



The Society for Cardiovascular Angiography and Interventions

SCAI President's Page

Pay for Quality – What Every Interventional Cardiologist Needs to Know: Part I

Gregory J. Dehmer, MD, FSCAI
Professor of Medicine
Texas A&M School of Medicine
Director, Cardiology Division
Scott & White Clinic
Temple, Texas
President
Society for Cardiovascular Angiography and Interventions

and

Wayne Powell, MFS
Senior Director
Advocacy and Guidelines
Society for Cardiovascular Angiography and Interventions



The consensus among most in healthcare is that a “pay-for-performance” (P4P) program will eventually be implemented for all Medicare providers. Because the membership of the Society for Cardiovascular Angiography and Interventions (SCAI) treats a high proportion of Medicare patients, we are actively engaged in the P4P issue, advising legislators and regulators at every opportunity. As in all of SCAI’s advocacy efforts, our goal is to assist the healthcare system to implement strategies that improve outcomes for our patients. Because of the complexity of the P4P initiative (especially as it applies to invasive and interventional cardiology), I will dedicate two President’s Pages to this topic. The first will examine the background and goals of P4P and SCAI’s advocacy efforts related to this ini-

tiative. Next month’s President’s Page will consider the challenges of implementing a P4P system that is both fair and effective. Because of his pivotal role for SCAI in these efforts, I have asked Mr. Wayne Powell, Senior Director for Advocacy and Guidelines, to co-author these two President’s Pages. Mr. Powell has a strong background in the development of healthcare

Correspondence to: Gregory J. Dehmer, M.D., FSCAI, Professor of Medicine, Texas A&M School of Medicine, Director, Cardiology Division, Scott & White Clinic, 2401 South 31st Street, Temple, Texas 76508. E-mail: president@scai.org

DOI 10.1002/ccd.20852
Published online 13 June 2006 in Wiley InterScience (www.interscience.wiley.com).

policy and is an enormous asset to the Society at this time.

Efforts to Improve Quality

Efforts to improve quality in healthcare have evolved over the past 20 years. Most physicians are familiar with the quality assurance (QA) process, which is designed to identify and eliminate “low-end performers or outliers” leaving only the acceptable performers. This can be likened to trimming the dead branches off a tree so it will be a better tree. Quality assurance is important, but has now been supplanted by continuous quality improvement (CQI). CQI is a methodology to continually improve the processes associated with providing a product or service in order to meet or exceed expectations. This can be likened to putting the necessary water and fertilizer on a tree to make it a stronger and bigger tree with fewer dead branches. It is a proactive process designed to continuously improve quality rather than a passive process to identify and manage problems when they occur. In reality, the CQI process is a collection of techniques borrowed from the fields of systems theory, statistics, engineering, psychology, and others and is based on the work of pioneers in industrial management [1]. As a management philosophy, CQI is an organized, scientific process for evaluating, planning, improving, and controlling quality. Simply stated, the goal of CQI is to reduce variation and improve overall performance. Positive experiences in other industries led to the application of CQI methods in healthcare in the hope that reduced variation and better performance would improve patient outcomes and result in cost savings. Unfortunately, as good as this sounds “on paper,” progress has been slow and the healthcare industry remains in an awkward adolescence regarding the implementation of proven-quality initiatives. Few studies have formally examined and documented the benefits of CQI, but this is now beginning to change. Moscucci and colleagues [2] recently described a statewide CQI initiative in Michigan, specifically devised for the cardiac catheterization laboratory. As a result of the CQI program, there were demonstrable decreases in bleeding, transfusion requirements, vascular complications, and a trend for a reduction in contrast nephropathy. However, as noted in the accompanying editorial, there are substantial barriers to the implementation of CQI programs, including the cost [3]. The fundamental conflict is that everyone wants a quality product, but few are willing to invest the time and monetary resources to produce it, especially in an environment where reimbursement is frequently decreasing. The mindset

of one price for all regardless of the level of quality is beginning to change.

The Background of P4P

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare’s traditional fee-for-service program, MedPAC’s statutory mandate includes analyzing access to care, quality of care, and other issues affecting the Medicare population. MedPAC meets publicly to discuss policy issues and formulate its recommendations to Congress. Formal reports, issued in March and June of each year, are the primary outlets for the Commission’s recommendations. In the March 2005 report to Congress, MedPAC recommended that Congress establish a quality incentive payment policy for hospitals, home health agencies, and physicians receiving Medicare payments [4]. While P4P today goes by many mostly interchangeable names, I prefer “pay-for-quality” (P4Q) because the term emphasizes *quality*, a goal that all of the stakeholders in healthcare support.

This recommendation by MedPAC joined, and has subsequently been followed by, recommendations from many other groups, all with the unified goal of improving patient care. This was not the first time the concept of an incentive payment policy was proposed. Earlier, MedPAC recommended P4P programs for Medicare Advantage plans and dialysis providers. Quality measurement for physicians is proposed to begin with structural and, after a transition, process measures. Under such a program, the reimbursement physicians receive for treating Medicare patients will be affected by their ability to document they have delivered care meeting specific performance measures. Physician-level P4Q has gained the attention of legislators, regulators, and third-party payers. The Centers for Medicare and Medicaid Services (CMS) has now implemented the Physician Voluntary Reporting Program (PVRP), an entirely voluntary demonstration project geared toward helping physicians and healthcare systems “focus their resources on system redesign to improve patient safety, enhance quality, increase efficiency, and reduce scientific uncertainty and unwarranted variation” [5]. There are 16 core elements in this initial PVRP (Table I). Participating physicians receive confidential feedback on their data reporting and performance rates.

