

Testimony of Dale Bratzler, D.O., MPH  
Oklahoma Foundation for Medical Quality  
on behalf of The American Health Quality Association  
before the House Energy and Commerce  
Subcommittee on Oversight and Investigations  
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Good morning Mr. Chairman, Mr. Deutsch, and Members of the Subcommittee. Thank you for inviting me here today. I am Dr. Dale Bratzler, Principal Clinical Coordinator at the Oklahoma Foundation for Medical Quality, the Medicare Quality Improvement Organization (QIO) for the state of Oklahoma. I am here today testifying on behalf of The American Health Quality Association (AHQA). AHQA represents the national network of Quality Improvement Organizations (QIOs, formerly known as Peer Review Organizations).

The QIOs' primary mission is to monitor and measurably improve the quality of health care delivered to Medicare beneficiaries. QIOs concentrate on systems of care, rather than the care delivered to one patient at a time. This systems approach improves the quality of care for all Americans receiving services at health facilities working with QIOs. I am here today because the vast majority of the quality improvement tasks assigned to QIOs are preventive in nature whether they are primary prevention efforts, which prevent the onset of a disease, or secondary prevention efforts, aimed at early detection or prevention of the recurrence or progression of a diagnosed disease.

This panel already understands the importance of preventive health services. I want you to know that QIOs are on the ground promoting these services by taking evidence based preventive health practices from the "bookshelf to the bedside." QIOs promote and enhance the delivery of preventive services to seniors, and resolve the barriers to greater utilization of these services. I will also describe some additional interventions that QIOs are using to target vulnerable and underserved populations across America.

The work of the QIOs in the Medicare program is defined by the Centers for Medicare and Medicaid Services (CMS). CMS selects the clinical areas and the quality indicators that QIOs use based on their public health importance and on the feasibility of measuring and improving quality

for those indicators. All of the clinical conditions discussed in my testimony this morning are important causes of morbidity and mortality among the Medicare population, and the U.S. population as a whole, and account for substantial numbers of hospitalizations and a large share of health care costs.

Here are some examples of what QIOs do to enhance the utilization of services recognized by experts as best practices:

- We teach clinical staff how to abstract data from patient medical records to evaluate performance and track progress in improving care.
- We interpret a vast amount of medical information obtained through medical records and health care claims data, as well as develop interventions specific to a particular hospital or doctor's patient population's needs.
- We develop "toolkits" with step-by-step instructions on how to assess and change systems of care to make sure the right things are done in certain ways at the right time
- We implement various kinds of reminder systems that not only help prompt patients to seek care, but also prompt clinicians to provide certain types of care.
- We develop software or paper-based tracking systems or provide access to online services that a facility would not otherwise have.

It is important to note that QIOs work to improve care for fee for service Medicare beneficiaries as well as those enrolled in Medicare+Choice (M+C) managed care plans. Although the data-gathering phase of our quality improvement techniques may differ depending on the payment arrangements, in either case QIOs employ a systems improvement approach.

To promote primary prevention through immunizations and diabetic care. Let me give a few examples of ways QIOs work.

### *Immunizations*

There is universal agreement among health care providers regarding the value of immunizing seniors against influenza and pneumonia. Yet, immunization rates among the senior population are far below Healthy People 2010 goals, even for patients in institutional settings like nursing homes. QIOs promote vaccination in two ways: First, QIOs educate consumers on the importance of receiving vaccinations for influenza and pneumonia. Second, QIOs promote screening of patients to check if they have received them, so doctors and nurses can provide the vaccine when needed.

One of the most successful interventions employed by the QIOs to enhance vaccination rates is the implementation of “standing orders.” Regardless of the health care setting, the use of standing orders allows appropriately trained health care providers to administer vaccine to patients in need.

Despite the evidence that standing orders are a sound intervention strategy, there are barriers to implementing standing orders programs nationally. A particularly frustrating barrier is contained in Medicare facility “Conditions of Participation” rules. Medicare CoPs generally prevent the use of standing orders in institutional settings by requiring that every vaccination be ordered by the individual physician. Another barrier has been the delays in influenza vaccine delivery that have occurred over the past 2 years.

QIOs have also implemented programs to address barriers to immunization within disparate populations. In Oklahoma, we surveyed African American and Caucasian beneficiaries to determine the cause of the disparity in immunization rates between these two populations.

