Measures Aim to Enhance Osteoporosis E&M

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MONTREAL — Performance measures for the evaluation and management of osteoporosis have already been developed and soon could be making their way into clinical practice. But clinicians across specialties will need to collaborate to implement the measures and make certain that patients do not miss screening when they have a fragility fracture or other risk factors, according to several experts.

"I think we all have a consensus there is a need to improve the standard of quality of care in our patients with osteoporosis and osteoporotic fracture," said Dr. Stuart L. Silverman, professor of clinical medicine at the University of California, Los Angeles, one of several speakers on this topic at the annual meeting of the American Society for Bone and Mineral Research.

Strategies must start at the national level but also involve specialty and primary care medical societies, hospitals, individual clinicians, and public education. Now that osteoporosis performance measures have been developed by both the Joint Commission and an American Medical Association–led coalition of societies, specialty and primary care medical societies need to develop fracture treatment advocacy statements, Dr. Silverman said.

The Joint Commission's Measures

Evidence-based monographs such as the Joint Commission's "Improving and Measuring Osteoporosis Management" are produced by expert panels with the goal of providing voluntary measures to attain in managing a disease. They are not considered standards until field-testing has ensured that measures are valid and can be obtained. The publishing of such measures as standards can "make many people feel they should be followed," said Dr. Ethel S. Siris, professor of clinical medicine at Columbia University, New York.

"I have argued for the past couple of years that one of the reasons that we have not been more successful in getting more people evaluated and treated is because as a young field, we don't yet have an established standard of care," Dr. Siris said.

Standards that can be established as "core measures" for hospitals and emergency departments can then become a part of the accreditation process for a hospital. Home health agencies, long-term care facilities, rehabilitation centers, and subacute care facilities, such as skilled nursing facilities, may be required to fulfill a core measure, but other care delivery settings, such as ambulatory care at a doctor's office, would not be required to maintain the standards.

Field-testing of the Joint Commission's performance measures, which were published in January, will require $380,000 over 2 years "to be validated and ultimately published as recommended standards," she said.

Society-Backed Measures

The American Medical Association's Physician Consortium for Performance Improvement (PCPI) partnered with the American Academy of Family Physicians, the American Academy of Orthopaedic Surgeons, the American Association of Clinical Endocrinologists, the American College of Rheumatology, the Endocrine Society, and the National Committee for Quality Assurance to approve six osteoporosis performance measures in 2006. Of the 6 measures, 5 are identical or similar to 5 of the 10 measures that have been proposed by the Joint Commission. (See box.)

The PCPI measures focus primarily on outpatient management, whereas the Joint Commission document includes inpatient measures, said Dr. Kenneth G. Saag of the University of Alabama at Birmingham.

Orthopedists' Perspective

Orthopedists "have a central role in the evaluation and management of patients who sustain fragility fractures. But the problem is that we don't really fulfill the role that we could," said Dr. Joseph D. Zuckerman of the New York University Hospital for Joint Diseases, speaking on behalf of the American Academy of Orthopaedic Surgeons.

It has been tough to get orthopedists to "buy into" evaluating and managing fragility fracture patients for osteoporosis, said Dr. Zuckerman, who chaired the AAOS Council on Education from 1999 to 2005. "They just didn't accept it as an essential part of the practice of orthopedic surgery."

Orthopedists have cited a lack of expertise, general interest, and available consultants, as well as concerns about malpractice liability and the viewpoint of it being a medical and not a surgical problem, he said.

"We are really in the best position to initiate screening and fracture treatments, but that can only be done in a context where we have a partner or partners to work with, whether it is a rheumatologist or a primary care physician with interest in this."

Studies have shown how orthopedists can team with other clinicians in caring for these patients. In one study, an orthopedist's participation in a standardized protocol for ordering bone mineral density testing led to a BMD evaluation in 93% of patients and initiation of treatment in 74%. In comparison, the act of sending a letter to a primary care physician that advised him or her of guidelines for osteoporosis screening had almost no impact (J. Bone Joint Surg. Am. 2008;90:953-61).

Challenges Ahead

It is hoped "that there can be some blending or melding [of the two sets of performance measures] so that we can talk about similar outcomes or processes and numerators, and similar target populations," Dr. Silverman said.

