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Future of Training and CME in Europe

Individualised CME in a Disease Management Programme (DMP) – Does it Change Decision Making?

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Basic Features of German DMP

- Structured care programmes between 1998 and 2002
- Disease management programmes (DMP) – a linkage of structured care and financial incentives for compulsory health insurance companies ("risk structure compensation")
- DMP are running since 2003 (diabetes mellitus type 2, breast cancer), 2004 (cardio vascular disease), and 2006 (diabetes mellitus type 1, bronchial asthma, COPD)
- Major and common features:
  - Focus on improvement and continuity of care (examinations at regular intervals, preferred use of approved medications, interdisciplinary cooperation of general practitioners and specialists / hospitals, active participation of the patients in education and self management)
  - Defined set of indicators ("quality targets") in relation to structure, process, and outcome of care

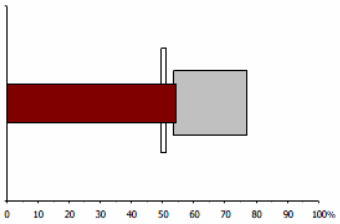
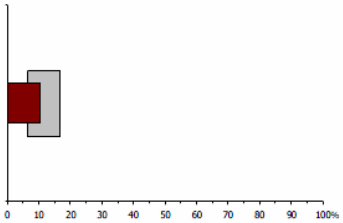
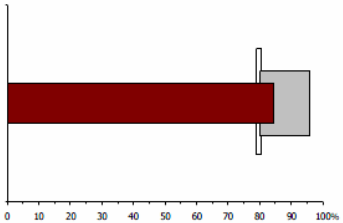
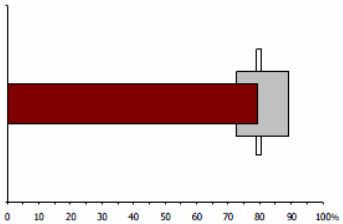
Basic Features of German DMP (continued)

- Major and common features (continued):
  - Individualised feedback of quality indicator related results to the physician at regular intervals
  - Evaluation of the programmes' results in a complete region at regular intervals

Features of Feedback in the North Rhine Area (1)

- Standardised, indentically structured and automatically generated reports, for each indication twice in a year, including:
  - Summary of results, main report, additional report plus CME (different themes), lists of critical patients
- Specifically tailored reports for general practioners vs. specialists
- Integration of medical experts and representatives of the DMP contracting partners in the development of the report contents
- Presentation of individual vs. common results (benchmarking) and commentaries in case of large discrepancies
- Analyses of results related to quality targets, subgroup analyses, and long term analyses of central outcome parameters as well as individual cases
- Analyses of the addresses' rating of the reports' form and contents

Features of Feedback in the North Rhine Area (2)

Qualitätsziel	erreicht?	Vergleich
Normotensiver Blutdruck bei arterieller Hypertonie: Mindestens 50 % der Patienten mit arterieller Hypertonie sollen normotone Blutdruckwerte (< 140/90 mmHg) aufweisen.	ja (49/90)	
Reduzieren des Anteils rauchender Patienten: Unter allen Patienten soll der Anteil von Rauchern gesenkt werden.	keine Zielvorg. (10/97)	
Thrombozyten-Aggregationshemmer: 80 % der Patienten ohne Kontraindikationen sollen Thrombozyten-Aggregationshemmer erhalten.	ja (82/97)	
β-Blocker: 80 % der Patienten ohne Kontraindikationen sollen **β**-Blocker erhalten.	nein (77/97)	

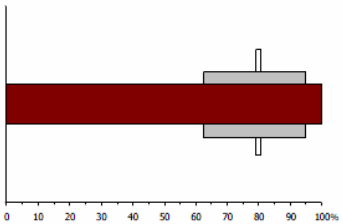
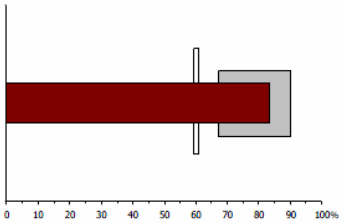
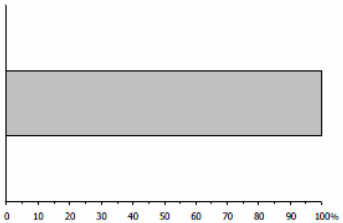
Qualitätsziel	erreicht?	Vergleich
ACE-Hemmer bei Herzinsuffizienz: 80 % der Patienten mit einer Herzinsuffizienz und ohne Kontraindikationen sollen ACE-Hemmer erhalten.	ja (25/25)	
Statine: 60 % der Patienten ohne Kontraindikationen sollen HMG-CoA-Reduktasehemmer (Statine) erhalten.	ja (81/97)	
Überweisungen: Patienten mit einer neu aufgetretenen typischen oder atypischen A.p.-Symptomatik oder einer neu aufgetretenen Herzinsuffizienz sollen überwiesen werden.	keine Zielvorg. (0/1)	

Illustration of report analyses: Meeting the target values (red bars = own results, grey bars = 25th to 75th percentile of all participants)

