

## Simplifying Data Reporting

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qualifications, including diagnostic acumen, clinical reasoning, and medical knowledge. This [law] is a significant step forward in recognizing the value of MOC in advancing health care quality.”

Under the Patient Protection and Affordable Care Act of 2010—one of the two major health reform laws—the Health and Human Services secretary will decide how MOC will fit into the PQRI process. The hope is that this will be clarified within the year, Dr. Cassel said.

The ABIM and other specialty boards want to help CMS officials write the regulations for implementing the process, she said. “Our concept is that it would be kind of an alternative pathway [that] would include all the same conditions and

measures as PQRI, but be even more comprehensive.”

Family physicians already have some experience with using MOC as an alternative to PQRI. The American Board of Family Medicine received approval from Medicare to use its MOC registry for the PQRI process, said Dr. Michael Hagen, the ABFM’s senior vice president. Instead of using Medicare “G” codes, physicians report actual patient data.

In 2008 (the first year of the registry), 260 family physicians participated. They could report on 15 patients over a 6-month period to receive half of the bonus, or 30 patients over a year to receive the full bonus. Last year, all participants were required to report during the full year, and about 720 family physicians participated, Dr. Hagen said in an interview.

Dr. Hagen said he doesn’t expect the ABFM process to change soon, but he envisions a future in which physicians can submit data for PQRI, MOC, and meaningful electronic health records in one fell swoop.

As the three programs are currently structured, he added, “nobody wants the same information in the same way, and it’s just driving people nuts.” ■

## IOM: Federal Limits on Added Sodium Would Cut Deaths, Costs

BY ELIZABETH MEHCATIE

An Institute of Medicine report recommends changing federal standards to require a marked reduction in the amount of sodium that can be added to food by manufacturers, restaurants, and food service companies.

The report on strategies to reduce sodium intake recommends an incremental stepwise approach that would gradually reduce sodium content to allow people to become accustomed to lower sodium levels in food.

Excessive dietary sodium intake in the United States is an “urgent public health problem,” Dr. Jane E. Henney, chair of the committee that wrote the report, said during a briefing held by the IOM.

The report’s main recommendation calls for the Food and Drug Administration to set mandatory standards for the safe levels of sodium that is added to food. Reducing sodium intake has the potential to prevent 100,000 deaths per year and save billions in health care costs, she said. The average amount consumed in the United States is “far beyond” the essential levels needed, noted Dr. Henney, professor of medicine at the University of Cincinnati—an average of more than 3,400 mg of sodium a day, or about 50% more than the recommended maximum recommended intake of 2,300 mg.

A statement issued by the FDA in response to the release of the IOM report said that the agency plans to review the report’s recommendations and will “continue to work with other federal agencies, public health and consumer groups, and the food industry to support the reduction of sodium levels in the food supply.” In addition, an interagency working group on sodium will be established by the Department of Health and Human Services.

The IOM report, done at the request of Congress in 2008, was sponsored by the FDA; the Centers for Disease Control and Prevention; the National Heart, Lung, and Blood Institute; and the Office of Disease Prevention and Health Promotion at HHS. ■

The report is available at [www.iom.edu/Reports/2010/Strategies-to-Reduce-Sodium-Intake-in-the-United-States.aspx](http://www.iom.edu/Reports/2010/Strategies-to-Reduce-Sodium-Intake-in-the-United-States.aspx).

### TALK BACK

**How confident are you that maintenance of certification data can be adapted to accommodate the PQRI process?**

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### VERBATIM

*‘Although the trend is going in the right direction, which is good, the pace is unacceptably slow.’*

Dr. Carolyn Clancy,  
on improvement in the quality  
of health care, p. 45

## Excessive Variability

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threefold greater risk of cardiovascular events.

Moreover, Dr. Sever and his coworkers showed that the calcium channel blocker–treated group had significantly less blood pressure variability over time than did those treated with atenolol. This finding provides a plausible mechanistic explanation for the previously reported superior clinical outcomes with the calcium channel blocker.

Patients on the amlodipine-based regimen had a mean visit-to-visit variability in systolic blood pressure of 10.9 mm Hg, compared with 13.4 mm Hg in those on the atenolol-based regimen. Only 9.1% of patients on the amlodipine-based regimen had a systolic blood pressure reading of 180 mm Hg or more at any time during follow-up, compared with 19.2% of those on atenolol-based therapy.

Blood pressure was measured three times at each office visit. In addition, more than 1,900 ASCOT participants underwent annual 24-hour ambulatory blood pressure monitoring. Although greater within-visit and 24-hour blood pressure variability were statistically associated with increased rates of stroke and coronary events, those were much less robust predictors than was visit-to-visit blood pressure variability, Dr. Sever said.

Several recent large meta-analyses indicate that although calcium channel blockers and diuretics reduce blood pressure variability, beta-blockers, angiotensin receptor blockers, and ACE inhibitors actually increase it, he continued.

Within the ASCOT population, older age, diabetes, known vascular disease, and smoking were associated with greater between-visit blood pressure variability.

“We believe variability is a surrogate for vascular stiffness, and probably for the aging-related impairment in

the baroreceptor reflex, a hypothesis we’ll look at more closely in the near future,” Dr. Sever said.

Discussant Dr. Carlo Di Mario of Royal Brompton Hospital, London, proposed “a more mundane theory” to explain the better outcomes in the amlodipine-treated group: Isn’t it likely that a calcium channel blocker–based antihypertensive regimen would be better tolerated than a more fatiguing beta-blocker–based therapy, with resultant better treatment compliance?

Dr. Sever replied that ASCOT included pill counts as a compliance measure, which showed similar results for the two study arms.

In an interview, Dr. Sever suggested that the regular oc-

currence of more than about a 10- to 15-mm Hg difference in systolic blood pressure from office visit to visit can be viewed as a practical indicator of excessive variability. It’s something that physicians have traditionally shrugged off as random variation and clinically unimportant, but the new ASCOT findings indicate otherwise.

“If those patients aren’t on a calcium channel blocker, you should be thinking about switching them to a calcium channel blocker,” he advised. ■

**Disclosures:** The ASCOT study was funded by Pfizer and Servier. Dr. Sever disclosed having served on the speakers bureau for Pfizer.

## BP Variability Emerging as Predictor of Stroke Risk

**MY TAKE** The post hoc analysis by Dr. Sever and his colleagues of the ASCOT trial demonstrates that blood pressure variability is a stronger predictor of stroke and coronary events compared with mean BP. This is an important observation.

One must consider this new information alongside the results of a recent review by Dr. Peter M. Rothwell of John Radcliffe Hospital, Oxford, England (*Lancet* 2010;375:938-48). This review, which strongly supports the findings reported by Dr. Sever, emphasizes the importance of BP variability as a predictor of stroke risk. Moreover, studies have shown that only dihydropyridine calcium channel blockers and thiazide diuretics minimize BP variability, and this may account for their benefits in terms of stroke reduction. This information strongly suggests that BP variability is an important predictor of stroke.



These observations should draw attention to lifestyle factors that can affect BP variability, including high salt intake, excessive periods of stress, excessive alcohol consumption, and untreated sleep apnea.

The authors are to be praised for considering this type of analysis. It reinforces the important use of ambulatory BP monitoring to help detect variability in everyday BP in individuals who have labile office pressures.

GEORGE BAKRIS, M.D., professor of medicine at the University of Chicago, was a member of the Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) writing committee. He reported financial relationships with Abbott, GlaxoSmithKline, Novartis, Merck, Gilead, and other companies.