He added that he thought that because the "measures were based on referring to fracture only," the target population of the measures may need to change, perhaps to those defined in the new National Osteoporosis Foundation (NOF) guidelines as having low bone mass and high risk on the World Health Organization Fracture Risk Assessment Tool (FRAX).

"Should we change the wording in some of these performance measures to include these target populations as well?" Dr. Silverman asked.

The implementation of the measures as standards faces potential problems because they are not mandatory and the financial incentives for reporting them may not be worth the cost and time that is required, Dr. Silverman said. Not only may the data be hard to locate across different electronic health record systems, but the lack of reimbursement to individual hospitals for diagnosis-related groups that have been assigned for treating and diagnosing a fracture may make the measures harder to implement. The NOF has raised only $60,000 of the $380,000 that will be required to validate the Joint Commission's measures, he added.

All of the speakers disclosed relationships with companies that manufacture osteoporosis medications, including speakers bureau, consulting fees, performing paid research, and/or being on an advisory committee or other paid committee. ■

Proposed Osteoporosis Performance Measures

Many measures proposed by the Joint Commission are similar to those suggested by the AMA's Physician Consortium for Performance Improvement (PCPI):

► **Screening women at risk.** How many women patients aged 60-64 years with one or more risk factors, and those older than 65 years, have had at least one central DXA exam?

PCPI measurement: What percentage of female patients aged 65 years and older have had a central DXA exam ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months?

► **Secondary causes.** For all patients with a new diagnosis of osteoporosis, how many have had an appropriate, minimal laboratory investigation ordered or performed prior to discharge within 3 months of the initial diagnosis?

PCPI measurement: What percentage of patients aged 18 years and older with one of the following conditions or therapies has had a central DXA ordered or performed or pharmacologic therapy prescribed within 12 months: use of oral glucocorticoid therapy for greater than 3 months; aromatase therapy for breast cancer; hypogonadism; fracture history; transplant history; obesity surgery; malabsorption disease?

► **BMD testing of glucocorticoid patients.** How many patients older than 18 years who have taken oral glucocorticoids for at least 3 months have had a DXA exam ordered or performed since the initiation of therapy?

► **Dietary education.** How many patients with a diagnosis of osteoporosis or their caregivers have received information about calcium and vitamin D within the past year?

PCPI measurement: What percentage of patients, regardless of age, with a diagnosis of osteoporosis have either received both calcium and vitamin D or had documented counseling regarding both calcium and vitamin D intake, and exercise at least once within 12 months?

► **Osteoporosis activity counseling.** How many patients have received documented, age-appropriate activity information or referral for activity counseling within 36 months?

► **Pharmacotherapy.** How many patients at least 50 years old with a diagnosis of osteoporosis have been provided with pharmacotherapy within the most recent 12 months?

PCPI measurement: What percentage of patients aged 50 years and older with a diagnosis of osteoporosis were prescribed pharmacologic therapy within 12 months?

► **Risk assessment or treatment for osteoporosis after fracture in an acute care setting.** What percentage of patients aged 50 years or older with new fracture in an emergency department or a mental hospital have received a central DXA exam or a prescription for pharmacotherapy for osteoporosis prevention or treatment? (This is a potential core measure that "would have teeth," Dr. Siris said.)

PCPI measurement: In what percentage of patients aged 50 years and older treated for a hip, spine, or distal radial fracture is there documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis? (Dr. Saag noted that this is the only measure that differs from the Joint Commission's recommendations.)

► **Risk assessment or treatment for osteoporosis after fracture in a nonacute care setting.** What percentage of patients aged 50 years or older who have a documented history of a fracture within the past 3 months have received a central DXA exam or a prescription for pharmacotherapy for osteoporosis prevention or treatment?

PCPI measurement: What percentage of patients aged 50 years and older with a fracture of the hip, spine, or distal radius have had a central DXA exam ordered or performed or pharmacologic therapy prescribed?

► **Smoking and alcohol counseling.** How many patients with a diagnosis of osteoporosis or fracture have received counseling for excess alcohol consumption or smoking cessation? (This is a potential core measure.)

► **Fall risk and personal safety education.** How many patients aged 50 years or older with a new diagnosis of osteoporosis or fracture (or their caregivers) have received documented fall risk and safety education to minimize the risk of falls within 3 months of the event?