Additional CME Reports in the North Rhine Area

	DMP	Thema	n_T	n_B	Quote
2005/2	KH	Kalziumantagonisten	428	3.495	12,2
2006/1	KH	Thrombozyten-Aggregationshemmer	638	3.778	16,9
2006/1	D2	Diabetes im Alter	450	4.102	11,0
2006/2	KH	ACE-Hemmer	488	3.764	13,0
2006/2	D2	Orale Antidiabetika	523	4.119	12,7
2007/1	KH	Beta-Blocker	440	3.910	11,3
2007/1	D2	Diabetischer Fuß	365	4.201	8,7
2007/2	KH	Raucherentwöhnung	335	4.113	8,1
2007/2	D2	Diabetische Retinopathie	240	4.309	5,6
2008/1	KH	Akutes Koronarsyndrom	316	4.307	7,3
2008/2	CO	Nationale Versorgungsleitlinie COPD	122	3.052	4,0
2008/2	KH	Lipidsenker	143	4.245	3,4
		zusammen	4.488	47.395	9,5

List of additional CME reports: time period, indication, theme, number of participants, number of reports, and proportion of participants

CME Report 2005/2: Calcium Channel Antagonists

In Ihrer Praxis

Von Patienten im Alter ... erhalten ... Kalzium-Antagonisten

	Anzahl	in %
bis 55	1	25,0
56 bis 65	2	22,2
66 bis 75	9	42,9
über 75	3	30,0
insg.	15	34,1

