

QIOs: Partners for Quality Improvement Under the Medicare Drug Benefit

Presentation to
The 2nd Annual National Medicare
Prescription Drug Congress

David Schulke
Executive Vice President
The American Health Quality Association
November 1, 2005

The American Health Quality Association (AHQA)

AHQA is a national trade association, founded in 1973, with 18 staff who lobby, educate and recruit active stakeholder support for health care quality measurement and improvement.

The mission of AHQA, a national network of community-based independent quality evaluation and improvement organizations, is to promote and facilitate fundamental change that improves the quality of health care in America.

Q: What is a QIO?

A: Quality Improvement Organization

QIOs --

- ❖ Private, independent, mostly not for profit organizations, present in every state and territory.
- ❖ Have contracts with Medicare under a federal program created by Congress in 1982. (Most also work for Medicaid and others.)
- ❖ Hold Medicare contracts renewable every three years by law, called "Statement of Work" (now in "8th SOW," 2005-2008)
- ❖ Assist doctors, health facility personnel, MA and PDP plans in measuring and improving clinical quality.
- ❖ Bring their own funding, plus physicians, epidemiologists, and biostatisticians who understand quality measurement -- and a lot of talent and creativity.
- ❖ In MMA, Congress assigned QIOs to help practitioners and plans improve the quality of pharmacotherapy under the drug benefit.

QIOs work in diverse care settings on pharmacotherapy

- **Hospital:** heart attack, heart failure, community acquired pneumonia
 - **Nursing Home:** pain management
 - **Home Health:** pain management and patient ability for oral self-medication
 - **Ambulatory Care:** Influenza and PPV immunizations.
 - **Sources of Error:** Primarily underutilized pharmacotherapy, timing, product selection, overuse.
 - **Partners:** Rarely involved pharmacists in the past – new relationships must be forged (next step in this process at AHQA national conference Nov. 17-18).
-

Evidence of QIO Effectiveness

- ❖ CMS evaluates QIO program without comparison groups (like other quality assurance and oversight programs), leaving some people unsatisfied with the evidence of success.
- ❖ Since 1995, CMS instructed QIOs to recruit providers and other stakeholders, to support their efforts, and to share credit for results – good for partnerships but makes it difficult to separate the contribution of each and attribute results to QIO assistance.
- ❖ CMS began to redesign the QIO quality measurement and contractor evaluation system in 2002, making additional changes 2005-08.
- ❖ QIOs have done their own studies, often with comparison groups, that strongly suggest they are having a significant impact on provider and practitioner quality performance.
- ❖ In 2002-2005, providers and practitioners that worked closely with QIOs improved significantly more on standardized quality measures than those who received little or no QIO assistance (Source: CMS data, publication pending).

Evidence of QIO Effectiveness

- ✓ QIOs and hospitals improved care, reduced AMI mortality in four states compared to hospitals without QIO support in the rest of the country. (Source: JAMA, May 1998).
- ✓ QIO measurement, feedback, and best practices significantly improved CABG quality in 20 hospitals compared to state and national controls. (Source: JAMA, June 2001.)
- ✓ Patient safety and care improved nationally on 20 of 22 evidence-based quality indicators targeted by QIOs. (Source: JAMA, Jan. 2003).
- ✓ QIO improved rural hospital pneumonia care vs controls (Source: Ann Int M, Feb '03)
- ✓ 3-state QIO education campaign for diabetes patients significantly increased use of therapeutic footwear compared to control states. (Source: Diab Care, June 2003)
- ✓ QIO-hosted collaborative to present best practices improved quality of cardiovascular care in 24 Massachusetts hospitals. (Source: Arch Int Med, Jan. 2004).
- ✓ 10-state QIO project improved quality and outcomes in carotid vessel surgery (550 lives/year would be saved if replicated nationwide). (Source: J Vasc Surg, Feb '04).
- ✓ QIOs had programs in over 90% of 105 randomly selected hospitals; QIOs were rated “helpful/very helpful” by over 60%. (Source: Hlth Svcs Rsrch, April 05).
- ✓ 44 hospitals receiving QIO assistance in states across the nation improved surgical care and reduced infection rates by 27% in one year. (Source: Am J Surg, June '05).
- ✓ QIO and 20 Texas nursing homes significantly improved pressure ulcer care; more improvement led to lower ulcer incidence. (Source: J Am Med Dir Assn, May 2005).



