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SETMA to Participate in the Guidelines Advantage Program
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Your Life Your Health
The Examiner
March 1, 2012

SETMA has begun participating in **The Guideline Advantage**, which is jointly sponsored by the **American Heart Association**, the **American Diabetes Association** and the **American Cancer Society**. The Ideal Measures analyzed by the program cover the following areas:

- Trial Fibrillation
- Cancer
- Coronary Artery Disease
- Diabetes
- Heart Failure
- Peripheral Artery Disease
- Preventive Care and Screening for Chronic Disease and Stroke
- Metrics developed specifically for the Guideline Advantage

The Guideline Advantage is another program with which SETMA will challenge all healthcare providers to improve the care which our patients receive. As with all of the quality metrics we track, we will publicly report the results of each of SETMA's provider's performance on these measures.

What is The Guidelines Advantage benefit to SETMA -- Benchmarking

Why another quality metric set for SETMA to track? When we completed SETMA's application for the **National Quality Forum's National Quality Healthcare Award**, we found that a great deal of stress was placed on quality reporting, transparency of performance and benchmarking.
SETMA is fully transparent and committed to measure quality by natural standards. The one deficiency we found in our data was benchmarking. The Guidelines Advantage program will begin filling in that benchmarking.

Some quality metrics have national standards established such as in the case **NCQA's Diabetes Recognition Program** and the **Joslin Diabetes Affiliate performance standards**. The **HEDIS quality metric set, also an NCQA product,** publishes benchmarks for its quality metric set also. Often, however, benchmarking, which is highly desirable for measuring quality and for designing quality improvement programs, are not available.

The great value to SETMA of The Guidelines Advantage program is that quarterly, we will receive benchmarked results on our performance. Like the **RTI International study of SETMA's Medicare Fee-for-Service beneficiaries** (published at www.jameslhollymd.com under ***In-The-News***) this benchmarking can reinforce where we are doing well and it can guide us

where we need to improve. Remember, as in travel, in healthcare we need a **GPS**, which can tell us where we are in relationship to where we want to be, and which can give us signpost along the way so that we can know if we are going in the right direction and if we are making progress.

What is the Guideline Advantage Program?

Formerly the AHA's Get With The Guidelines®-Outpatient (GWTG-Outpatient) program, this program works with practices' existing EHR or health technology platform (system where the site enters clinical or administrative data) to seamlessly extract relevant patient data and provides quarterly reports and benchmarking on adherence to guidelines. The program re-launch the week of March 28, 2011 will incorporate the data collection and reporting of relevant cancer and diabetes elements to the existing cardiovascular elements outlined in GWTG-Outpatient. This expansion in data collection will allow participating practices and clinics the ability to submit information across several chronic disease conditions. In addition, our oversight Steering Committee now includes volunteer leadership from both cancer and diabetes specialties.

What are the benefits to participating physicians/practices?

- Valuable analysis of patient care using proven guidelines known to improve quality of care
- Longitudinal care analysis
- Enhanced teamwork and camaraderie among staff as you improve performance together and celebrate measurable gains
- Official AHA recognition for commendable patient care
- Additional opportunity for you to secure financial incentives or reimbursements
- Professional education opportunities, including Webinars and networking events
- Full access to AHA patient education materials
- Ongoing contributions to research that can further scientific knowledge and improve standard medical practices

What is the role of the Duke Clinical Research Institute (DCRI)?

The Duke Clinical Research Institute is a non-profit organization whose mission is to share knowledge and improve patient care through innovative data analysis. DCRI is the largest organization of its kind and will provide data warehousing, analysis and confidential, secure reporting to participating physicians and program administrators.

Requirement of SETMA Providers

There will no additional requirements for providers. As we analyze the data which will be extracted form our data base, we may add some clinical decision supports so that you can be sure that you are fulfilling the measures judged by The Guideline Advantage. As those Guidelines change, we will update that in the EHR.

The following is a summary of the Ideal Measures which will be measured in the Guidelines Advantage program. Several abbreviations are used:

- **PQRS** – Physician Quality Reporting System, previously the PQRI, these measures similar to those SETMA has reported for four years.
- **AHA** – American Heart Association – these are measures developed by AHA.
- **PCPI** – The Physicians Consortiums for Performance Improvement – this is the AMA- led program which develops measure sets. SETMA already reports on many PCPI Measure Sets as can be seen on our website.
- **ACCF** – American College of Cardiology Foundation

IDEAL MEASURES

ATRIAL FIBRILLATION

- Assessment of thromboembolic risk factors: Patients with an assessment of all of the specified thromboembolic risk factors documented during the 12-month reporting period. (AMA PCPI/AHA/ACCF 2007)
- Chronic anticoagulation therapy: Patients who were prescribed warfarin during the 12- month reporting period. (AMA PCPI/AHA/ACCF 2007)
- Monthly INR: Number of calendar months in which at least one INR measurement was made. (AMA PCPI/AHA/ACCF 2007)

CANCER

- Screening mammography: Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months. (PQRS-comparable)
- Colorectal cancer screening: Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening. (PQRS-comparable)

CORONARY ARTERY DISEASE

- Oral antiplatelet therapy prescribed for patients with CAD: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy. (PQRS-comparable)
- Beta-blocker therapy for CAD patients with prior myocardial infarction (MI): Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy. (PQRS-comparable)
- Angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for patients with CAD, diabetes and left ventricular systolic dysfunction (LVSD): Percentage of patients aged 18 years and older with a
- diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy. (PQRS-comparable)

  Drug therapy for lowering LDL-cholesterol: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy

