Opportunities for Improved Health Service Delivery
Healthcare Commission Ideas for Governor Freudenthal
June 29, 2005

Implement Use of Clinical Guidelines in State Employee Benefit Plan

1) What is the problem?

a) Although some movement has been made to explicitly adopt evidence-based medicine in Wyoming, representatives of the hospital association and the medical society both acknowledge that progress has not been as rapid as in other states.[1]
  i) Evidence-based medicine is "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients". Clinical guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances." [2]

b) Rand's Community Quality Index Study found that overall, participants received 55% of recommended care. Under use was a greater problem than overuse. Overall performance was strikingly similar in all communities studied. Quality varied substantially across conditions:
  i) People with cataracts received about 79% of recommended care.
  ii) People with coronary artery disease received 68% of recommended care.
  iii) Patients with hypertension received less than 65% of recommended care.
  iv) Patients with colorectal cancer received 54% of recommended care.
  v) People with diabetes received only 45% of the care they need.
  vi) Patients with pneumonia received 39% of recommended care.
  vii) People with alcohol dependence received about 11% of recommended care.[3]

c) Patients receive treatments each year that they do not need, leading to complications, reduced productivity, and significantly higher costs. Experts estimate that approximately 20 to 30 percent of health care treatments are unnecessary. Overuse has been well documented for numerous types of invasive surgery and tests; an estimated 16 percent of hysterectomies and 17 percent of coronary angiograms performed each year are unnecessary.[4]

2) Describe your ideas.

a) Work toward Wyoming being a state in which all health care provided, regardless of the payer, is based on best practices and sound scientific evidence. Step one is to make a concerted effort to implement the use of commonly accepted clinical guidelines by all providers participating in the state employee benefit plan.
  i) A limited number of very credible guidelines would be selected by a coalition of health care stakeholders and would initially focus on areas that the Gardner data indicate are of concern in Wyoming.[5] For example, diabetes, asthma, and musculoskeletal conditions. This could be a function of the autonomous "Federal Reserve Board"-type entity for healthcare.
  ii) Wyoming WOULD NOT develop its own guidelines, but rather rely on the plethora of professionally accepted guidelines already in existence for these kinds of conditions.

b) Step Two would be to incorporate a more comprehensive Total Health Management approach to care provided in the state employee benefit plan, as well as WyoCare. However, further research is needed before proceeding down this path.

3) Who are your partners?

a) Step One: Select initial set of guidelines
  i) Health department
  ii) Health plans
  iii) Physicians
  iv) Hospitals
  v) Mountain Pacific Quality Foundation
  vi) APS (Medicaid Disease Management Vendor)
  vii) Employers
  viii) University of Wyoming

ix) Milbank 15-state consortium

b) Step Two: Change state employee health benefits and oversee dissemination of selected guidelines to physicians and facilities treating state employees
- **i)** Wyoming Department of Administration and Information would need to help communicate regarding the guidelines to state employees.
- **ii)** Great West (or current state health plan) to incorporate guideline compliance in practitioner and facility reimbursement protocols.
- **iii)** Other health plans
- **iv)** Physicians and professional societies
- **v)** Hospital Association

4) Please provide supporting evidence and data for the proposal.

a) Implementation of evidence-based clinical practice guidelines is one strategy Veterans' Health Administration (VHA) has embraced to improve care by reducing variation in practice and systematizing "best practices". Guidelines, as generic tools to improve the processes of care for patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research.[6]

b) Among its descriptions of clinical guideline implementation successes, the Institute for Clinical Systems Improvement (ICSI), a Minnesota collaborative promoting guidelines, notes:
- **i)** Park Nicollet increased the percentage of 24-month old children seen for clinic visits who had received all scheduled immunizations from 78% to 94%. The percentage of 24-month old children who received an immunization for varicella as well as all scheduled immunizations increased from 42% to 88%.
- **ii)** North Clinic applied advanced access changes to reduce delays in mammography scheduling. The waiting time for an appointment decreased from 40 days to 18 days; the rate of patients up-to-date for a mammography screen increased from 72% to 83%.
- **iii)** Family HealthServices Minnesota implemented a series of steps to improve the documentation of tobacco status. The percentage of patients whose use status was documented and who were advised to quit increased and the smoking prevalence rate decreased.
- **iv)** Park Nicollet Health Services selected primary PCI as its preferred reperfusion strategy and has ED physicians initiate the primary intervention without waiting to consult a primary physician or cardiologist. The process change reduced median door-to-balloon time from 88 to 61 minutes.
- **v)** Seven ICSI member medical organizations participated in the creation of this report on the development of anticoagulation management programs or anticoagulation clinics (ACC) to improve care for patients receiving anticoagulation medications. These programs have demonstrated significant improvement in clinical outcomes when patients were managed in a consistent manner.
- **vi)** CentraCare achieved rates at or above 80% of patients up-to-date on colon cancer screening tests at two pilot sites.
- **vii)** HealthPartners implementation of Wagner's model for improving care for patients with chronic conditions resulted in improvement in patients with diabetes and cardiovascular conditions.[7]

c) Local guidelines disseminated via practice-based education improve the management of diabetes and possibly of asthma in inner city, non-training practices.[8]

