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Hearing on New Frontiers in Quality Initiatives

The American Health Quality Association (AHQA) represents independent private organizations -- known as Quality Improvement Organizations (QIOs) -- that hold contracts with the Centers for Medicare & Medicaid Services (CMS) to improve the quality of health care for Medicare beneficiaries in all 50 states and the U.S. territories.

AHQA is pleased that the Ways and Means Subcommittee on Health is conducting a hearing to examine federal and private sector initiatives to improve health care quality. While recent reports published by the Agency for Healthcare Research and Quality (AHRQ) and the Medicare Payment Advisory Commission (MedPAC) show that the quality of care provided to Medicare beneficiaries is improving for a number of important quality measures, it also shows a clear gap between the care beneficiaries need and what they actually receive. To close this gap, it is imperative to develop, test and implement initiatives that will accelerate the pace of quality improvement.

WHY THE QIO APPROACH WORKS

The Medicare QIO program represents the largest coordinated federal effort dedicated to improving the quality of health care for Americans. QIOs are local organizations, employing local professionals, with a national mandate to improve systems of care. As such, QIOs are catalysts for change trusted by both beneficiaries and providers. QIOs educate beneficiaries about preventive care and encourage hospitals and doctors to adopt and build “best practices” into daily routines for treating seniors with common and serious medical conditions.

Medical professionals work voluntarily and often enthusiastically with QIOs because QIO projects reduce duplication of effort for doctors participating in multiple hospitals and health plans. These projects also reduce the burden on hospitals that participate in multiple health plans, by bringing the parties together to work on the same urgent clinical priorities, using the same measures, the same abstraction tools, the same key messages. Even the best consultants working for individual hospitals cannot have this effect—and many providers cannot afford costly consultants. In short, QIOs accelerate diffusion of evidence-based medicine to all providers—small, large, urban and rural—in all health care settings.

The QIOs are helping to close the gap in quality of care by continuing to work on the health care quality improvement aims set forth by the Institute of Medicine in its landmark 2001 report "*Crossing the Quality Chasm*," -- that care is safe, timely, effective, efficient, equitable, and patient-centered. Today, QIOs are working to:

- Improve patient safety and reduce common and dangerous errors of omission.
- Ensure that appropriate care is delivered in a timely manner.
- Ensure care is provided in accordance with professional standards of care.
- Ensure preventive care is delivered to avoid unnecessary costs to the health care system.
- Eliminate health care disparities among minority populations.
- Help consumers use available quality information to make health care decisions and resolve beneficiary complaints about the clinical quality of care they receive.

NURSING HOMES

As part of the CMS National Nursing Home Quality Initiative (NHQI), QIOs have been assisting long-term care facilities on a national basis since 2002. The effort has involved helping consumers understand and use publicly reported quality data for making better health care choices,

providing informational material and workshops for facilities, as well as offering intensive technical assistance to a smaller group of nursing homes in each state-with a specific focus on nursing home quality measures (addressing pain, pressure sores, delirium, and others) approved by the National Quality Forum.

Historically, most nursing homes have focused on compliance with regulations and quality assurance. But the impetus of public reporting of quality data and the availability of QIOs for technical assistance has resulted in more and more nursing homes developing a quality improvement approach to improving resident outcomes and quality of life. Across the country, nursing homes are voluntarily connecting with QIOs that are training nursing home managers to implement quality improvement systems in a culture where front line staff not only participate in quality improvement projects, but also are empowered to continually identify and solve problems.

While the initiative has been in place for just a year and a half, nursing homes and their QIO partners already boast unprecedented nationwide improvement on selected quality measures (see nursing home success stories at www.ahqa.org). In January, CMS reported that since the NHQI began in 2002:

- Approximately 2,500 nursing homes are actively pursuing quality improvement efforts with the help of their state QIO, and nearly all (99.5%) of the nation's 17,000 nursing homes have been contacted by their local QIO to participate in quality improvement efforts.
- Residents with chronic pain dropped by more than 30% (from 10.7% to 7.3%) and improvement has been achieved in every state.
- Residents who were physically restrained declined by 15% (from 9.7% to 8.2%) nationally and improvement has been achieved in 92% of states.
- Short stay residents who experienced pain decreased nationally by 11% in one year (from 25.4% to 22.6%).

In fact, every QIO is surpassing its required targets for quality improvement in the nursing home setting as measured by the publicly reported quality indicators. But performance on some measures has not improved as rapidly as others. So QIOs are working with nursing homes --and continuing to engage other stakeholders such as state survey agencies, long-term care ombudsmen, and hospital discharge planners-- on new and innovative ways to drive performance and build on early successes.

HOME HEALTH

QIOs also are playing a pivotal role in a federal initiative to help home health agencies improve the quality of their care and assist beneficiaries in understanding how publicly reported quality data can be used to select a home health agency provider. QIOs are training agency caregivers to evaluate their own performance using standardized Medicare quality measures; select treatment processes for improvement; create and implement step-by-step plans to improve care; and integrate continuous quality improvement into ongoing staff training.

