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Reforming the Health Care Delivery System: Change Must Happen on the Ground

On behalf of the national network of health care Quality Improvement Organizations (QIOs), the American Health Quality Association (AHQA) commends Chairman Baucus for his leadership in addressing the need for reforms to the health care delivery system in his *Call to Action on Health Care Reform*. We believe the Baucus proposals set a policy course that will revitalize and improve the efficiency and quality of health care in the United States.

Health care in the United States is often justly criticized for its high cost and suboptimal performance in meeting the needs of the public and the expectations of health care professionals. But dramatic improvements in quality and efficiency cannot occur until improvements take place in health care operations. The change must take place at the ground level. The Baucus policy prescription raises expectations and creates incentives to motivate providers to reach higher. Yet, the plan can't achieve its full potential without a field force to accelerate the pace of learning and improvement in care. The QIOs are that field force of expediters.

We respectfully submit the following policy proposals to complement the Baucus plan through targeted reliance upon the capabilities and expertise of the nation's state-based network of Quality Improvement Organizations. The national network of QIOs represents a valuable public infrastructure, trusted by key stakeholders, experienced in responding to federal direction, and effective in quality performance measurement, public education, and quality improvement.

Overview: QIO Contributions to Reforming the Health Care Delivery System

The national QIO infrastructure will support successful implementation of the Baucus policy prescription by supporting those who provide everyday care--

(1) Ensuring payment incentives work as intended, and do not widen the quality gap between "have" and "have not" providers and practitioners.

(2) Assisting health professionals in planning for, purchasing, and using health information technology in daily practice to promote wellness and timely preventive care, and to manage patients' chronic care needs.

(3) Incorporating evidence-based comparative effectiveness findings into daily care practices.

(4) Linking hospitals and providers of ambulatory care in community-based initiatives that improve the safety and reliability of transitions between care settings and reduce hospital readmissions.

(5) Analyzing, reporting and explaining new transparency reports about quality performance data to providers, practitioners, purchasers and the public.

Safeguard Against Inequitable Outcomes Resulting from Payment Incentives

The Baucus blueprint would use financial incentives to encourage providers to self-assess and publicly report quality performance. These are useful tools for bringing about awareness of clinical shortcomings and stimulating improvement. The Baucus proposals are carefully phased-in, and would reward providers for improvement as well as for attainment of quality targets, as recommended by HHS in its November 2007 Value Based Purchasing Report to Congress. Even with this sensible policy approach, we believe the proposal would be strengthened by a strategy to ensure equitable access to the proposed incentive payments.

Providers serving patient populations that are well-insured, healthier, better-educated, or from a higher socioeconomic stratum are well positioned to hire consultants or draw on shared corporate resources to respond to financial incentives for reporting and improvement. However, many providers are already less able to compete for lucrative partnerships, academic affiliations, or attract better educated, well-insured customers seeking elective procedures. These providers include safety net providers, providers disproportionately serving vulnerable patient populations, and low volume providers such as small community hospitals and rural providers.

These providers are likely to struggle to hire and retain the experienced staff and commercial consultants needed to lead implementation of cutting-edge, high-performance practices. Without special assistance, incentive payments are likely to widen the quality gap between the "have" and "have not" health care providers[1]. This problem will worsen if Congress finds it is necessary to enact budget-neutral incentive programs in which the cost of payments to those who qualify for incentives are offset by reductions in payment to those who do not.

Recommendation: Special assistance should be offered to these providers by focusing Medicare QIO assistance on meeting their needs. In the area of public reporting, QIOs have been successfully providing assistance to Critical Access Hospitals (CAHs) for several years, resulting in steady growth in the number of CAHs reporting quality performance even in the absence of payment incentives offered to PPS hospitals. A number of studies strongly suggest that QIOs have effectively assisted providers in improving care (see appended summary of studies).

