

Care Management for TIA and Stroke Patients: Riding the Quality Improvement Wave

Barbara Lennert, RN, BSN, CRRN, MAOM



The focus on quality improvement of the US healthcare began in 1999 with the first report of the Institute of Medicine related to serious quality gaps in our delivery system. A push toward greater quality of care has intensified since then and is still evolving. Nevertheless, serious gaps in care delivery and quality still exist. Furthermore, many quality-related organizations still do not see stroke and stroke prevention as key concerns, despite the serious consequences and prevalence of stroke and recurrent stroke. Lack of agreement among the different quality groups is apparent when it comes to stroke care. The problem with stroke management is not a lack of knowledge on the part of stroke experts or stroke centers. But once a patient leaves the hospital, proper follow-up and stroke prevention in the outpatient setting are often inappropriate. Inpatient care managers are the gatekeepers of quality of care, focusing on the continuity of care beyond the hospital, but their involvement does not extend to the outpatient setting, where lack of providers' knowledge and patient adherence present major obstacles, especially in relation to stroke and recurrent stroke. It may require a push by providers to drive the message of the true cost of stroke and help turn it into a major disease state deserving the focus of health plans and other payers and therefore into a collaborative effort between payers and providers. [AHDB. 2009;2(suppl 8):S24-S27.]

Quality of care has not always been a topic of concern for the US healthcare delivery system. In recent years, an increased awareness of gaps in quality of care has become a major concern for those involved in the delivery of care and quality-related organizations. The health-related quality improvement movement was launched in 1999, with the first Institute of medicine (IOM) report, which triggered the initial demand for public reporting of quality of care.¹ The report pointed out problems in our healthcare regarding preventable deaths resulting from the variability of care in the country, and the way hospital care was being delivered and managed. The second IOM report, issued in 2001, emphasized the need to change the direction of the US healthcare system, noting that even if we try harder in the way healthcare is being delivered, it is not going to be the answer to the problem.² New solutions were clearly needed.

Quality of Care

The IOM reports recommend the implementation of some key changes:

- Public reporting of performance measures should be an integral component of a pay-for-performance (P4P) program for Medicare

Ms Lennert is Director at Xcenda, Palm Harbor, FL.

- Department of Health and Human Services (DHHS) should offer **incentives to providers** for the submission of performance data
- DHHS should develop and implement a strategy to ensure that virtually all Medicare providers submit performance measures for **public reporting** and participate in P4P
- For many institutional providers, participation in public reporting and P4P **can and should begin immediately.**

In 2007, the Centers for Medicare & Medicaid Services (CMS) launched its Physician Quality Reporting Initiative (PQRI), with new measures being added annually. The public reporting environment currently encompasses many organizations and quality-focused groups, as outlined in the **Figure**. Public reporting now includes all the facets of healthcare—hospitals, groups in clinics and centers, health plans and pharmacy benefit management organizations, home health and long-term facilities, and individual providers.

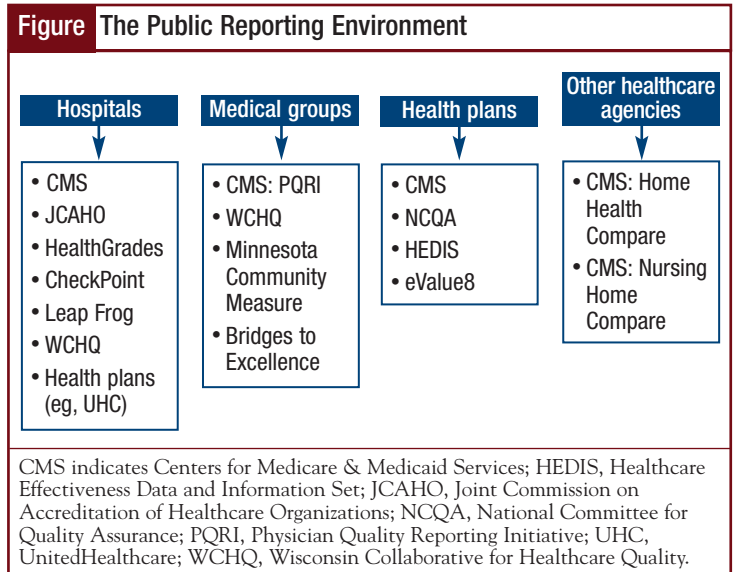
Stroke Metrics

As far as stroke programs and metrics are concerned, several of the organizations concerned with quality of care have established a variety of stroke programs (**Table 1**). However, as can be seen in **Table 2**, these programs are not well aligned with regard to stroke-specific met-

rics. Although there are many overlaps in these metrics, there are also many inconsistencies and gaps among the different organizations. Stroke and transient ischemic attack (TIA) are clearly not on everybody’s radar screen. There is some alignment regarding stroke metrics but also much disagreement on what to focus on. Much remains to be done in terms of stroke care.

