

West Virginia State Health Plan

*Accountability/Measures**

I. BACKGROUND

Public accountability received considerable national attention with the passage of two laws in 1993. The Government Performance and Results Act of 1993 (GPRA) required federal agencies to develop strategic plans for how they would deliver high-quality products and services to the American people. The National Performance Review (NPR) Act was an attempt to reinvent government. One NPR initiative was to foster collaborative, systematic benchmarking among public organizations. In February 1997, NPR released its benchmarking study report on performance measurement. Among the findings:

- for results, accountability must be clearly assigned and well-understood;
- performance measurement systems must provide intelligence for decision-makers, not just compile data;
- performance measurement systems should be positive, not punitive; and
- results and progress toward program commitments should be shared openly with employees, customers and stakeholders.

The report recommended that necessary data gathering be focused, flexible, and programmatically consistent. It also offered several suggestions for effectively transforming data into information:

- as information needs differ by user, make information responsive to the specific needs of the user;
- use appropriate analytic tools for effective performance analysis;
- make analysis more sophisticated over time, as performance data become more specific and definitive, and more widely available, and as the performance measurement process matures, and
- present performance data in a variety of innovative ways to find the most effective presentation for the issue and audience being addressed.

Given the major public investment in health care, these suggestions have direct application to the health system, where performance measurement and public accountability have a long and spotty history. Most trace efforts to document performance and enhance public accountability to Ernest Codman, M.D., a prominent Boston physician in the early 1900s. He not only called for measuring performance in health care, but also urged surgeons to systematically collect data on the outcomes of their surgical procedures and care and to make this information publicly known so patients might make informed decisions in selecting their surgeons. There have been intermittent efforts ever since to find ways to enhance public accountability in the health care delivery system.

II. SYSTEM ASSESSMENT

A. Context

Public accountability for health care system performance and accountability in West Virginia, as elsewhere, is fragmented and somewhat haphazard. There is limited coordination, collaboration, and concentration on critical problems and issues.

*Note: tables and maps referenced but not contained here may be viewed and obtained, in their entirety, at the West Virginia Health Care Authority.

The public and private sectors employ an array of indicators and measures oriented to hospitals and public health services (e.g., maternal and child health and immunizations). This is largely because historically most performance measures and data reporting have consisted of reporting by hospitals (mandated and voluntary) to disparate public and private organizations (e.g., WVHCA, Medicaid, licensing agencies, West Virginia Hospital Association, American Hospital Association, Joint Commission on the Accreditation of Healthcare Organizations) and mandated reporting of selected conditions and events by public health agencies.

In contrast to hospitals and public health services, there are less public domain data available for managed care, long-term care, behavioral health, home health, physicians' offices, ambulatory care settings, medical devices, primary care, and various other services, conditions, and treatments. Data describing these services typically lack sufficient detail, comprehensiveness, comparability, and timeliness to permit the development of specific, reliable performance measures.

The heightened demand for information on the performance of the health care system, providers, hospitals, and plans necessitates using valid, reliable performance measures and an information system that can supply data needed to support the measures. Dissemination of information to the different interested parties in ways and formats that are useful to them is also part of ensuring accountability.

Improving health care system and public accountability by all elements requires taking advantage of existing resources, adopting new performance measures where none now exist, collecting and reporting the data needed to apply the measures, and developing effective information dissemination and education strategies.

B. Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis

1. Strengths

West Virginia has several longitudinal health databases that can be used to enhance public accountability. These include hospital financial and use data, nursing home financial and use data, Public Employees Insurance Agency (PEIA) data, Medicaid data, and Workers' Compensation data.

There are several performance measurement systems and performance measures available for use. They include FAACT (Foundation for Accountability); HEDIS (Health Employer Data & Information Set), CAHPS (Consumer Assessment of Health Plans Survey), and AHCPR (Agency for Health Care Policy & Research) Quality Indicators. Several of the organizations that developed these indicators work continuously to make their products and services compatible with states' needs.

West Virginia can benefit from the experiences of other states (e.g., Florida, Maryland, New Jersey, New York, Pennsylvania, Texas, and Utah) that have produced hospital, physician, and health plan performance reporting programs.

Selected summary information for West Virginia hospitals and health plans is available on-line from JCAHO (Joint Commission for the Accreditation of Healthcare Organizations), NCQA (National Committee for Quality Assurance), HCFA (Health Care Financing Administration), and the West Virginia Hospital Association.

The planning and regulatory processes, including certificate of need, can be used to promote adoption and reporting of performance measurement.