> *Caveat*: While AHQA recommends making substantial QIO assistance available to providers and practitioners least able to qualify for incentive payments because of their size, funding, or service to vulnerable populations, we caution against unduly restricting QIO assistance so that it is available *only* to these providers. Both to improve equity and to permit effective learning techniques, it is important to permit QIOs to recruit significant numbers of high-performing providers to participate in quality improvement initiatives. This will ensure QIOs can engage both higher performing and lower-performing hospitals in learning collaboratives to share improvement strategies. This method aims to accomplish *community-based* quality improvement in which a large number of health care providers work together to offer patients the best possible care, raising the quality of care across the board and minimizing the likelihood that a consumer will choose or be referred to a low quality provider.

Implementing Health Information Technology and Health Information Exchange

Public policy debate about health information technology (HIT) has focused on the slow pace of adoption in the United States; a positive impact on the quality of care is generally assumed. While HIT been shown in several studies to improve processes of care where it is in place and used by clinicians[2], some studies have not confirmed this finding.[3] Others note that while processes may improve with use of HIT, there is little evidence of HIT improving patient outcomes other than in the care of end stage renal disease patients.[4] In their recent study, Linder and colleagues found no association between ambulatory care quality and possession of EHR technology, cautioning that "as EHR use broadens, one should not assume an automatic diffusion of improved quality of care…Policy makers should consider steps to increase the likelihood that further diffusion of EHR has the desired effect of improving quality of care."

The slow pace of HIT adoption is unquestionably a problem that calls for action. But physicians and health professionals lack training and experience in the process of evaluating their current care processes, conceiving a better way to organize their care teams, and retraining themselves to take advantage of the capabilities of new information systems. There is evidence many providers and office practices have purchased inadequate clinical decision support software (CDSS), or are not using their CDSS to improve care management despite having purchased a fully functional system[5].

Unfortunately, it is no one's job to help them, and commercial consultancy firms have little interest in serving typical office practices and small providers, even if those practices and providers could afford to hire them. This is unfortunate, because the majority of ambulatory care physicians work in practices of three or fewer physicians.

The Baucus proposal would grant financial rewards to recognize the value of physician office practices qualified for designation as a "primary care medical home." As defined by NCQA and MedPAC, this includes using health information technology (HIT) for care management, adoption of a formal quality improvement program, and other process requirements. Recognizing the risk that typical physician practices will be least capable of qualifying for the incentives, the Baucus plan calls for "additional technical assistance to help providers assess [HIT] products, understand their needs, and manage implementation and ongoing maintenance."

QIOs worked with hundreds of hospitals and 3,600 physician offices from August 2005-July 2008, assisting them in re-designing their clinical workflow to incorporate HIT into daily practice. The practices exceeded expectations in using their EHRs for care management, and the QIO program influenced HIT vendors to make significant changes in their programming to enable physicians to generate care management reports. Demand was so strong that QIOs had to turn providers away. Three-quarters of practices were satisfied with the QIOs' knowledge of technology options, their ability to appropriately assess the practice's technology needs, and their assistance in improving the quality and efficiency of care.[6, 7]

Recommendation: Medicare should build on the success of the QIO program helping providers and practices plan for adoption of HIT, select software and hardware, and modify daily clinical workflow to incorporate technology into their caregiving. QIOs also help providers report their performance, supporting public accountability. QIO assistance should not be limited to practices that already possess EHRs, as it is today, but should once again be made available to speed the pace of adoption and reduce the number of providers that fail in their implementation efforts.

Ensuring Implementation of Comparative Effectiveness Research Findings

The Congressional Budget Office has reported that "hard evidence is often unavailable about which treatments work best for which patients and whether the added benefits of more-effective but more expensive services are sufficient to warrant their added costs" and suggested that "generating additional information comparing treatments would tend to reduce federal health spending somewhat in the near term," though perhaps not enough to offset the costs of research in the short term.[8] The Medicare Payment Advisory Commission (MedPAC) concluded that "the Congress should establish an independent entity whose sole mission is to produce and provide information about the comparative effectiveness of health care services."[9] Senate Finance Committee Chairman Baucus and Budget Committee Chairman Conrad have jointly introduced legislation to implement this recommendation (S. 3408).

