**West Virginia Health Care Authority**
**Quality Utilization Advisory Group**
**July 29, 1999 - 10:15 a.m. - 3:00 p.m.**
**Embassy Suites, Charleston, West Virginia**

**Present:** Tanya Cyrus, Carla Hall, Jim Kranz, Colin Drozdowski, Max Fijewski, Martha Morris, Nell Phillips, Bobbie Hatfield, Bert Flanagan, George Pickett, Ann Stottlemyer, Anne Carpenter, Bonnie Brauner, Mary Emmett, John Alfano, Bill Asbury, Ben Taylor, Barbara Banonis, Cindy Tennant, James Forsythe, Dr. S. Kenneth Wolfe, Louie Paterno, D. Parker Haddix, Cathy Chadwell, Sallie Hunt, Linda Sovine, John Grey.

## Welcome and Introduction

Parker Haddix, Chairman of the West Virginia Health Care Authority, and the Quality Utilization Advisory Group (QUAG), called the meeting to order at 10:15 a.m. Mr. Haddix extended his appreciation to those present for their participation. Mr. Haddix stated that since the first meeting of the QUAG on April 20, 1999, the three sub-teams, Necessity of Admissions, Quality of Care, and Length of Stay, all met in May 1999. Mr. Haddix then introduced the meeting facilitator Marsha Boggess, with Organization Performance Initiatives Corporation. The Advisory Group members were then asked to introduce themselves.

## Process Overview

Marsha Boggess, meeting facilitator, indicated that the morning session would review the work done in each subteam meeting. Ms. Boggess stated that the session in the afternoon would include the development of recommendations for the West Virginia Health Care Authority to evaluate and then determine the appropriate course of action to fulfill the intent of Senate Bill 458 in creating the Utilization Advisory Board.

All handout materials are reflected in this meeting summary.

## Session Objectives

1. Review work of sub-teams
2. Develop more specific details regarding approach and required actions

**Necessity of Admission Sub-Team Recommendations**
**Presentation by James Forsythe, Ph.D.,**
**West Virginia Medical Institute**

## What Questions Do We Propose to Answer?

- Define necessity
- Define appropriateness
- What role will physicians play in admissions?
- What role will managed care play?
- What outpatient care options are available in West Virginia?

- What are the appropriate criteria?
- Are there protocols that proscribe admissions?
- Use of pre-certification
- Inpatient procedures in West Virginia that may be outpatient elsewhere.
- Who can control admissions (other health care organizations)?
- Does admission rate include re-admissions? If so, necessity for re-admissions
    - Injury
    - Compliance (social factors)
    - Evaluate the point of entry
    - Referral source:

**Data Collection**

- Admissions
- Re-admissions
- Pre-cert programs
- Referral sources
- Types of admission
- Litigation: failure to admit
- Population demographics
- Access of care
- Outcomes of admissions
- Inpatient vs. outpatient

**Approach**

- Select three target areas for NOA focus
    - Two diseases related
    - One injury/surgical
- Collect general data and data relative to focus areas
- Confirm target areas
- Comparisons

**Target Areas**

- End of life
- Respiratory disease
- Depression
- CV>
- Diabetes
- Backs - surgical

**Data Sources**

- HCA - admissions by code and surveys/readmission data
- WVMI - Medicare and Medicaid (necessity and outcomes)

- Private Insurers
- Hospitals and other providers
- External data from other states (other models)
- Federal data - i.e. NIOSH
- Maryland indicators>
- ACHPAR (outcome data)

**Conclusion**

- Who decides and controls admissions?
- How will admissions be monitored?
- How will reductions in admissions be encouraged and/or enforced?
- How will results be used for feedback and quality improvement?

**Comments and Clarifications From Breakout Sessions and Large Group Discussions**

- "Can you separate NOA from medical interventions?"
- "The healthcare system changes moment to moment, suggestion, look at Entry into the system versus NOA.
- "There is a need for reduction in admissions."
- "The 360,000 uninsured in WV will eventually end up in the hospital."
- "Predetermine the population you will look at, kids are different than adults."
- "Readmits within 30 days need to be studied."
- "By studying referral source, you will gain understanding as to why there is a significant number of admissions.">
- "Need to look at what other states have done."
- "Need to determine where people seek care."
- "Outcomes of admissions could be used as a bottom line in terms of success."
- "Need to look at financial and utilization outcomes:
    - What has the state saved?
    - How has it impacted the consumer?
    - The need to track customer satisfaction.