(based on current ACCF/AHA guidelines). (PQRS-comparable) • Symptom and activity assessment: Percentage of patients aged 18 years and older with a diagnosis of CAD who were evaluated for both level of activity and anginal symptoms during one or more visits. (AMA PCPI/AHA/ACCF 2005)

- Symptom control: Percentage of visits for patients aged 18 years and older with a diagnosis of CAD who are angina-free OR are prescribed at least two anti-anginal medications. (AMA PCPI/AHA/ACCF 2005)
- Cardiac rehabilitation patient referral from an outpatient setting: All patients evaluated in an outpatient setting who within the past 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis are to be referred to such a program. (AACVPR/AHA/ACCF 2010)

DIABETES

- Hemoglobin A1c poor control: Percentage of patients aged 18 through 75 years with diabetes who had most recent hemoglobin A1c greater than 9.0%. (PQRS-comparable)
- HbA1c good control: Comprehensive diabetes care-percentage of members 18 through 64 years of age with diabetes (type 1 and type 2) whose most recent hemoglobin A1c (HbA1c) level is less than 7.0% (controlled). (NCQA)
- Low-density lipoprotein (LDL-C) control: Percentage of patients aged 18 through 75 years with diabetes who had most recent LDL-C level in control (less than 100 mg/dl).(PQRS-comparable)
- High blood pressure control: Percentage of patients aged 18 through 75 years with diabetes who had most recent blood pressure in control (less than 140/80 mmHg). (PQRS-comparable)
- Dilated eye exam: Percentage of patients aged 18 through 75 years with diabetes who had a dilated eye exam. (PQRS-comparable)
- Urine screening for microalbumin or medical attention for nephropathy: Percentage of patients aged 18 through 75 years with diabetes who received urine protein screening or medical attention for nephropathy during at least one visit within 12 months. (PQRS- comparable)
- Foot exam: The percentage of patients aged 18 through 75 years with diabetes who had a foot examination. (PQRS-comparable)

HEART FAILURE

- Left ventricular function (LVF) assessment: Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded. (AMA PCPI/AHA/ACCF 2005)
- Angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for left ventricular systolic dysfunction (LVSD): Percentage of

patients aged 18 years and older with a diagnosis of HF and LVSD (LVEF
- < 40%) who were prescribed ACE inhibitor or ARB therapy. (PQRS-comparable)
- Beta-blocker therapy for left ventricular systolic dysfunction (LVSD): Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy. (PQRS-comparable)

HYPERTENSION

- Blood pressure control: Percentage of patients with BP_140/90 or who are taking or were prescribed two or more antihypertensive agents at most recent visit during the previous 12 months. (ACCF/AHA 2009)

PERIPHERAL ARTERY DISEASE

- Cholesterol-lowering medications (statin): Drug therapy for lowering low-density lipoprotein cholesterol in patients with PAD. (AHA/ACCF/ACR/SCAI/SIR/SVM/SVN/SVS 2010)
- Smoking cessation: Smoking-cessation intervention for active smoking in patients with PAD. (AHA/ACCF/ACR/SCAI/SIR/SVM/SVN/SVS 2010)
- Antiplatelet therapy: Antiplatelet therapy to reduce the risk of myocardial infarction, stroke, or vascular death in patients with a history of symptomatic PAD.
- (AHA/ACCF/ACR/SCAI/SIR/SVM/SVN/SVS 2010)

PREVENTIVE CARE AND SCREENING FOR CHRONIC DISEASES AND STROKE

- Body Mass Index (BMI) – screening and follow-up: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. (PQRS-comparable)
- Inquiry regarding tobacco use: Percentage of patients aged 18 years and older who were queried about tobacco use one or more times within 24 months. (PQRS-comparable)
- Advising smokers to quit: Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking. (PQRS-comparable)
- Unhealthy alcohol use – screening: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months. (PQRS-comparable)
- Influenza immunization for patients ≥ 50 years old: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February). (PQRS-comparable)
- Pneumonia vaccination for patients 65 years and older: Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine. (PQRS-comparable)

- Blood lipid therapy and control: Proportion of patients who meet current LDL-C treatment targets OR who are prescribed _1 lipid-lowering medications at maximum tolerated dose. (AHA/ACCF 2009)
- Weight management: Counseling to achieve and maintain ideal body weight at least once within the past two years. (AHA/ACCF 2009)
- Blood pressure measurement: Measurement of blood pressure in all patients. Patients for whom blood pressure (BP) measurement is recorded at least once in the last two years. (AHA/ACCF 2009)
- Aspirin use in patients without clinical evidence of atherosclerotic disease who are at higher CVD risk: Patients who were advised to use aspirin. (AHA/ACCF 2009)

METRICS DEVELOPED SPECIFICALLY FOR THE GUIDELINE ADVANTAGE PREVENTIVE CARE AND SCREENING

- Colorectal cancer screening: The percentage of adults 50–75 years of age who had appropriate screening with tests and intervals (based on ACS guideline) for colorectal cancer.
- Cervical cancer screening: The percentage of women 21–69 years of age who received one or more Pap tests to screen for cervical cancer during the past 2 years.
- Breast cancer screening: The percentage of women 41-69 years of age who had a mammogram to screen for breast cancer.
- Ongoing low-density lipoprotein (LDL-C) control: Percentage of patients aged 18 years and older with a documented LDL-C _ 100 mg/dl and with a prior history of diabetes mellitus, peripheral artery disease, coronary artery disease, stroke or TIA whose most recent LDL-C level is in control (less than 100 mg/dl).
- Calculate time to lipid control
- Preventive care and screening: Percentage of patients aged 18 and older with prior history of peripheral artery disease, coronary artery disease, heart failure or prior stroke who had most recent LDL-C level in control (less than 100 mg/dl) who are on maximum dose statin or multiple lipid-lowering drugs.