



THE AMERICAN HEALTH QUALITY ASSOCIATION

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Reducing Medical Errors and Improving Health Care Quality for Medicare Beneficiaries

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

Congress created the QIO network to monitor and improve the quality of care delivered to Medicare beneficiaries and supports the work of the QIOs with about \$300 million annually from the Medicare Trust Fund. In the early years of the program, QIOs were known as Peer Review Organizations and focused on oversight — on catching “bad” doctors and hospitals. However, over the past decade QIOs have dramatically changed their approach.

QIOs today work directly and cooperatively with hospitals and medical professionals across the country to implement quality improvement projects that address the root causes of medical errors. QIOs today are working to accomplish what this committee—in its announcement of this hearing—suggests should be a major bipartisan goal: resolving endemic problems that result from failing systems of care.

QIOs are improving the quality of health care not only by targeting errors of “commission” — medical errors that make the headlines — but also by systematically working with medical professionals to reduce errors of “omission” that result in care that falls short of evidence-based medicine. Examples of errors of omission include failure to administer antibiotics prior to major surgery, or failure to prescribe ACE inhibitor drugs to appropriate heart failure patients.

The American Health Quality Association represents organizations and health care professionals working to improve patient safety and the quality of health care nationwide.

Why The QIO Approach Works

QIOs are local organizations, employing local professionals, with a national mandate to improve systems of care. As such, QIOs act as catalysts for change trusted by both beneficiaries and providers. QIOs educate beneficiaries about preventive care and encourage hospitals and doctors to adopt and build into daily routines “best practices” 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 and burden on 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.

What QIOs Have Accomplished

QIOs use data to track progress towards eliminating errors and improving treatment processes. They use data to measure hospital and provider performance on a list of clinical indicators over the course of a QIO project, and then compare results to baseline data to document change.

From 1996-1999, QIOs worked on local projects to improve clinical indicators in care for diseases and conditions that broadly afflict seniors— heart attack, congestive heart failure, stroke, pneumonia, diabetes, and breast cancer. Results from these projects show that QIOs have already made a significant difference. The latest available national data (1996-1998) show QIO projects resulted, for example, in:

- 34% more patients getting medications to prevent a second heart attack;
- 23% more stroke patients receiving drugs that prevent subsequent strokes;
- 12% more heart failure patients getting treatment needed to extend their active lives;
- 20% more patients hospitalized with pneumonia receiving rapid antibiotic therapy.

In 1999, CMS launched a national campaign for QIOs to improve care for cardiovascular conditions, pneumonia, diabetes, and breast cancer. The campaign began with creation of the first

national quality portrait for Medicare. This baseline data showed considerable room for improvement in standard care in the six targeted clinical areas.

The baseline data for heart attack treatment, for example, shows the following percentages of patients (by state) receiving evidence-based care:

<u>Clinical Process</u>	<u>Best State</u>	<u>Worst State</u>
Prompt aspirin administration	97%	67%
Aspirin at discharge	97%	60%
Prompt beta blocker administration	79%	33%
Beta blocker at discharge	93%	47%

Recent re-measurement of a significant segment of this national data (for 19 states) indicates that QIO interventions are having substantial impact. For example, initial re-measurement data on reducing system failures in the treatment of heart attacks and pneumonia show:

<u>Heart Attack Clinical Process</u>	<u>Median State Improvement</u>
Prompt aspirin administration	16%
Aspirin at discharge	18%
Prompt beta blocker administration	26%
Beta blocker at discharge	26%

<u>Pneumonia Clinical Process</u>	<u>Median State Improvement</u>
Antibiotic within 8 hours	8%
Appropriate antibiotic administration	29%
Pneumococcal vaccination	15%

Besides participating in the national campaign to improve care in these six critical areas, QIOs are working to improve care in rural areas, to improve care for minority and ethnic populations, and to cooperate more closely with community-based groups that focus on better health care. QIOs are also working with nursing homes on the prevention of pressure sores, fall prevention, pain management, development of quality measures for rehabilitation services, improving diabetes outcomes, improving anticoagulant use, and conducting state-wide immunization campaigns.

Looking Ahead

CMS recently announced new directions for QIO efforts over the 2002-2004 contract period. National QIO quality improvement efforts will be expanded beyond the six original clinical areas to include care provided by nursing homes and home health agencies, reduction of surgical site

infections in hospitals, and work with physicians offices on improving care for chronic diseases and preventive services such as cancer screening and adult immunizations.

QIOs will also be deeply engaged in a new CMS initiative to educate consumers with quality information to help them choose higher quality providers and motivate poor performers to improve. While CMS will be publishing the data, QIO efforts will be critical to public comprehension and use of the data. Nursing homes motivated to improve performance will receive QIO technical assistance to implement strategies that have worked in similar settings.

Recommendation

We urge the Committee to take closer note of what this program has accomplished and to verify its value through discussions with leaders of the medical community. We look forward to working with the Committee as it considers legislation to improve the quality and safety of Medicare.