IOM: Time for Pay-for-Performance Standards

BY JENNIFER LUBELL
Associate Editor, Practice Trends

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 the IOM's 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 improvement, he said.

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. ■

TALK BACK

How important is it to have a national, universally accepted set of clinical performance measures?

Weigh in at www.familypracticenews.com

We look forward to hearing from you!

POLICY & PRACTICE

President's Health Care Agenda

The federal government has a responsibility to provide health care for the poor and the elderly, as well as confront its rising costs, strengthen the doctor-patient relationship, and help people afford insurance coverage, President Bush said in his State of the Union address. "Medical liability reform is a top priority of the AAFP, whose members include family physicians in small and large practices and in rural and urban areas. It is imperative that the president fulfills his promise for tort reform and that Senator Frist fulfills his to bring the issue to a floor vote in 2006," Dr. Larry S. Fields, president of the American Academy of Family Physicians said in a statement. But Ron Pollack, executive director of the consumer group Families USA, noted that the president failed to mention the recent efforts by the White House and Congress to cut Medicaid funding. "These Medicaid cuts will drive many low-income seniors and children out of the system and leave millions of people without any health care coverage whatsoever."

Health Care Spending 2004

Growth in U.S. health care spending slowed for the second straight year in 2004, increasing by only 7.9%, according to the Centers for Medicare and Medicaid Services' annual report on health care spending. This compares with an 8.2% growth rate in 2003 and a 9.1% growth rate in 2002. The report attributed slower growth in prescription drug spending as a contributor to this overall slowdown. In 2004, prescription drugs accounted for only 11% of the growth in national health care expenditures, a smaller share of the increase than in recent years. In a statement, the Pharmaceutical Care Management Association attributed the slowdown to increased reliance on generic drugs and mail-service pharmacies. Spending for physician services grew 9.0% in 2004, nearly the same as 2003's 8.6% increase.

Foreign Drug, Wrong Drug

Filling prescriptions abroad may have adverse health consequences because of confusion with drug brand names, the Food and Drug Administration cautioned in an advisory. In an investigation, the agency found that many foreign medications, although marketed under the same or similar-sounding brand names as those in the United States, contain different active ingredients. For example, Norpramin is the brand name for the antidepressant desipramine in the United States. In Spain, the same brand name is used for a drug that contains the proton pump inhibitor omeprazole. The FDA also found 105 U.S. brand names with foreign counterparts that look or sound so similar that consumers who fill such prescriptions abroad may receive a drug containing the wrong active ingredient. For example, in the United Kingdom, Amyben is the brand name for the antiarrhythmia medication amiodarone. And in the United States, Ambien is the brand name for the hypnotic drug zolpidem.

Emergency Care Gets a 'C–'

Emergency care provided in 80% of the states earned mediocre or near-failing grades according to the first-ever National Report Card on the State of Emergency Medicine, conducted by the American College of Emergency Physicians. Overall, the nation's emergency medical care system received a grade of C–. Half the states provided less-than-average support for their emergency medical systems, earning poor or near-failing grades. No state received an overall A grade, although the highest overall B grades were given to California, ranked first in the nation, followed by Massachusetts, Connecticut, and the District of Columbia. Arkansas, Idaho, and Utah had the weakest systems, receiving the worst overall grade of D. Emergency care suffers from overcrowding, declining access, high liability costs, and a dwindling capacity to deal with public health or terrorist disasters, the report stated. "Americans assume they will receive lifesaving emergency care when and where they need it, but increasingly this isn't the case," said Dr. Frederick C. Blum, ACEP president.

Evidence-Based Research

More cost-effectiveness studies are needed to evaluate public health interventions, Barbara K. Rimer, Dr.P.H., a member of the Task Force on Community Preventive Services, said at an audioconference sponsored by AcademyHealth, Washington. The task force is an independent, nonfederal group that was convened by the Department of Health and Human Services. There are a number of areas where researchers can build on existing evidence-based public health research, said Dr. Rimer, who is also the dean of the school of public health at the University of North Carolina in Chapel Hill. Researchers should evaluate the most effective sites and providers for public health interventions.

Help for Vets With MS Proposed

Sen. Patty Murray (D-Wash.) has proposed legislation to help more veterans with multiple sclerosis qualify for disability benefits from the Department of Veterans Affairs. "A growing number of veterans from the first Gulf War are now developing symptoms of MS, but they often face an uphill battle in obtaining disability benefits from the VA," the senator's office noted in a press release. Under current law, veterans have 7 years after discharge to link MS to their military service; however, many veterans don't start developing symptoms of the disease until after that time, forcing them to go through a long appeals process. The bill would remove the 7-year limitation and make MS a "presumptive disability," entitling them to care no matter when their symptoms appear. So far, about 500 Gulf War veterans have been diagnosed with service-connected MS, and many more are symptomatic but not yet diagnosed, according to Julie Mock, president of the National Gulf War Resource Center and an MS patient.

—Jennifer Lubell