From a health plan standpoint, for plans to pay attention to stroke, it is clear that those involved in stroke care need to elevate this disease state so it becomes as important to health plans from a cost or a business perspective as are some of the major diseases, such as diabetes, asthma, or heart disease. One way in which this could happen would be for the National Committee for Quality Assurance (NCQA) to set specific guidelines that will be part of the Healthcare Effectiveness Data and Information Set (HEDIS) measures around stroke/TIA and stroke prevention.

Furthermore, the stroke metrics listed in Table 2 as part of the metrics of those organizations are mostly voluntary measures. These metrics are not obligatory. That is even true for Get With The Guidelines (GWTG) and for CMS’s PQRI. These metrics represent a bonus payment. That is, there is no penalty for not following these metrics, which further illustrates that stroke or stroke prevention is not yet a top priority for any of the



health organizations, including quality programs, and therefore for health plans. These “pay-for-reporting” metrics stipulate that providers need only report on 3 measures that are applicable to their practice to get the bonus. The measures they choose may not include those related to stroke. This means following these metrics

Table 1 Health Organizations with Stroke Programs

Organization	Program	Program description/goal
National Institute of Neurological Disorders and Stroke	The Brain Attack Coalition	Group of professional, voluntary, and governmental entities dedicated to reducing the occurrence, disabilities, and death associated with stroke
American Stroke Association/American Heart Association	Get With The Guidelines—Stroke	Ensure continuous quality improvement of acute stroke treatment and ischemic stroke prevention—focus on protocols
Joint Commission on Accreditation of Healthcare Organizations	Primary Stroke Center Certification	Recognizes centers that make exceptional efforts to foster better outcomes for stroke care
National Quality Forum	Consensus Standards for the Prevention and Management of Stroke Contributor of many Physician Quality Reporting Initiative measures for Centers for Medicare & Medicaid Services	Identify and endorse measures that address the clinical, system, and care coordination aspects involved in effective stroke care across the continuum of care
National Committee for Quality Assurance	Heart/Stroke Recognition Program	Recognize physicians who use evidence-based measures and provide excellent care to persons with cardiovascular disease or who have had a stroke

Table 2 Stroke Metrics, by Organization

	GWG-Stroke	JCAHO	NQF	PQRI ^a	NCQA
CT or MRI reports				✓	
Carotid imaging reports				✓	
Deep-vein thrombosis prophylaxis	✓	✓	✓	✓	
Discharged on antiplatelet therapy	✓	✓	✓	✓	✓
Anticoagulant for AF at discharge	✓	✓	✓	✓	
t-PA considered	✓	✓	✓	✓	
Screening for dysphagia		✓	✓	✓	
Consideration of rehabilitation services		✓	✓	✓	
Cholesterol-reducing medications at discharge	✓	✓	✓		
Stroke education		✓	✓		
Smoking-cessation advice/counseling/treatment	✓	✓	✓		✓
Antithrombotic by end of hospital day 2	✓	✓	✓		
Functional communication measures (eg, reading, writing, memory, attention, motor speech, etc)			✓		
Blood pressure <140/90 mm Hg					✓
Lipid profile annually					✓
LDL <100 mg/dL					✓

^aPQRI has blood pressure and lipids measures, but these are not specific to stroke patients.

CT indicates computed tomography; MRI, magnetic resonance imaging; AF, atrial fibrillation; t-PA, tissue-plasminogen activator; LDL, low-density lipoprotein.

varies from physician to physician and from clinic to clinic. This further highlights that stroke is not among the “big 5” diseases—diabetes, asthma, chronic obstructive pulmonary disease, heart disease, and cancer—that are the focus of all plans.

Based on the information presented by Dr Elkind and Dr Mitchell in this publication, the problem is not that clinicians do not know how to treat patients with TIA or stroke fairly consistently in stroke centers. They do. But we do not do much to prevent stroke, and outpatient care for the stroke or TIA patient is lacking. The problem begins once the patient gets out of the

hospital or stroke center. Outpatient care is not focused on stroke, and many primary care providers are not sure how to deal with stroke/TIA patients. In addition, non-adherence is a major problem, as in other diseases. Patients are nonadherent for a variety of reasons, such as forgetting to take their medications, costs, lack of understanding of the importance in relation to their overall health, or concern over side effects. This lack of adherence was likely a contributing factor in the development of their original stroke or TIA. In stroke, non-adherence can mean another stroke, or even death.

