Innovations in Quality Improvement: Managed Care Leads the Way

Improving quality—and proving things are better—has become the domain of managed care organizations, including PBMs. This article contains snapshots of some innovative quality improvement programs introduced by organizations in managed care.

MARY JANE GORE

MARY JANE GORE is a freelance writer based in Charlottesville, Virginia.

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Higher quality health care springs from sound data. Managed care organizations are structured to collect and evaluate data as part of their mission. Thus, managed care organizations (MCOs) are leading the way in quality improvement in health care nationwide. Not only is the difficult quest for improved care a goal, but many organizations also are finding ways to demonstrate lower costs of care.

Stephen Lash, Pharm.D., who is a director on the Board of AMCP, says that quality, as defined in contemporary terms, is compliance to an accepted standard. Quality improvement should be a concrete and unchanging goal.

"The concept of quality improvement is intact, but whether people are getting better at measuring it, is something else," Lash says. "I hope that the concept of quality improvement is not just a fad that comes and goes. 'Out-

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comes measurement' was really the buzzword a few years ago, and now it is 'disease management.' My fear is that quality measurement is something that might go out of fashion."

Quality improvement rests on the ability to demonstrate in concrete terms that some condition or situation has gotten better. "If you are treating people's hypertension, and you change their treatment so that the disease is managed better, so that the patient is healthier and happier, hopefully such a standard and process won't come and go," he says. Employers more frequently are consulting and contracting with disease management firms, which primarily seek to reduce costs of care, says Lash.

The National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are the two major groups helping to evaluate quality and accredit organizations that strive for higher quality (see *JMCP*, Vol. 1, No. 1, pp. 40-51, for a review of the concept of quality and processes of quality assurance, including the DUE model advocated by JCAHO).

The NCQA is a private, not-for-profit organization that both assesses and reports on the quality of managed care plans. Quality improvement is one of six areas in which NCQA accredits these plans. Briefly, NCQA seeks to learn the following:

- ▲ If the plan fully examines the quality of care given to its members;
- ▲ How well the plan coordinates all parts of its delivery system;
- ▲ What steps a plan takes to ensure that members have access to care within a reasonable period of time; and
- ▲ What improvements in care and service the plan can demonstrate.

Some pharmacists complain that there are no explicit indicators for pharmacy procedures among the NCQA indicators of quality. Lash, director of clinical services for Wellpoint Pharmacy Management, a division of Blue Cross of California, says that there is "absolutely no need for pharmacy indicators." Lash maintains that "many pharmacy pro-

grams, projects, and processes fit beautifully into the way NCQA has crafted its indicators."

Lash says that most other disciplines in medicine "can't create the measurements that pharmacy can, because of the powerful databases that run the pharmacy systems. Pharmacists can make incredibly accurate measurements of potential drug interactions, allergies, duplicate therapies—lots of things require chart review, but a lot of things that pharmacists do can be done with great accuracy and power in the databases." Then pharmacists can make interventions and measure again. If things have improved, that is a powerful tool to put into the NCQA documentation for official review, Lash says.

Barry Scholl, an NCQA spokesman, says that the organization's quality improvement standards require that there be "a real operational quality improvement at the health plan, and that there is documentary evidence that both describes the program and outlines its successes." If a program involving pharmacy "falls under the domain of a quality improvement or a quality management program, then it is something that NCQA would consider" in its accreditation process, Scholl says.

NCQA is always "open to communicating with any health plan that has been involved in the organization's accreditation process or that hopes to go through that process," Scholl says. Participants receive NCQA publications, a copy of standards, the guidelines that reviewers use—all of these things put together constitute a roadmap to what NCQA is looking for, Scholl says.

The JCAHO has begun to accredit health care networks, including HMOs, PPOs, PHOs, IPAs, and other integrated networks. JCAHO standards for health care networks include issues that cover patient rights, organization ethics, continuum of care, patient education, information management, and other areas.

THE MANAGED CARE ADVANTAGE

At Rocky Mountain HMO in Grand Junction, Colo., ideas for quality improvement come from medical literature, the needs of members and providers, and local issues. "It is important to focus on what is meaningful and measurable," says Nanette Emerson, R.Ph., a clinical pharmacy specialist with Rocky Mountain. Emerson, with her hospital background, says that hospitals and HMOs think in different terms. "Certainly hospitals are concerned with safety and costs, but their approach is different from that of an HMO."