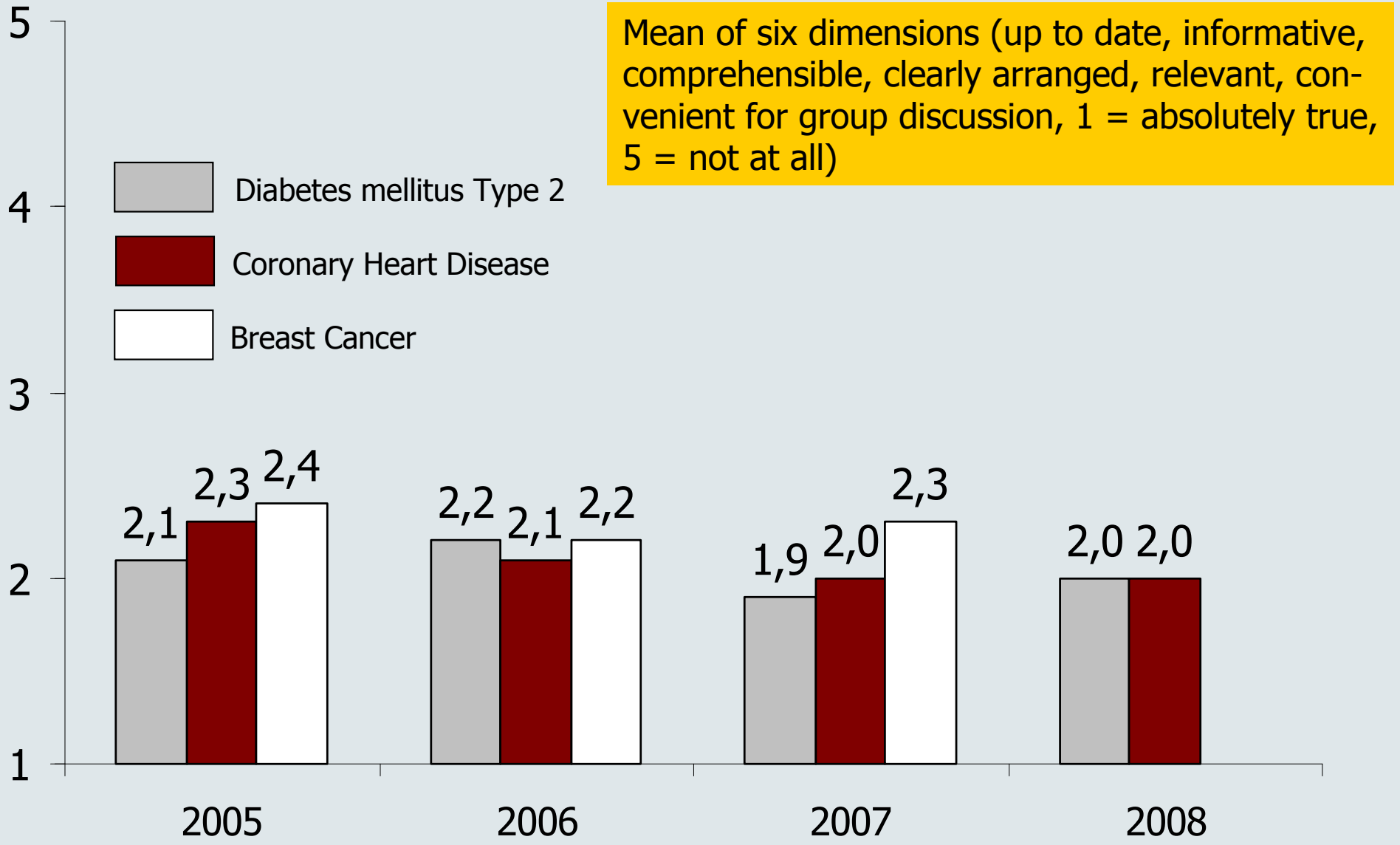
In allen Praxen

Von Patienten im Alter ... erhalten ... Kalzium-Antagonisten

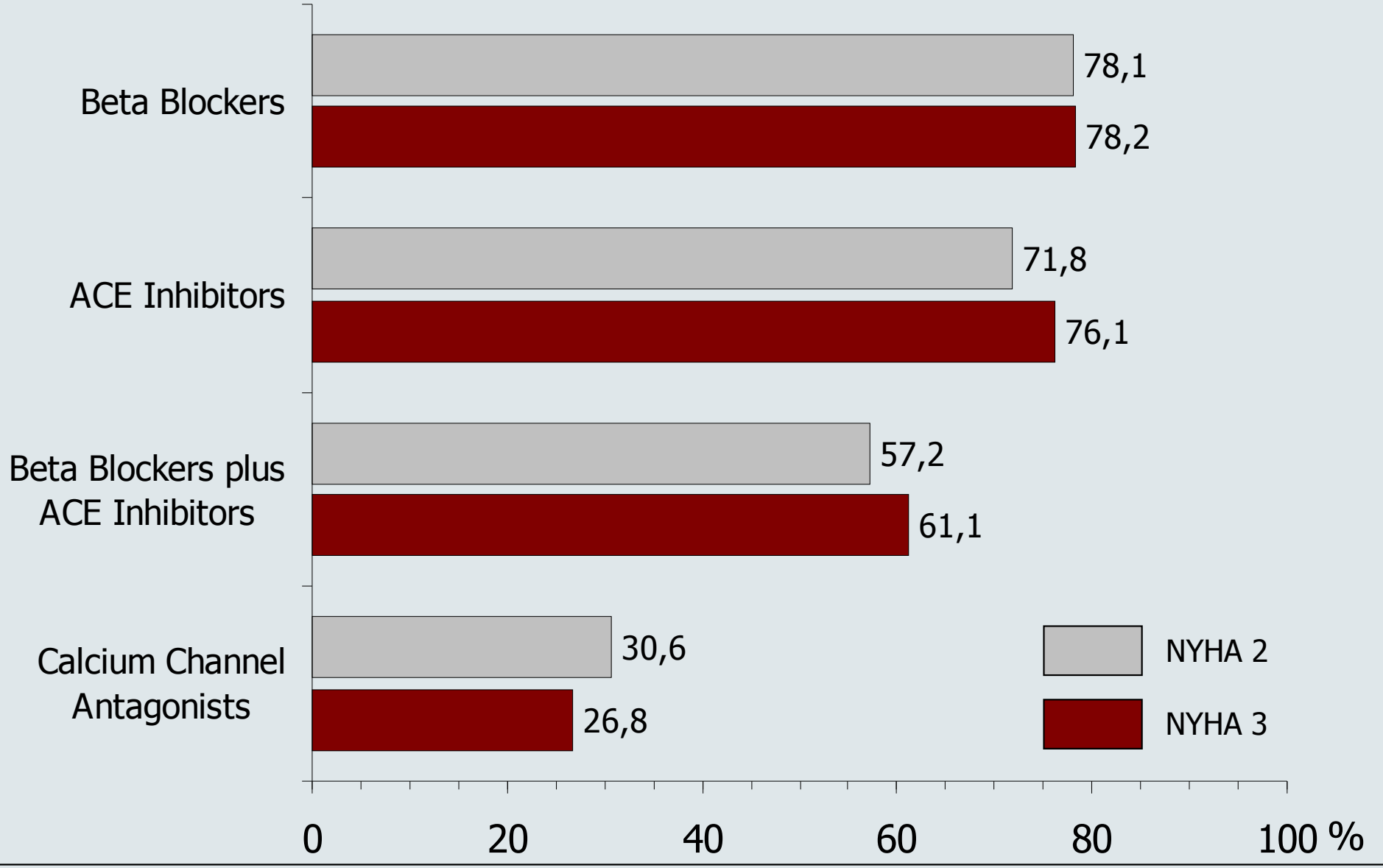
	Anzahl	in %
bis 55	1236	13,9
56 bis 65	4157	20,8
66 bis 75	9723	25,3
über 75	7919	28,6
insg.	23035	24,3

Illustration of CME report analyses: Prescription of calcium channel antagonists by age of patients (left side = own results, right side = results of all participants)