The difficulty with measuring metrics also to a large extent relates to the patient engagement, and patient adherence. Initially the patient is adherent after a stroke, but gradually, the good habits fall to the wayside, and the patient is back to nonadherent behavior. In 2 years, many patients are not taking their medications anymore. My experience as a nurse manager suggests that it may start trailing off after 3 to 6 months.

What can be done to change this situation? One solution is for health plans and clinicians to work with the appropriate organizations to develop and adopt additional meaningful metrics. Knowing the influencing factors and developing relationships with the specific organizations that have the right influence may yield some positive results. The following list describes the type of impact the different organizations or policies have on different stakeholders:

- **JCAHO** (Joint Commission on Accreditation of Healthcare Organizations) has an influencing hold on hospitals
- **NCQA** has attracted the attention of managed care organizations
- **PQRI** influences providers
- **NQF** (National Quality Forum) influences CMS, which now has the PQRI measures
- **GWG** has more of an indirect influence, but it does influence hospitals, particularly those with stroke centers, as well as neurologists dealing with stroke.

We need to work with these organizations to get the stroke metrics on their radar screen and have them focus on TIA and stroke prevention.

Care Management

Care managers view themselves and act as patient advocates and patient educators in much of their work (Table 3). Care managers help patients understand their current health status, what they can do about it, and why those treatments are important. However, whether patients listen and follow through is a different issue.

Care managers also coordinate care beyond the specific episode. The care manager tries to set up appropriate care for that patient on a long-term basis, beyond the hospital stay. However, once the patient leaves the hospital, the inpatient care manager is not involved in the actual care in the outpatient setting. Ideally, care management is then transitioned to a health plan-based or community-based care manager; but this is not always the case.

Those involved in care management are the gatekeeper of patient care, with the goal of getting the right care at the right time in the right setting so that it is the most cost-effective quality care possible. A heavy caseload is a major obstacle for care managers, and does not allow them to devote a lot of attention to a particular disease state or a particular patient in the course of 1 day, 1 week, or 1 month.

Finally, as the baby boomers age and require more care, what does that do to care managers' caseloads? Even at double these rates, we will need many more care managers in any of these agencies to deal with the baby boomers and their burgeoning needs. As they have more strokes and more myocardial infarctions (MIs), more hip surgeries, hip fractures, knee replacement surgeries, and so on, support care needs will escalate accordingly. We are already facing a nursing shortage again—where will organizations find care managers to fill these needs?

What Can Be Done?

There are several steps we can take to improve the quality of and access to stroke care and establish stroke prevention. These include:

- Development and implementation of software tools to identify at-risk patients. For example, a software tool could be created to identify patients with stroke risk factors, such as hypertension, hyperlipidemia, smoking, older age, previous TIA/stroke events, MI, peripheral artery disease, and diabetes
 - Remember: the more risk factors, the higher the risk
 - Consider the weight of the risk factors; eg, previous stroke means greater risk than gender; Framingham risk formula
 - Queue actions to be taken by the health plan toward patients and providers to address risk factors
 - Involve quality and disease management persons, case managers, medical/pharmacy directors in the follow-up process
 - Copay structures for chronic diseases, including stroke, that support patient adherence
- Implement comprehensive disease management programs.

Table 3 The Role of the Care Manager

- Primarily patient advocates and patient educators: Help patients understand their current health status, what they can do about it, and why those treatments are important
- Coordinate care beyond the specific episode or situation with services directed at behavior change, healthy lifestyles, and optimal outcomes
- Requires clinical knowledge, expertise in care guidelines (eg, Milliman), knowledge of quality organization standards (eg, National Committee for Quality Assurance, Utilization Review Accreditation Commission)
- Goal: best care, at the right time, in the right setting, to achieve the most cost-efficient quality outcomes

Conclusion

There is a widespread agreement that TIA and stroke are not on the radar screen of health plans at this point, and these serious conditions are not getting the attention they deserve. The question remains, how can it be placed on the radar screen if not through the NCQA? It is not going to happen otherwise, because of the limited resources, and because it is not perceived as one of the major disease states. There is a case to be made about the costs of stroke care that may help elevate stroke and stroke prevention to its proper place and ensure it gets the attention it deserves. Involving all relevant stakeholders in the process will be a big help.

Another approach that would likely help would be partnerships between public and private payers, as well as key neurologists, such as Dr Adams and Dr Mitchell, and care managers, who may be able to design programs for stroke prevention that are beneficial to all stakeholders. Patients would have better clinical outcomes and quality of life, payers would have lower healthcare costs, and incentives could be aligned to provide incentives to providers to make appropriate care and prevention of stroke a priority. It may boil down to our ability to demonstrate the true cost-benefit from stroke prevention that will finally get health plans to advocate stroke prevention. ■

References

1. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. November 1999. www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf. Accessed September 3, 2009.
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