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Prescriptions for Excellence in HEALTH CARE

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The Role of Medicare Quality Improvement Organizations

By Donald F. Wilson, MD

The major strategies of the national health policy to improve the performance of the American health system are to:

- Develop better tools to monitor performance,
- Increase transparency by making performance information available to purchasers and consumers, and
- Develop appropriate incentives to drive performance improvement.

Medicare Quality Improvement Organizations (QIOs) are critical enablers for the implementation of these strategies on the national level. Created by an act of Congress in 1982, every state has a QIO with the primary mission of improving health care for all Medicare beneficiaries.

Nursing Homes

In the fall of 2002, nursing homes became the first provider group to have mandatory reporting on a set of performance measures at the national level. QIOs were involved in publicizing the initial release of performance data and helping nursing homes learn the mechanics of proper data collection and submission. They also provide ongoing support to improve performance. A list of publicly reported nursing home performance measures and performance data for any nursing home can be viewed on the *Nursing Home Compare* Web site at www.medicare.gov/NHCompare. Areas of national focus for improvement include high-risk pressure ulcers, rate of physical restraints, and incidence of chronic pain.

Home Health Agencies

Reporting became mandatory for all home health agencies in the fall of 2003. Current home health measures are available on *Home Health Compare* at www.medicare.gov/HHCompare. Again, QIOs facilitated national implementation of these measures and have provided ongoing assistance with performance improvement. A major area of focus has been to reduce the rate of acute care hospitalization among patients receiving home health services. QIOs in every state have been working with their state agencies to implement interventions for improved home monitoring, which allows for timely modifications to treatment plans, thus avoiding the need for acute care hospitalizations.

Hospitals

A major breakthrough for hospital performance monitoring occurred in 2002 when The Joint Commission and the Centers for Medicare and Medicaid Services (CMS) began to standardize their hospital performance measures. Hospitals accredited by The Joint Commission are required to submit self-collected performance data on a set of measures for acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia. Standardization enabled transmission of the same data to a national QIO data warehouse. Access to these data enabled QIOs to assist hospitals with planning QI interventions.

The American Hospital Association teamed with other national stakeholders to create a hospital voluntary public reporting initiative that eventually became the Hospital Quality Alliance (HQA). Hospitals were asked to voluntarily report performance on a set of 10 measures: 5 for AMI, 2 for CHF, and 3 for pneumonia. In the fall of 2004, HQA data became publicly available. Initially, QIOs were tasked with helping hospitals understand the mechanics of data submission. QIOs also were instrumental in recruiting hospitals to participate in this voluntary program.

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The program became somewhat less than voluntary with the passage of the Medicare Modernization Act of 2003 that required hospitals to report on this starter set of 10 measures in order to receive their full annual payment update. Almost overnight, all hospitals were participating. The requirements for reporting have now been expanded to include 21 measures. Performance data on these measures can be viewed on the *Hospital Compare* Web site at www.hospitalcompare.hhs.gov.

A recent change in hospital performance evaluation occurred with the creation of composite measures called Appropriate Care Measures (ACM). The initial composite measures gather data from the original 10 HQA measures. A hospital must obtain credit for having provided all care as measured by the 10 starter measures in order to be counted in the numerator for the ACM measures.