The Baucus health reform plan seeks to promote a renaissance of scientific knowledge concerning the comparative value of medical technologies and clinical services. However, most studies trace the poor performance of the current system to failures by health care organizations, providers, practitioners and even patients to routinely implement, day-in and day-out, what is already known. The nation's continuing challenge is to move new research findings from the bookshelf to the bedside. Dissemination of comparative effectiveness research, too, is likely to languish on the bookshelf without a sustained national effort at incorporating that knowledge into the local, day-to-day clinical workflow.

QIOs are perfectly situated to accomplish this mission. Fostering integration of evidence-based medicine in everyday clinical care has been a primary purpose of the QIO program ever since the multi-state Cooperative Cardiovascular Project demonstrated in 1995 that QIOs improved use of evidence-based heart attack treatments and reduced mortality. Today, QIOs combine clinical expertise with change management techniques that have a proven track record of speeding the adoption of evidence-based medicine.

Recommendation: The Medicare program should task QIOs to help physicians implement Comparative Effectiveness findings that the Secretary determines would yield clinically significant improvements in the safety or effectiveness of health care. The Secretary would be required to evaluate QIO work using measures that have been endorsed by a consensus based entity such as the National Quality Forum.

Improving Transitions of Care and Reducing Readmissions

MedPAC reported to Congress in 2007 that unsafe and poor quality care occurs with disturbing frequency as patients transition from one care setting to another. One result is that about 18% of Medicare patients discharged from a hospital are readmitted within 30 days; MedPAC estimated three-quarters of those readmissions are preventable, adding $12 billion to Medicare costs[10]. A similar proportion of patients discharged from a hospital experience an adverse event within 3 weeks of discharge from a hospital, with two-thirds of the problems being adverse drug events—most of them preventable.[11]

Systems to follow up hospitalizations and assure that patients receive safe and effective care after being sent home or to a nursing home are generally lacking. Following up with these patients after discharge is currently no one's job; patients and families must manage these transitions for themselves. The skilled health professionals working in hospitals, nursing homes, home health agencies and in physician offices are isolated from one another in care "silos" and often don't understand what the "downstream" providers need in the way of information and follow up. Many have proposed "bundling" payments to providers and practitioners so they have a shared financial as well as professional interest in better linkage of care between settings. However, bundling methodologies are not close to being implemented, and when they are, the providers will implement them faster with assistance.

For many years, QIO initiatives have focused on the hospital discharge component of care transitions. QIOs have helped hospitals more reliably give patients written discharge medication orders after hospitalization for heart attack, heart failure and community acquired pneumonia—to reduce the risk for readmission due to missing needed long-term drug therapy. Quality measures for these important hospital functions have steadily improved during this period. However, little has been done by QIOs or others to ensure that caregivers in the community have the information they need and are working together to provide timely follow up after a patient transitions from a hospital.

In 2008, CMS launched a series of QIO pilots in 14 states to improve critical aspects of care transitions. These projects include discharge instructions for hospital patients; follow up "coaching" phone calls after discharge; and convening of community-based workgroups of hospital, physician, and post-acute care provider staff who have informal referral relationships that result in them often treating the same patients. The QIOs introduce practices to ensure the timely flow of information between the providers and practitioners, and trigger timely follow-up, such as physician visits within a few days of discharge. Results from the initial pilot suggest dramatic reductions in rehospitalizations are being achieved. These initial results bode well for saving Medicare money through safer and better quality care.

Recommendation: Medicare should expand to a nationwide initiative the current 14-state QIO project to improve coordination and follow up of patient care as patients transition from one care setting to another.

Publicize and Promote Use of Quality and Cost Performance Data

The Baucus proposal would promote the publication of provider performance data, consistent with standards set by Medicare and an Independent Health Coverage Council, and is supportive of aggregating Medicare and private performance data to create a more complete picture of the care provided in communities.

