Care Quality Rises, Driven by Public Reporting

BY ALICIA AULT
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WASHINGTON — Thousands of lives are being saved each year as health plans and physicians more closely follow quality measures such as giving β-blockers after a heart attack, managing hypertension and hypercholesterolemia, and controlling hemoglobin A_{1c} levels, according to the latest report card from the National Committee for Quality Assurance.

And, plans that report publicly on these measures deliver higher quality care, said NCQA president Margaret O'Kane in a briefing.

The NCQA's recently released report card shows that commercial and Medicaid plans that publicly disclose NCQA-tracked quality measures perform anywhere from half a percent to 16% better than plans that do not disclose their data.

However, even with some notable successes, some of the gains—such as in controlling blood sugar—are starting to plateau, said Ms. O'Kane. And, there are still gaps in quality between top-performing and average health plans. Thousands more lives could be saved if the laggards did as well as the top performers in the NCQA database, she said.

The report is based on data that are voluntarily submitted to the NCQA, which also accredits health plans. In 2006, 767 organizations—626 managed care plans covering private patients and Medicare and Medicaid enrollees, and 83 commercial and 58 Medicare PPO plans—submitted data using the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) .

Much of the data come from claims, but some also come from chart reviews. None of them are adjusted for severity-of-illness, socioeconomic, or other factors.

Approximately 84 million Americans were enrolled in plans that used HEDIS measures to report to the NCQA in 2006. Although that is a big number, at least 100 million Americans are in health plans that do not report quality data, and some 47 million have no insurance, said Ms. O'Kane. The quality picture is completely dark for the uninsured, she said.

But for those plans that did report, the news was good. Overall, commercial plans improved performance in 30 of 44 HEDIS measures where a trend could be discerned, Medicaid plans notched increases in 34 of 43 "trendable" measures, and Medicare plans achieved increase only on 7 of 21 trendable measures.

Among the biggest successes was that 98% of commercial plans, 94% of Medicare, and 88% of Medicaid plans reported prescribing a β-blocker upon discharge after acute myocardial infarction. Over the last 6 years, β-blocker treatment has saved an estimated 4,400-5,600 lives, said Ms. O'Kane.

Given the high prescribing rates, the NCQA will no longer track this measure. Instead, the organization will collect data on how many patients still receive β-blockers 6 months after discharge—currently, only about 74% in commercial plans and 70% for Medicare and Medicaid.

Childhood immunization rates are also at all-time highs, at about 80% for commercial plans and 73% for Medicaid plans for the recommended series of vaccinations.

There has been "stalling" in some of the older HEDIS measures, however, said Ms. O'Kane. Baseline screening for HbA_{1c} has plateaued at 88% in commercial plans and is down slightly for Medicare and Medicaid, at 87% and 78%, respectively.

Cholesterol screening and control of total cholesterol is also trending flat or down. The NCQA has no explanation for the leveling off, said Ms. O'Kane.

Adherence to mental health measures—which are already abysmally low—has also been flat for almost a decade. For instance, only 20% of commercial, 21% of Medicaid, and 11% of Medicare plans are meeting the benchmark of treating newly diagnosed depression patients with an antidepressant and following up with at least three visits within the 12-week acute treatment phase. These rates have stayed virtually the same since 1998.

Similarly, patients who have been hospitalized for a mental illness are not getting quality care, said Ms. O'Kane. Only 57% of patients in commercial plans, 37% of those in a Medicare plan, and 39% of those in a Medicaid plan had a follow-up within a week of hospitalization. Rates improved somewhat a month out, to 75%, 55%, and 58%. Studies have shown that follow-up care decreases the risk of repeat hospitalizations and improves adherence, according to the NCQA.

The low follow-up rates are "a national disgrace," said Ms. O'Kane, adding that for anyone to be "out 30 days with no one checking on you is unacceptable."

Several new HEDIS measures are in place for 2007, including tracking of potentially harmful drug-disease interactions in the elderly.