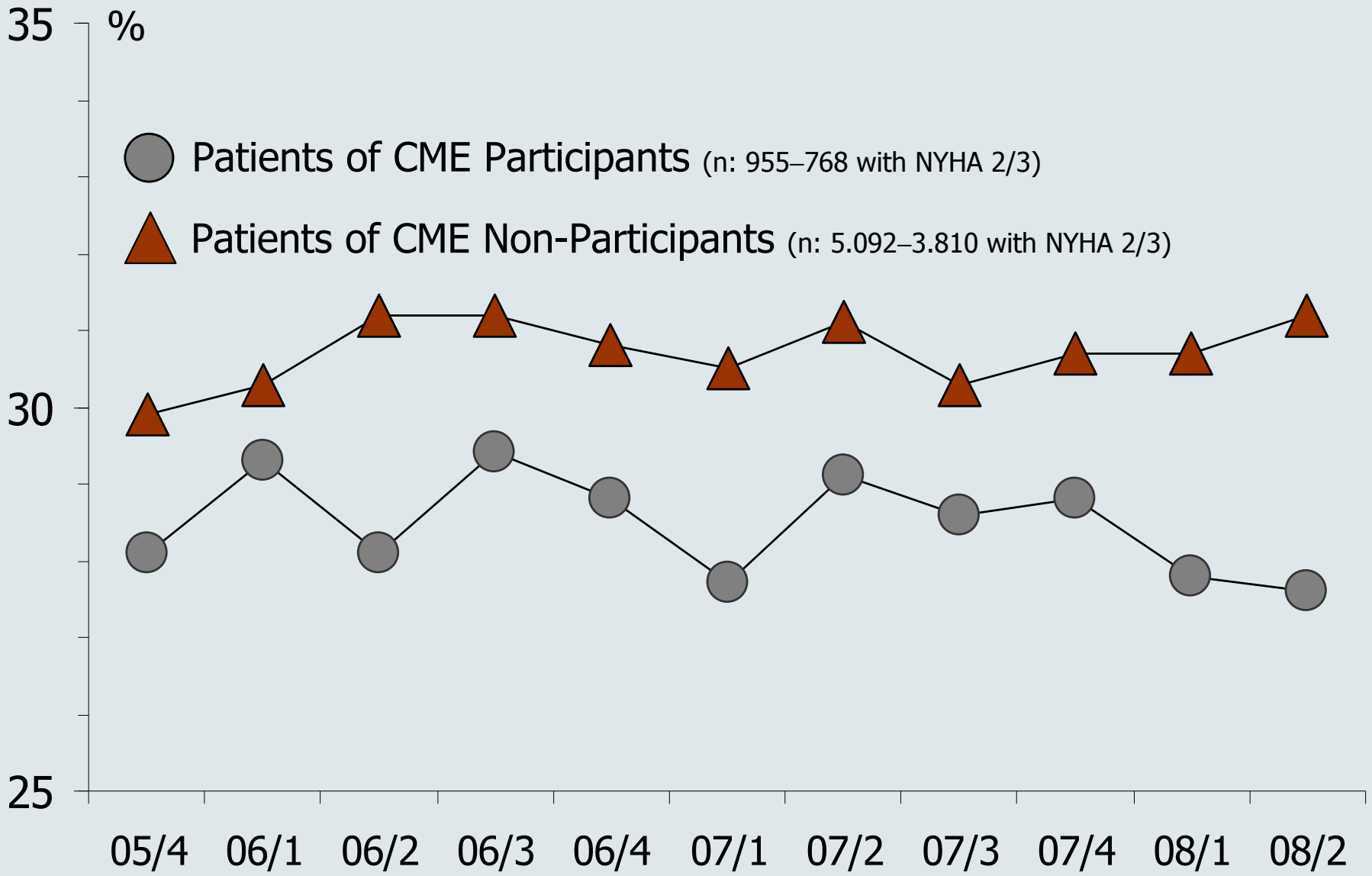
Time Course of the Addressees‘ Rating of the Reports



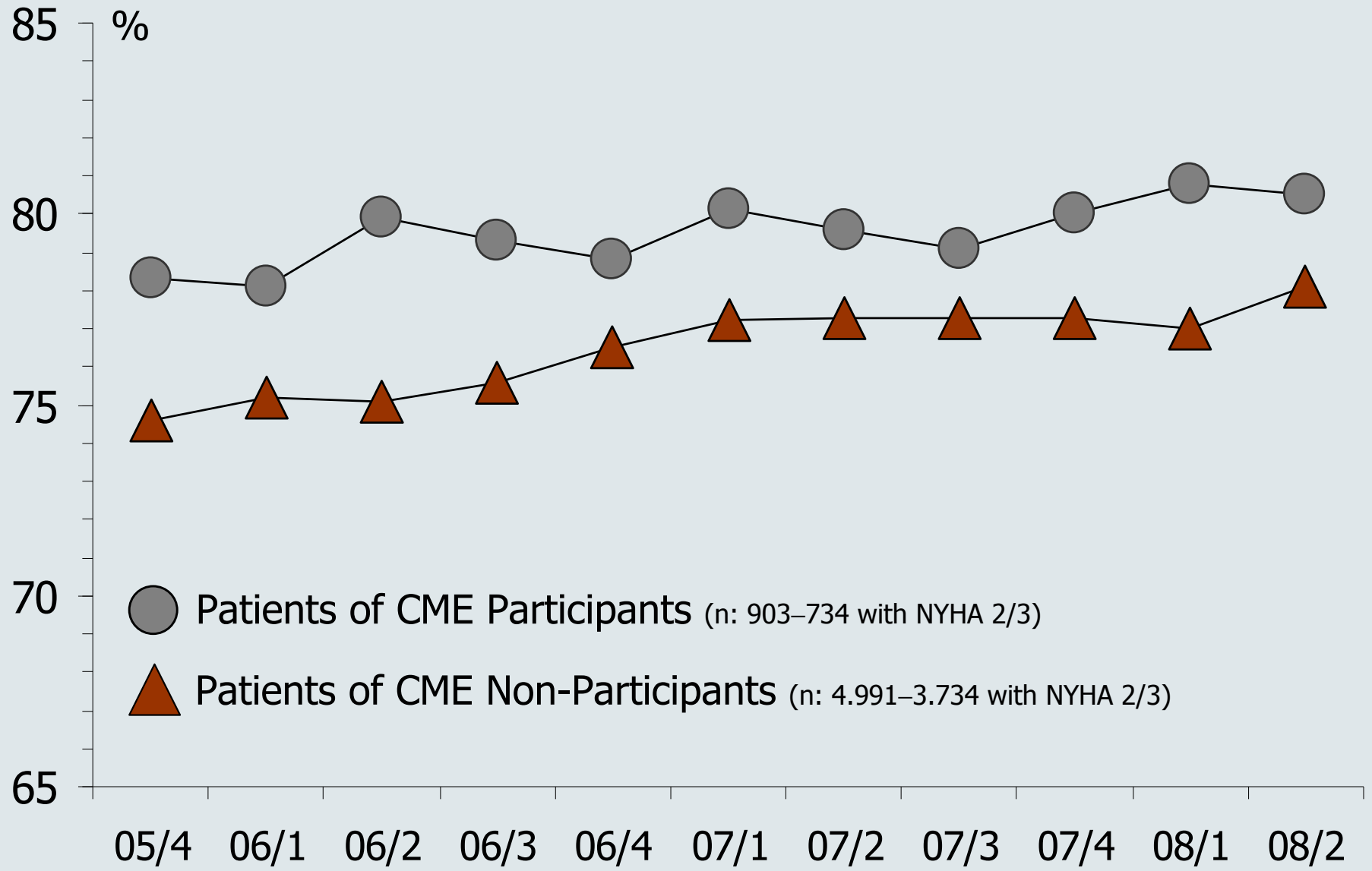
Prescription of Beta Blockers, ACE Inhibitors, and Calcium Channel Antagonists in 2005



