

Testimony of Sallie S. Cook, MD
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Good afternoon Chairman Deal, Ranking Member Brown and distinguished members of the Subcommittee. My name is Dr. Sallie Cook, and I serve as the President of the American Health Quality Association (AHQA). AHQA is the national association representing Quality Improvement Organizations (QIOs) and professionals working to improve health care quality in communities across America. I am also Chief Medical Officer of the Virginia Health Quality Center, the Medicare QIO for the Commonwealth of Virginia. Thank you for this opportunity to provide testimony about the QIO program and ways to strengthen this important national infrastructure.

The Medicare Physician Payment Reform and Quality Improvement Act of 2006, HR 5866, outlines a vision for a stronger QIO program, and we commend the superb leadership of Congressman Burgess and the bipartisan roster of 33 cosponsors of this bill.

As we all know, health care quality is not what it should be -- Americans get only about half of the recommended care for their condition and more patients die each year from medical errors than from car accidents. All the while, the cost of health care keeps rising. Neither patients, nor providers, nor payers are satisfied. These outcomes are rarely the fault of individual health care providers, but mostly arise from unsafe systems of care.

QIOs are community-based experts in every state and territory who work with hospitals, doctors, nursing homes, home health agencies, pharmacies and health plans to improve patient care. Under our performance-based contracts with Medicare, QIOs work collaboratively with health care providers to redesign systems of care so that every patient receives the right care every time.

Health care quality does not improve by itself – it takes hard work. Physicians, nurses, and others are working hard every day, and these professionals benefit from our expert help identifying quality gaps, and learning how to close those gaps. QIOs offer the only nationwide field force of experts dedicated to understanding the latest strategies in quality improvement and working with health professionals at the local level to make good care better.

As an example of some of the great partnerships between QIOs and providers, I'd like to relay to you a story, Mr. Chairman, from your 10th district of Georgia. There, the Georgia Medical Care Foundation, the QIO for the state, has been working with dozens of local providers, including the Gordon Health Care nursing home in Calhoun. Together, the QIO and Gordon have reduced the number of residents in physical restraints from 11% of residents in 2004 to zero. Dawn Davis, Gordon's director of nursing, credited help from the QIO for the success, saying GMCF provided facility staff with "much needed information" and training on the dangers of restraints and potential alternatives. Ms. Davis reports that the facility is now restraint free, and plans to keep it that way.

This March, in a report requested by Congress, the Institute of Medicine said that the country's QIOs should play an integral role in federal performance improvement initiatives like the work I just described, and recommended modernization of the program to fully realize its potential. The QIO provisions in Title II of Congressman Burgess' bill would enact most of the recommendations made in the IOM's report on QIOs. The bill would modernize the law by requiring that QIOs help providers in all settings to redesign their systems of care, adopt health information technology, decrease health disparities, and submit data on valid measures of quality that can be used for reporting and incentive programs.

QIOs do these things today and the bill will bring the law up to speed with current efforts. For example, right now QIOs are helping more than 4,000 small and medium-sized primary care practices to adopt health IT and use it to improve care. Many of these practices treat higher

proportions of underserved patients. In this way, we're helping doctors improve care, as well as helping build the data collection infrastructure needed for quality measurement and pay for performance.

HR 5866 would also improve the way QIOs handle complaints from Medicare beneficiaries about quality of care. Congress entrusted this important function to us in 1986, and many QIOs have now integrated their quality improvement methods into the way they respond to complaints. However, regulations have lagged behind today's understanding of effective quality improvement. Congress must reform this process to make it more patient-centered. The law must permit QIOs to make the complaint process more transparent for beneficiaries. Dr. Burgess' legislation does that.

We also support the QIO governance reforms in this bill. Any organization entrusted with the work of serving Medicare beneficiaries and health care providers must be held to high standards of accountability. Every nonprofit member of AHQA has adopted the Association's high standards for organizational integrity. We also support provisions to increase contractor competition and improving quality under Medicaid.

We encourage the Subcommittee to utilize the QIOs to help improve the efficiency of health care by directing them to focus on efficiency measures which, we believe, should be based on the cost of providing high quality care. QIOs already share quality data with providers and work with them to improve. The same could be done with efficiency data, especially if coupled with data on clinical quality.

In his August Report to Congress on the QIO program, Health and Human Services Secretary Michael Leavitt said: "The QIO program has the potential to make a substantial contribution to efficiency of resource use in Medicare." We agree with that vision. The QIOs can collaborate with physician stakeholder organizations, particularly state medical societies, to share efficiency and quality data with physicians. For those with quality and cost data that is outside the

norms of their peer group, these physicians could work voluntarily with the QIO to implement efficient, high quality processes in areas where there is reliable data and accepted treatment guidelines. For example, QIOs could coordinate exchange visits that convene doctors to share effective change methods.