New QIO Initiatives in Medicare

Congressional Quality Agenda (Source: MMA)

- Sec. 101: Providing Comparative Information to Beneficiaries*
- Sec. 101: Medication Therapy Management*
- Sec. 101: Grievance and Appeals*
- Sec. 101: Electronic Prescription Program*
- Sec. 109: Quality Improvement Organizations in Rx Benefit*
- Sec. 501: Submission of Hospital Quality Data*
- Sec. 649: Medicare Care Mgt Performance Demonstration
- Sec. 721: FFS Chronic Care Improvement Pilot
- Sec. 722: Medicare Advantage Quality Improvement Pgm
- Sec. 723: Chronically Ill Medicare Beneficiary Research, Data, Strategy
- Sec. 944-945: EMTALA Improvements*

*Significant QIO Role

CMS (Medicare) Objectives for QIOs: 2005-2008

- Offer to help MA plans and PDPs measure and improve the quality of drug therapy;
- Persuade 950 hospitals to report quality performance data on an expanded set of measures;
- Reduce patient care failures in heart attack, heart failure, and pneumonia by 50% in 420 hospitals;
- Reduce surgical complications by 25% in 280 hospitals;
- Work in 660 rural hospitals to improve the quality of care;
- Facilitate adoption of electronic health records in 75% of 6,000 physician offices;
- Reduce pressure ulcer rates by 25% in 2,000 nursing homes;
- Reduce use of restraints on residents by 35% in 2,000 nursing homes;
- Reduce nurse aide turnover by 15% in 2,000 nursing homes;
- Reduce hospitalizations of home health agency patients by 35%;
- Improve patient complainant satisfaction to 90 percent.

CMS on QIO Role in Physician Voluntary Reporting Program, October 28, 2005

“Medicare's contracted Quality Improvement Organizations (QIOs) are helping physicians move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. In specific, QIOs are providing assistance to help physicians create systems so that the measures can be more easily reported.”

National Voluntary Physician Reporting System Measure Set: 1

- 1) Aspirin at arrival for AMI*
- 2) Beta blocker at time of arrival for AMI*
- 3) Antibiotic administration timing for patient hospitalized for pneumonia*
- 4) Hemoglobin A1c control in patient with Type I or Type II diabetes, age 18-75
- 5) Low-density lipoprotein control in patient with Type I or Type II diabetes, age 18-75
- 6) High blood pressure control in patient with Type I or Type II diabetes, age 18-75
- 7) Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker* therapy for left ventricular systolic dysfunction
- 8) Beta-blocker therapy for left ventricular systolic dysfunction
- 9) Beta-blocker therapy for patient with prior AMI
- 10) Antiplatelet therapy for patient with coronary artery disease
- 11) Low-density lipoprotein control in patient with coronary artery disease
- 12) Osteoporosis screening in elderly female patient
- 13) Screening of elderly patients for falls

*Same or similar to current QIO quality indicator

National Voluntary Physician Reporting System Measure Set: 2

- 14) Screening of hearing acuity in elderly patient
- 15) Screening for urinary incontinence in elderly patients
- 16) Dialysis dose in end stage renal disease patient
- 17) Hematocrit level in end stage renal disease patient
- 18) Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis*
- 19) **Warfarin therapy** in patient with heart failure and atrial fibrillation
- 20) **Smoking cessation intervention** in chronic obstructive pulmonary disease*
- 21) **Prescription of calcium and vitamin D supplements** in osteoporosis
- 22) **Antiresorptive therapy and/or parathyroid hormone** treatment in newly diagnosed osteoporosis
- 23) Bone mineral density testing and **osteoporosis treatment and prevention** following osteoporosis associated nontraumatic fracture
- 24) Annual assessment of function and pain in symptomatic osteoarthritis*

*Same or similar to current QIO quality indicator

National Voluntary Physician Reporting System Measure Set: 3

- 25) Influenza vaccination*
- 26) Mammography*
- 27) Pneumococcal vaccination*
- 28) Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
- 29) Antidepressant medication duration for patient diagnosed with new episode of major depression
- 30) Antibiotic prophylaxis in surgical patient*
- 31) Thromboembolism prophylaxis in surgical patient*
- 32) Use of internal mammary artery in coronary artery bypass graft surgery
- 33) Pre-operative beta blocker for patient with isolated coronary artery bypass graft
- 34) Prolonged intubation in isolated coronary artery bypass graft surgery
- 35) Surgical re-exploration in coronary artery bypass graft surgery
- 36) Aspirin or clopidogrel on discharge for isolated coronary artery bypass surgery patient

*Same or similar to current QIO quality indicator

Examples of Problems in Pharmacotherapy QIOs May Address

New Medicare QIO Drug Therapy Quality Initiative: CMS Proposal

- 1) QIOs will conduct an assessment of the physician practice and pharmacy environment related to e-prescribing, *and*
- 2) Each QIO will also conduct one project from this list:
 - Improve prescribing, emphasizing e-prescribing (e.g., Beers drugs, frequency of drug interactions, generic use); *or*
 - Improve patient self management through Medication Therapy Management Services (MTMS - e.g., percent getting MTMS, patient satisfaction with MTMS); *or*
 - Improve disease specific therapy with integrated Medicare A, B, and D data (e.g., avoiding drug disease interactions or ensuring appropriate therapeutic monitoring); *or*
 - Propose and secure approval of “QIO-directed project.”

