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## Health-Care Quality Programs Under Fire

Researchers Question Efficacy  
Of Federal Initiatives  
To Improve Patient Care  
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The largest federal program to improve the nation's medical practices is coming under fire, as critics question whether it is effective in fixing some of the most persistent and costly gaps in health-care quality.

The multibillion-dollar program aims to address the enduring problem that many patients don't get the most effective and up-to-date treatment. In fact, research shows that patients in the U.S. receive only half the care recommended by medical evidence. To improve that bleak statistic, the federal program educates health-care professionals about best practices in medicine that can improve patient outcomes. The efforts -- such as starting antibiotics for pneumonia patients within four hours of arrival at the hospital -- can lead to fewer days spent in the hospital and lower death rates.

But while the government has spent more than \$2 billion on the past two rounds of the program's contracts, critics say there is little evidence to show whether the money is being well-spent. The government is now evaluating whether to continue the program in its current form.



Getty Images

*A large federal program aims to teach the most up-to-date medical practices, but results are mixed.*

Initiatives to improve quality in health care have become a huge focus of money and effort in both the government and private sector. But criticism of quality-improvement programs has increased. A study of the federal program published last month in the *Journal of the American Medical Association*, which analyzed data on the care for heart attack, stroke and other patients in five states, concluded there was no difference in quality between hospitals that participated in the program and those that did not between 1999 and 2001. The study evaluated hospitals on how closely they adhered to certain "best practices" associated with improved outcomes, such as prescribing the right drugs to stroke and heart-attack patients at discharge and admission. The quality program, which evolved in the late 1990s from a decades-long initiative to combat Medicare fraud, is operated by the Center for Medicare and Medicaid Services, which in turn contracts with 40 private firms known as Quality Improvement Organizations. These QIOs actually conduct the education efforts.

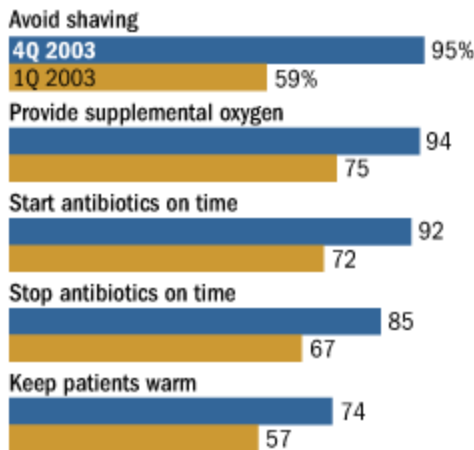
But researchers in the JAMA study found that when quality did improve, there was no clear direct link to the QIO efforts. "Quality may be improving in hospitals regardless of involvement by QIOs," says study co-author Claire Snyder, who did the research for her doctoral thesis at Johns Hopkins University's Bloomberg School of Public Health. "And that raises questions about whether the investment that Medicare is making is worthwhile."

Meanwhile, a growing number of states, health plans and nonprofit quality-advocacy groups have launched their own quality-improvement programs in recent years, which they are better able to enforce, raising a debate about whether Medicare QIOs have become redundant. "There is some question whether outsiders can really come in and help you improve quality, and whether this is the right model and the right way to spend the money," says Margaret O'Kane, president of the nonprofit National Committee for Quality Assurance, which sponsors several quality programs and accredits managed-care

## Best Practices

A large federal program aims to improve quality of care for patients by educating doctors and hospitals about the latest, best medical practices.

The program helped 44 hospitals reduce surgical infections by 27%. How compliance with best practices improved between two periods in fiscal 2003:



Top five projects the program is now pursuing to improve health care:

- Reduce surgical complications in 300 hospitals by 25%.
- Cut error rate in heart attack, pneumonia and heart-failure treatment by 50% in 450 hospitals.
- Assist 5% of physicians' offices in using electronic medical records.
- Reduce pressure ulcers and use of patient restraints in 1,500-2,400 nursing homes.
- Halve preventable hospitalizations of patients in 1,400 home health agencies.

Sources: American Journal of Surgery;  
American Health Quality Association

companies. "There isn't that much hard evidence that they are doing any good, and it is probably a good thing to step back and ask if there is another way."

