Public Reporting by Plans Fosters Rise in Quality

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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 issued by the National Committee for Quality Assurance.

There are still gaps in quality. Thousands more lives could be saved if the laggards did as well as the top performers.

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 from 0.5% 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, Ms. O'Kane said. 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).

Most of the data come from claims, but some also come from chart reviews. None of the data 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, Ms. O'Kane said. 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, while Medicare plans achieved increases on only 7 of 21 trendable measures.

Among the biggest successes was that 98% of commercial, 94% of Medicare, and 88% of Medicaid plans reported prescribing a β-blocker upon discharge after acute myocardial infarction. Over the last 6

Prevention and Services Info

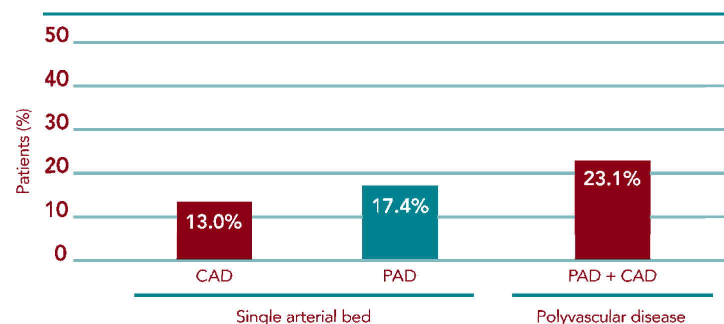
The Alliance for Health Reform is offering an online booklet that contains links to resources describing the basics of Medicare private fee-for-service plans, advantages and incentives of the plans, and difficulties encountered by beneficiaries. To download the booklet, go to www.allhealth.org/publications/Medicare/Medicare_Private_Fee-for-Service_Plans_65.pdf.

And the second edition of "The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals" is available from the Centers for Medicare and Medicaid Services at www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf. It provides information on coding, billing, and reimbursement for prevention services and screenings covered by Medicare.

CMS also has updated preventive services brochures for health professionals in the following areas: expanded benefits, diabetes-related services, cancer screenings, adult immunizations, bone mass measurements, glaucoma screenings, and smoking and tobacco-use cessation counseling. To download the brochures and view them online, visit www.cms.hhs.gov/MLNProducts/MPUB/list.asp. ■

Peripheral Arterial Disease
Making the CV Connection
The major health impact of an underdiagnosed, undertreated disease

About 1 in 5 patients with established PAD had a major cardiovascular event within 1 year[1]



The REACH (REduction of Atherothrombosis for Continued Health) Registry is the first outpatient registry to outline the real-world burden of atherothrombosis on a global basis. Baseline data have been collected from more than 68,000 patients in 44 countries. A total of 64,977 patients were included for the 1-year follow-up.
REACH is sponsored by sanofi aventis and Bristol-Myers Squibb.
*Causes for hospitalization included TIA, unstable angina, and other ischemic arterial events, including worsening of PAD.

The REACH Registry, which included more than **68,000 patients,** is one of the largest and most recent observational studies to outline the real-world burden of atherothrombosis.[1]

years, treatment with a β-blocker has saved an estimated 4,400-5,600 lives, Ms. O'Kane explained.

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, with the recommended series of vaccinations given by about 80% of commercial plans and 73% of Medicaid plans.

There has been "stalling" in some of the older HEDIS measures, however, Ms. O'Kane said. 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, she said.

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, Ms. O'Kane said. Only 57% of patients in commercial plans, 37% of those in Medicare, and 39% of those in Medicaid had follow-up within a week of hospitalization. Rates improved somewhat a month out, to 75%, 55%, and 58%, respectively. 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.