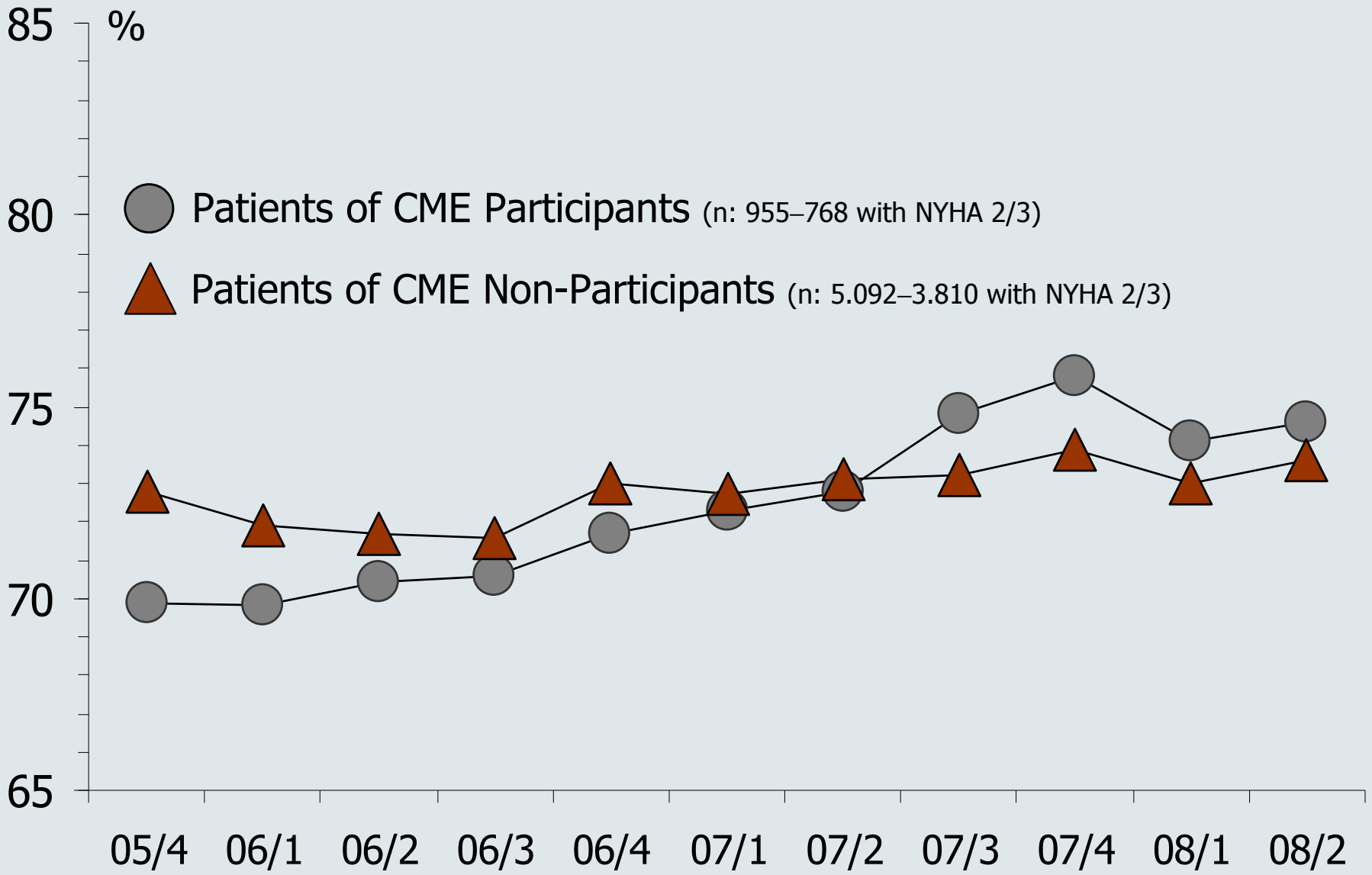
Time Course of Prescription of Calcium Channel Antagonists



