

**Quality Utilization Advisory Group  
Quality of Care Sub-Team  
May 25,1999**

**Welcome and Introduction**

Marsha Boggess, Facilitator of the Quality Utilization Advisory Group called the meeting to order at 10:05 a.m. To set the tone for the meeting, Marsha Boggess shared a thought with the group taken from the "Good Morning America" program that morning, as follows, the definition of happiness is;

**H**appy Genes  
**A**ltruism  
**P**urpose  
**P**ositive Attitude  
**I**ntimate Relationships  
**N**ever Retire  
**E**xercise  
**S**piritual Life  
**S**mile

The group was asked to introduce themselves and provide some professional background information, to give the members insight into the various roles and contributions they would contribute to the process.

**Members Attending**

Bert Flanagan, Cindy Tennant, Max Fijewski, Cyndy Haynes, Nell Phillips, John Alfano, Lou Ann Hartley, Ann Carpenter, Colin Drozdowski, T.S. Lanava, MD, Gloria Pauley, James Forsythe, James Kranz, Dr. Mary Emmett, Evan Jenkins, Kenneth Wolfe, MD.

**West Virginia Health Care Authority Staff Attending**

Parker Haddix, Louie Paterno, Garry Black, Greg Morris, Sallie Hunt, Cathy Chadwell

**Process Agreement**

Marsha Boggess provided an overview of a process agreement, which included the following:

1. Start meetings on time
2. Conduct meeting within established timelines
3. Refrain from side conversations
4. Adopt a team approach
  - o Look for common goals

- Listen to ideas of others
  - Provide positive and constructive feedback
  - Share responsibilities for follow-up actions
5. Adopt a strategy of collaboration vs. advocacy
  6. Keep cynicism in check
  7. Be patient with the process
  8. Resist "Not invented here", "We've done this"
  9. Use experience and knowledge to fullest
  10. Make this effort fun for you and others
  11. Avoid "air sucking"

All members consented to the process agreement terms. Marsha Boggess indicated that the list would be an "Evergreen List" to be added to as needed.

Marsha Boggess then guided the group in the process of identifying the following:

### **Questions We Are Trying To Answer Now**

- Through whose "eyes" are we looking at quality?
  - Payor, provider, patient?
  - Having a benchmark? To whom and what?
    - Services = appropriate and quality
    - Use the patient perspective
    - Whose criteria for benchmarking
    - Consistency (lack of)
    - Perspective of quality
      - Provider vs. Patient needs
      - Confusing = do we need quality standards?
        - common quality standards
        - consistent review
        - benchmark = what do we get players to accept?
        - Outcomes: bridge the issues of confidentiality collect and share concerns regarding breach of confidentiality
        - Problems:
          - Lawsuits - patterns and behaviors that are problems
          - Fragmentation of care and the need for a common data base
- 
- Payor source - US/MV, should it impact QOC?
  - What is QOC/interpreted? How does the definition vary across organizations and providers?
  - QOC varies by size of facility?

- What is role of hospital in improving QOC?
  - Activities/ownership in relation to
  - MD QOC> when not employed by hospital
  - Disease state (e.g. cardiovascular)
  - Volume to quality issues
  - Resource allocation quality
  
- MCOs impacting QOC? FFS? Prevention/coordination of care, etc.
- What is Quality of care?
  1. Assurance - meet standards
  2. PT/Consumer satisfaction
  3. Employer's role in QOC

### **What Questions Should We Be Trying To Answer as Part of This Initiative?**

- What do we do with poor quality providers?
- How can we work together to address this issue?
- Should we have a common review board?
- What authority do we have?
- How do we work together for the common goal of quality?
- Legislative process and medical process may not be consistent and focused upon
  - quality (due process)
- How do we balance legal and quality matters?
- Provider, payor, patient, legal, legislative
- How do we standardize processes?
- Peer review?
- How do we coordinate information and how does this get passed on to users?
- Benchmarks and outcomes
- \*\*\*Essential data collection systems
- Who/what should define quality of care? Value = cost/quality of care
- How much information should be given to the public?
  - Volume/type of information
- Measuring outcomes of QOC?
- Consumers options?
  - How should system operate?
  - What kind of questions/issues are addressed/redressed for consumer?
  - Consumer's confidentiality and privacy vs. demand for public accountability
- Who's going to pay?