5) Funding/Staffing needs.

a) In Colorado, the Clinical Guidelines Collaborative is a non-profit organization that does not receive any direct funding from the state. Instead, member organizations are asked to pay dues of roughly $3,000 per year to provide administrative and project management support. Expert clinical committees volunteer their time to select appropriate clinical guidelines, and their results are freely provided on a website (www.coloradoguidelines.org).

b) In Minnesota, the Institute for Clinical Systems Improvement (ICSI) is supported by six state health plans.

c) Incentives for providers who participate should be included. The cost of these incentives may be offset by improved cost performance for the state employee group.

6) Who is better off and how could you measure the improvement?

a) State employees whose care is dictated by clinical guidelines.
b) Broader Wyoming citizenship as providers incorporate clinical guidelines into their care of all patients, not just State employees.
c) Improvement can be measured in a variety of ways:
  i) Patient surveys
  ii) Claims data/WHIN analyses
  iii) Chart audits
  iv) HEDIS scores

7) Could this proposal be included in the Children and Families Initiative?

a) Yes – the result should include improved health status for children and adults.

8) Potential drawbacks and political considerations.

a) The entity that selects the conditions and guidelines to be followed will be exposed to tremendous political pressure and should be viewed as impartial to the maximum extent possible. The entity should also be buffered from political pressure as much as is feasible.
b) The number of conditions for which guidelines are available is steadily increasing, but many patients receive care for conditions or combinations of conditions for which suitable guidelines are not available.[9]
c) Even when guidelines are available and unambiguous, costly chart review is often necessary to determine whether it was followed. Few institutions or physician practices have information systems that enable them to extract detailed clinical data.[10]
d) Responsibility for adherence to a particular guideline is unclear when multiple physicians treat a patient, especially when the patient selects additional providers without the concurrence or even knowledge of the others. For example, an adult with diabetes mellitus could receive care regularly from an internist, ophthalmologist, and podiatrist. Who is responsible if that patient fails to receive a recommended drug treatment, or requires an amputation? What about the patient's responsibility?[11]
e) Some physicians resist the mandate of "cookbook" medicine and argue that medicine is more "art" than science.
f) Evidence-based medicine or clinical guidelines are often seen as "cost-cutting" vs. quality improvement.

9) Alternative possibilities.

a) Consider "pay for performance" incentives in State Employee Benefits plans to drive quality of care.
b) Consider expanding this implementation to include providers for all state beneficiaries
c) Work with other payers (self-funded plans and carriers) to coordinate guideline implementation..

10) How does this recommendation relate to other recommendations?

a) Progress should be measurable in the Quality/Cost Report card being recommended.
b) This supports efforts to promote higher consumer accountability that are embedded in the HSA and HRA recommendations for state employees.

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[1] Meeting of WHCC Demand Side Committee, April 7, 2005
[2] Timmermans, Stefan and Aaron Mauck, "The Promises and Pitfalls of Evidence-Based Medicine," *Health Affairs.* January/February 2005
[3] McGlynn, EA et al., "The First National Report Card on Quality of Health Care in America," *Rand Health Research Highlights,* 2004

[4] "About the National Quality Forum," http://www.qualityforum.org/about/home.htm, June 9, 2005
[5] WHIN database analysis for Wyoming Healthcare Commission, May 2005
[6] "Clinical Guidelines," Office of Quality and Performance, Veterans' Health Administration, www.oqp.med.va.gov/cpg/cpg.htm, June 10, 2005
[7] "Process Improvement Reports," Institute for Clinical Systems Improvement, www.icsi.org/knowledge/browse_bydate.asp?catID=105, June 10, 2005.
[8] Feder, Gene, et al., "Do clinical guidelines introduced with practice based education improve care of asthmatic and diabetic patients? A randomized controlled trial in general practices in east London," *BMJ* 1995;311:1473-1478 (2 December)
[9] Garber, Alan M., "Evidence-Based Guidelines as a Foundation for Performance Incentives," *Health Affairs,* January/February 2005
[10] Ibid.
[11] Ibid.