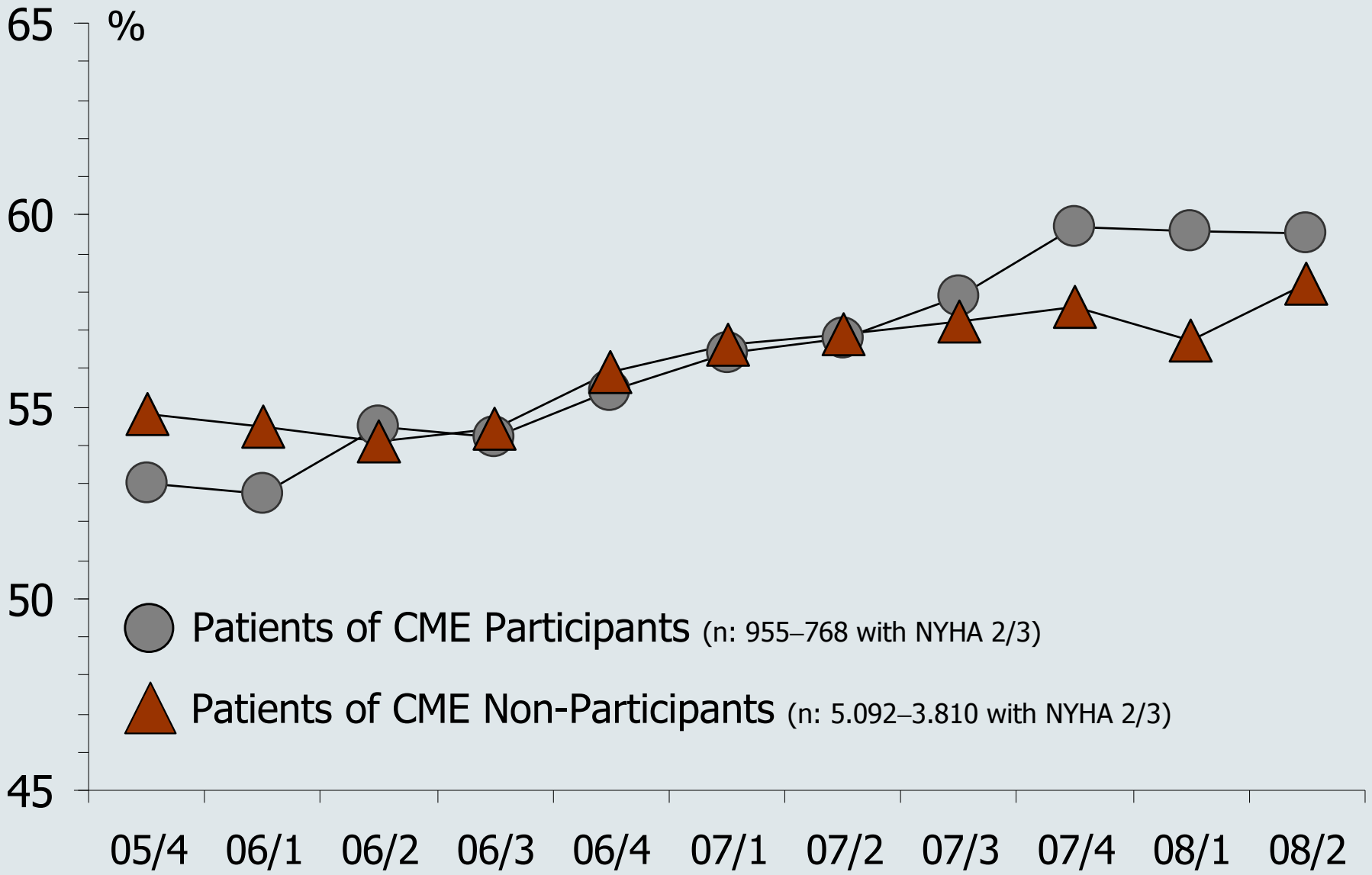
Time Course of Prescription of Beta Blockers



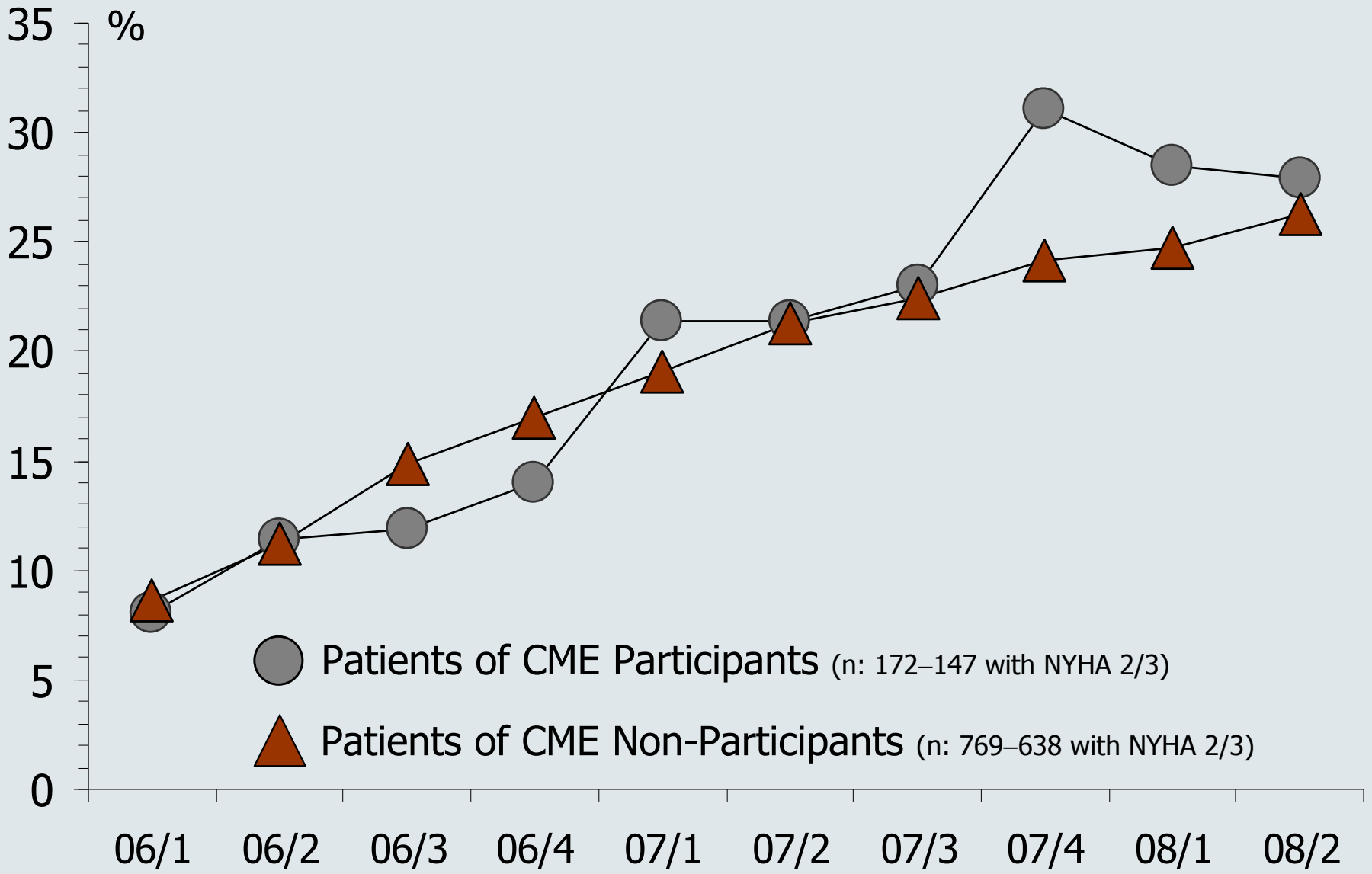
Time Course of Prescription of ACE Inhibitors