We found that there were significant differences in patient understanding and physician education between the two groups regarding the pneumonia and influenza immunizations. Attached

to my testimony the Subcommittee will find Table 1 and Table 2 that summarize answers to four key questions that our survey asked about each vaccine.

California's QIO identified similar barriers to immunization among the African American populations living in Alameda and Los Angeles counties. Through discussion groups and a telephone survey, they identified barriers such as lack of awareness about the need for vaccination and misconceptions about adverse effects of vaccinations. They found that a recommendation from a trusted physician is a key motivator for vaccination. They also found that leaders of churches and community centers could be effective partners in improving awareness and building trust among African American seniors.

#### *Diabetes*

QIOs are directed by CMS to focus on two primary prevention initiatives with diabetics: prevention of blindness through regular retinal exams and prevention of cardiac complications through regular testing of lipid levels. The QIOs are also engaged in a high priority secondary prevention effort to decrease the progression of diabetes by testing diabetics regularly for glycosylated hemoglobin (a blood test that measures a diabetic's exposure to unacceptably high glucose levels over a long period of time).

One of the barriers to patients receiving regular screenings is that many physicians do not have medical record information systems that allow them to access a "list" of diabetic patients that ought to be receiving regular reminders for preventive care services. Medical records are not filed by disease state, so patients who need reminders cannot be easily identified. In many states, including Washington, Oregon, and Wisconsin, QIOs provide physician offices with software that they can use to develop a disease registry, or patient database, that tracks the provision of preventive care and can generate physician reminders regarding preventive care. In many cases, the QIO staff

work directly with the physician to populate the database and minimize the burden on physicians when they start-up reminder systems.

QIOs have also found disparities between racial groups in diabetes care. The Florida QIO also uses the faith-based approach to community-wide education of the African American population in the state. They developed educational materials to train ministers and others within the church to help parishioners recognize and manage their condition. At the same time, they analyze Part B claims data by each zip code in the state and then take this data to providers to draw attention to the disparities in diabetes care that exist in their communities.

The South Dakota QIO is working closely with local Native-American reservation health facilities to increase diabetes hemoglobin testing. During the development of relationships with diabetes educators in the field, the QIO found that the native language is primarily spoken and not written, particularly among the elderly. As a result, the QIO is working to educate Native American elderly through radio and television messages translated into local languages.

Attached to my testimony is Table 3 that summarizes the progress of some of the QIOs to date related to our primary prevention efforts. The table shows the median statewide “failure rate” for these QIO indicators. The “failure rate” is the percentage of people who are eligible for a particular kind of care, and are appropriate candidates for the care, but were not receiving this care as of 1998. The results of projects to reduce the failure rate are in from two-thirds of the QIOs right now. We expect complete results later this summer.

QIOs also promote secondary prevention in mammography, heart attack, and congestive heart failure.

### *Mammography*

Mammography continues to be the gold standard diagnostic tool for early detection of breast cancer. QIOs strive to increase the number of cases of breast cancer diagnosed in “Stage 1,”

when the cancer is most responsive to treatment. The barriers associated with increased mammography rates are primarily due to access, especially in rural areas. In my state, Harman County is a rural county in the extreme Southwestern portion of Oklahoma. This county's only resource for mammography services is a mobile unit that visits that county only two days each year. Even in areas of the country where there is better access to care, QIOs have found that patients may not be receiving adequate education, counseling, and reminders about the importance of getting a mammogram.

My QIO delivered 3000 "Mammogram Toolkits" to primary care physician throughout the state. The toolkit contained educational resources including patient education videotapes and materials to assist physician offices in setting up mammogram reminder systems.

Some populations are especially vulnerable to underusing mammography screening. In some Hispanic communities, it is culturally inappropriate to speak about mammography. The Colorado QIO, created a project to overcome these social barriers by having female leaders in the Hispanic community speak to other women in Hispanic Roman Catholic Churches – a place where these conversations are safe to have. The Colorado QIO is also working with the staff of area clinics that care for largely Hispanic populations to make sure the messages are reinforced by health care professionals that patients trust, so patients are scheduled for mammograms.

In California, the QIO developed a multi-lingual, culturally appropriate program targeted to Asian Pacific Islander women who suffer high rates of breast cancer. Because one-third of this target population is not proficient in English, they developed educational literature in Chinese, Tagalog, and Vietnamese. Both the National Cancer Institute and CMS plan to conduct focus group tests across the country to implement a nationwide rollout of this program.