TABLE I. The Physician Voluntary Reporting Program (PVRP) Core Starter Set

Aspirin at arrival for acute myocardial infarction
Beta blocker at time of arrival for acute myocardial infarction
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus
Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus
High blood pressure control in patient with Type I or Type II diabetes mellitus
Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
Beta-blocker therapy for patient with prior myocardial infarction
Assessment of elderly patients for falls
Dialysis dose in end-stage renal disease patient
Hematocrit level in end-stage renal disease patient
Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis
Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
Antibiotic prophylaxis in surgical patient
Thromboembolism prophylaxis in surgical patient
Use of internal mammary artery in coronary artery bypass graft surgery
Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Why P4Q?

As characterized by the Institute of Medicine, America's health system is a tangled, highly fragmented web that often wastes resources by duplicating efforts, leaving unaccountable gaps in coverage, and failing to build on the strengths of all health professionals [6]. In its 2005 report, MedPAC noted that those who treat Medicare patients are paid the same fee for a service regardless of the patient's outcome or the quality of care delivered. More alarming, it was noted that Medicare often pays more when a serious illness or injury occurs or recurs while patients are under the system's care [4]. To improve care, MedPAC has advocated designing a system that links a portion of the payment to satisfactory performance. The Commission further urges Congress toward a program that rewards improvement as well as attaining or exceeding certain benchmarks. This is being done to motivate hospitals and clinicians to embrace and implement CQI and with an appreciation of the cost and time commitment required for CQI program implementation. This represents a fundamental shift in the paradigm because now there will be a financial incentive for quality.

What Are the Goals of P4Q?

Although it would be naïve to deny that there are certain political agendas embroiled in this and other debates about healthcare, the goals of P4Q include—

- Supporting and facilitating quality improvement processes,
- Improving patient outcomes,
- Reducing errors, and
- Strengthening the U.S. healthcare system.

These goals intersect with SCAI's mission and quality agenda. The major concerns now are whether P4Q programs will actually accomplish their goals and whether P4Q can be implemented in a way that does no harm to patients, hospitals, and physicians. This is a huge effort because measuring hospital and physician quality is complex and challenging.

What Is the Status of P4Q, and Where Does SCAI Stand?

Legislation is anticipated on Capitol Hill that, if passed, would mandate CMS to implement a P4Q program and SCAI expects congressional hearings in the coming months. This is not the first time P4Q legislation has been introduced in Congress. Last year a P4Q measure, the Medicare Value Purchasing Act of 2005, was linked to the elimination of the 4.3 percent across-the-board physician fee cut for 2006 by the Senate. However, following objections from the American Medical Association and other medical societies, the P4Q measure was removed in conference committee before the bill made it to the President's desk.

The lesson from last year's legislative attempts to implement P4Q is that some form of this initiative is likely to be established in the future. It is also important to note that government officials are actively looking to the physician community for guidance on how to measure quality. Be assured that SCAI is weighing in on all aspects of the debate. Our Advocacy Committee led by Co-chairs Joseph D. Babb, M.D., FSCAI, and Carl Tommaso, M.D., FSCAI, is working closely with CMS officials, representatives from the Agency for Healthcare Research and Quality (AHRQ), and the National Committee on Quality Assurance (NCQA), among many others. SCAI is a voting member of the American Medical Association's Physician Consortium for Performance Improvement and, both independently and as part of the Consortium, is prepared to offer testimony during hearings on this topic.

SCAI is also working closely with fellow cardiovascular organizations, such as the American College of Cardiology (ACC) and the American Heart Association (AHA). Both organizations have contributed greatly to the development of cardiovascular performance measures. I believe it is essential we work together with the ACC, AHA, and other members of the Consortium to help Congress and regulatory agencies develop a P4Q

system that will truly improve the quality of healthcare without being onerous or inequitable.

In next month's President's Page, I will examine more closely the complexities of measuring quality in the real world of medicine and, more specifically, interventional cardiology. As always, I encourage your feedback on this and SCAI's other initiatives. Please contact me at *president@scai.org*

REFERENCES

1. Juran JM. Juran on Quality by Design: The New Steps for Planning Quality into Goods and Services. 1992. New York: The Free Press.
2. Moscucci M, Rogers EK, Montoye C, Smith DE, Share D, O'Donnell M, Maxwell-Eward A, Meengs WL, De Franco AC, Patel K, McNamara R, McGinnity JG, Jani SM, Khanal S, Eagle KA, for the Blue Cross Blue Shield of Michigan Cardiovascular Consortium (BMC2). Association of a continuous quality improvement initiative with practice and outcomes variations of contemporary percutaneous coronary interventions. *Circulation* 2006;113:814–822.
3. Brindis RG, Dehmer GJ. Continuous quality improvement in the cardiac catheterization laboratory: Are the benefits worth the cost and effort? *Circulation* 2006;113:767–770.
4. Medicare Payment Advisory Commission. 2005. Report to Congress: Medicare Payment Policy. Washington, DC: MedPAC. Available at www.medpac.gov.
5. Medicare expands opportunities for physicians to earn performance payments for improving quality. News release issued March 22, 2006. Centers for Medicare and Medicaid Services, Department of Health and Human Services, Washington, DC.
6. Committee on Quality of Health Care in America: Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.