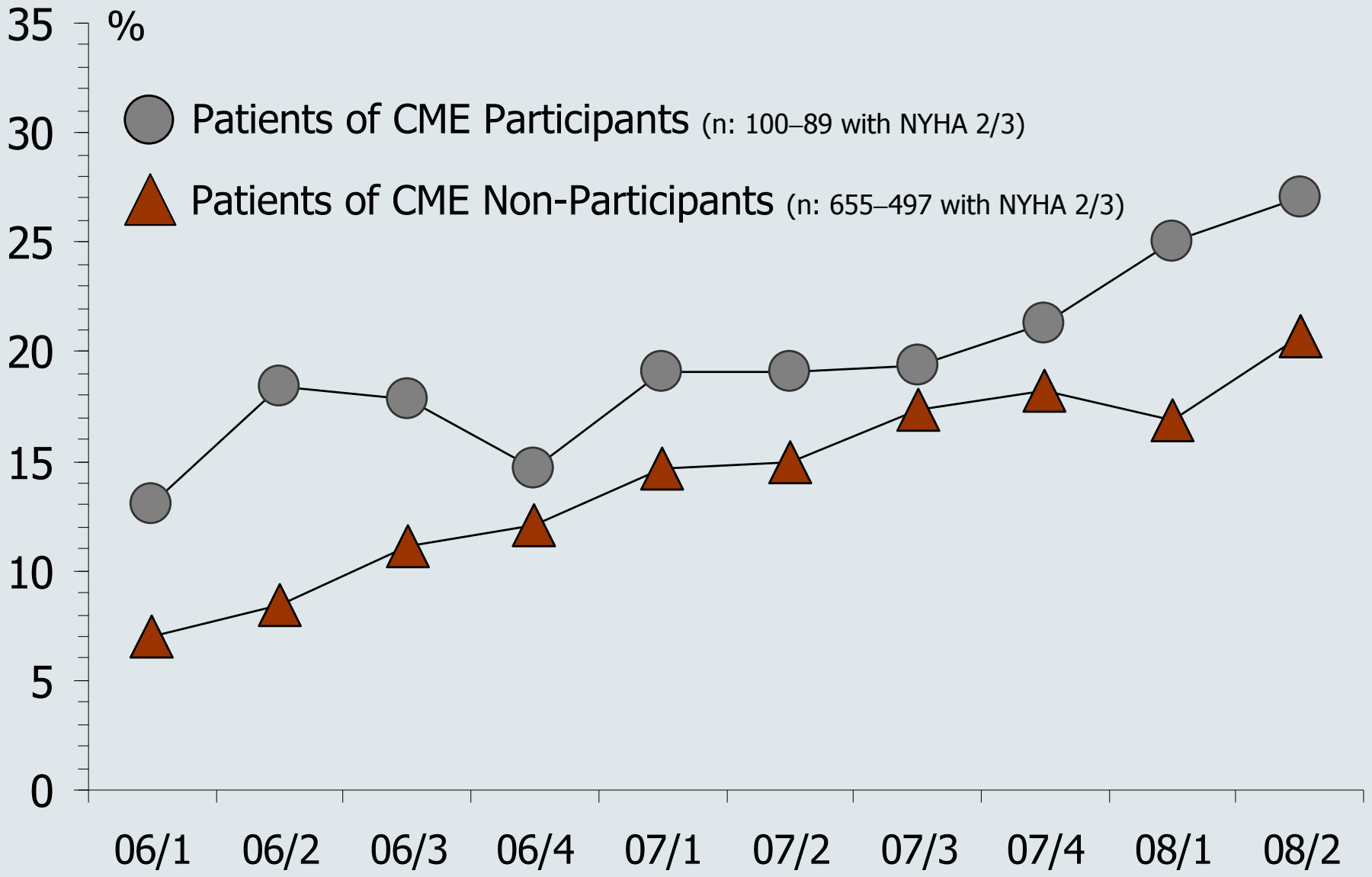
Time Course of Combined Prescription of Beta Blockers and ACE Inhibitors