QIOs are training home health agencies in an evidence-based process-called Outcomes-Based Quality Improvement (OBQI). OBQI involves collection, analysis, and feedback of data on quality of care and patient progress that is of practical value to clinicians. The data documents how well agencies are helping patients improve grooming, bathing, dressing, meal preparation, and other activities. OBQI provides home health agencies with methods for interpreting patient data, targeting care processes for improvement, restructuring care, and monitoring how change in care impacts patient recovery and quality of life.

The Delmarva Foundation, the QIO for Maryland and the District of Columbia, trained all QIOs in the OBQI method prior to the launch of the initiative, and those QIOs in turn trained the home health agencies in their states that volunteered to participate. As of this week, 5,275 agencies, or three-quarters (76%) of all Medicare-certified Home Health Agencies, have been trained by

QIOs. Nearly two-thirds (63%) of all Medicare-certified HHAs have submitted quality improvement plans of action based on their OBQI training and self-assessment, and more than half (55%) of all HHAs have signed up to share quality improvement information with other agencies via the website OBQI.org, where they can also receive refresher trainings from QIOs. These Home Health Agencies continue to demonstrate a persistent dedication to working with QIOs on improving their residents' clinical outcomes and quality of life (see home health success stories at http://www.ahqa.org/pub/media/159_766_4627.CFM).

HOSPITALS & PHYSICIAN OFFICES

QIOs work with hospitals and physician offices to improve clinical care for heart attack, congestive heart failure, pneumonia and post-surgical infections in the inpatient setting, as well as diabetes, breast cancer and influenza and pneumonia in the outpatient setting. QIOs work in these settings to assess the use of accepted best practices, analyze systems for providing care and assist with implementation of quality improvement interventions. As outlined in a January 15, 2003 JAMA article by Jencks, et al, the QIOs, working with the medical community, reduced the overall gap in quality by about 13% between 1998-2001. For example, for the median state, prescription of the correct antibiotic for pneumonia patients went from 79% (a quality gap of 21%) in 1998-1999 to 85% (a quality gap of 15%) in 2000-2001. This 6-point absolute improvement represents a 32% closing of the quality gap, expressed in the study as “relative improvement.” Areas showing strong gains nationally in relative improvement also included administration of aspirin for heart attack with 24 hours (15% relative improvement), beta-blockers at discharge for heart attack patients (28% relative improvement), avoidance of nifedipine for acute stroke patients (77% relative improvement), annual hemoglobin test for diabetes (29% relative improvement), and bi-annual lipid test for diabetes (38% relative improvement). QIOs are refining their methods in areas where

improvement was less significant. (Please see hospital success stories at http://www.ahqa.org/pub/media/159_766_4627.CFM.)

REDUCING DISPARITIES/IMPROVING RURAL CARE

As part of their contracts with CMS, each QIO conducts a quality improvement project in their state to improve care for rural beneficiaries or address racial and ethnic disparities in care between minority populations and the general Medicare populations.

QIOs have partnered with local coalitions addressing disparities, particularly faith-based organizations, to reach out to African Americans, Hispanics, and other minority beneficiaries to assist them in getting evidence-based health care. In addition, QIOs work with health care providers and practitioners on ways to recognize and eliminate racial and ethnic disparities that may exist in their treatment of patients. The establishment of systematic, reliable methods of routinely delivering evidence-based care to every patient can eliminate much of the under treatment that otherwise afflicts vulnerable populations.

About 20 QIOs are currently working with critical access hospitals, health centers, and clinics to improve care delivered to rural beneficiaries. However, the demand for QIO assistance in rural areas far exceeds available funding. AHQA supports statements by MedPAC and others recommending that the HHS Secretary increase and dedicate funding for QIO work in rural areas, so the rural population can receive more attention without undermining work that focuses on high-volume providers in order to achieve the greatest benefit for Medicare beneficiaries.

CASE-BASED QUALITY IMPROVEMENT

Case-based quality improvement helps QIOs improve patient safety, protect beneficiaries and identify opportunities to improve systemic quality of care. Investigating beneficiary complaints,

ensuring proper coding, adjudicating certain beneficiary appeals and reviewing EMTALA cases are all examples of how QIOs protect both beneficiaries and taxpayers by ensuring that quality care is delivered appropriately, and that the Medicare trust fund does not pay for unnecessary care.

PUBLIC REPORTING

Public reporting of health care quality data can help many consumers make more informed health care choices. Equally important is the effect of public reporting on providers – making apparent clinical areas where the quality of their care can be improved, and motivating them to seek out assistance to do so. While participation in QIO quality improvement activities is voluntary, the volume of providers seeking assistance has been tremendous, and appears to have been increased by public reporting.

Beginning in 2002, CMS launched new national quality initiatives in nursing homes, home health agencies and hospitals. Consumers can turn to their local QIOs in those initiatives for help in understanding the publicly reported quality measures and how they can be used to make better health care decisions. QIOs are also assisting hospitals, nursing homes and home health agencies to ensure the accuracy of the information they collect.