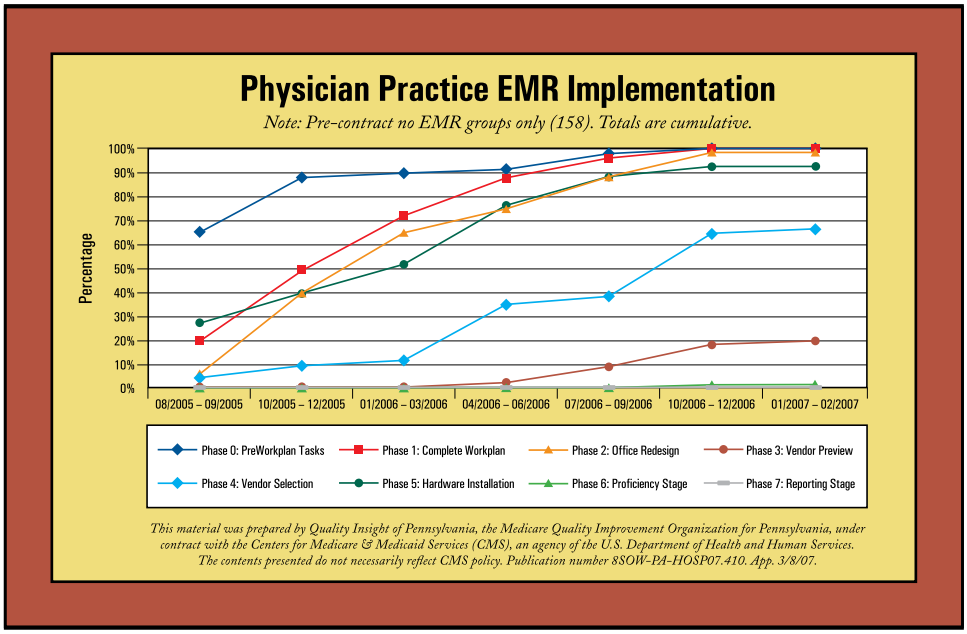
QIOs have continued to work with hospitals throughout the process, providing technical assistance for improving internal care processes and thereby improving performance. This assistance has ranged from face-to-face visits at hospitals with one-on-one consultation, to facilitation of large, statewide hospital collaboratives that promote sharing of best practices. Steady performance gains have occurred in the overall ACM measurements as well as the topic-specific ACMs for Pennsylvania and the nation.

Physicians and Other Individual Providers

A major barrier must be overcome for large-scale public reporting of performance measures to occur at the individual practitioner level. Currently, the only mechanism that exists for collecting and reporting performance data at the individual provider level is administrative claims data. These data have many significant limitations. Most experts agree that the only viable long-term solution is widespread adoption of electronic medical records (EMRs), followed by standardized electronic health information exchange (HIE). HIE will not only facilitate more efficient care, but will allow for provider-specific performance data to be collected and transmitted to appropriate warehouses for analysis and reporting.

To help fuel the adoption of EMRs, QIOs have been involved in the national Doctor's Office Quality – Information Technology (DOQ-IT) initiative for the past 3 years. Currently, QIOs are working with up to 5% of the primary care practitioners in each state to facilitate EMR adoption. Following EMR implementation, physician practices will be supported in using health information technology to provide better preventive care and improve care management for their patients with chronic diseases. They will also be supported as they begin to transmit performance data directly from their EMRs into a national data warehouse for analysis and feedback.

Figure 1



The Pennsylvania QIO is working with approximately 200 practices to implement and effectively use an EMR. We have developed a road map for tracking our progress with the practices. The goal is to get as many practices to the reporting stage as possible by the completion of the project in July 2008. Figure 1 depicts our progress to date.

Value-Based Purchasing

As noted in the opening of this article, the last strategy to be implemented on a large scale will be the concept of value-based purchasing. Congress has directed CMS and other public programs to conduct pilot initiatives that will lead to broader implementation.

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Going forward, providers will receive differential payments for Medicare based, initially, on their reporting of quality measures and, eventually, on their actual performance on the measures.

By passage of the Tax Relief and Health Care Act in December 2006, Congress has already mandated implementation of the Physician Quality Reporting Initiative (PQRI), a pay-for-reporting program for Medicare providers, effective July 2007. More information, and the list of included performance measures, can be viewed at www.cms.hhs.gov/pqri. QIOs have been tasked with disseminating information about the initiative and encouraging providers to participate in this still voluntary effort. QIOs will undoubtedly be involved in the successful implementation of a hospital value-based purchasing initiative scheduled for launch sometime within the next year.

This is an exciting time for health care in the United States. We have finally begun a long-overdue transformation of our health care system. QIOs should be viewed as a precious national resource that works to keep us focused and moving forward.

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