Quality Measures: Looking in All the Wrong Places

It is difficult to avoid seeing information about full accreditation status of managed care organizations (MCOs) in their promotional materials and reports. I, for one, am pleased that the National Committee for Quality Assurance (NCQA) exists and that the Health Plan Employer Data and Information Set (HEDIS) was developed. Clearly, knowing what percent-age of diabetic patients receive annual ophthalmologic exams is superior to not knowing this statistic, and MCOs might work to increase the number knowing that it might be used as a proxy for quality in comparisons of health plans.

However, knowledge about eye exams, or about the percentage of women having mammograms, is only mildly helpful to health care consumers. All of this information is roughly equal to the information given by a pilot to the passengers on an airplane just before takeoff. When the plane is on the ground, few people are concerned about visibility from the cockpit window, yet the pilot announces that current visibility is three miles or half a mile, and that the wind is at eight miles per hour from the north-northeast.

Pilots need to know wind speed and direction, as well as visibility, but it is likely that most passengers have no interest in these statistics unless there is a problem. The same is true, in most cases, for eye exams for diabetics, pediatric immunization schedules, and mammograms as factors that influence decisions on choosing health plans. But mention what an MCO does for male-pattern baldness and the ears of a 35-year-old healthy male will perk up.

In reality, health plans do not practice medicine: That is done by practitioners who work pretty much independently and who make decisions based on their best judgments, considering the individual factors surrounding each individual patient. So, one can now begin to recognize that while aggregate scores for whole MCOs might have some value in a gross,

crude, or macro-level way, they do not answer the most relevant questions—those about individual practitioners.

If an MCO had 10 internists caring for diabetic patients and 8 of those 10 referred every diabetic patient for annual eye exams, but 2 never referred any patients, the MCO's score for diabetic eye exams would be 80%, which is more than adequate. Given that information, a diabetic patient might be in for a real surprise if he or she selects one of those two physicians who never refers a patient for an eye exam, having had no way of knowing this in advance.

This is similar to the old story about the airplane pilot who graduated from pilot school with an average grade of B. Unfortunately, the story goes, the pilot had an average of A+ in takeoffs but had only a C– in landings. This would not be my first choice as a pilot. In these examples, the consumers were not given enough information to enable them to make practitioner-level decisions.

This dilemma is similar to Donabedian's construct of the three means to conduct quality studies (structure, process, and outcomes).¹ We look at structure or process, when in fact the only really valuable information to assist in rational decision making is outcomes data associated with the individual practitioner.

I would want to know which surgeon had the best results, which cardiologist had the longest survival rates for congestive heart failure patients. Here, the average result for all of the surgeons is of little value when the result for one is wanted. And with the cardiologist, the answer is not what proportion of patients were on aspirin or beta blockers, but the survival times from the time of diagnosis.

MCOs want to have information about individual practitioners regarding percentage drug formulary compliance, percentage of prescriptions for generic drugs, and the average cost per prescription, among many other variables. This observer, however, would gladly trade

those data for the percentage of cases requiring re-surgery for each surgeon, their patient survival rates, and with regard to specific specialty areas or disease states, the average level of HbA_{1c} for their patients for endocrinologists as well as the percentage of their patients persisting with their prescribed drug regimen at one year. These proxies reveal which doctors take the time, or use effective communication, or whom patients trust.

In cardiology, I would want to know the comparative percentages of normotensive patients for each practitioner, the percentage of their patients taking aspirin or statins, and compliant with their anti-hypertensive medications after six months and one year.

The current quality measures are good first steps toward a more telling and useful system, but rather than perfecting this system for the next decade, this writer believes that it is time for us to start making perceptible steps toward a real quality-measurement system—one that tells us more than wind speed and direction at an elevation of 10,000 feet.

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Reference

1. Donabedian A. Definition of quality and approaches to its assessment: Exploration in quality assessment and monitoring. Vol. 1, Ann Arbor, MI: Health Administration Press, 1980; 160.