Most often, an HMO or MCO will accomplish quality objectives by searching and sorting a powerful and extensive database. "I think that is second nature to HMOs," Emerson says. "Data are very valuable and HMOs understand that."

Lash agrees. "Pharmacy's strength is that we have data. The pharmacy databases are extremely powerful and accurate when you compare them with medical databases, which are subject to coding variations, and are very subjective." He cautions that pharmacists must also visit with patients and review charts, "but we have a big advantage just with our databases," which can measure medication dosing forms, dosing times, and other aspects of care involving medications.

PBMS HELP OTHERS HELP THEMSELVES

Pharmacy benefits management firms (PBMs) offer powerful computer resources that can assist MCOs in their quest for improved quality. Rocky Mountain has worked in tandem with its PBM to perform and track some of its quality studies. "Our PBM has a lot of clinical programs and computer capabilities in place," Emerson says. She says that Rocky Mountain HMO and its PBM tailor computerized programs so

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that the HMO can best use information. For example, Rocky Mountain recently examined its members who use a high volume of controlled substances. The PBM provided a basic program that was tweaked to suit Rocky Mountain HMO's needs.

PBMs are becoming very active both in quality improvement initiatives and disease management programs. While reducing the cost of care is an important aspect of PBM programs, reducing the cost of pharmaceuticals is not necessarily the goal. In the September-October 1995 issue of *Pharmacotherapy*, a report sponsored by Diversified Pharmaceutical Services, a Minneapolis-based PBM, noted that if the entire medical picture were analyzed, use of more expensive drugs in some cases might lower total direct medical costs¹: "The availability of information to demonstrate differences, if any, in total treatment costs between two agents would considerably enhance therapeutic decision-making and would guide treatment by an outcome-based drug formulary. The question that requires an answer is centered on the value equation:

$$\text{Value} = \text{Outcomes/Cost.}$$

Before paying more for drug A than for drug B, the payer will demand to see value. When available, direct and indirect cost information will be applied to position drugs appropriately in a drug formulary."

Some PBMs have embarked on multiple generations of quality improvements initiatives. For example, in 1994, PCS Health Systems announced an ongoing initiative called the PCS Generic Performance Incentive (GPI) program, which initially attracted 71 plan sponsors who agreed to implement the program. This program gave pharmacists the opportunity to dispense appropriate generic prescription drugs and become eligible for incentive payments. During July, August, and September 1994, the first quarter year of the initiative, the generic dispensing rates were assessed as showing "minimal improvement" over the baselines in each state.² Performance and "missed

opportunities" reports were issued after the first-quarter results. GPI's primary purpose is to demonstrate the impact of generic counseling and other cognitive services on the cost-effectiveness of a prescription drug benefit.

Doug Stephens, Vice President of Network Administration for PCS, reports that the GPI has been a success in two ways. Today more than 8 million people are enrolled in that program. "The result is client-specific, based on where they were going in the program," Stephens says. "If they came in with a low generic dispensing percentage initially, we found that it did have a significant impact. We found increases in generic substitution 2-4% higher than we would have expected without the GPI."

GPI's success was slated to lead to a new program called the Performance Network. The network consists of pharmacies that have agreed to align their own incentives and goals with those of PCS's customers and improve performance to reduce drug costs. These pharmacies are encouraged to take a more active role in patient counseling and have agreed to be evaluated against a set of criteria that measures their performance in such areas as purchasing practices, generic substitution, and usual and customary pricing.

Pharmacists receive incentive fees if they improve performance above the baseline for their geographic area. A fee is deducted if performance falls below baseline in any calendar quarter. The Performance Network is "an opportunity for both independent pharmacies as well as pharmacy chains to make a difference and to be rewarded for their efforts," says Steve Geringer, President and Chief Executive Officer of PCS. Performance Network, along with a Performance Drug List, and Performance Interventions, comprise the Performance Rx program to ensure appropriate clinical results for patients and control costs.

