Using clinical guidelines to allocate health care benefits

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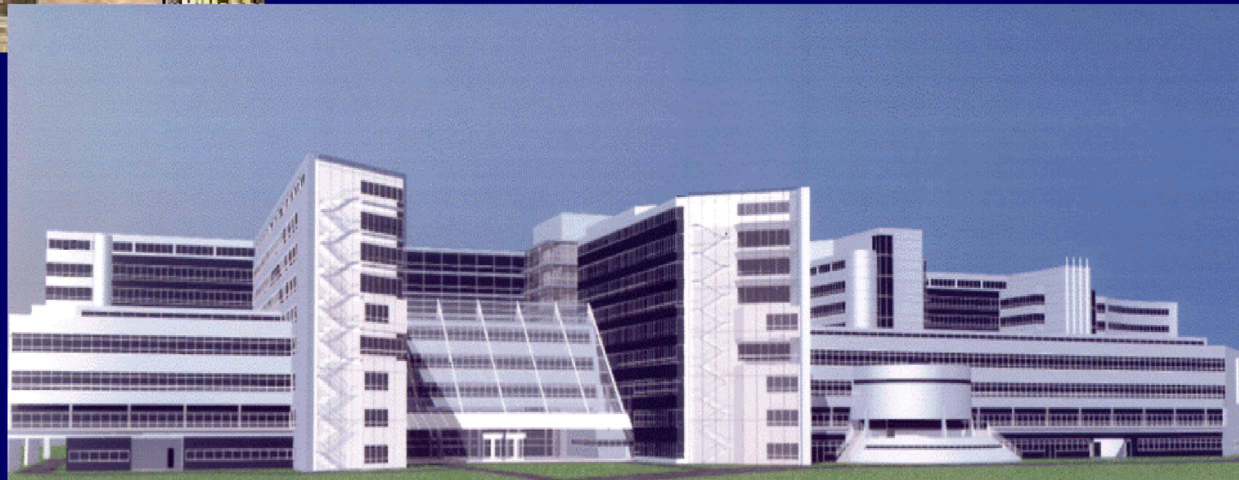

Why Clinical Practice Guidelines? (IOM 1990)

- Convert science-based knowledge to clinical actions and connect outcomes research to clinical practice
- Clarify medical choices for the consumer and make explicit different standards of care where they exist
- Strengthen link between quality and the management of health care

Clinical guidelines to allocate health benefits

- How can clinical guidelines affect the way health insurers spend their money ?

- How can hospitals managers, governments, accreditation agencies… patients, health industry utilize clinical guidelines

Towards Evidence Based Health Policy ?

How insurers/health policy makers can use clinical guidelines

1. To design benefits packages that include only appropriate services
2. To deny reimbursement for inappropriate procedures
3. To improve the quality of care using several measures,
   - by studying the effectiveness and appropriateness of practices
   - by quantifying and comparing outcomes of treatments
   - by comparing physicians' practices with those of his/her peers
4. To control costs
5. To provide physicians, patients and consumers with accurate information regarding the effectiveness of care

Clinical Guidelines for Practitioners

Clinical Practice Guidelines for Practitioners

Coalition Recommendations for Clinical Preventive Services

- Introduction
- Maternity
- Birth to 18 Years
- 19 to 39 years
- 40 to 64 years
- 65 Years Plus
- High Risk Categories
- Bibliography

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The conflict of interest between the health policy maker and the physician

Health policy maker objectives

- To measure the appropriateness of health care services.
- To influence provider behaviour
- To decrease costs

Physician views of the objectives of health policy makers

- To decrease costs
- To challenge physician's autonomy

"If we do not set our rules, payers or the goverment will do it"

National survey among French physicians (1998, Conseil de l'Ordre) n = 62,000

- 82 % of French physicians believe that health care financing will be the major problem in the coming years
- 72 % are in favor of evaluation of medical practice
- 56 % are in favor of mandatory practice guidelines

Problems

1. Which health problems should be addressed ?
2. Which guidelines should be used ?

Key characteristics of clinical guidelines used for health policy formulation

<u>THEY MUST BE</u>

- Precise and explicit, without ambiguity
- Key recommendations should be easily identifiable AND evidence based
- Guideline development must be independant of financial organisations
- Tools for implementation and evaluation must be available

  - Agree

  - Clearinghouse

Who can use the National Guideline Clearinghouse ? (*www.ahcpr.gov*)

- Individual physicians
- Health care organizations
- Medical specialties and professional societies
- Employers and purchasers, *to assist them in making health care benefits purchasing decisions*
- State and local governments

Problems

1. Which health problems should be addressed ?
2. Which guidelines should be used ?

3. How do we apply guidelines to a population/ versus applying them on an individual basis
4. How do we take patient preferences into account ?
5. How do we use guidelines ?
   - Which implementation strategies will further their routine use ?
   - Which information system can be be used to routinely evaluate the impact ? e.g. what do we do about case-mix differences among providers ?

