC is already arranging meetings with national payers who are interested in the Physician Recognition Program.

The following are highlights of each work group and pilot programs with expected outcomes:

### **Information Technology/Electronic Medical Records**

The purpose of this work group will be to stimulate the ACC to promote a set of data elements of usage and ability for IT standards. The IT/EMR group shall be responsible for researching and producing a working document for publication. The document shall be an interim finding of necessary data elements for cardiovascular specialists to refer to when considering an Electronic Medical Database.

### **Appropriateness Criteria for Imaging**

Aims to produce interim appropriateness criteria for specific modalities based on data provided by MDI medical director participants.

### **Pilot projects on recognition/Gold Star Cardiologist**

The ACC is already meeting with national payers to discuss the possibility of a recognition program whereby physicians and their offices would meet certain agreed upon criteria for clinical care and electronic solutions and be recognized for that achievement.

### **Disease Management**

A pilot project to highlight the value of a team based approach to care.

### **Next Steps**

MDI is in the process of developing a structured schedule to ensure that there are deliverables during 2005.

Next steps include:

1. Confirmation by the ACC Executive Committee for the expedited action plan
2. Coordination of all groups within the ACC working on Imaging/Appropriateness and IT/EMR to ensure MDI goals are achieved including deliverables in a timely manner
3. Create a suitable pilot program plan
4. Reorganizing the MDI Steering Committee to create the Advisory Panel including ACC members and medical directors