**Some Member Comments**

- "Can you separate NOA from medical interventions?
- "Without strict clinical indicators there is risk for not admitting"
- "The healthcare system changes moment-to-moment, suggestion: look at entry into the system versus NOA"
- "You must look at the person and the terrain - clinical purpose versus geographic issues."
- "There is a need for reduction in admissions."
- "360,000 uninsured in West Virginia will eventually end up in the hospital."
- Determine which population you might be looking at, kids are different than adults."

- "Cost is what is driving this, cost increases 17% each year."

**Other Concepts and Ideas Captured**
1. How will appropriateness be encouraged versus reductions
2. Might it be more appropriate to look at admissions to the healthcare system versus facility - look for a gateway that might include collaboration
3. Look at data collection results first before we develop process and make conclusions - segment WV data

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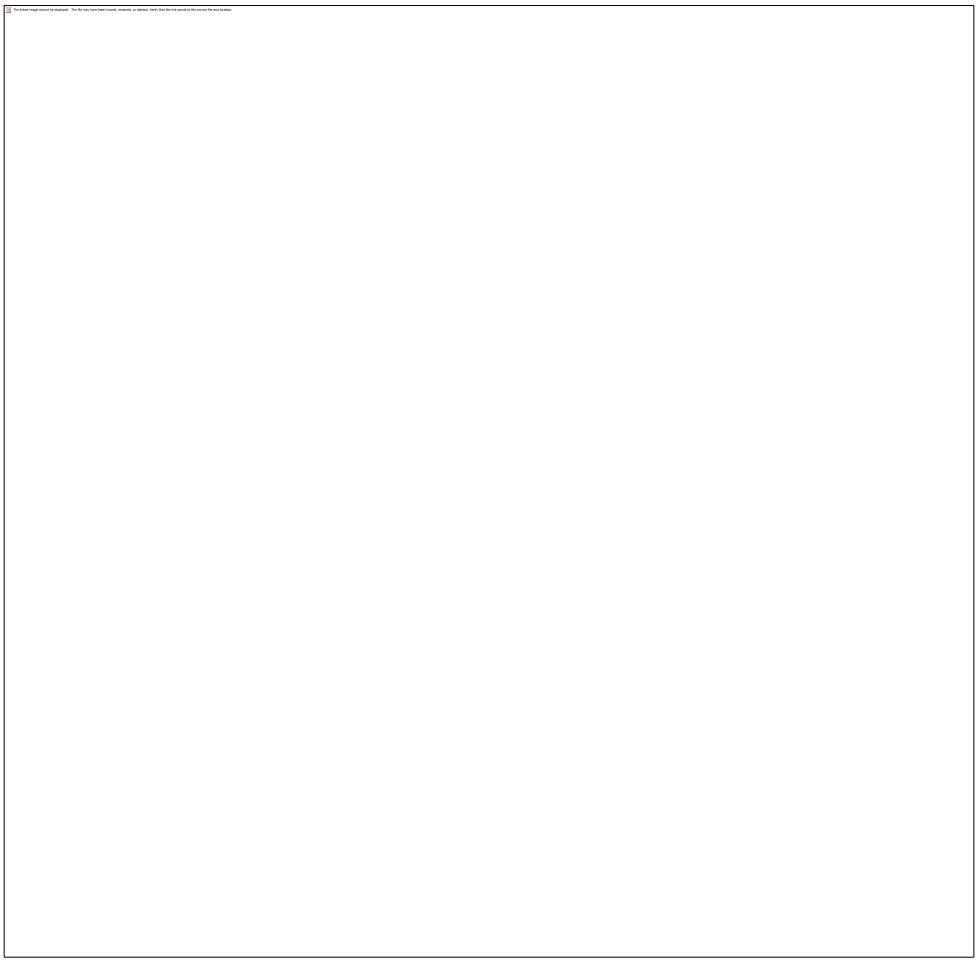

**GOAL:**
Reformulate task to examine:
1. Appropriateness of intervention (sub census necessity of admissions)
2. Review of all elements of care (including cost, length of stays, effectiveness, etc.) for episodes of care through the entire spectrum of care

Consider focus on areas such as: 1) end of life care; 2) cardiac disease; and, 3) psych conditions. If variation found after research, this becomes area for education, etc.

Target date: December 1999
Responsible: Full-time researcher -West Virginia Health Care Authority in collaboration with committee

## Quality of Care Sub-Team Recommendations
## Presentation by: James Forsythe, PhD, West Virginia Medical Institute
## Through Whose "Eyes" Are We Looking At Quality?