Still, the federal government is planning to spend additional funds on the QIO program. Starting in August, CMS will award \$1.2 billion in a new round of three-year contracts, asking the QIOs to sharply accelerate their activities. The groups will step up efforts to investigate claims of fraud and denial of care, and take on new tasks such as promoting the adoption of electronic medical records. And they will work more intensively with hospitals in each state to improve surgical and in-patient care, and home in on three areas where quality shortfalls are prevalent and costly: heart attack, congestive heart failure and pneumonia patients.

There is more recent evidence to suggest that some QIO efforts may be working, contradicting the JAMA study. A new study published in the latest issue of the American Journal of Surgery showed 44 hospitals participating in a QIO-sponsored surgical-infection-prevention program covering 34,543 cases decreased infection rates by 27% over a one-year period.

Also, the American Health Quality Association, which represents the individual QIOs, dismisses the JAMA study, saying it relied on outdated data from before 2002 when the program was substantially revised to use more effective techniques to speed adoption of best practices. Moreover, AHQA says, the study gathered the data at the halfway point in a three-year contract, when some hospitals in the study sample had been working with the QIO for only a short time and some hadn't started the work at all.

David Schulke, the association's executive vice president, says newer data show today's QIOs are having a significant impact in hospitals, nursing homes and doctor's offices. The QIOs worked with almost 4,000 hospitals nationwide on quality measurement and public reporting over the past three years, says Mr. Schulke. Preliminary data from those efforts, gathered by CMS from its Medicare records, show that hospitals that worked intensively with QIOs achieved greater improvement in nine out of 10 measures of care that have been shown to improve outcomes -- such as immunizing elderly patients against pneumonia -- than did hospitals that received little or no QIO assistance.

The government is aware of the QIO's program mixed reputation. And now it has launched an effort to assess its success. The Institute of Medicine, a government advisory body, is evaluating the effectiveness of the quality groups under a directive in the 2003 Medicare modernization law. The IOM is due to report back early next year on whether Medicare should continue the program, and if so, whether it should seek other types of organizations to bid for the quality contracts. (Right now QIOs only face competitive bidding if they perform poorly on contracts, and in the few instances where that has happened, the contracts have been won by other QIOs.) Barry Straube, CMS Acting Chief Medical Officer, says even before the IOM's results are out, the agency is looking "more carefully" at the QIO programs, which he says must "demonstrate to us that the programs they are putting in place are in fact leading to improvements."

According to the Institute of Medicine, it can take 17 years for evidence of what works to be widely adopted in health care -- and the QIO's mission is to close that gap. QIOs recruit hospitals to send staffers to voluntary training sessions on how to get their institutions to abandon outmoded practices in favor of techniques that have been shown by medical evidence to lead to better outcomes. For example, scientific consensus was reached in the 1980s that prescribing drugs known as beta blockers to heart attack patients at discharge could prevent many second heart attacks. But hospitals often don't put simple procedures in place, such as standing orders that require all such patients to get the drugs.

In QIO "collaboratives," which can include dozens of participants across many states, hospitals or nursing homes can share information about how to make best practices stick, such as getting administrators to agree on a written policy for such drugs to be given automatically unless there is a drug allergy or other reason not to. QIO staffers, who include doctors, nurses, epidemiologists and former hospital administrators, teach strategies for overcoming resistance from doctors and hospital executives. But because the programs are voluntary, there is no way to ensure that participants follow through or keep up with the quality improvement strategies once the training sessions are over.

In addition, QIOs continue to face stiff resistance from some hospital executives who don't support the quality-improvement proposals and from doctors who think they are already providing the best care. One study of the QIO program's

effectiveness through 2002, published earlier this year in the journal Health Services Research, showed only one-quarter of hospitals believed quality of care would have been worse without the QIO programs-though 60% rated QIO programs as helpful or very helpful.

Some quality experts say that while the groups aren't perfect, they have a powerful role to play in closing the quality gap in American health care. "This is still the only major public investment in improving care," says Don Berwick, head of the nonprofit Institute for Healthcare Improvement, and a member of the Institute of Medicine group that is studying the federal program. "Nowhere else as a matter of policy are we attempting to survey care and reach out to help players who aren't doing so well and wouldn't improve otherwise."