Another efficiency topic we are already working on is preventing avoidable hospital admissions among patients receiving home care. In just a little more than a year, by partnering with home health agencies, this QIO initiative has already saved Medicare approximately \$130 million in reduced unnecessary hospital admissions.

We know from published reports, summarized in an attachment to my written testimony, that the QIO program is making a critical difference in the lives of America's seniors. The latest article appeared just two weeks ago in the *Annals of Internal Medicine*. It showed intensive efforts by the QIOs led to nationwide improvements in the quality of health care in a wide variety of settings. In 18 of the 20 measures studied, greater improvement was observed among providers working closely with the QIO.

This and other studies show that Medicare is getting good value for its investment in QIOs, which currently amounts to less than one-tenth of one percent of Medicare spending. We are troubled that the quality improvement budget of this successful program has been shrinking both in relative and absolute terms. But we are working hard with Medicare's investment to produce substantial returns in quality and efficiency, and we will do much more with additional resources.

On behalf of the QIO community, thank you for your thoughtful deliberation on the future of this important program.

Closing the Quality Gap

Published evidence continues to mount documenting the positive impact QIOs are having on improving patient care in America. In addition to the strong endorsement from the

distinguished IOM panel in their March report, the value of the QIO program was recently extolled by Secretary Leavitt in his August report to Congress in response to the IOM's report.

The Secretary's report characterized the QIO program as "a cornerstone [of CMS] efforts to improve quality and efficiency of care for Medicare beneficiaries," saying that "The Program has been instrumental in advancing national efforts to measure and improve quality, and it presents unique opportunities to support improvements in care in the future." Many of the Secretary's recommendations are aligned with HR 5866.

And those who directly benefit from our help also say that our impact on patient care is positive and strong. A January independent study confirmed that these stakeholders are deriving tremendous value from the services provided by the QIOs. The study found that three out of four stakeholders agreed that "providers are providing better care because of QIOs."

Among other results, the survey showed that:

- 91% found the information and assistance provided by their QIO valuable.
- 90% were satisfied with all interactions and partnerships with their QIO.
- Of those respondents who have an "on-going partnership" with their QIO – nearly all (98%) reported being satisfied with QIO efforts, including 84% who were very satisfied.

Survey respondents included a broad cross-section of key stakeholders, including members of several of the organizations testifying before the Subcommittee today, including the American Academy of Family Physicians, American College of Physicians, and the American Medical Association. The survey findings are a strong endorsement of the QIO contribution at the front lines of the effort to improve health care quality, and further confirm that QIOs are making health care better.

Additional data was released earlier this month documenting the impact of the QIO program during the most recent three-year period of performance, from 2002-2005. According to a study in the September 5 *Annals of Internal Medicine*, intensive efforts by the nation's QIOs likely led to nationwide improvements in the quality of health care in a wide variety of settings. And care tended to improve more among providers working with QIOs.

The study, conducted by federal researchers, assessed improvement in care in areas such as diabetes management, appropriate heart failure treatment, and pain management in nursing home residents. QIOs worked intensively with a subset of health care providers in physician offices, nursing homes, and home health agencies. These providers achieved greater improvement on 18 of 20 clinical quality measures than providers that did not work intensively with a QIO, including significant progress among nursing homes and home health agencies—two new areas of QIO work that began nationwide in 2002. Among the most significant findings:

- Nursing homes working with QIOs improved on all five measures studied – while those working intensively with a QIO improved to the greatest degree. For example, QIOs and nursing homes working most closely together halved the number of nursing home residents in chronic pain (from 13% of residents to 6.2%), and halved the percentage of nursing home residents who were restrained (reduced from 16.5% to 8.4%).
- Home health providers working with QIOs improved to a greater extent than providers not working with QIOs on eight of 11 clinical quality measures. Those working most closely with the QIOs improved to a greater extent than other agencies on all 11 measures.
- Physician offices working with QIOs improved in all four measures studied, and improved by greater amounts than offices that did not work with the QIOs. The

greatest improvement was seen in the quality of care for patients with diabetes.

Timely blood sugar testing improved by about 9% and timely lipid profile testing improved by about 11%. QIOs working more intensively with physician practices were able to reverse two apparent trends. These practices increased the number of women receiving timely mammograms and the number of patients with diabetes receiving a key retinal eye exam. Practices not working with their QIO saw decreases in these two measures.

- Hospital care improved in 19 of 21 measures studied. The study could not compare hospitals that worked with QIOs with those who did not because QIOs were asked to help hospital providers throughout their state to improve. However, substantial improvement in surgical infection prevention occurred at a time preceding the adoption of surgical infection measures by the JCAHO and public reporting of hospital performance on these measures.

