



CME Provider Update *March 2010*

Utilizing Quality Measures for Gap & Outcomes Analysis

CME Updated Criteria now requires a planning process that includes identifying practice gaps (C2), developing CME programs that are designed to change physician competence or performance (C3) and finally, evaluating the results of the CME (C11). The availability and utilization of quality measures at hospitals and other institutions can help CME departments achieve these guidelines and produce valuable results for the organizations.

What are Quality Measures? Quality measures, also referred to as core measures, performance measures, or process of care measures are nationally recognized evidence-based standards of care that have been shown to get the best patient outcomes. Physicians and healthcare organizations voluntarily report their performance of these measures to quality agencies such as the Center for Medicare & Medicaid Services (CMS) and the Joint Commission. The performance results are made public for consumers to view on report cards such as the HHS *Hospital Compare*. Tracking and reporting quality measures not only link healthcare organizations to reimbursement and pay-for-performance incentive programs but allow them to compare their performance to other entities on a local or national level while continuously learning, and improving their delivery of care.

Where Do Measures Come From? Quality measures are developed by numerous institutions and are driven by clinical guidelines. For example, the Joint Commission works in collaboration with the CMS to develop a common set of core measures for hospitals. These measures are approved by the Hospital Quality Alliance, (HQA) and endorsed by the National Quality Forum (NQF), the national clearinghouse for quality measures. Other developers of measures include the National Committee for Quality Assurance (NCQA) that develops the HEDIS measures used largely by health plans, and AMA's Physician Consortium for Performance Improvement (PCPI).

What are Some Examples of Quality Measures? The core measure sets used by hospitals include: Acute Myocardial Infarction (AMI); Surgical Care Improvement Project (SCIP); Heart Failure (HF); Pneumonia; Perinatal Care; Venous Thromboembolism (VTE); Stroke; and Children's Asthma Care (CAC). An example of one quality measure for stroke would be prescribing Ischemic stroke patients antithrombotic therapy at hospital discharge. Measurements always consist of a numerator and denominator. So, in the case of the above stroke measure — the numerator is the # of Ischemic stroke patients prescribed antithrombotic therapy at discharge and the denominator would be the total of Ischemic stroke patients. The quotient is the percent of time that a hospital gives that recommended treatment.

Quality Measures and CME. CME activities can be planned around gap data derived from performance measures. AMI, heart failure, infection control, and DVT are several focus areas where CME and Quality Improvement departments are working together on the development of educational interventions that will deliver information to physicians and other members of the healthcare teams about new standards of care, the scientific evidence that support them and their newly developed related protocols. One

accredited hospital provider reported that in 2007 they were in compliance with the SCIP measurement only 63% of the time. After developing and implementing CME along with other interventions, the measurement results reached 100% compliance within three years. Another hospital showed how a 39% compliance rate for non-surgical VTE prophylaxis in 2006 went up to 75% within three years after implementing an educational campaign that involved identifying and addressing physician and system barriers to change. Still, another hospital provider of CME has changed the overall strategy of its education department from just "filling the calendar with commercially supported CME" to focusing more on core measure compliance and the hospital's service line needs.

Are There CME Challenges Using Quality Measures?

Physician resistance to change has been largely reported by CME providers who are engaged in improving their organization's performance of quality measures. "*Cottage Industry to Postindustrial Care – The Revolution in Health Care Delivery*" an article in the *New England Journal of Medicine* reports that using standardized processes of care is controversial, evoking fears of "cookbook medicine, loss of professional autonomy, a misinformed focus on the wrong care..." but concludes that "quality measures and transparency are not only improvement tools that are essential to modernizing care delivery, but also the key to preserving the values to which our current system aspires." Those values include improving patient outcomes and saving lives. The authors point out that growing evidence highlights the dangers of continuing to operate in "cottage-industry" mode, that fragmentation of care has led to suboptimal performance, and the gap between disciplined science and current practice is wide.

Does Quality Measure Compliance Improve Outcomes?

Performance measures should be looked at as a quality tool to improve patient outcomes rather than just a rating tool. Dependable delivery of care does improve outcomes. For example, according to the CMS Premier Hospital Quality Incentive Demonstration Project, 250 participating hospitals raised their overall quality by an average of 17.2% over four years based on their delivery of more than 30 nationally standardized and widely accepted care measures to patients in five clinical areas. These improvements saved the lives of nearly 4700 heart attack patients.

References:

www.jointcommission.org; www.premierinc.com; *Cottage Industry to Postindustrial Care — The Revolution in Health Care Delivery*, Stephen J. Swensen, M.D. et al, *NEJM*, 01/20/2010.

Provider Updates can be found on the CMS CME webpage at: www.cms.org/cme/Home.html