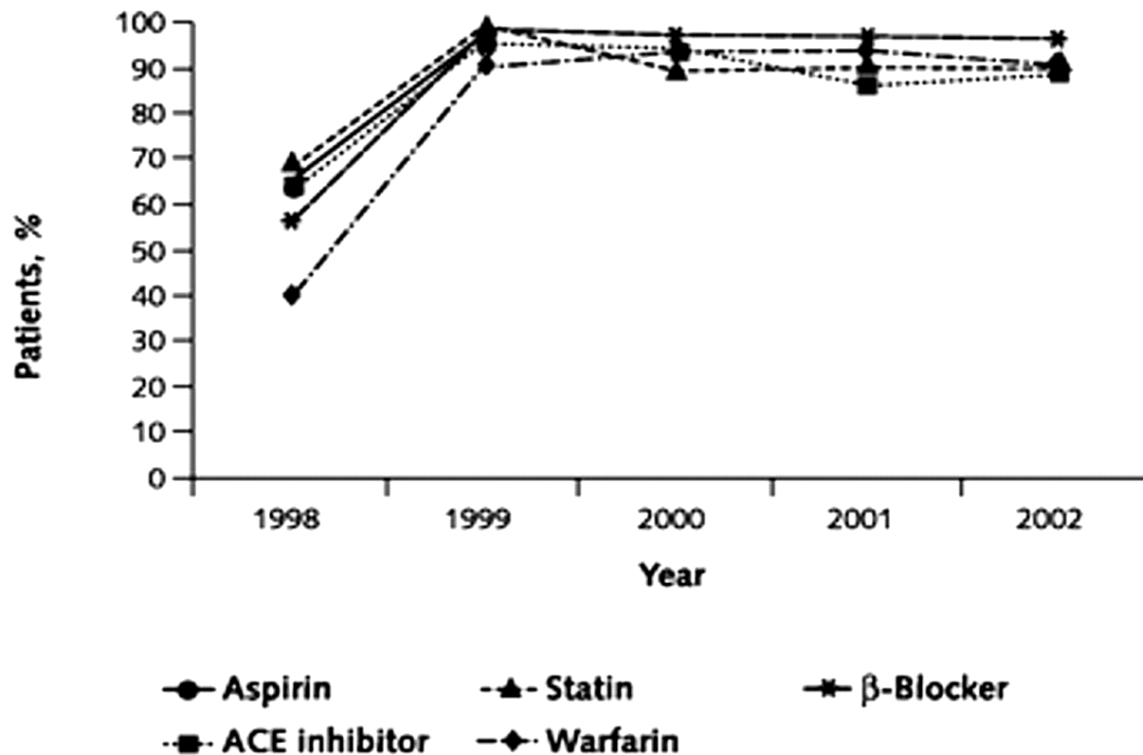
Adverse Drug Events in the Transition from Hospital to Home

- 400 consecutive patients discharged home from a large Boston hospital.
- 19% of patients had an adverse event (AE) within 3 weeks of discharge home.
- 66% of AEs were adverse drug events (ADEs).
- Most ADEs were preventable or ameliorable, unlike other AEs.
- Clinical process improvements suggested:
 - Identify unresolved problems at discharge
 - Patient education re: treatment plan
 - Post-discharge monitoring and follow up

(Source: Forster et al Annals IM February 2003)

Evidence Supporting Integration of Hospital and Primary Pharmaceutical Care

Proportions of patients receiving appropriate prescriptions



Lappe et al Annals of Internal Medicine September 21, 2004

IHC promoted discharge orders for treatment of CVD

Results:

- Sustained 90% prescription adherence rates
- CHF: 23% reduction in 1 year mortality; 9% reduction in readmissions
- Non CHF: 19-21% reduction in 1 year mortality

National Conference on Quality Improvement in Medicare Drug Benefit

- ❖ **Purpose:** Bring MA and PD plans, QIOs, pharmacists and other stakeholders together to identify exemplary MTM and quality improvement approaches.
 - ❖ **November 17-18, 2005**, across the Potomac.
 - ❖ **Convened by:** The American Health Quality Association
 - ❖ **Register at www.ahqa.org**
 - ❖ Look for notice in the NMPD Congress program
-