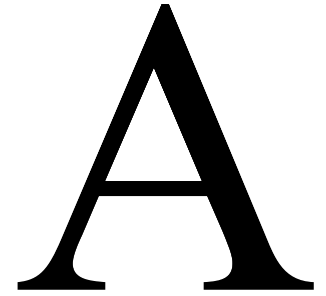
APPENDIX A

Clinically based indicators of access to care for Medicare beneficiaries

APPENDIX



Clinically based indicators of access to care for Medicare beneficiaries

Ensuring beneficiaries' access to necessary medical care is a primary goal of the Medicare program. Some policy experts fear that beneficiaries residing in certain rural areas may have more difficulty getting needed services and quality care as compared with their urban counterparts (see Chapters 2 and 3). To address these issues, MedPAC contracted with Direct Research LLC for a study using clinically based measures of access to care. As reported in Chapter 2, except for residents of the most remote rural areas, MedPAC found that rural beneficiaries were nearly as likely as their urban counterparts to receive necessary care.

The clinically based indicators of needed care (Table A-1, see page 136) used by Direct Research LLC were developed by a research team at RAND as part of a project which was funded by MedPAC's predecessor, the Physician Payment Review Commission (PPRC 1995, PPRC 1997). RAND designed these indicators to reflect basic clinical standards of care for common medical diagnoses. Necessary care was defined as care for which (1) the benefits of care outweigh the risks, (2) the benefits to the patient are likely and substantial, and (3) physicians have judged that not recommending the care would be improper (Asch et al. 2000). For the indicators, RAND selected medical conditions that had a high prevalence or incidence among the elderly population, for which effective medical treatment was available, and that were readily identifiable from diagnoses coded on claims forms.

RAND developed two types of measures: those reflecting minimum standards of acceptable care for certain diagnoses and those representing potentially avoidable outcomes. Therefore, measures do not necessarily document optimal care, but rather define the minimally acceptable care or services for certain diseases. Measures of potentially avoidable care include use of emergency services or hospitalizations that might have been averted had patients received better outpatient disease management and treatment. Because these measures can be derived from claims and administrative data, they provide a relatively inexpensive and easy method to monitor underuse of medical services by Medicare beneficiaries.

TABLE A-1

Clinically based indicators of access to needed care for elderly Medicare beneficiaries with certain diagnoses

Anemia

- For patients with iron deficiency anemia: gastrointestinal workup
- Hematocrit/hemoglobin between one and six months following initial diagnosis of anemia

Breast cancer

- For patients with breast cancer and eventual mastectomy: interval from biopsy to definitive therapy (surgery delay time) should be less than three months
- Visit every six months for breast cancer patients who have undergone mastectomy and cytotoxic chemotherapy
- Mammography every year for patients with a history of breast cancer
- At initial diagnosis of breast cancer, mammogram
- At initial diagnosis of breast cancer, chest X-ray
- Visit every year for breast cancer patients who have undergone mastectomy without cytotoxic chemotherapy

Diabetes

- Glycosolated hemoglobin or fructosamine every six months for patients with diabetes
- Eye exam every year for patients with diabetes
- Visit within four weeks following discharge of patients hospitalized with diabetes
- Visit every six months for patients with diabetes

Gastrointestinal bleeding

- Visit within four weeks following discharge of patients hospitalized with gastrointestinal bleeding
- Hematocrit within four weeks following discharge of patients hospitalized with gastrointestinal bleeding
- Follow-up visit within four weeks of initial diagnosis of gastrointestinal bleeding

Heart and circulatory system

- Visit within four weeks following discharge of patients hospitalized with myocardial infarction (MI) or heart attack
- Cholesterol test every six months for patients hospitalized with MI who have an elevated cholesterol level
- Electrocardiogram (EKG) during emergency department visit for unstable angina
- Visit within four weeks following discharge of patients hospitalized with unstable angina
- Visit every six months for patients with stable angina
- Follow-up visit or hospitalization within one week of initial diagnosis of unstable angina
- Chest X-ray within three months of initial diagnosis of congestive heart failure (CHF)
- Visit within four weeks following discharge of patients hospitalized for CHF
- EKG within three months of initial diagnosis of CHF
- Visit every six months for patients with CHF
- Visit within four weeks following discharge of patients hospitalized with malignant or otherwise severe high blood pressure

Pulmonary system

- Visit every six months for patients with chronic obstructive pulmonary disease (COPD)

Stroke

- EKG within two days of initial diagnosis of transient ischemic attack (TIA)
- For TIA patients with eventual carotid endarterectomy: interval between carotid imaging and endarterectomy less than two months
- Visit within four weeks following discharge of patients hospitalized for TIA
- Visit every year for patients with diagnosis of TIA
- For patients hospitalized for carotid territory stroke: carotid imaging within two weeks of initial diagnosis
- For cerebral vascular accident (CVA) patients with eventual carotid endarterectomy: interval between carotid imaging and endarterectomy less than two months
- Visit within four weeks of discharge of patients hospitalized with CVA

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TABLE A-1

Clinically based indicators of access to needed care for elderly Medicare beneficiaries with certain diagnoses

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Avoidable outcomes

- Among patients with angina, three or more emergency department visits for heart-related diagnoses in one year
- Among patients with gall stones, diagnosis of perforated gallbladder
- Among patients with COPD, subsequent admission for respiratory diagnosis
- Nonelective admission for CHF
- Among patients with diabetes, admission for diabetic coma
- Among patients with pneumonia, diagnosis of lung abscess or empyema

Preventive care

- Visit every year
- Assessment of visual impairment every two years
- Mammography every two years in female patients

Other

- Cholecystectomy (open or laparoscopic) for patients with gall stones and inflammation of the gall bladder, bile duct and/or pancreas
- Arthroplasty or internal fixation of hip during hospital stay for broken hip
- Visit within two weeks following discharge of patients hospitalized for depression

Note: A visit may be with a physician or a nonphysician provider, including a nurse practitioner or a physician assistant.

Source: Hogan (2001).

References

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