PCS has also turned to disease management initiatives, as presaged in the initial GPI report.² Since then, PCS has assumed responsibility for its pharmaceutical owner Lilly's Integrated Dis-

ease Management group, with its outcomes-based measures. One PCS representative says that the company looks at outcomes to "continuously improve what we have implemented and to measure a difference" in many disease states, including asthma, diabetes, depression, hypertension, gastroesophageal reflux disease, and peptic ulcer disease.

DISEASE MANAGEMENT SPARKS QUALITY IMPROVEMENT INITIATIVES

The largest disease management organizations are concerned with improving the care and costs of asthma, hypertension, diabetes, and estrogen-replacement therapy, among other diseases.

"Everyone is managing asthma, because you can turn around an asthmatic almost immediately and see changes in hospitalization rates," Lash says. "An asthmatic who is not being treated well can, within days or weeks, be turned around." A diabetic requires more time and effort, but diabetes swallows so much money that it is one of the big topics, Lash says. Likewise, hypertension and estrogen-replacement therapy have "down the road" payoffs.

Congestive heart failure, which accounts for most of the hospitalizations in the country, is a good candidate for better management, but "probably the huge dollars involved in CHF involve the employer more in terms of productivity, so the focus of CHF programs originates with employers," Lash says.

Certain types of patients with CHF are candidates for an added ACE-inhibitor to their drug regimen, says Cynthia Pigg, R.Ph., M.H.A., who was promoted recently within CIGNA HealthCare, where she had been Director of Regional Pharmacy Services in Richmond, Va. "This helps get to patients out of the hospital, gives them better quality of life and longevity."

Following published recommendations for certain cardiac patients, CIGNA specialists reviewed the data-

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base for patient criteria, and mailed letters to all relevant physicians, citing articles and suggesting that they evaluate their patient for an ACE inhibitor, with patient name and information.

Since the mailing, CIGNA has followed up to learn how many patients have received an ACE inhibitor, but the data were not finalized at press time.

Similarly, studies have shown that certain diabetic patients also may benefit from an ACE inhibitor. CIGNA again identified patients, based on their drug histories, who would fit the criteria for those that might benefit from that drug addition.

At Rocky Mountain HMO, the focus of a quality initiative may be to impact overall medical quality and cost or may be more specifically directed toward pharmaceutical use.

One of the specific pharmaceutical initiatives undertaken involved patients with severe asthma who use high quantities of β -agonist drugs. Rocky Mountain HMO evaluated these patients to learn which patients did not receive concurrent inhaled steroids, because the combination of drugs is much better for management of that disease. "You want to identify the members who are not receiving the second drug, and get them started on it," Emerson says. "This combination might help them to avoid doctor visits, emergency room visits, and hospitalizations. If you're looking at this with blinders on, you would only see pharmacy budget expenditures increase for those members, but looking at the big picture, it results in healthier members."

Looking at both quality and cost improvement, Rocky Mountain has recently studied the use of H_2 -receptor antagonist drugs, which the members may take chronically. Initially these products are started out at an acute dose for 6–8 weeks, then reduced to a lower ("maintenance") dose. It is common, however, for patients simply to continue at the acute dosage level. By retrospectively reviewing their claims data, Rocky Mountain HMO was able to identify patients whose dosage had not been reduced.

"We were then able to provide physicians with the names of their patients who were candidates to have their dosage reduced. This results in a cost savings, which at the same time improves quality by not exposing patients to a higher dose of medication than is necessary," according to Emerson. Rocky Mountain and their PBM examines pharmacy claims data for quantities of the medication, estimating the dosage based on prescription quantities, when the prescription was filled, and how many times and when it has been refilled, Emerson says. "Then our associate medical director and I sign a letter that goes out to the physicians who have had patients identified by the study, reminding them of the suggested course of therapy, *H. pylori* treatment, and so on."

MENTAL HEALTH TREATMENT QUALITY MEASUREMENTS COME OF AGE

Pigg says that the mental health arena, including substance abuse, is another area ripe for quality explorations.

CIGNA's subsidiary, MCC Behavioral Care (MCC), a national managed care company based in Minnesota that provides mental health, substance abuse, and employee assistance services, has been developing and refining its Clinical Quality Information System (CQIS) since 1992. John Bartlett, M.D., then MCC's Vice President and Corporate Medical Director, assumed the job of creating a way to measure outcomes of MCC's mental health and substance abuse services. Bartlett envisioned a continuous process for outcomes data collection, analysis, and application that would be "engineered" into clinical and business operations.