The findings underscore other recent research showing how QIO assistance helps providers improve care they deliver to Medicare beneficiaries. The 2005 *National Healthcare Quality Report*, released by the Agency for Healthcare Research and Quality earlier this year, found that QIO measures for heart disease and pneumonia showed a combined rate of improvement that was almost four times higher than all other non-QIO measures. The *American Journal of Surgery* last year published a report on a national QIO project involving 43 hospitals that reduced their post-surgical infection rate by 27% with QIO assistance.

All of these studies are consistent with our experience that when QIOs and providers work together, the quality of care improves faster. Of course, much of the credit for these improvements goes to providers who are willing to change and work with QIOs to improve patient care.

Pay for Performance

Last week, in its highly anticipated report on pay for performance, the IOM called for a phased-in national pay for performance program that will provide financial incentives for care that is safe, effective, timely, patient-centered, efficient, and equitable. In its report, the IOM said QIOs offer an “important national resource in building the necessary infrastructure” for the technical assistance that providers need to qualify for payment incentives. “Technical assistance for quality improvement will become increasingly important throughout Medicare as pressure to contain health care costs grows, and providers place more emphasis on quality improvement with the expansion of pay for performance programs,” the IOM said.

We support payment to reward high levels of quality and improvements in quality. But the IOM is right to say that payment rewards alone won’t get the job done, and that quality improvement technical assistance through the QIO program should be available to more providers to help them succeed. These recommendations would become law if HR 5866 is enacted.

We also encourage Congress to utilize QIOs as an independent national feedback mechanism for the “active learning system” that the IOM recommended in its payment for performance report. QIOs can report back to federal agencies on consumer, employer, and provider perceptions regarding federal transparency initiatives. QIOs serve as expert feet on the ground and could alert these agencies to measurement problems and unintended consequences of pay for performance efforts – such as decreased patient access. Feedback from consumers and stakeholders is essential in developing a sustainable program to meets the needs of the public and the providers. QIOs are a uniquely qualified national infrastructure with both the strong local relationships and the expertise needed to help the Secretary continuously improve this program.

The primary role for QIOs in pay-for-performance is to support local providers through technical assistance and the provision of evidence-based guidelines. We agree with the IOM’s

finding that QIO assistance must be a central part of future performance improvement initiatives because it reflects our experience that success in quality improvement happens faster when doctors work in partnership with experts who understand cutting-edge improvement techniques.

Helping Physicians Adopt Health Information Technology

There is great interest in Congress and the administration in promoting health information technology as a tool for improving care and supporting data collection. And we know that many barriers stand in the way of widespread adoption among physician practices. Chief among these barriers is of course a real and perceived financial burden.

While financial help is of paramount importance, our experience tells us that even free equipment and software is unlikely to improve quality on its own. The promise of HIT lies not in simply automating current practices, but in transforming them. To achieve transformation, physicians need help from local experts to guide them through the process of preparing and planning, selecting a product and vendor, redesigning their clinical operations and then using their new system to improve care. These are daunting tasks for busy clinicians who cannot stop seeing patients.

Literature and experience tell us that as many as half of all IT implementations fail for one reason or another, often because practices did not go through the rigorous preparation and development necessary for success. QIOs across the country are helping physicians protect the value of their investments by providing this help at no cost.

In Utah, for example, one clinic had been using their EHR system for seven years, but had never turned on the clinical decision support or disease management functions because using those functions on a regular basis simply did not fit into their daily workflow. The clinic asked their QIO, HealthInsight, for help. HealthInsight showed the clinic how to evaluate their existing workflow

and redesign their care processes so that the practice could utilize these high-level functions of their IT equipment – functions which are central to improving quality.

Despite the fact that QIOs don't subsidize physician purchase of HIT or implement these systems, in just one year, 4,308 practices signed up for assistance from their local QIO, including 1,162 practices that treat higher proportions of underserved patients. Of the total number of practices we are working with, nearly three quarters have just one to three physicians, while the remaining quarter practice in groups of four to eight physicians. These are exactly the kind of practices that most need help – those who cannot afford to buy the kind of expert consultants that can have a tremendous impact on the cost and effectiveness of the IT adoption and implementation process. As Congress considers two very important health IT bills, we hope you will expand the availability of this assistance.

Helping the frail and elderly

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. QIOs educate nursing home staff on the principles of quality improvement with guideline-based clinical training that is relevant to publicly-reported measures. QIOs work with all nursing homes throughout their states to set quality improvement targets for certain measures on an annual basis.

Historically, most nursing homes have focused on compliance with regulations and quality assurance. But the impetus of public reporting and the availability of QIOs for technical assistance on these measures have resulted in more nursing homes developing a quality improvement approach to improving resident outcomes and quality of life. Across the country, QIOs 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.

QIOs also work with a group of nursing homes to collect information on resident and staff satisfaction and assist these nursing homes to decrease staff turnover. QIO staff train nursing home administrators and directors of nursing to promote a culture of quality improvement in their facilities.