2. *Weaknesses*

Reliable, accurate data are limited to a few settings; additional data collection will be necessary.

Key parties have not adopted a core set of performance measures.

Preparing for and sustaining performance measurement (i.e., selecting and applying measures, data collecting and reporting) will require additional expenditures, at least in the near term, in a system that is already facing serious financial pressures.

Currently, there is no agreement on access to, or dissemination of, performance information. Agreement on the data products and reports to be developed and made available to stakeholders is necessary.

Consumer and user education must necessarily be components of any dissemination plan for performance measurement to be productive. Although cost-effective in the long run, this will be an additional short-term cost.

Not all providers will want to be publicly accountable, to provide their data, and to have their experiences reported publicly.

Most of West Virginia's hospitals are accredited by JCAHO, but only one health plan has received NCQA accreditation.

Access to the Internet, which may prove to be one of the more cost-efficient means of education and dissemination, may not be a realistic option for many West Virginia residents.

Although the West Virginia Hospital Association and its members participate in the Maryland Hospital Association Quality Indicators Project, these data are not publicly accessible.

There are few enforcement mechanism(s) in place for use if providers do not report data.

Licensed health plans are not now required to seek NCQA accreditation and report HEDIS data to the state.

3. *Opportunities*

Policymakers would like to know more about the health of their constituents and about the practical steps they can take to help improve personal and community health.

If West Virginia takes full advantage of existing information technology, and available performance measures and systems, this should help to control expenses while improving the comparability, and therefore the usefulness, of results.

4. *Threats*

Providers, hospitals and health plans could oppose, and effectively block, additional data collection and reporting.

Public and stakeholder expectations for performance measurement and improvement may exceed what can be achieved, or what is feasible, at least in the near term.

Health status and access in West Virginia are such that many may feel that all available resources should be channeled into the direct provision of care rather than documenting and evaluating system performance.

III. PROBLEM STATEMENT

Variations in health care access and use throughout West Virginia, the demographic profile of the population, and anticipated changes in the health care marketplace are factors that all point to the need for improved system performance. High morbidity and mortality, and the reported high prevalence of many negative personal health behaviors linked to the higher-than-expected morbidity and mortality statistics, suggest that performance measures when adopted should be designed to help explore the complex connections between personal and community behavior, health status, and the system response to both. Unlicensed services and programs should be added later.

Near term, the best approach appears to be the incremental development of an integrated health information system that supports performance measurement and improvement statewide. It should be expanded gradually into a comprehensive system that includes all licensed services and programs, and initially incorporates reliable, valid, accepted measures and indicators with gradual expansion to include additional services and providers. An underlying question is how to establish trust and cooperation among all interested parties in developing statewide performance measurement and accountability enhancement that can be used to improve personal and community health.

IV. ANALYSIS

A performance measurement system is a tool to improve service delivery, promote access to care, reduce costs, educate decision-makers, and help all parties make informed decisions. The process of disseminating publicly collected and reported information as part of this system helps fix accountability. The objective is not gratuitous criticism or punishment, but rather better care, lower costs, easier access, and informed decisions.

Measurement of health quality and health system performance is an evolving discipline, perhaps still as much an art as an exact science. The process involves different approaches and different types and sources of data. The traditional framework for measurement has three dimensions:

1. Structure - the characteristics of the care setting. Assessment of structure includes measures of safety code compliance, equipment maintenance, physical access, personnel certification, training and continuing education, disciplinary oversight for staff, hours of operation, scheduling, and telecommunications and information system availability and use.
2. Process - what is done for patients. Assessment of process includes measures of technical or clinical quality, the quality of interpersonal interaction between patient and provider, access to care, and appropriateness of care.
3. Outcomes - how patients respond to care. Common outcome measures include death, disease, disability, discomfort, dissatisfaction, and economic efficiency indices.

Measuring quality, access, and system performance is complex and challenging. Experts suggest the best place to begin may be determined by addressing a few basic questions:

- What dimensions of quality or outcomes are important? (Each interested party is likely to have its own perspective.)

- What data are available to measure these dimensions?
- How much can be invested in collecting, analyzing, and reporting the data needed to permit assessment?

There has been a proliferation of performance measurement systems and performance measures developed by health services researchers, database developers, health care organizations, government (federal and state), and commercial vendors. The growth of these systems has taken place without a common language, framework, or evaluation structure. Performance measurement systems that may have specific application in West Virginia include:

ORYX: The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) initiative to integrate performance measurement measures into the accreditation process. Long-term, ORYX will establish a data-driven, continuous survey and accreditation process to complement JCAHO's standard-based assessment. ORYX is included as part of the accreditation programs for hospitals, long-term care, networks, laboratories, home care, and behavioral health.