"We strongly believe that adding on existing tools onto already overloaded workloads becomes prohibitive," in terms of labor and costs, says Zachary J. Meyer, Vice President of MCC's Quality Management Systems. "We have operationally integrated the collection of structured, standardized data elements into a typical clinical assessment."

CQIS is an ongoing improvement system, in which users can use feedback to improve patient care. "We are able to ask questions of the database at any time to see how we have been doing, and then to develop improved treatment protocols," says Elizabeth Opland, a senior clinical quality analyst with MCC.

In 1992, MCC partnered with the Institute for Health Services Research at the University of Minnesota, which already had extensive experience with clinical outcomes research under Robert L. Kane.³ In 1993, MCC Behavioral Care made its three-volume clinical standards reference guides available to health care, social service, and counseling professionals.

MCC perceives its data as being very "actionable," Opland says. For example, MCC data show that people who have financial or logistical barriers to attending treatment, like babysitting or transportation problems, or co-payments over \$20, are only half as likely to engage in treatment. "Now providers are developing solutions, such as offering transportation assistance or extending clinical hours or waiving co-payments," Opland says. "One of our sites in Richmond [Virginia] has started such process improvements. They decided to reduce the co-pay to \$5 for the first phase of treatment for substance abuse patients. This gets them involved in treatment, and at that point, other factors start taking primary importance about a successful outcome." MCC is now beginning to pilot combined mental health-substance abuse forms in its 65 offices. Likewise, MCC is piloting the substance abuse forms for MCC's high-volume external providers (outside of MCC offices), who see at least 50 patients per year.

The process for both the mental health and substance abuse modules includes several steps:

▲ Initial assessment—baseline information is gathered from a patient questionnaire. Data are used for the outcomes assessment process and also for clinical care plans, regulatory requirements, and other purposes.

▲ Treatment data collection—once treatment begins, MCC gathers data about type and intensity of treatment, provider characteristics, insurance eligibility and benefits, appointment scheduling, claims, authorization, and encounters.

▲ Follow-up interviews—during six- and 12-month interviews after treatment, patient functioning is evaluated again. Using nine outcome domains, the patient's function is detailed and adjusted for case mix.

The difference in patient function before and after treatment is the measure that illuminates patient outcomes and treatment effectiveness. The CQIS system also allows more than just treatment efficacy to be evaluated. MCC can also determine which form of treatment and which health care provider work best for which kind of patient. MCC uses that specific information to drive quality improvement in practice protocols and delivery systems.

Pigg notes that mental health is a natural area in which to involve pharmacy, because "one of the largest drug

expenditure areas is antidepressants, including Prozac." Many other organizations have arisen to determine treatment outcomes for substance abuse and mental health, including Philadelphia-based Deltametrics-TRI, which is devoted to such studies.

PHARMACIST INVOLVEMENT GETS RECOGNITION

Lash notes that pharmacists have a valuable role to play in health care quality initiatives both because of their direct contact with patients, in many cases, and because of their access to powerful information systems that yield easily-assessed measures of quality. Pharmacists are finding more opportunities to help develop and launch valuable QI programs, in this era of outcomes and quality measurement.

As a final example, staff pharmacists in Kaiser Permanente's Northwest Region helped to establish a smoking cessation program that involved pharmacists closely in its operation. Pharmacists worked closely with patients,

the health educator who instructs patients, and the prescribing physician. Pharmacists prescribed and monitored nicotine therapy replacement therapy by protocol, and monitored each patient for dose-response effect, adverse drug reactions, drug interactions, and progress and outcome. In one year, more than 80 courses were held with nearly 1,000 participants, and rates of long-term abstinence achieved compared favorably with literature rates for community-based group smoking cessation programs.⁴ Based on surveys, satisfaction of patients, pharmacists, and physicians, this three-year-old program has been rated as high.

The program serves as an example of how pharmacist expertise can be used to the fullest extent to improve patient health while keeping down costs to the health care system and society at large. By better managing and monitoring therapy, patient education, and patient behavior, pharmacists are proving themselves invaluable as leaders and members of quality improvement programs nationwide. ■

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