- Consumer
- Clinicians
- Providers
- Insurers/MCO's·
- Policy Makers

## What Is Quality of Care?

- Assurance - meet standards
- Common quality standards
- Improvement - beyond standards
- Benchmark
- Outcomes
- PT/Consumer satisfaction

## Define Quality Indicators

- >What are other states doing?
- What are the current standards of QOC for providers?
- Standards for the state?
- Can we integrate all of the standards

## Ideas on How to Begin Defining Quality of Care Indicators

- Guidelines
- JCAHO/NCQ/ORYX - HEDIS
- Consumer priorities - obj - sub (satisfied)
- Quality of life indicators
- Data sources for "best practices"
- Explore packaged programs to implement in state
- Population - based data
- QA - did you get the expected outcome? Was it an expected cost?
- HCA's utilization data
- Monitoring quality QA/QC
- Leadership for QI?

## Consumers Options?

- How should system operate?
- What kinds of questions/issues are addressed/redressed for consumer?
- Consumer's confidentiality and privacy vs. demand for public accountability.

## Regarding Approach to Development of a Plan for Review

### Phase I

- Define quality indicators
- Benchmarks
- Other indicators developed through input from perspective of acute care hospitals, and others as defined
- Decide attention focus for greatest impact on West Virginians

### Phase II

Develop system and methodology to assess and report quality (outcome and process) include:

- Collect data
- Analyze data
- Carrots and sticks
- Bridge to other programs

### Phase III

Implement the program as designed

- Breakthrough QOC improvement
- Incremental/Iterative QOC improvement

### Comments and Clarifications From Breakout Sessions and Large Group Discussions

- Regarding common quality standards; need to find at least one.
- Need to review existing guidelines regarding Quality of Care.
- Where do we find Quality of Care standards and can we go beyond the existing standards?

### Some Member Comments:

- "Early discharge from acute setting equals admissions to SNF."
- "As public servants, we are not doing our jobs looking at utilization just because it is a complicated issue doesn't mean we can refuse to look at it."
- "We realize that we must change the consumer expectations."

**Other Concepts and Ideas Captured:**

1. Early discharges result in readmits
2. Universal coverage: ultimate solution
3. Utilization appropriateness
4. Customer satisfaction

## Quality of Care Work Plan

Make recommendation(s) to the Legislature on how to organize a comprehensive agency(s) to remove communication barriers and improve quality of care and life in West Virginia.

1. Compare corporate organizational structure with other states
2. Draft organizational chart to meet desired goal
3. Include preventive care (cradle to grave coordination)
4. Wherever or however we organize there must be an education component with a substantial budget
5. Differentiate consumers of healthcare and coordinate their services
6. Have a mechanism to review government agencies to ensure they are meeting the ever-changing health environment
7. Consider a single point of entry for access to the health care system (holistic approach)
8. Review work of committee (QOC) to make recommendations based upon existing structure
9. What are the QOC issues effecting the delivery of care: (i.e., lack of a single point of entry)
10. Expanded knowledge of all available programs
11. Educate the consumer on how to use the current systems
12. "Forcing functions" to change behavior

- a. reimbursement
- b. have consumer be actual purchaser

## Length of Stay Sub-Team Report
## Presentation: Dr. James Cogan, MD,
## Cigna Healthcare

### What Questions Do We Propose to Answer?

1. Who makes the decision regarding the Length of Stay?
2. What are the factors that influence the Length of Stay?
3. What is the payment source?

4. What are the true medical indications (type of problem and intensity)?
5. Does the threat of litigation influence the Length of Stay?
6. What are the government regulations that shape or impact the Length of Stay?
7. What are the West Virginia factors that might influence the variations in Length of Stay, i.e. geography?
8. Are there other states with lower Lengths of Stay or Best Practices that influence lower Lengths of Stay?
9. Are there best practices, which are formalized and become the standard of care:

- Risk models
- Not-at-risk models (where outcomes justify lower lengths of stay)

10. What is the appropriate Length of Stay?
11. Does competition impact Length of Stay?
12. What is the impact of the Balanced Budget Act on Length of Stay?
13. How do consumers influence Length of Stay?

