Gaps In Quality of Cardiovascular Care
Transcend Social Bias

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At first glance, the article by Rathore et al., which appeared in a recent issue of the journal and is on demographic and socioeconomic differences in the treatment of acute myocardial infarction, seems to be one more study showing that being a middle-to-upper class white male has its advantages in this world—even during an acute myocardial infarction. Other investigations have shown that such patients are more likely to receive invasive procedures during the treatment of acute myocardial infarction. The new contribution shows that women, blacks, and the poor are less likely to receive medical therapies known to improve outcomes, including reperfusion, aspirin, and β-blockers.

Health Plan Employer and Data Information Set Data

Just how quickly improvement can occur can be demonstrated by a review of data from health maintenance organizations (HMOs) collected by the National Committee for Quality Assurance (NCQA), the nonprofit organization that evaluates the quality of care delivered by managed care organizations. Among the tools used to evaluate these plans are Health Plan Employer and Data Information Set (HEDIS) measures. The performance of HMOs on HEDIS measures is often published in lay publications; hence, older HEDIS measures, including the use of β-blockers after a myocardial infarction, have become key foci for HMO quality improvement initiatives.

Since 1996, HEDIS data has shown an increase in the rate of use of β-blockers after acute myocardial infarction, from 62.5% in 1996 to 74% in 1997 and to 80% in 1998. These rates varied throughout the country in 1998, ranging from 69% in Dallas, Texas, to 90% in Boston. Furthermore, the best 10% of HMOs by this measure had a 94% compliance rate, compared with a 64% compliance rate for the worst 10th percentile. These rates are based on younger patients who are mostly in commercial insurance plans, and fewer data exist on Medicare HMO patients. However, available data indicate that HEDIS data on the use of β-blockers in Medicare HMO patients are in the same range.

The opinions expressed in this editorial are not necessarily those of the editors or of the American Heart Association.

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There is every reason to believe that the trends suggesting an improvement in the use of β-blockers in managed care organizations are real. Data collection is audited by NCQA, and there has been little or no improvement on other HEDIS measures, such as cervical cancer screening, which actually declined slightly from 70.4% in 1996 to 69.9% in 1998. An unscrupulous HMO trying to “game” the system would be unlikely to inflate their performance for patients with acute myocardial infarction while downplaying the quality of their care for healthy young women.

Furthermore, the 62.5% rate in 1996 is in the same ballpark as the 1994 to 1996 data reported by Rathore et al. Whether the cohorts described by NCQA and by Rathore et al are truly comparable, however, is not the issue. More important are the questions of whether marked improvement in use of β-blockers and other preventive measures since 1996 has occurred outside of managed care organizations and whether managed care organizations have improved in areas not directly assessed via HEDIS measures. In the absence of data, it is impossible to know. There is every reason for skepticism or, at least, an expectation that the rates of improvement have been slow.

How have managed care organizations been able to improve their use of β-blockers? First, data on their performance were being collected and published, which created a sense of accountability for correcting gaps in care. Second, they invested in systems to improve performance, such as critical pathways that automatically pose the question of whether aspirin and β-blockers should be used at key junctures in hospitalization. Some HMOs and integrated delivery systems have implemented disease management programs that use case managers to ensure that patients who have coronary events receive appropriate secondary prevention measures.

Such systems are, of course, blind to race, sex, and socioeconomic status. An issue worth exploring is whether the differences in patterns of care demonstrated by Rathore et al are present in managed care organizations for β-blockers and other issues measured in HEDIS. Quite possibly, racial and other differences may have widened: the rich-get-richer, poor-get-poorer care scenario. My hypothesis, which should be tested, is that the differences have been reduced or eliminated.

Such systems to improve care are more readily developed in managed care organizations, which usually have the data to identify deviations from recommended therapeutic strategies and the financial resources to invest in systems such as case management. However, individual physicians’ offices and other provider organizations also have the ability to make their care more systematic by integrating the collection of data into their routine processes.

In summary, Rathore et al provide important findings from a valuable database, and readers may differ on which gaps in quality they find most disturbing—those between the subsets of the population or between the overall care and the ideal. One hopes that all of the gaps have narrowed since 1996. However, hope is not as likely to promote improvement in quality as much as collection of data and the development of systems to support physicians in their efforts to care for their patients.

References
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