

# Interventions

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HoW participants candidly discussed implementations of interventions within their organizations. Success stories and barriers encountered were shared during the November 2003 HoW meeting. Some of the barriers appeared to be unique to Arizona and may be the result of outside factors influencing health care in the state. These factors include:

- ♥ Arizona is highly penetrated by managed care organizations (MCOs).<sup>1</sup>
- ♥ Arizona ranks seventh in the nation for persons under 65 years of age without insurance coverage.<sup>2</sup>

Interventions directed toward modifying physician behavior can be challenging. This was the experience expressed by many participants. The American College of Cardiology and the Heart Failure Society of America have developed written guidelines in support of ACE-I use prior to use of an angiotensin receptor blocker (ARB). Many physicians, however, prefer to prescribe an ARB. Current literature provides conflicting support for the use of ACE-I.

One of the most successful interventions involved physician-to-physician discussion that included individual data results. Several sites reported successful implementation of this intervention. Their interventions were based on the premise that physicians were data driven and frequently did not have a clear understanding of their own performance. Providing individual results benchmarked against other physicians practicing within the organization and the national mean was effective in promoting physician change.

Arizona was one of the three states chosen by CMS to participate in the Hospital Public Reporting Pilot (HPRP). Because of this, physicians found that data directly related to their performance was now displayed on a public Web site. Hospitals found this a great motivator for physicians to become involved with the hospital's quality program.

A common barrier identified by the hospitals was difficulty in identifying the physician most accountable for each patient's care. Multiple physicians are frequently involved in providing care to a single patient. The individual physician writing discharge orders may not be the primary provider of medical care. Overcoming this barrier remains a challenge and is the focus of a HPRP subcommittee.

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<sup>1</sup> In 2000, 17.8 percent of Medicare beneficiaries in the United States were enrolled in managed care. During the same time period in Arizona, 35.8% of Medicare beneficiaries were enrolled in managed care. Table 148, page 362, *Health, United States, 2003*.

<sup>2</sup> In 2000, 16.5 percent of the population in the United States was without health insurance. During the same time period in Arizona, 20 percent of the population was uninsured. Table 151, page 367, *Health, United States, 2003*.

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Better performing sites had successfully implemented forms and reminder systems to assist the physician. Sites involving physicians and staff members with the development of the form or reminder reported the greatest success with implementation.

**Note:** Several examples of these interventions are included in the Appendices of this *Change Package*.

# Barriers and Successes to ACE-I at Discharge

## Barriers Identified by Arizona HoW Participants

- ♥ Physician documentation does not reflect ACE-I contraindications that may be present in the medical record.
- ♥ Physicians do not understand the necessity of documenting why they prefer to use an ARB rather than an ACE-I.
- ♥ Multiple physicians provide episodic care. During the course of a 48-hour stay the patient may be admitted by an ED (Emergency Department) physician who writes admission orders, seen early in the stay by the hospitalist who represents the patient's managed care organization (MCO), and also seen by a cardiologist. If the patient's stay occurs during a time period when the MCO hospitalists change rotation, the patient may be seen by a different physician each day.
- ♥ Hospitalists are reluctant to order discharge cardiac medications, preferring to have a cardiologist write the prescriptions.
- ♥ It is difficult to determine the accountable physician when tracking physician performance.
- ♥ Physicians are hesitant to change a patient's drug classification from ARB to ACE-I. Patients admitted on ARBs are often discharged on ARBs without physician investigation as to why an ACE-I is not prescribed.
- ♥ Staff and physicians may not be aware that a coder will classify a patient with a primary medical diagnosis of heart failure (HF). HF diagnoses may be reimbursed at a higher rate. A medical diagnosis code may be used for patients admitted for a surgical procedure, i.e., patients admitted for AICD (Automatic Implanted Cardiac Defibrillator) implantation may be coded as HF.
- ♥ Patients admitted with the diagnosis of heart failure are often patients who have multiple admissions. The documentation in medical records for subsequent admissions is sometimes meager.

## National Barriers to Prescribing ACE-I at Discharge<sup>1</sup>

- ♥ Incomplete documentation.

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<sup>1</sup>Adapted from MedQIC.

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- ♥ Belief that it's not the provider's role/responsibility.
- ♥ Primary care physician's lack of involvement in treatment/preventive care.
- ♥ Inadequate discharge planning.
- ♥ Lack of resources.
- ♥ Concern about patient's poor compliance.

## **Successful Interventions for Prescribing ACE-I at Discharge**

- ♥ Medical director meets one-on-one with the physician to discuss individual analysis of compliance with the indicator in comparison to benchmarks and indicator target performance.
- ♥ Physician performance is profiled using the same medical records used by abstractors for national data collection.
- ♥ Physician discharge prescription form contains discharge medication guidelines and space for five individual prescriptions.
- ♥ Early cardiology involvement during the inpatient stay increased compliance with the indicators.
- ♥ Reminders were developed by clinical team members who also took ownership of the indicator. The reminders developed by the team were in cartoon form.
- ♥ An organizational study demonstrated a strong correlation between patients attending an outpatient HF clinic and decreased re-admission rates.
- ♥ Clinical team members at the bedside were provided education about the indicators.
- ♥ Dedicated cardiac team used root cause analysis to better understand discharge medication processes.

## **National Interventions for Prescribing ACE-I at Discharge**

- ♥ Educate providers.
- ♥ Implement system changes.
  - o Clinical Forms
  - o Reminder Systems

## Additional Factors Affecting Physician Performance

During the discussion about barriers affecting implementation of interventions and improvement to the quality indicator, several factors relating to physician performance were discussed. These factors included:

- ♥ Physicians are data driven.
- ♥ Without data, individual physicians often do not have a clear understanding of their own performance.
- ♥ Public reporting makes a difference. The concept that the public has access to an organization's quality results has captured physicians' interest.
- ♥ Current medical literature is conflicting.
  - o ACE-I should be used for AMI and HF patients regardless of ventricular function.
  - o ARBs are as effective as ACE-I (see VALIANT study, #25 in the Bibliography).
  - o ACC (American College of Cardiology) and HFSA (Heart Failure Society of America) guidelines support ACE-I for LVSD. (These guidelines are included in the reference section of this manual.)

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