**What Issues Would Be of Greatest Interest and Have the Greatest Impact?**

1. End of Life inpatient days
2. Cardiovascular issues
3. Availability of discharge services
4. Patient Education services and how it is related to a timely discharge
5. Impact of lifestyle and culture on admissions and subsequent Length of Stay
6. Information on best practices for a few select services
7. Hospital use of best practices (consider survey)

## Scope of the Length of Stay Effort

Approach should include review of:

- Availability of discharge services
- Education of the patient regarding their condition or health status
- Determining best practices in use within WV as well as outside WV
- Impact of lifestyle and culture on admissions and subsequent Length of Stay
- Need for dissemination of information regarding best practices

## Approach

1. Get physicians and hospitals involved
    - What are they doing in this area?
2. Condense questions we are trying to answer

3. What information is out there regarding End of Life and Cardiovascular including Oncology, Chronic Obstructive Pulmonary Disease?
    - Determine what measurements are out there
    - Regional and West Virginia
    - Select states/regions with best outcomes
    - Build a nice knowledge base of acceptable indicators
4. Assimilate, compare, focus

    - Recommendations for improvement interventions (need measurement systems)

5. Package results and determine how to communicate
and how to implement interventions
6.On-going effort to measure, compare and publish/take action
per recommendations

**More Specific Actions Needed in the Approach**
**Length of Stay Work Plan**

**Physician Involvement**

1. Face to face meetings with providers and associations to communicate goals and objectives

2. Ask what agencies/providers are already doing in measuring Length of Stay
3. Find out what programs the associations have in place
4. Encourage participation by provider groups

**Condensing the Questions**

1. Define the problem and intensity
2. Factors that influence Length of Stay

    - Payment type
    - Litigation
    - Government
    - Geography/demographics
    - Competition
    - Hospital type
    - Medical indicators

3. Who should be making the decision
4. Best practices/appropriate Length of Stay
5. Consumerism

## Research

1. Designate a research person
2. Focus on two targeted areas End of Life and Cardiovascular
3. Literature search

- *Measurements
- *WV specific research/measurement
- *Length of Stay criteria
- *best practices

4. Review QUAG survey results
5. Solicit feedback

## Assimilate, Compare and Focus

A. General identification of major areas of concern in West Virginia
B. Look for specific topics by DRG (especially where West Virginia has greatest variances)
C. Evaluate/validate/weigh data
D. West Virginia/Regional/US benchmarking (outcomes emphasis)
E. Recommendations (develop with stakeholders/experts)

## Package, Communicate and On-Going Measurement

A. Get consensus on 4/5 codes
B. Package/roll out
C. Publish/measure/report out

## Comments and Clarifications From Breakout Sessions and Large Group Discussions

1. Will probably require a full-time research person assigned to the task (perhaps HCA) in collaboration with community.
2. Consider focus on areas such as EOL care, CVD, Psych. If variation found after research, then it becomes an area for education.
3. Consider reformulating the task to:·

- Examine the appropriateness of intervention and subsume NOA
- Review of all elements of care (include cost, LOS, effectiveness, etc.)

**Some Member Comments:**

1. "The responsibility of the hospital is to give feedback to the system. Hospital Board Members have a certain responsibility."
2. "We must have some recommendations for the legislature."

## Other Concepts and Ideas Captured

1. Episodes of interventions versus focus on hospitals
2. Days going down - costs are not
3. Inpatient versus outpatient cost shifting
4. If cost was intent, look at drug costs
5. Focus on research is good - look at alternative approaches
6. Cost - cost of technology - not same produce comparisons
7. Who should be ordering technology
8. Is technology being used appropriately
9. Medical intervention versus healthcare
10. Go back to the Legislature to determine the intent and the scope of future efforts
11. Give the Legislature some guidance

## Conclusion

"Based upon the outcome of today's meeting, Parker Haddix indicated that he felt the HCA will now be able to provide a good report to the Legislature. He thanked Dr. Forsythe and Dr. Cogan for their presentations. He indicated the next steps in the process would be for HCA to analyze the information presented and forward a report to the Legislature.

Regarding the QUAG "it's too early to say what its future may be". Perhaps the sub-teams may reconvene periodically on certain issues.

The QUAG will be kept informed via the website and a final report will be mailed to the members.

Prior to the meeting critique it was brought to the group's attention that the West Virginia Coalition for Quality Health Care is looking at a number of health related issues in West Virginia, using the Dartmouth Atlas Approach.

## Meeting Critique
## Positive/Benefits

1. "Good Lunch"
2. "We are moving forward and making progress."
3. "Admitting that this is one big task and coming up with the recommendations for the legislature is an accomplishment."
4. "A very positive process."
5. "There was genuine gratification received from hearing the perspective

of others.
6. "It is rare to see this many together at this level of government.
7. "This was a very well organized process, the meetings, agenda, and materials.
8. "This process is starting to build resource capacity within the state."
9. "This process has initiated a linkage between the key people."

## AREAS FOR IMPROVEMENTS/CONCERNS

1. Healthcare systems as a whole can be compared to "A Never Ending Story" some people are left out of the safety net.
2. When developing the final plan do not add more burden and cost.

**ADJOURN**