- How do we measure the cost of quality?
- What is being done (nationally)?
  - What can we learn?
  - Possible partnerships: Do they have same or similar quality indicators?
- Standardization
  - How to Adopt Consistent Standards of care (example: there are 26 ways to measure a c-section, Illinois has 3 separate ways)
  - Utilization (appropriateness of care)
  - Data validity

### **Group Discussion: Ideas on How to Begin Defining Quality of Care Indicators**

- Guidelines
- JCAHO/NCQA/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 at an expected cost?
- HCA'S utilization data
- Monitoring quality QA/QC Need to Define role/legislative intent
- Leadership for QI? Need to Define role/legislative intent

### **Quality of Care Sub-Team Recommendation Regarding Approach To**

#### **Development of a Plan for Review**

##### **Phase I.**

- Define quality indicators
- Benchmarks
- Others indicators developed through input from perspective of acute care hospitals, and others as defined
- Decide where we should focus our attention to have the greatest impact on people of West Virginia

**Phase II.** Develop a system and methodology to assess and report quality (outcomes and process) including:

- Collect data
- Analyze data
- Report data

- Carrots and sticks
- Bridge to other programs

**Phase III.** Implement the program as designed

**Group Discussion on Phase I: Define Quality Indicators (build commonality)**

- What are other states doing?
  - approach and process
- What are the current standards of quality for providers?
  - standards for the state?
  - can we integrate all of the standards?

Example: observation beds (24 hours vs. 72 hours)

- What is the common database?
  - uniformity
  - consistency
- Medicare is the most stringent
  - Maryland = DRG state
  - Johns Hopkins/Bethesda
  - What are Q indicators?
- What are Q indicators?
- Very complex: Do they include:
  - Cost
  - Access to care
- What are the legal and medical issues impacting quality of care?

**Next Steps**

52. Develop information to explain need for "expansion" of legislation – an integrated approach to quality that goes beyond hospitals
53. Compile notes and distribute information to sub-team
54. Prepare presentation for the full advisory group meeting to be held in July

**Positives/Benefits of Meeting**

55. Lunch
56. Group make-up
57. Lot of good comments
58. Participation
59. Web page access
60. Members of Health Care Authority were present
61. Notes - we can read

62. Good attitude

**Concerns/Room for Improvement**

63. Where is our starting point

64. Room is too tight

Meeting adjourned at 2:46 p.m.

Meeting Materials Provided as Follows:

<p><b>MEDICARE 6<sup>th</sup> SCOPE OF WORK</b> Mark K. Stephens, M.D., M.S.H.A.</p> <p><b>Principal Clinical Coordinator</b></p>	<p><b>PURPOSE OF 6<sup>th</sup> SCOPE OF WORK</b></p> <p>Two broad functions:</p> <ul style="list-style-type: none"><li>▪ To promote quality health care services for Medicare beneficiaries; and</li><li>▪ To determine if services rendered are medically necessary, appropriate, and meet professionally recognized standards of care.</li></ul>
<p><b>6<sup>th</sup> SCOPE OF WORK REQUIREMENTS</b></p> <ul style="list-style-type: none"><li>▪ PROs will continue to use the HCQIP project. Process started during the 4<sup>th</sup> scope of work in 1993.</li><li>▪ PROs will continue to do individual case reviews as required by statute.</li></ul>	<p><b>MANDATORY REQUIREMENTS FOR HEALTH IMPROVEMENT PROJECTS</b></p> <ul style="list-style-type: none"><li>▪ PROs will be responsible for improving Statewide beneficiary health on specific quality indicators.</li><li>▪ HCFA's national health improvement priorities are clinical topics (i.e., related to direct treatment or prevention of diseases and conditions) with a major impact on Medicare beneficiaries.</li></ul>
<p><b>NATIONAL HEALTH IMPROVEMENT TOPICS</b></p> <ul style="list-style-type: none"><li>▪ Topics were selected based on their clinical significance and their ability to support</li></ul>	<p><b>NATIONAL HEALTH IMPROVEMENT TOPICS</b></p> <ul style="list-style-type: none"><li>▪ Over 3 year course of contract, PRO shall adopt, design, implement, and/or support</li></ul>

