Measuring, monitoring and reporting functional health outcomes: opportunities and challenges in a bold national initiative

In this issue of the Journal, Cooper et al. describe the Health Outcomes Survey (HOS), a joint initiative of the Health Care Financing Administration (HCFA) and the National Committee on Quality Assurance [1]. That initiative has the potential to do nothing short of revolutionizing health care and its role in our society. The initiative also has the potential to wreak havoc in ways that outweigh any advantages it yields. A lot depends on how the initiative moves forward into the public release phase, in which it will compute and report health outcomes for hundreds of Medicare HMOs nationally.

While this editorial articulates several concerns related to the public release of HOS data, the comments are not intended to detract from the HOS initiative as a whole. The past 10 years have seen unprecedented investments of financial and human resources in the field of health care quality assessment — yet, by most accounts, the assessment field and its application to improve health care quality remain in their infancy. The HOS initiative boldly puts measures of functional health status into widespread use in an effort to measure, monitor, and improve patient care. In doing so, it charts new territory, and has the potential to contribute enormously to both the quality of patient care, and to our national dialogue about quality improvement. HCFA and NCQA have shown courage and leadership in undertaking this effort.

It is the second of the three goals outlined by Cooper et al. that can take our collective breath away. As we think about the potential ramifications: providing information about quality to Medicare beneficiaries to assist them in selecting among managed care plans [1]. Public reporting of outcomes data? Holding health plans accountable for their members’ outcomes? Giving outcomes information to patients to inform their choices? While most who have had even one eye on the quality assessment field these past several years have imagined this day — and in a few isolated instances, like the public reporting of cardiac surgery outcomes in New York State [2], have seen days like this — there has never been a nationwide initiative like this one.

Although the authors do not mention the expected time-frame for the first public release of HOS data [1], there are several reasons that the initiative may be more successful, and contribute more to health care quality in America, if it delays this public reporting component for several cycles. First, it is unclear whether there will be meaningful plan-level outcome differences for patients to learn about and act upon. And there is reason to suspect that there may not be. While the paper reports a sizable distribution of mean SF-36 scores among 287 Medicare HMOs, these reflect only the baseline health status scores. These scores tell us that the plans are serving populations whose average health status differs substantially, but they tell us nothing about what the distribution of outcomes will look like among plans. Empirical evidence from other studies employing the SF-36 to monitor outcomes, and as well as from other plan-based quality assessment initiatives, suggests that outcome differences among plans will be extremely small — particularly within a given region or market area. The majority of Medicare HMOs operating today are network-model HMOs. These HMOs rely on many — and sometimes all — of the same physicians and hospitals as their competitors. For health plans in Boston, Chicago, Los Angeles, Miami, Minneapolis, or Denver to distinguish their outcomes from their local competitors who rely on the same doctors and hospitals to care for their patients would require the plans to have policies and procedures that are more radically different from one another and prescriptive about clinical management and care than has ever been suggested to be the case.

Far more likely is that the HOS initiative will discover regional differences both within states and among them, in the functional health outcomes achieved by plans. Since the HOS is not intended to help Medicare beneficiaries make relocation decisions, but rather to help them differentiate among choices available to them locally, it is unlikely that public reporting of these data will be very helpful to beneficiaries. This, of course, begs the question about how the initiative will guide patients in identifying a meaningful difference among plans — a difference worth switching for — and it presumes that choice will remain available to Medicare beneficiaries in their local markets. The report does not indicate whether these issues have been considered.

Other important reasons to delay the public reporting phase of the HOS pertain to case-mix adjustment and non-response. The report by Cooper et al. indicates that neither of these methodological complexities has been resolved [1]. Before outcomes are reported publicly, the accuracy of the case-mix adjustment methodologies — including the ability to account for various combinations of conditions at varying stages of severity — must be extremely well established. The
failure to adjust adequately for case-mix in computing plan-level health outcomes will almost surely have serious adverse consequences for all parties in the health care system – particularly patients. If, for example, the adjustment methodology substantially underestimates the expected functional decline associated with arthritis, then health plans will be left with a powerful incentive to exclude arthritics from their membership (so as not to be unfairly ‘dinged’ on their outcomes), and patients with arthritis will be poorly served by an initiative that brought this about.

Moreover, patients are not the only ones likely to ‘shop’ and ‘drop’ health plans based on reported outcomes. Clinicians, hospitals and other health care providers can be expected to make decisions about their affiliations based on these data. The importance of getting the case-mix adjustment methodology right is clear. With some of the leading methodologists from the health outcomes field involved in the HOS, the initiative has the capacity to do so, but the report by Cooper et al. suggests that it is presently far from this point [1].

Similarly, the issue of non-response is critical here, and the article does not suggest that it has been thoroughly considered to date. Rates of non-response at baseline ranged from 21% to 71% among the Medicare HMOs [1]. Public reporting of outcomes data that are based on such divergent proportions of a plan’s sample – without a detailed understanding of how non-response affected the results – would do patients a disservice. And whatever the response rates, patients will need a way to determine how well ‘people like them’ are represented – however they define that (e.g. age, ethnicity, medical conditions). In making health plan enrolment (or disenrolment) decisions, the family of a nursing home patient should know whether the outcomes data reflect the experiences of a largely non-institutionalized population – and the limitations of generalizing from those experiences should be clear. And an 85-year old African–American woman in south Florida should be able to discern whether most of the outcomes information she sees in the HOS report was obtained from a younger, healthier and largely Caucasian group of respondents in her area.

Despite these reservations about the public reporting component of the HOS initiative, the initiative itself is a bold one that has the potential to have an enormously positive impact on patient care – even without the public reporting component. It is not new to observe that our health care system presently functions largely as a disease care system. But initiatives like the HOS have the potential to change that. Cooper et al. point to the challenges that health plans will face when they are held accountable for the functional health outcomes of their members [1].

In 1948, the World Health Organization (WHO) defined health as a state of complete physical, social and mental wellbeing, not merely the absence of disease or infirmity [3]. The SF-36, on which the HOS measures are based, measures health in these terms [4]. It measures the elements of health that are salient in patients’ lives – whether they can participate in their daily role activities, their physical functioning, their energy level, their mental functioning. In a nation whose illnesses are largely chronic and a care system charged with managing these chronic conditions, health-related quality of life has a legitimate and important place in the conversation between doctor and patient, doctor and health plan, health plan and hospital, and so forth. While some will argue that functional health and well-being are beyond the realm that can be influenced by doctors or by health care, it seems premature to draw that conclusion. Indeed influencing a patient’s functional health status seems likely to emerge as very much within the doctor’s sphere of influence – if (s)he chooses to include it, inquire about it, and address it with the patient. The HOS has the potential to change the nature of the conversation between doctors and patients, and therein, to engage our health care system in improving patients’ health – broadly defined. In the end, as a society, we may decide that caring for disease, and preventing it, is all that we can ask of the medical care system. But it should not be for lack of having tried and seen its limitations to affect health more broadly.

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References