Références médicales opposables (RMOs)

A program of mandatory guidelines for controlling the cost of health care in private practice

Références médicales opposables (RMOs)

Recognized scientific criteria that make it possible to define inappropriate care and prescriptions, and the frequency with which such care or prescriptions are used by the patient

EXAMPLE : It is inappropriate to treat systemic hypertension before having measured arterial blood pressure 3 times over a two-month period

Références médicales opposables (RMOs)

- Topics are selected by representatives of French insurance funds and doctors’ unions
- Guidelines are elaborated by ANAES
- RMOs are selected from these guidelines by representatives of French insurance funds and doctors'unions
- In 1997, 48 topics , 194 RMOs (between 1 to 10 RMOs per topic)
- Physicians who do not follow RMOs can be fined

Are French family physicians aware of RMOs 5 years after implementation of this policy

- A questionnaire was administered to 352 family physicians
- 93.8 % of physicians declared that they received RMOs
- 80 % declared that they read the text of RMOs
- 44.3 % declared that they sometimes refer to the text of RMOs at the time of consultation
- The average score concerning the knowledge of RMOs was 50.5, not different from the score that would have been obtained by chance

Durieux et al : Arch Fam Med, 2000;9:414-418

Why the French program of mandatory guidelines failed ?

- Topic selection : Large number of RMOs, Questionnable usefulness of some RMOs
- Guideline elaboration methods : some RMOs were questioned
- Application of RMOs on an individual basis: difficulties in controlling physicians
- Implementation strategy: passive dissemination even associated with the threat of fiancial penalties is not enough
- Absence of an information system which can be used routinely to evaluate physicians'practice
- + Political context :Persistent conflict between the governement and medical unions

Quality and costs

Quality and costs

- Health care quality problems =

  Underuse + overuse + misuse
- Insurers have incentives to act on overuse (to reduce the cost), not on underuse or misuse (when sometimes it is important to increase the cost)
- Clinical guidelines should address these three problems
- All health care professionals are responsible for quality improvement

Example

- French Décret concerning medical evaluation and health expenditures in ambulatory care, December 1999:

« Promoting the strict respect of cost control in accordance with quality, security and effectiveness of care »

- WHO definition of evaluation of quality of care:

« ...the best health outcome, consistent with current scientific knowledge at the best cost »

A National Program of Educational Outreach Visits to Improve the Processes of Care for Patients with Type 2 Diabetes Mellitus

Caisse nationale d'assurance maladie des travailleurs salariés (CNAMTS)