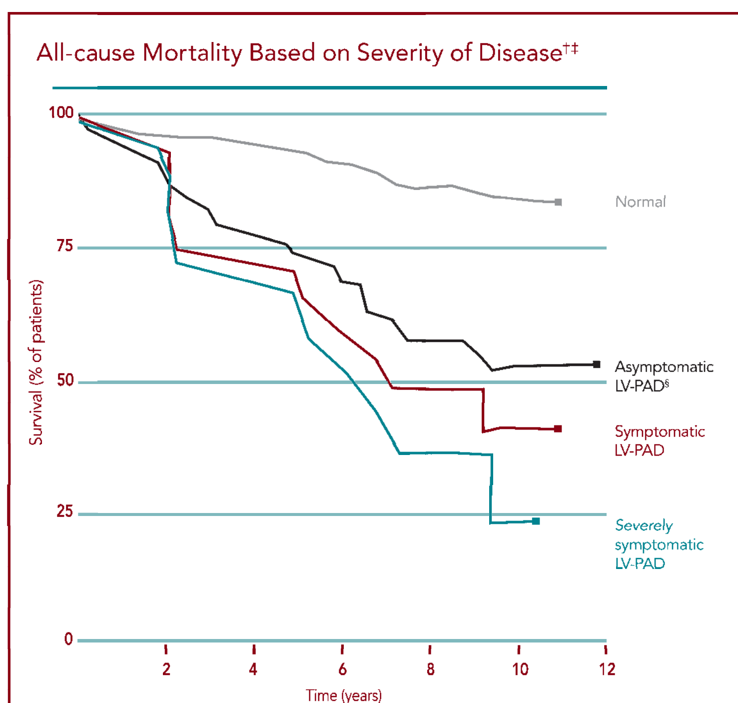
And, for the first time, health plans are being asked to report on their use of resources in treating various conditions. In 2007, they are diabetes, asthma, and low back pain. In 2008, chronic obstructive pulmonary disease, hypertension, and cardiovascular disease will be added. These conditions account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

8 million Americans suffer from PAD[2]

It is estimated that between 12% to 20% of the US population 65 or older have PAD.[2]

PAD patients face an increased risk of mortality



Patients with PAD were **5.9 times more likely to die** of CV disease than patients without PAD.[3]

*Adapted from Criqui et al. *N Engl J Med.* 1992;326:381-386.
‡Kaplan-Meier survival curves based on mortality from all causes.
§LV-PAD=large-vessel PAD.

PAD and the Health Care Provider

ACC/AHA PAD guidelines point out that primary care providers are in the best position to detect PAD.[4]

It is estimated that

only 25% of patients diagnosed with PAD are undergoing treatment[2]

The ACC/AHA PAD Guidelines Class 1 Recommendations for PAD patients include both:

—Symptom relief management for claudication

—CV risk reduction to reduce future events such as MI, stroke, and vascular death

Find out more about PAD

The Peripheral Arterial Disease (P.A.D.) Coalition, www.padcoalition.org, is an alliance of more than 50 leading health organizations, vascular health professional societies, and government agencies united around a common purpose—to raise public and health professional awareness about lower extremity PAD.

The P.A.D. Coalition offers tools and information to improve the prevention, early detection, treatment, and rehabilitation of people with, or at risk for, PAD.

Bristol-Myers Squibb/Sanofi Pharmaceuticals Partnership is a proud sponsor of the P.A.D. Coalition.

References: 1. Steg PG, Bhatt DL, Wilson PWF, et al, for the REACH Registry Investigators. One-year cardiovascular event rates in outpatients with atherothrombosis. *JAMA.* 2007;297:1197-1206. 2. American Heart Association. *Heart Disease and Stroke Statistics—2007 Update.* Dallas, Tex: American Heart Association; 2007. 3. Criqui MH, Langer RD, Fronek A, et al. Mortality over a period of 10 years in patients with peripheral arterial disease. *N Engl J Med.* 1992;326:381-386. 4. Hirsch AT, Haskal ZJ, Hertzer NR, et al. ACC/AHA 2005 guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic). 2006. http://www.acc.org. Accessed May 4, 2006.

CV=cardiovascular.
PAD=peripheral arterial disease.
CAD=coronary artery disease.
CVD=cerebrovascular disease.
ACC/AHA=American College of Cardiology/American Heart Association.

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