Although this work is relatively new, our partnerships with nursing homes and other long-term care stakeholders have already produced remarkable progress nationwide. According to the *Annals* article, nursing homes working intensively with a QIO improved more on all five measures studied. For example, QIOs and nursing homes cut in half both the number of nursing home residents in chronic pain and the percentage of nursing home residents who were restrained.

QIO assistance for nursing homes is coordinated with the quality improvement efforts of the federal government and the nursing home industry, such as the new provider-driven, national quality campaign called Advancing Excellence in America's Nursing Homes, which is scheduled to kick off at a summit meeting tomorrow.

Home Health

QIOs also are working to accelerate the pace of quality improvement among patients receiving care in their own home. In particular, QIOs are partnering with home health agencies (HHAs) to reduce acute care hospitalizations, promote the adoption of telehealth systems, increase immunization screenings during patient assessments, and evaluate and improve HHAs' organizational culture.

Since 2002, thousands of HHAs have formed effective partnerships with their local QIO and committed to improving care on publicly-reported home health quality measures using the Outcomes-Based Quality Improvement process. This has been a fruitful relationship that is

achieving better quality care for patients receiving treatment at home. For example, according to the *Annals* article, home health providers working with QIOs improved to a greater extent than providers not working with QIOs on 8 of 11 clinical quality measures. Those working most closely with the QIOs improved to a greater extent than other agencies on all 11 measures.

But there are opportunities for even greater advancement, and QIOs are now working with home health agencies and other community health care stakeholders—including hospitals, consumers, physicians, survey agencies, nursing homes, and others—to help prevent avoidable hospitalizations. Currently, 28% of all home care episodes end in an acute care hospitalization—with more than 3.6 million home health episodes each year, that means there are more than 1 million hospitalizations. While many sick patients need to utilize hospital services, research indicates that there are best practices, such as effective hospital discharge planning, better medication administration, improved communication, and the use of telehealth services that are effective in preventing the exacerbation of patient’s conditions and therefore preventing an unnecessary hospitalization. Furthermore, a recent report on hospitalizations among home health patients found that a 3% reduction in the national hospitalization rate could save \$1.2 billion. As noted above, QIO efforts to reduce avoidable hospitalizations by working with home health agencies have made a substantial down payment toward these potential savings.

In addition, QIOs are helping home care agencies ensure that America’s seniors receive their influenza and pneumococcal immunizations. Health care providers and stakeholders have a shared responsibility to ensure that vulnerable elders are immunized, and the QIOs are ready to help incorporate immunization screening into comprehensive patient assessments and deliver vaccinations safely. QIO also are working with agencies to utilize home telehealth technology to improve the effectiveness and efficiency of home care. QIOs have information and tools about telehealth that agencies can use to reduce hospitalizations and improve care.

Hospitals

QIOs are providing educational support and information on preventing surgical complications to hospitals under the Surgical Care Improvement Project (SCIP). QIOs also are offering hospitals assistance on collecting data and publicly reporting their performance in implementing clinical processes proven to make surgery safer. QIOs are bringing hospital teams together for collaborative learning sessions; offer hands-on assistance helping teams adopt safer practices, and provide guidance on overcoming barriers to change.

QIOs are also engaging in a patient-centered approach to improve care across multiple inpatient topics using a composite measure, called the “Appropriate Care Measure” (ACM). The ACM combines 10 publicly reported quality measures (five acute myocardial infarction measures, two heart failure measures, and three pneumonia measures) into one rate that provides a more accurate description of how a hospital treats patients across the spectrum of care.

In addition, QIOs are partnering with hospitals to redesign their organizational culture and systems of care -- including the use of computerized physician order entry, barcoding and telehealth -- to boost performance on all of these clinical topics. QIOs also are helping rural and critical access hospitals, through a new rural-focused task, to use telehealth and other technology, collect and submit performance data, as well as identify and resolve gaps in patient safety.

Future QIO Assistance

As I’ve outlined today, the field force of QIOs offers health care providers in every state free, necessary assistance for improving quality. From supporting and accelerating physician adoption of EHRs to working with nursing homes, hospitals, home health agencies and others, QIOs are helping health professionals utilize the latest techniques in quality improvement to eliminate medical errors, reduce suffering and improve the quality of life for patients across the country. As HIT, pay-for-performance and health information exchange increasingly become vital

tools for transforming quality, all providers will need performance improvement assistance from quality experts like QIOs.

The QIO program represents the largest coordinated federal investment in improving health care quality – right now, that investment accounts for less than one tenth of one percent of overall Medicare spending. We hope you will strengthen this invaluable program by passing Dr. Burgess’ visionary legislation and making the program a central fixture in our collective drive to provide the right care to every patient, every time.