Monitoring Adherence to Guidelines

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In our current medical environment, which is characterized by oversight, accountability, practice guidelines, and documentation, it was inevitable that practice patterns would be monitored to rank compliance with guidelines as an index of the quality of care. It is a small step to a “pay-for-performance” approach, which is well intentioned because it uses data from clinical trials and guideline recommendations to reward physicians who are using treatment strategies known to be effective. Such an approach is aimed at identifying and reforming doctors who do not use “evidence-based” therapy.

Article see p 98

In this issue of Circulation: Heart Failure, Fonarow and colleagues\(^1\) review the data on \(\geq 15,000\) patients with heart failure cared for in 167 outpatient cardiology practices in the United States. The results can be viewed as encouraging or discouraging, depending on your expectations, and as an optimistic step in the right direction to ensure quality care or as a depressing retreat from individualized care, depending on your point of view.

If one assumes that an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker and a \(\beta\)-blocker are mandated therapy for patients with heart failure and a low ejection fraction, nearly 80% of patients were receiving appropriate therapy. That might seem encouraging, given prior lower figures for compliance and the evidence that other diseases, such as hypertension, are being treated inadequately.\(^2\) Nevertheless, whereas hypertension treatment is judged by blood pressure response, the analysis by Fonarow et al\(^1\) of drug therapy for heart failure is limited to whether a prescription has been given. In the absence of dosing or compliance data, one cannot assume that patients are being treated adequately. Clinical trial evidence for efficacy is based on target doses of drugs. Because there is no suitable intermediate marker for such heart failure therapy, the analysis in the present issue gives equal weight to drugs given in trial-mandated doses and drugs given in small doses that are unlikely to be effective.

Should evidence from clinical trials on mean response in a large, heterogeneous population be translated into guidelines that mandate that all individual patients be treated the same?

Many would argue that it should, but evidence for therapy can derive from other sources based on physiological, pharmacological, and individual insights. Can knowledgeable physicians violate trial data and guideline recommendations to the betterment of clinical outcomes? We know that there may be striking differences in drug response based on genetic or environmental characteristics. For example, although Fonarow et al\(^1\) allude to isosorbide dinitrate/hydralazine therapy, they do not address its use, especially in blacks, who represented 9% of their population and in whom guidelines suggest the drug combination should be mandated on the basis of trial data.\(^3\) Other data suggest angiotensin-converting enzyme inhibitors are less effective in blacks.\(^4,5\) Would a physician be justified in treating heart failure in a black patient with isosorbide dinitrate/hydralazine and not an angiotensin-converting enzyme inhibitor? How can he or she avoid being penalized?

Does this analysis of prescription patterns provide insight into adequacy of care? The best physician for a patient with heart failure would be one with excellent training, extensive experience, and superb judgment with regard to all aspects of the disease. He or she would provide individualized care; would not necessarily follow guidelines slavishly; could monitor jugular venous pressure and appropriately adjust diuretic therapy; would educate patients about their disease, the drugs being used, and the need for compliance; and would understand if, how, and when to use devices on the basis of the patient’s individual characteristics. Such physicians are no longer rewarded for their excellence. All physicians are paid at the same rate, which is based on their units of work instead of their competence. In no other profession is this equal pay for equal work principle applied. A pay-for-performance approach would reward a prescription. This approach may raise the minimum level of care for heart failure, but it is certainly not necessarily designed to encourage excellence. Can we monitor for excellence in care? That is a problem we eventually may need to solve.

Are there unintended consequences of our efforts to seek adherence to guideline-recommended therapy? Today’s recommendations may be outdated tomorrow. A change in what is viewed as effective therapy may occur while the ponderous process of selecting and tracking prior markers for quality of care grinds on. Most of the therapeutic advances incorporated in current guidelines were the product of deviant behavior that violated traditional practice. Rewards for adherence may discourage efforts to innovate. How to preserve creativity in a data-driven environment may be the ultimate challenge.

Disclosures

None.
References

Key Words: Editorials ▶ heart failure ▶ outpatients ▶ quality of care
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Circ Heart Fail. 2008;1:87-88
doi: 10.1161/CIRCHEARTFAILURE.108.795294
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1941-3289. Online ISSN: 1941-3297

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circheartfailure.ahajournals.org/content/1/2/87

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