IOM Calls for Standard Performance Measures

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While various organizations have made substantial progress developing health care performance measures, it's time for Congress to establish an entity that can standardize these measures across the health care system, according to a report from the Institute of Medicine.

Such a board should be part of the Department of Health and Human Services, according to the report.

In particular, any participating provider should be required to submit performance data to the board, so that Medicare could use the information for quality improvement activities or as a basis for payment incentives and public reporting, the IOM committee wrote. The committee's efforts were mandated by Congress and sponsored by the HHS.

In a statement, Dr. C. Anderson Hedberg, president of the American College of Physicians, praised the IOM's intention to establish a centralized organizing structure.

"This may be one way to set clear quality goals, coordinate performance measurement efforts, support fair comparisons of cost and quality, and ensure stable funding for organizations involved in performance measurement," Dr. Hedberg said.

A standard nationwide set of measures "would avoid the morass of everyone developing their own, including the government," Dr. Larry Fields, president of the American Academy of Family Physicians, said in an interview.

But it may not necessarily take a national board to get people to adopt a consensus on measures, he added. The key is to have a set of measures that are accepted as reasonable by these programs. "Other measures can be added as necessary."

Performance measures are benchmarks by which health care providers and organizations can determine their success in delivering care. Examples include regular blood and urine tests for diabetic patients, a facility's 30-day survival rate among cardiac bypass patients, or perceptions of care collected from patient surveys.

The problem is all of these independent initiatives have led to duplication in some areas and neglect in others that are important to national health goals, the committee noted. Individual stakeholders understandably focus on certain features of care that they consider to be the highest priority for improvement. "But they frequently overlook areas of national interest that are difficult to quantify, such as whether care is equitable, efficient, and well coordinated."

As an initial step toward achieving a universally accepted set of measures, the report recommended the adoption of an evidence-based "starter set" of existing measures that would cover care delivered in ambulatory, acute care, and long-term care settings and in dialysis centers. As one of the founding members of the Ambulatory Care Quality Alliance (AQA), the ACP was pleased that the starter set proposed by the IOM comprised the AQA's 26 clinical performance measures for the ambulatory care setting.

The board should also guide development in areas that are currently lacking in performance measures, such as efficiency, equity, and patient-centered care, the committee noted.

"One of the biggest obstacles to overcoming shortfalls in the quality of health care is the absence of a coherent, national system for assessing and reporting on the performance of providers and organizations," said IOM committee chair Steven Schroeder, Ph.D., professor of health and health care, University of California, San Francisco. Leadership at the federal level is needed to ensure that performance measures achieve national goals for health care improvement, he said.

A big obstacle to overcoming shortfalls is the absence of a coherent system.

DR. SCHROEDER

The committee recommended that Congress should authorize $100 million to $200 million in annual funding for the national board from the Medicare Trust Fund. This amounts to less than one-tenth of 1 percent of annual Medicare expenditures.

What's lacking in the report is a recommendation for Congress and the private payers to put money into the system to help defray costs of this type of reporting, Dr. Fields said. "The two must go hand in hand, because this type of reporting costs money." Otherwise, pay for performance is going to be an extreme burden to physicians—primary care physicians in particular—if they don't have technology to do pay for performance, he said.

Questions remain on whether pay for performance can improve quality, Dr. Fields noted. "Some of the private payers don't buy into that. When they talk about quality, what they really mean is saving money." For certain diseases, this type of reporting has been effective, "but it's not yet been shown to be effective over a wide series of medical problems."

If a universal system is instituted, it needs to be pilot tested first, to find out if it can improve quality, he said. "There needs to be a gradual shift from reporting aspects [of clinical measures] to actual quality measures."

Requested by Congress, the report is the first in a series that will focus on the redesign of health insurance to accelerate the pace of quality improvement efforts in the United States. Subsequent reports will evaluate Medicare's Quality Improvement Organization program and analyze payment incentives. ■

POLICY & PRACTICE

APA Policy Outlook for 2006

The American Psychiatric Association is keeping an eye on a host of issues for the New Year. Once again, securing parity for mental health care treatment is at the top of the APA's list of priorities. Other issues being watched by the organization are expansion of the psychiatric workforce, implementation of the Medicare drug benefit, and National Institutes of Health (NIH) funding, according to Nicholas Meyers, director of government relations at the APA, Arlington, Va.