National Program to Improve the Care of Type 2 Diabetes Mellitus
METHODS

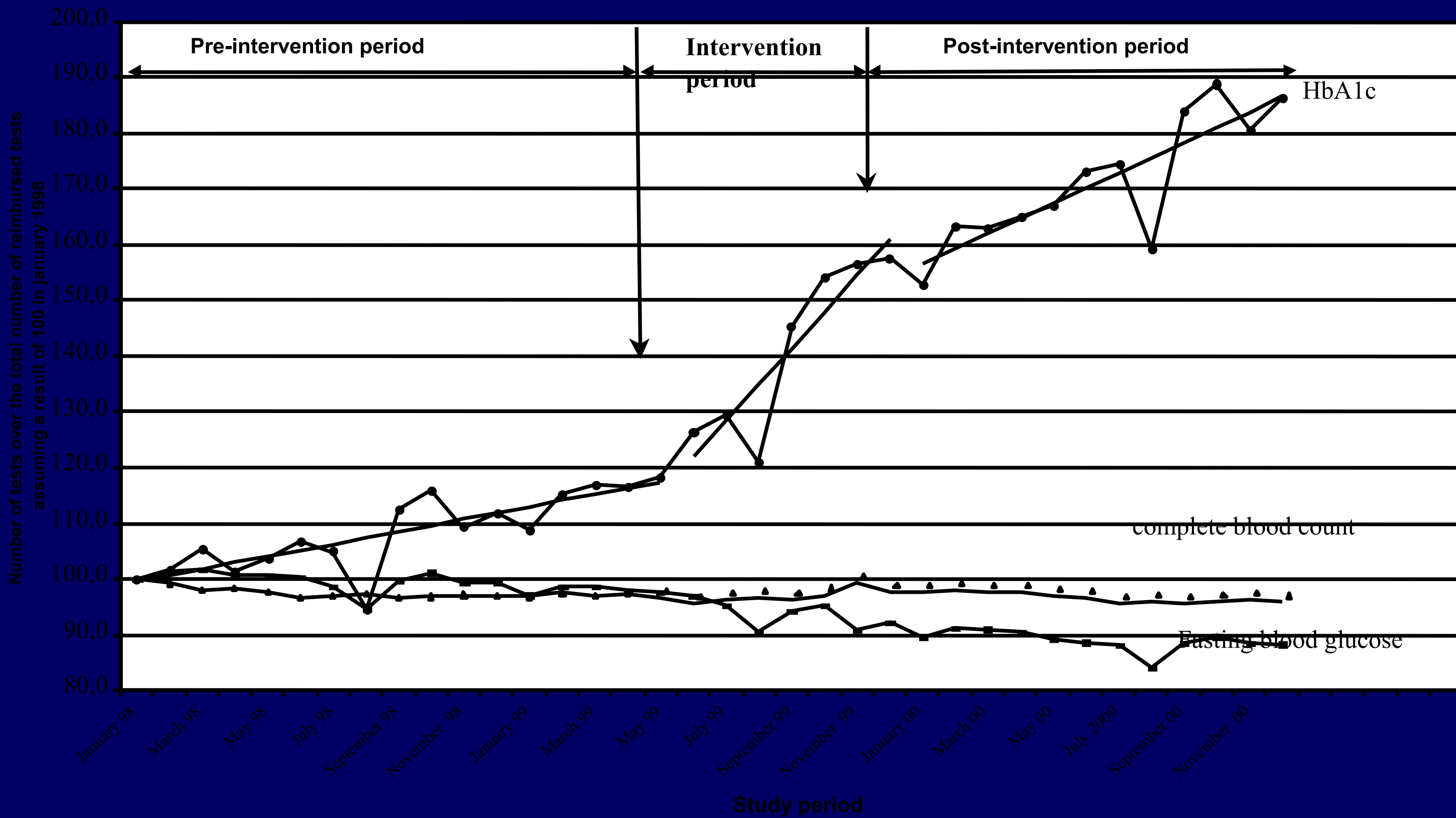
- Objective : to implement national guidelines on type 2 diabetes. To improve the frequency with which appropriate tests for type 2 diabetes are ordered by French physicians
- Intervention : Educational outreach visits (office visits or phone discussion) performed by trained medical advisors salaried by health insurance funds
- Outcome measures : number of recommended tests ordered for diabetes follow-up (HbA1c, fasting blood glucose, urine microalbumin, ophtalmologic examination…)

National Program to Improve the Care of Type 2 Diabetes Mellitus

RESULTS

- A total of 24 584 visits were performed during the 6-months intervention period
- A total of 22 192 physicians were visited, 35.7 % of French physicians who were considered in the position of managing type 2 diabetes mellitus
- A dramatic increase of orders of HbA1c tests was observed

National program to improve the care of type 2 diabetes mellitus – Monthly proportion of the number of HbA1 tests over the total number of laboratory tests – Interrupted time series analysis



Conclusion

1. Clinical guidelines are and will continue to be used by health policy makers to influence physicians'behavior
2. Clinical guidelines must address the three problems of quality : overuse, miseuse and underuse
3. Several problems are to be taken into consideration :
   – Choice of health problems, quality criteria…
   – We do not know how to apply all the results of research to clinical guidelines implementation
4. How to inform, patients, consumers and health professionals

Clinical Guideline Implementation: Health Policy Approaches in France

- Passive dissemination through mailings (ANAES)
- Mandatory continuing medical education (government and medical unions)
- Financial disincentives (government, health Insurance funds and medical unions)
- Educational outreach visits (health insurance funds)