### *Heart Attack and Congestive Heart Failure*

Finally, a word about secondary prevention in the hospital setting. The QIOs are directed to increase the utilization of certain pharmaceutical therapies that are known to decrease rehospitalization, reoccurrence, and progressive worsening of these diseases. For example, patients who are discharged from the hospital following a heart attack should be on at least beta-blockers and aspirin. When these medications are administered together and appropriately, mortality rates (both 30 days and one year after their first heart attack) and the readmission rates due to another heart attack can be reduced by up to one third.

Table 4, attached to my testimony, shows the failure rate in these secondary prevention indicators and the progress that some of the QIOs have made in reducing those rates. To improve these rates, QIOs work to ensure that systems are in place that help every patient, including: putting checklists in patient records to remind clinicians of the best practices that should be followed; developing discharge screening questions and checklists to make sure patients do not leave the hospital without the appropriate prescriptions; making sure follow-up appointments are scheduled with their doctors before they leave the hospital.

Congress has a lot to say about one barrier to more effective use of secondary prevention for heart attack. The work of the QIOs in the area of pharmacotherapy is focused only on the inpatient setting right now in the absence of Medicare outpatient drug data. As you develop a drug benefit for seniors, remember that the QIOs are ready and willing to extend their quality improvement work to the outpatient environment. They can present physicians with a complete picture of their patient populations, which will greatly improve the continuity of care in the health care system. QIOs can do this new work under any drug benefit structure from discount cards to a full prescription drug benefit. As long as the QIOs have access to the claims data that will be generated, they can expand their work to promote secondary prevention.

Mr. Chairman, I hope that the Subcommittee will look to the national network of Quality Improvement Organizations to expand outreach to Medicare beneficiaries and their caregivers about important preventive benefits covered under the Medicare program. Under current law, QIO activities to promote prevention may be funded through the Medicare trust funds.

Table 1

## Evaluating Disparity

### *Why didn't you get the flu shot?*

	African Americans N=1252	Caucasians N=660	P
"Didn't know I needed one."	20%	9%	<0.001
"Afraid it will make me sick."	40%	26%	<0.001
"The doctor did not recommend it."	28%	17%	<0.001
"I don't like needles or shots."	18%	8%	<0.001

**\*Based on a survey of 26,194 Oklahoma Medicare patients (31.4% response rate).**

Table 2

## Evaluating Disparity

*Why haven't you ever taken the pneumonia vaccine?*

	African Americans N=1408	Caucasians N=918	P
"Didn't know I needed one."	43%	43%	0.724
"Afraid it will make me sick."	21%	8%	<0.001
"The doctor did not recommend it."	42%	41%	0.567
"I don't like needles or shots."	13%	5%	<0.001

**\*Based on a survey of 26,194 Oklahoma Medicare patients (31.4% response rate).**

**Table 3**

# QIO Primary Prevention Increased Utilization of Flu/Pneumonia Vaccines

(data for 36 states)

	Median State Failure Rate* At Baseline %	Median State Failure Rate* At Remeasurement %	Relative Improvement in Failure Rate %
State Immunization Rates			
Influenza	25.2	22.3	<b>11.6</b>
Pneumonia	52.6	41.1	<b>21.9</b>
Hospital Screening and Immunization Rates			
Influenza	88.5	78.1	<b>11.7</b>
Pneumonia	81.4	72.1	<b>11.4</b>

\* The "failure rate" is the percentage of people who are eligible for a particular kind of care, and are appropriate candidates for the care, but were not receiving this care as of 1998.

<b>Table 4 QIO Secondary Prevention</b> <b>Increased Use of Preventive and Timely Services</b> <b>for Breast Cancer, Heart Attack, and Diabetes</b> (data for 36 states)			
	Median State Failure Rate* At Baseline %	Median State Failure Rate* At Remeasurement %	Relative Improvement in Failure Rate %
Mammography	44.5	39.7	10.8
Heart Attack (AMI)			
• Aspirin at discharge	16.5	14.3	13.3
• Beta blocker at discharge	24.7	16.9	31.6
Diabetes			
• Glycosylated hemoglobin blood test	43.0	30.7	28.6
• Eye examinations	25.2	24.1	4.4
• Measure lipid profiles (“cholesterol”)	39.4	23.2	41.1
* The “failure rate” is the percentage of people who are eligible for a particular kind of care, and are appropriate candidates for the care, but were not receiving this care as of 1998.			