<p><b>interventions to promote improvement.</b></p> <ul style="list-style-type: none"> <li>▪ <b>Goal is to improve the health status of all Medicare beneficiaries who have one or more of these conditions.</b></li> <li>▪ <b>Six national priorities for which specific clinical indicators have been developed and validated.</b></li> </ul>	<p>interventions aimed at improving the statewide performance on the six sets of quality indicators.</p> <ul style="list-style-type: none"> <li>▪ Statewide baseline measurement and remeasurement to assess improvement in statewide performance.</li> </ul>
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<p style="text-align: center;"><b>WHAT DO THE NATIONAL PROJECTS MEAN FOR THE HOSPITAL?</b></p> <ul style="list-style-type: none"> <li>- CDACs will be doing statewide baseline measurement and remeasurement during course of 3-year contract</li> <li>- Hospitals will receive request from CDAC for medical records</li> <li>- Medical records will need to be copied and sent to CDAC <i>within 60 days</i> of the request. <i>This is a condition of participation.</i></li> </ul>	<p style="text-align: center;"><b>WHAT DO THE NATIONAL PROJECTS MEAN FOR THE HOSPITAL?</b></p> <ul style="list-style-type: none"> <li>- All hospitals will participate in projects for the national topic areas</li> <li>- PROs will be working closely with hospitals to increase the rate of compliance on the quality indicators</li> <li>- PROs will be working to increase the state-wide rate of compliance on each quality indicator</li> </ul>								
<p style="text-align: center;"><b>LOCAL HEALTH IMPROVEMENT TOPICS</b></p> <ul style="list-style-type: none"> <li>- PROs will be able to conduct 1 or more state-specific health improvement projects of each of two types:</li> <li>- For national clinical conditions (diabetes, MI, CHF, pneumonia, breast cancer, stroke) addressing alternative settings of care, delivery systems, vulnerable populations, and/or prevention</li> <li>-For beneficiaries with other clinical conditions</li> </ul>	<p style="text-align: center;"><b>LOCAL HEALTH IMPROVEMENT TOPICS</b></p> <ul style="list-style-type: none"> <li>- Reduce the disparity in indicator performance between beneficiaries living in the state who are members of a disadvantaged group</li> <li>- The PRO shall design a local project to reduce the targeted disparity. This project should use the quality indicators from the national project topics.</li> </ul>								
<p style="text-align: center;"><b>IMPROVEMENT PROJECTS WITH MEDICARE CHOICE PLANS</b></p> <ul style="list-style-type: none"> <li>- Starting 1/99 all plans must do QI projects as part of Quality Improvement</li> </ul>	<p style="text-align: center;"><b>PAYMENT ERROR PREVENTION PROGRAM (PEPP)</b></p> <ul style="list-style-type: none"> <li>- Payment error is defined as a number of dollars found to be paid in error out</li> </ul>								

<p><b>System for Managed Care (QISMC) standards.</b></p> <ul style="list-style-type: none"><li>- Required to implement specific number of QI projects.</li><li>- HCFA may specify clinical topic and indicators to be used in projects (first one is diabetes).</li></ul>	<p><b>of total dollars paid for inpatient PPS services.</b></p> <ul style="list-style-type: none"><li>- Statewide surveillance system will be used to provide state-specific estimates on the payment error rate.</li></ul>
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