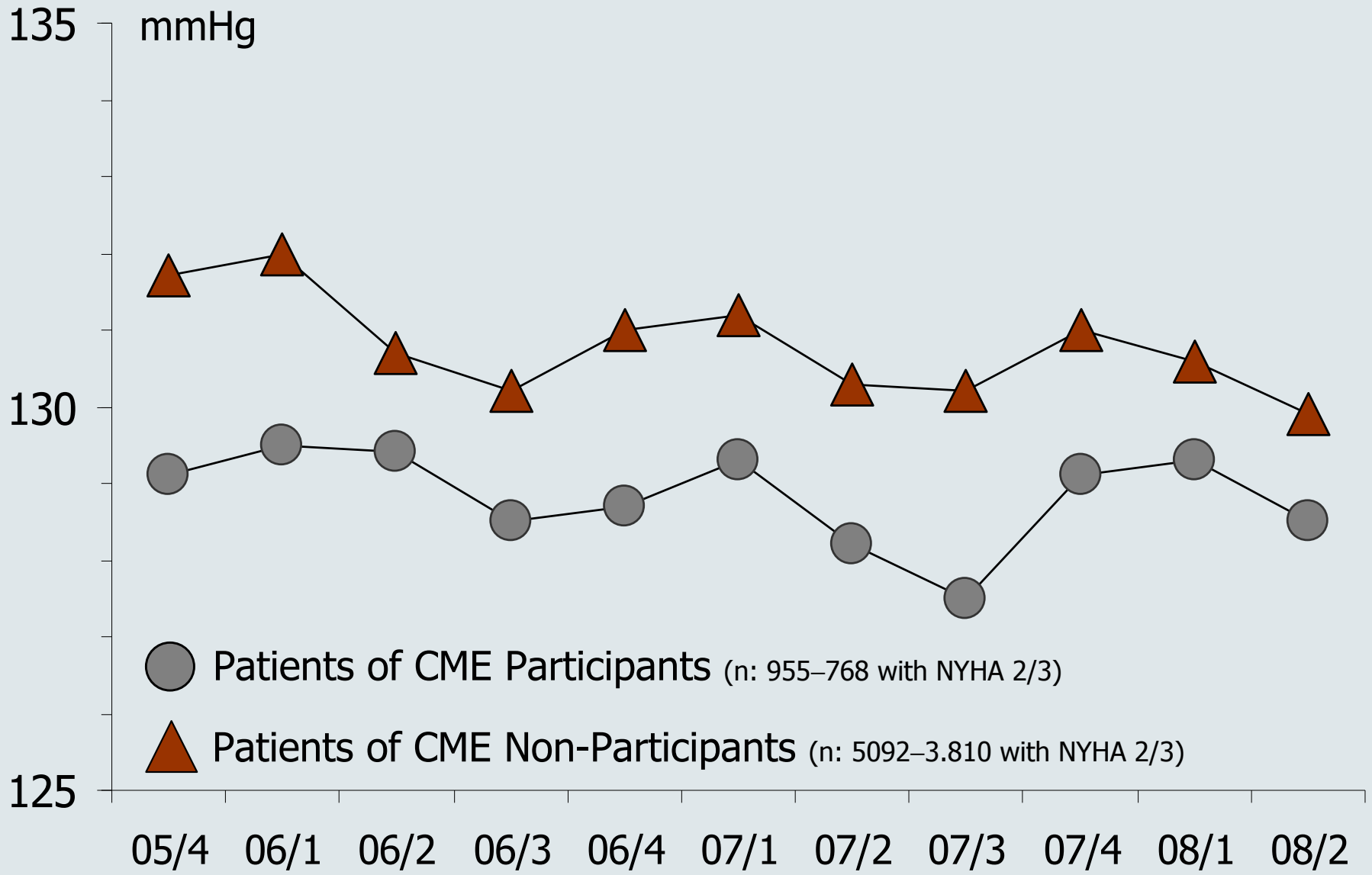
Time Course of Combined Prescription of Beta Blockers and ACE Inhibitors 2005/4 Beta Blockers only



Time Course of Combined Prescription of Beta Blockers and ACE Inhibitors 2005/4 ACE Inhibitors only



Time Course of Systolic Blood Pressure



Summary of Results

- Proportion of participants in the CME is rather low and decreases over time
- Despite this the reports are very positively rated by the addressees
- Between 2005 and 2008 prescription of calcium channel antagonists remains relatively high in patients with heart failure
- From the beginning there are systematic differences:
  CME participants prescribed less often calcium channel antagonists in patients with heart failure, non-participants prescribed them more often
- There is only a weak tendency towards an increase of this difference
- All of the other relevant prescriptions as well as the combined one are, independently of CME participation, more frequent at the end of observation period
- Blood pressure of patients with heart failure is well kept below or near 130 mmHg

Conclusion

- Taking part in CME is self selective act: participants show even at baseline a different prescription behaviour
- CME effects are very small or unvisible in the long run, and secular trends are much stronger
- Probably a more intensified mixture of different instruments (feedback in regular intervals, CME, repeated clinical reminders, group discussions) would be a more promising way to change prescription behaviour
- Nevertheless both prescription behaviour and blood pressure level show a positive development, which can be explained at least in parts as an effect of structured care within the disease management programme