Mental Health Parity

The APA hopes that Congress will pass legislation requiring nondiscriminatory coverage for treatment of mental illness. "We have last year's bill introduced in the House, with the addition of [parity for] alcohol and substance abuse treatment," Mr. Meyers said. He said the group is waiting for Sen. Ted Kennedy [D-Mass.] and Sen. Pete Domenici [R-N.M.] to introduce companion legislation in the Senate. The last parity bill in Congress had the support of two-thirds of the Senate and half of the House. Why did it not pass? "Timing is everything. The issue isn't parity; it's business objections to what they perceive is a coverage mandate," he said. Further, he said, Congress has been preoccupied with Iraq and issues such as Medicare and Medicaid.

Addressing Medicare

The parity bills now in Congress apply only to private health insurance plans, Mr. Meyers pointed out. The bills do not address Medicare, even though Medicare beneficiaries have to pay a higher copay—50% of the bill—for mental health care than they do for physical health care, for which they pay only 20%. There are bills in both the Senate and the House that would gradually phase out the 50% copay and lower it to 20%, the same as for all other services, he said.

New Drug Benefit

The APA also is aiming for technical changes to the new Medicare drug benefit—for instance, making sure mental health patients have appropriate access to psychotropic drugs. One problem is the exclusion of benzodiazepines from the new coverage, "but there are lots of ways of limiting access beyond not covering a drug, like tiered pricing and 'fail first' policies," Mr. Meyers said. The association is concerned that various Medicare prescription drug plans are treating coverage for buprenorphine and other alcohol-abuse and opioid-dependence drugs in different ways. Then there is the fate of dual eligibles—mental health patients who are on both Medicare and Medicaid. They formerly got drug coverage through the Medicaid program, but they now will get coverage through Medicare. "This requires a broad knowledge base and a lot of work by psychiatrists, who will be asked questions by patients and have to know what happens if they prescribe a particular medication and it's not covered, or if the patient will have to pay more, or if it's not covered until the patient has failed on another drug that [the psychiatrist] knows isn't going to work."

NIH Issues

The APA has two areas of concern when it comes to NIH: reorganization and budget issues, Mr. Meyers said. "Potentially, the reorganization of NIH would be an attempt to restructure it." In written testimony to the House Committee on Energy and Commerce last July, NIH Director Dr. Elias A. Zerhouni did not address reorganization directly, except to say, "I agree that each institute and center should have a defined purpose in support of the overall mission of NIH." He also talked about having an office that would coordinate research projects that spanned various NIH institutes. Mr. Meyers also is concerned about a slowdown in funding for NIH. He predicted that the agency would still get an increase in funding but that it would be smaller than that seen over the last several years.

Psychiatric Subspecialties

Another issue of importance to the APA is keeping up the supply of practitioners in some of the psychiatric subspecialties, particularly geriatric psychiatrists and child and adolescent psychiatrists. The association is interested in a bill sponsored by Rep. Patrick Kennedy (D-R.I.) that would allow the government to repay up to $35,000 in educational loans or provide scholarships to medical students who agree to provide child and adolescent mental health care for at least 2 years. On the geriatric side, the Positive Aging Act, sponsored by Sen. Hillary Rodham Clinton (D-N.Y.) in the Senate and Rep. Kennedy in the House, would establish a deputy director for older adult mental health services within the Substance Abuse and Mental Health Services Administration to "develop model training programs for mental health professionals and caregivers serving older adults," among other responsibilities.

Privacy Concerns

Health privacy is also a major issue. "We have really serious concerns about maintenance of medical records confidentiality" under laws such as the Patriot Act and the Health Insurance Portability and Accountability Act, Mr. Meyers said. "We are concerned about the ability of government agencies to snoop in people's health records." In addition, the advent of electronic health records brings its own privacy concerns. "On the plus side, electronic records help reduce medical errors and assure that physicians are able to get real-time records about what kind of medications patients are on," he said. "On the other hand, unless there are acceptable standards for the protection of records, such as informed consent with regard to their release, we are obviously concerned about what effect this has on patients."

—Joyce Frieden