Health Employer Data and Information Set (HEDIS): The National Committee on Quality Assurance's (NCQA) most commonly used tool for assessing health plan performance using administrative data and clinical records. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to compare reliably the performance of managed care health plans.

Consumer Assessment of Health Plans Survey (CAHPS): a survey instrument developed through funding by the Agency for Health Care Policy and Research (AHCPR) that solicits patient assessment of quality, access, and the overall experience of obtaining and receiving care. The core module includes questions about waiting time, continuity, access to specialists, and patient-physician communications. Supplemental modules were developed for children and for special populations such as Medicare or Medicaid beneficiaries. HEDIS data collection was expanded in 1999 to include CAHPS survey questions.

The AHCPR **Healthcare Cost and Utilization Project (HCUP)** includes state-level hospital discharge data from 22 states. The **HCUP Quality Indicators (QI)** were developed to meet the short-term needs for information on health care quality. The HCUP QIs are a set of 13 clinical performance measures that enable (1) hospital self-assessment of inpatient quality and (2) public (state and community) assessment of access to care.

The Foundation for Accountability (FACCT): A not-for-profit coalition of purchasers and consumer organizations dedicated to helping consumers make better health care decisions. FACCT believes the ability to create a more responsive health care system depends on informed, empowered consumers who can help shape the system, hold it accountable for quality, and act as partners in improving health.

FACCT has built and tested a consumer information framework designed to simplify information sharing and education about performance. FACCT organizes comparative information about quality into categories suggesting how consumers think about their health care: basics (access, coordination of care); staying healthy; getting better; living with illness, and changing needs (caring for people and their families at the end of life). FACCT also has created performance measures for common and costly

conditions such as adult asthma, diabetes, breast cancer, and major depression. Measures for additional conditions are being developed.

The **Maryland Hospital Association Quality Indicators Project** is a clinically based, comparative database that helps providers understand and improve their performance. In addition to comparative analyses, the project provides indicator sets for acute, psychiatric, long-term nursing and home care, and technical support and service. More than 1,500 facilities nationwide participate in the **MHA-QI Project**.

Although private organizations such as the JCAHO and NCQA can establish quality measures, and grant accreditation status to those health care providers who use them, only governments can require hospitals, health plans, and others to collect data and disclose quality measurements.

Information to measure provider performance must be placed in the public domain to help ensure prudent and cost-effective health care purchasing and informed decision-making and to give health care providers reliable, comparable information for continued improvement of patient care. Approximately 40 states, including West Virginia, have legislative mandates requiring hospitals to submit data about discharged patients. (States protect patient-specific identifiable data; these data are not released.) Agencies such as WVHCA routinely collect, analyze, and disseminate comparable, reliable information about the use, costs, quality, and effectiveness of hospitals and other providers in their states. Their reports and data products are useful tools that hospitals and other providers may use to improve their performance and that interested parties can use to better understand the performance of hospitals and the health care system.

States are expanding data collection and reporting to include non-hospital settings such as hospital ambulatory surgery programs, freestanding ambulatory surgery centers, emergency departments, nursing homes, residential care facilities, physician offices, and home health. With managed care penetration increasing, state data organizations are requesting health plans to provide operational and performance data. The National Association of Health Data Organizations reports that 18 states required managed care plans to submit performance data in 1998.

V. ACTION STEPS

West Virginia can benefit from the experiences of other states and organizations in selecting accountability measures. Rather than attempt to develop and use unique measures, which would be likely to restrict comparability across states and among multi-state health plans, and would be expensive and time-consuming to develop and test, West Virginia should monitor and participate in ongoing performance measurement development initiatives, as appropriate, nationwide.

The following action steps are suggested:

- WVHCA should inventory performance measures and indicators, and the information systems that support them, used as benchmarks by leading public sector and private sector health entities.
- WVHCA should work with providers, purchasers, the public, and other interested parties statewide to develop a core set of accountability/performance measures. Measures should cover the structure, process, and outcome of care. Data collection and reporting processes should be tailored to these measures.
- Any system should ensure that benchmark accountability measures address identified at-risk populations, access, and vulnerable populations issues and use existing measures/indicators

whenever possible. Consideration should be given to AHCPR HCUP Quality Indicators, HEDIS, CAHPS and FAACT guidelines, and other national initiatives and clinically accepted guidelines that have shown promise. Any measure selected should have been demonstrated to be reliable, comparable, valid, and timely.