Public reporting of hospital quality data depends on capturing large amounts of comparable data, requiring a set of uniform quality measures and a data collection tool that permits easy reporting of a standard set of quality data. The QIO program funded the creation of a sophisticated set of evidence-based clinical quality process measures, now widely used in both public and private sectors, which provides an ongoing assessment of the quality of fee for service health care under Medicare. In addition, all QIOs have been offering technical assistance to hospitals to facilitate their use of a free, CMS-developed data collection tool, and to help providers submit quality data to a centralized data warehouse.

PAY FOR PERFORMANCE

The concept of payment-for-performance holds real potential for spurring improvement and should be examined carefully. CMS should continue to test ways to provide differential payments to providers and practitioners that provide high quality care. QIOs are available to assist hospitals in the Premier Hospital Quality Incentive Demonstration with data submission and quality improvement. CMS is also using QIOs through the Doctors Office Quality -- Information Technology project (DOQ-IT) to implement the care management performance demonstration required by the Medicare Modernization Act. In this capacity, QIOs will work with physicians to implement technology to improve care for chronically ill beneficiaries, provide technical assistance with quality improvement interventions and care process redesign, and measure provider performance on quality measures that could lead to increased payment.

Some QIOs are also working with private sector innovators to examine options for differential payment. One key challenge of such programs is that no payer, public or private, should offer additional payments for performance that has not been verified by an independent organization such as a QIO. The Virginia Health Quality Center (VHQC), which serves as the Medicare QIO for the Commonwealth of Virginia, is participating in a private pay-for-performance initiative sponsored by Anthem Blue Cross and Blue Shield of Virginia (Anthem). VHQC is facilitating the initiative as a Patient Safety Organization, designated under Virginia state law. The QIO receives quality and safety measures submitted by hospitals, and validates them against confidential medical records, so that Anthem can be assured of paying only for verified quality improvement. The Anthem – VHQC partnership is a model for national payment incentives program that we urge Congress to emulate in the context of the Medicare program.

PATIENT SAFETY

The IOM's 1999 report *To Err is Human* publicized previous research finding as many 98,000 deaths annually are attributable to health care errors in the inpatient setting alone. Clinical quality improvement efforts by QIOs are reducing errors of commission and errors of omission in a wide variety of settings. MedPAC notes in their March 2004 report to Congress that Medicare QIO program measures show improvement in the areas of timeliness and effectiveness of care, two key dimensions of quality identified by the IOM in its work on patient safety and quality.

The current work of the QIOs to reduce the frequency of surgical site infections will soon be expanded in the Surgical Complication Improvement Project (SCIP), a vital initiative to improve patient safety while reducing costs. States are also increasingly turning to QIOs in their patient safety efforts, and some QIOs are serving as Patient Safety Organizations, in addition to their work for Medicare to improve health care quality.

HEALTH CARE INFORMATION TECHNOLOGY

More than a decade ago the IOM presciently recommended that electronic health records become the standard for patient care. The widespread adoption of electronic health records and other technologies holds great potential for transforming the health care system by accelerating the pace of quality improvement, reducing and preventing errors, increasing efficiency, and promoting development of systems of patient-centered care.

While the potential for health information technology to improve quality is great, a number of challenges remain. Barriers to the automation of clinical information include the lack of national standards for interoperability, privacy, security, and confidentiality of information, and little to no means to finance investments in new technology, particularly for rural providers. However, many experts agree that the most challenging barrier to the widespread adoption of electronic health records and other IT tools is managerial in nature, demanding redesigned clinical processes and

workflow in office practices and hospitals. QIOs are building the expertise required to effectively educate and assist practitioners and providers in adopting information technology in clinical practice.

NEW OPPORTUNITIES FOR QUALITY IMPROVEMENT

The MMA has created major new opportunities for quality improvement, expanding the work of the QIOs to Medicare Advantage plans under Part C and outpatient prescription drugs under Part D. QIOs will offer quality improvement assistance to providers, practitioners, MA plans and prescription drug plans with regard to medication therapy. The QIOs are in a unique position to integrate inpatient and outpatient claims and medical record data with prescription drug data to provide a more complete view of patient care. This will be a powerful tool for efforts to support the safe and effective use of prescription drugs in the health care of Medicare beneficiaries.

CONCLUSION

AHQA supports full consideration by Congress and the administration of innovations to accelerate the pace of quality improvement. We believe it will take a coordinated effort on the part of government and the private sector to close the significant quality gaps that exist in American health care. There are clear indications that the QIO program is helping private plans and providers employ standardized quality measures, report them publicly, and work together to eliminate those gaps. Without QIO assistance, the pace of progress would slow down, as every plan and provider would be obliged to rediscover proven techniques already implemented by others.

In the year 2002, Medicare spent just \$6.33 per beneficiary to fund the quality improvement activities of the QIOs. While these funds are being put to effective use, the resources are extremely low in relation to the scope and size of the problem. The QIO program is an investment in a coordinated national effort to improve health care. AHQA urges Congress and the administration to ensure that the investment is adequate to meet the goals the program is striving to achieve.