Practice Guidelines and Case Management

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Why Guidelines Now?

- Increased financial pressures
- Rapidity of spread of technology
- Data showing inappropriate care
- Active management tools for QA
- Continuous quality improvement

Peer Review

- Slightly better than “Chance” findings *Goldman JAMA 1992*
- Marked variability in applied inpatient criteria *Rubin JAMA 1992*
- Marked variability in the office setting *Weiner JAMA 1995*

The Philadelphia Inquirer

Vol. 322, No. 30 · Monday, July 30, 1990 · Thirty-Five Cents

For some, MRI symbolizes medical care's costly spiral

By Gilbert M. Gaul
Inquirer Staff Writer

The city of Altoona, an enclave of 57,000 in south-central Pennsylvania, serves as a textbook example of how America's obsession with expensive medical technology is causing it to spread out of control.

Consider:

In July 1983, officials at Mercy Hospital coughed up $1.5 million for a magnetic resonance imaging device, a fancy diagnostic tool that provides high-resolution images of the brain, spinal cord, heart and joints.

By providing sharper pictures than X-rays, some doctors say MRI helps them make better diagnoses.

Within three years, radiologists at the 183-bed community hospital were doing more MRI scans — 9,093, at prices ranging from $471 to $814 per scan — than any other hospital in the state, records show.

All that activity apparently caught the eye of other radiologists in Altoona. Two years ago, a private group of physicians opened a competing MRI center — Blair Imaging Associates — with a larger, more expensive machine.

A relatively short trip across the Allegheny Mountains, a consortium of four hospitals in Johnstown also took notice. It spent $2.5 million in 1987 to open an MRI center. And last year doctors there performed nearly 3,200 scans at a charge of $875 per scan.

The four hospitals said they saved money by jointly operating an MRI, and justified the MRI by noting that it was sometimes difficult to drive over the mountains from Johnstown to Altoona.

In theory, having three MRI devices within such close proximity might be expected to cut into Mercy Hospital's business. Guess again. In 1988, Mercy's doctors performed the equivalent of one scan for every 118 residents of Blair County, including Altoona. By comparison, the seven hospitals in Philadelphia County that owned MRIs performed one scan for each 112 residents.

Mercy's MRI, moreover, is continuing to hold its own, says Bill Polito, the hospital's vice president for planning and marketing. "I guess we've lost about 600 patients after each of the others opened. We're still seeing strong demand," he said.

Altoona's experience is not an isolated example. The costly imaging technology, which uses magnetic fields to make detailed pictures, is cropping up everywhere — in hospitals, in physician-owned clinics, even on trucks that haul the devices from health facility to health facility.

Nationwide, there are an estimated 900 MRIs, which have cost from $1 million to $3 million, plus installation costs. Average fees for scans vary from about $700 to $1,100, although centers often accept less from insurers. And despite some recent signs of a possible industry shakeout, the business continues to grow.

All of which is a concern to government officials and others worried about spiraling U.S. health expenditures — estimated at $600 billion in 1989 — and the overuse of expensive medical technologies.

The growth of MRI illustrates just

(See MRI on 4-A)

Some Definitions: *Standards (Eddy)*

- Virtual unanimity among patients about the desirability of the intervention, and about its proper use. Define good practice and bad practice.
- Synonym - strict criteria

Some Definitions: *Guidelines (Eddy)*

- Outcomes are well enough understood to permit meaningful decisions by a majority of people. Flexibility.
- Synonym - parameters, relative criteria

Consensus Panel of Experts Approach

- Implicit system
- Impossible to accurately estimate the outcomes of different options

Conflict?

- Chassin
  - RAND
  - Expert panels
  - Consensus statement
  - Value health sciences
- Eddy
  - Duke
  - Poor quality information
  - More rigorous approach
  - CMSS-Hartford Fund

Clinical Practice Guideline

Heart Failure

Quick Reference Guide for Clinicians

Number 11

Heart Failure: Management of Patients With Left-Ventricular Systolic Dysfunction

- Prevention
- Initial Evaluation
- Patient Counseling and Education
- Pharmacological Management
- Role of Myocardial Revascularization
- Algorithm

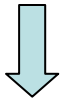
U.S. Department of Health and Human Services
Public Health Service
Agency for Health Care Policy and Research

TQM + The Medical Staff

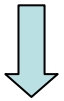
- *Critical Path* - detailed, hour by hour description of care plan; involves nurses
- *Practice Guidelines* - parameter, standard or guidepost for approach to a particular diagnosis. Literature and consensus panel driven
- *Case Management* - Global use of resources and patient placement. May be directed at arms length
  by third party payer or managed care organization