And, for the first time, health plans are being asked to report on their use of resources in treating various conditions. In 2007, they were diabetes, asthma, and low back pain. In 2008, chronic obstructive pulmonary disease, hypertension, and cardiovascular disease have been added. These conditions account for 60% of health care spending, said Ms. O'Kane.

The data will be used to determine the variations in resource use among health plans.

Coupled with the HEDIS quality measures, the NCQA will eventually be able to rate which plans give the best quality care for the least amount of money, said Ms. O'Kane. ■

Pay for Performance Boosts HbA_{1c} Testing, but Not Disease Control

BY MARY ANN MOON
Contributing Writer

A pay-for-performance program designed to improve quality of care for underserved patients succeeded in getting physicians to order more hemoglobin A_{1c} testing in their diabetic patients, as is recommended.

However, improving physicians' compliance with testing recommendations did not in turn improve their patients' control of the disease or affect outcomes, researchers wrote in the Journal of Health Care for the Poor and Underserved.

These findings indicate that earning a bonus for every HbA_{1c} test that is ordered according to guidelines does improve physicians' performance. But patient behavior and other factors are beyond the scope of the physician and contribute heavily to patient outcomes, said Katie Coleman, a research associate at the MacColl Institute for Healthcare Innovation at the Group Health Cooperative, Seattle, and her associates.

"While most pay-for-performance programs have been implemented by managed care companies and other large payers like Medicaid and Medicare, academic medical centers, hospitals, and clinics are starting to look at realigning incentives for their staff physicians as a way to enhance productivity and performance," the investigators noted.

Yet only a few randomized controlled trials have examined the impact of financial incentives on health outcomes, and none have assessed that impact in medically underserved communities. In addition, the results of these few studies have been mixed, Ms. Coleman and her associates said.

They analyzed data from a large Chicago network of health care organizations to assess how implementing a pay-for-performance program affected outcomes in patients with diabetes. The study involved 1,166 patients treated by 46 primary care physicians.

Almost all of the patients were low-income members of minority groups.

After the physicians were able to earn bonuses for ordering HbA_{1c} tests according to American Diabetes Association recommendations, the proportion of patients who were correctly referred for testing increased from 29% to 46%, a significant improvement.

However, the number of patients with controlled diabetes actually declined slightly during that time, and there was no change in average HbA_{1c} scores after the incentive program was introduced (J. Health Care Poor Underserved 2007;18:966-83).

"Patients spend less than 1% of their time with their doctors, managing their own health care the rest of the time. If you do a purely medical intervention, it really isn't surprising that we don't see major improvements in people's health.

"Pay-for-performance fills in half of the equation. Now we need to find ways to work on the other half—involving patients," Ms. Coleman said in a statement. ■

E-Prescribing Standards Are Proposed for Medicare Use

The U.S. Health and Human Services Department has proposed federal e-prescribing standards to be used for Medicare participating physicians, pharmacists, and software vendors.

The proposal was issued last month; comments are being accepted through mid-January.

E-prescribing is not required for participation in the Medicare Part D drug benefit.

But under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—the law that established the benefit—drug plans, physicians, and pharmacists who use electronic prescribing are required to meet the HHS standards.

AMA, National Community Pharmacists Association oppose mandate: 'We can see the benefits of it, but we can't ignore that there are costs involved.'

Some organizations have pushed for required e-prescribing for Medicare participation.

The Pharmaceutical Care Management Association (PCMA), which represents pharmacy benefit managers, is spearheading the effort. The organization launched a print and broadcast ad campaign in November that called for adoption of e-prescribing by 2010—the same deadline set by the Institute of Medicine in a report on reducing adverse drug reactions that was issued in July 2006.

The American Health Information Community has also urged the HHS to require e-prescribing for Medicare.

The American Medical Association and other groups oppose a mandate.

"From a practical side, a mandate would be premature," Stacey Swartz, Pharm.D., senior director of pharmacy affairs at the National Community Pharmacists Association, said in an interview.

"We can see the benefits of it, but we can't ignore that there are costs involved," she added.

The final e-prescribing standards are expected to be issued by April 1, 2008.

—Alicia Ault