Currently, QIOs are founding members of twenty out of twenty-four chartered value exchanges (CVEs), entities designated by HHS Secretary Leavitt as community based partnerships to promote transparency in health care cost and quality. In several cases, QIOs are co-leading the effort.

QIOs currently have extensive access to Medicare claims data, but operate under strong confidentiality requirements that prohibit the release of that data to the public or to other providers. The restrictions in current law exceed those governing private third party payers, which commonly share clinical data with physicians and others when needed to improve care or hold providers accountable. The QIO statute should be amended to allow QIOs to release aggregated de-identified quality and cost data for hospitals, nursing homes, home health agencies and physician practices. Standards must set limits on this authority to ensure that only valid and reliable data is published.

Transparency data that is not explained or provided in a user-friendly manner will have little influence on patient decision-making. QIOs are able to analyze and explain complex data to the public and to provide it both in a format and manner tailored to local seniors in their communities, while also respecting the limitations of the data. QIOs should also ensure that providers have an opportunity to review their data first in order to validate it and learn from QIOs how to interpret and appropriately respond to quality performance feedback reports.

Recommendation: Include in the Medicare QIO contracts the responsibility to conduct claims data analysis on cost and quality performance, educate the public (where possible by working with the CVEs and local partners) about what the findings mean, and work directly with providers, practitioners, and purchasers to improve care.

Appendix: Summary of Studies of the Effectiveness of the QIOs in Promoting Population-based Quality Improvement

In addition to targeted, case-based quality improvement, since the launch of the Cooperative Cardiovascular Project in 1994, QIOs have also implemented community-wide and statewide improvement initiatives to reduce the gap between scientific evidence and daily clinical care. Although the IOM could not find national studies published by late 2005 that proved QIO effectiveness to a scientific certainty, a number of studies published before and after the IOM review strongly suggest that QIO technical assistance to providers is valuable in improving the quality of care:

- 89% of respondents reported in a survey of 462 hospitals weighted to be representative that QIOs' influence on their quality improvement activities were "very positive" (59%) or "somewhat positive" (30%). (Medical Care and Review, June 2008)

- Nationwide, physicians, nursing homes, and home health agencies working intensively with QIOs achieved greater improvement on 18 of 20 clinical quality measures than providers that did not work intensively with a QIO. (Annals of Internal Medicine, September 2006)

- 33 hospitals reduced patient heart attack mortality by 21% to 26% working with the American College of Cardiology, the Michigan QIO, and supported by a local business coalition. (Journal of the American College of Cardiology, October 2005)

- A national QIO project reduced hospital post-surgical infections by 27%. The publication's editor called the outcome "a critical accomplishment in the surgical world, showing measurable and consistent improvement in performance." (American Journal of Surgery, June 2005)

- A QIO intervention improved the quality of cardiovascular care for patients in 24 Massachusetts hospitals, leading to "enhanced adherence to prevention guidelines" associated with better patient outcomes. (Archives of Internal Medicine, January 2004)

- QIO assistance to small rural hospitals substantially improved pneumonia care in 20 rural Oklahoma hospitals compared to a control group of 16 similar hospitals. Midway through the project, the QIO brought their intervention to the control hospitals, which improved to a similar degree. (Archives of Internal Medicine, February 2003)

- QIO interventions improved quality of bypass surgery in 20 Alabama hospitals over a two-year period, compared to control hospitals. (JAMA, June 2001)

- QIO quality measurement and assistance to hospitals improved adherence to evidence-based practice guidelines, significantly reducing heart attack mortality in four states compared to hospitals without QIO support. (JAMA, May 1998)

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[8] Research on the Comparative Effectiveness of Medical Treatment: Issues and Options for an Expanded Federal Role. Congressional Budget Office, December 2007.

[9] Report to Congress: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission, June 2007.

[10] Ibid

[11] Forster et al, The Incidence and Severity of Adverse Events Affecting Patients After Discharge from the Hospital. Annals of Internal Medicine, 2003; 138:161-167.