- West Virginia should develop a compliance and enforcement policy as part of the regulatory process (e.g., licensing, certification, certificate of need) or through contractual obligation (e.g., Medicaid, PEIA) that would require providers to collect and report data for accountability/performance measurement.
- WVHCA should develop an information dissemination strategy that includes reports, products, and education to meet the needs of different users (e.g., policymakers, payers, providers, health plans, and the general public).
- West Virginia should provide (seek) funding to support necessary information dissemination and indicator development activities.

VI. POTENTIAL SOLUTIONS

Accountability, by its nature, requires that the public sector play a leadership role in documenting and promoting it. Promoting collaboration between the public and private sectors will enhance the likelihood of better public accountability systemwide. Initial reliance on existing measures that will enable comparisons among West Virginia and other states, and providers located in other states, is advisable. Considerable insight may be gained by using existing databases (e.g., hospital discharge data, Medicaid, PEIA, Workers' Compensation) in conjunction with the measures and indicators now available. An analysis of preventable hospitalizations, using commonly available methods, also might be useful in identifying priorities.

Of concern will be the need to restrict additional data collection to legitimate accountability measures, the practicality of using existing regulatory controls to support data collection and reporting, and the need to balance improvement with the cost of collecting and reporting additional information.

VII. RECOMMENDATIONS

Ultimately, improvements in accountability and performance measurement are tied to having better, more complete, comparable, and timely information, in short, a statewide integrated health information system. The development of CHRIS (Consolidated Health-Related Information System), now under way at WVHCA should be viewed as the initial step in this direction.

Taking full advantage of publicly available resources (e.g., HCUP Quality Indicators, HEDIS, FAACT, etc.) is a prudent approach to improving accountability in a cost-effective manner. All interested parties should be invited to participate in developing a core set of accountability measures. Dissemination should be by consensus, if possible.

Collaboration will be critical for building trust among stakeholders, as well as for assuring that mandated data reporting is carried out and for devising implementation tools and applying sanctions for non-reporting.

VIII. FEASIBILITY

Increased accountability is being demanded throughout the health care industry. West Virginia can draw upon the experiences of other states, take advantage of the successes, and avoid the failures in promoting public accountability in its health care system.

Given the availability of data and initiatives already under way, West Virginia's initial efforts to enhance accountability probably should focus on hospitals, ambulatory surgery centers, nursing homes, and managed care plans. Imposition of additional accountability requirements should be gradual, across the continuum of care and among diverse populations as an improved information system permits. The growing elderly population and the identified at-risk populations are areas for which specific accountability measures should be developed as soon as possible.

All interested parties should be invited to participate directly in whatever process is chosen to deal with accountability questions. By its nature, public accountability has a highly subjective component. Each party will bring unique perspectives, knowledge, and experiences that can be useful in developing improved accountability.

IX. ACCOUNTABILITY

Accountability, as used in this section, refers to measures and indicators that can be used to assess provider and system performance and its responsiveness to identified health problems. Accountability is an important, non-clinical element of the health care delivery system because it provides a structural incentive for all parties to perform as effectively and efficiently as possible, and makes it possible to identify structural problems that may otherwise be unnoticed or misunderstood. Ultimately, a health care system that incorporates a high degree of accountability is likely to have better outcomes, more satisfied clients and providers of care, and more realistic expectations among all interested parties.

X. ISSUES FOR THE FUTURE

Potential issues for the future include:

- Establishing best practices benchmarks across all service settings.
- Monitoring feedback to providers of care in order to target at-risk populations and to document practice and behavior changes and their consequences, if any.
- Developing specific measures/indicators for targeting at-risk populations chosen for special focus.
- Assessing the responsiveness of information systems to provide data for newly developed measures.
- Documenting the costs and benefits of collecting, processing, and reporting performance data.
- Tracking the compliance of certificate of need recipients with conditions placed on their applications, as well as consistency with their financial and utilization projections.

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World Wide Web Sites

AHCPR/HCUP Quality Indicators

ahcpr.gov/data/hcup

Serving the American Public: Best Practices
in Performance Measurement

npr.gov/library/papers/benchmrk/nprbook

Foundation for Accountability (FACCT)	facct.org
Joint Commission on Accreditation of Healthcare Organizations	jcaho.org
National Association of Health Data Organizations	nahdo.org
National Committee for Quality Assurance	ncqa.org
Hospital Association of New York State Quality Links	hanys.org/resources/links/quality