Etiology of Case Management

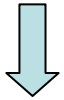
Unexplained clinical variation



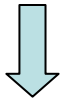
Standardization needed

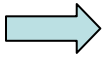


Expert/evidence based guidelines



Review criteria

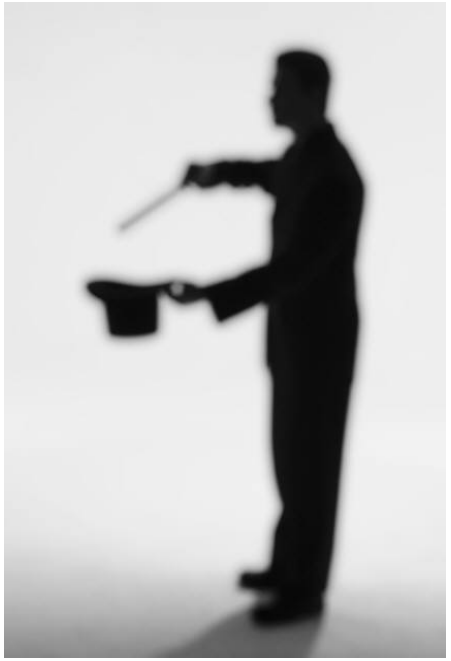


Critical paths  Case management

Case Management

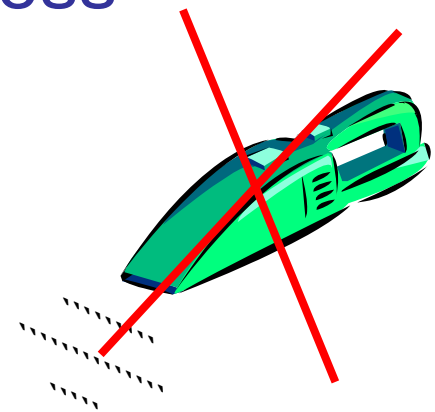
- Where does the “magic” occur?
- When we sit and analyze the process.

  In a way, it’s applied TQM



Case Management

- Cannot work in a vacuum.
- Needs to be part of a larger activity focused on process improvement.



Case Management vs. Disease Management

- Case managers help to implement the concepts of disease management.
- Disease management has important "population based" outcome measures.

Adjuncts to Case Management

- Better data systems
- Aligned incentives
- Marketplace forces

Challenges to Case Management

- Part of record or not?
- What to do about variances?
- Physician acceptance
- Promotion of interdisciplinary team

Where should case management be located in the organization?

- Evidence?
- Hunch — as visibly as possible
- Where not to put it
- How to kill it

Challenge to Guidelines: Technology as Moving Target

- Prostate drugs vs. TURP
- Lytic therapy vs. CABG
- Biologics vs. lithotripter

Will Guidelines Alter Practice?

- Kosecoff - NIH study
- Lomas - Canadian experience
- Eisenberg and Williams - Behavior

Guideline Nonadherence

- Cabana and colleagues, JAMA Oct 1999
- Differential diagnosis and framework for improvement
  - Lack of awareness
  - Lack of familiarity
  - Lack of agreement
  - Lack of self-efficacy
  - Lack of outcome expectancy
  - Inertia of previous practice
  - External barriers
  - Patient related barriers

Improving Physician Adherence to Clinical Practice Guidelines



Barriers and Strategies for Change

New England Healthcare Institute

Guideline Nonadherence

- Social influence theory
- Adult leaning
- Diffusion of innovation
- Social marketing

Social Influence Theory

- Decisions, actions and behaviors are guided by habit and custom
- Also guided by assumption, beliefs and values held by peers
- Prevailing practices and social norms that define appropriate behavior

Adult Learning Model

- Physicians respond to three types of behavioral influences
  - Predisposing factors - changing values, beliefs, perceptions
  - Enabling factors - providing MDs with necessary skills and resources
  - Reinforcing factors - visible results, support from colleagues and feedback from patients

Diffusion of Innovation

- Intervention to change behavior must emphasize improving skills and enhancing knowledge
  - Orientation
  - Insight
  - Acceptance
  - Actual change
- Early adopters - respond to scientific data
- Late adopters - need extra stimulus

Social Marketing Theory

- Source of the communication
- Medium of the communication
- Content of the message
- Characteristics of the audience
- Setting in which communication is received

Acceptance of a guideline will depend on how it is communicated and the stage at which it is received.

Will guidelines be tied to Credentialing?

- Atypical behavior
- Economic impact of practice

How to Change Physician Behavior?

- No magic bullets;
  need for ongoing approach
- Cultural barriers
- Academic detailing
- Eisenberg + Williams

Can we change physician behavior?
Eisenberg and Williams

- Education
- Feedback
- Financial rewards
- Financial penalties
- Participation
- Administrative changes

The Bottom Line

- Non-punitive feedback on performance
- Locally derived guidelines with demonstrated improvements in patient outcomes
- Physician champions at all levels
- Education, Education, Education


WELCOME!
BRIAN SAVAGE
"Thank God! A panel of experts!"

Practice Guidelines and Case Management

Summary