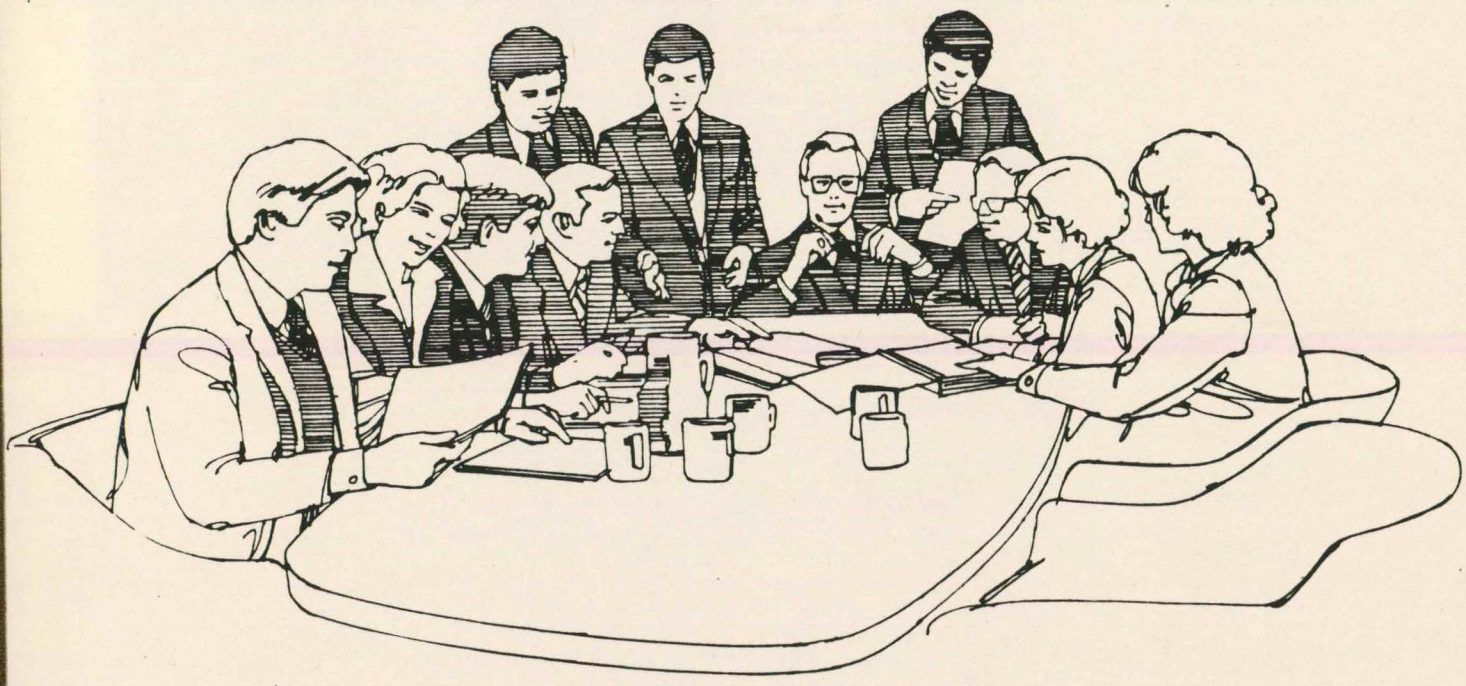
1990
ANNUAL REPORT
Health Care Utilization Task Force



HEALTH CARE UTILIZATION TASK FORCE

601 Locust Street, Suite 330
Des Moines, Iowa 50309 • (515) 243-6441

Background

The Health Care Utilization Task Force was appointed by the **Iowa Health Data Commission** to oversee a utilization of procedures study. The **Commission** itself was established by the Iowa Legislature in 1983 and given the mission of compiling and disseminating accurate health data, including information on price and usage. It was felt that collection and use of this data would be a stepping-stone for arriving at solutions for needed changes in health care delivery and financing, including stimulation of price competition.

Creation of the Commission was a response to steadily increasing health care expenditures in the United States. In 1989, health care costs amounted to $599 billion, nearly $2,400 for each person in the country, making up 11.5 percent of the nation's gross national product.

By the year 2000, health care spending is projected at $1.5 trillion--that's over $5,500 per person and 15 percent of the country's estimated gross national product. Even allowing for inflation, these figures are a drastic increase from the average $205 spent on each man, woman, and child in the United States for health care during 1965.

The Iowa Health Data Commission gratefully acknowledges the expertise and insight of the members of the Health Care Utilization Task Force, set up to advise on issues related to the utilization of health care.

HEALTH CARE UTILIZATION TASK FORCE MEMBERS

REPRESENTATIVE	ORGANIZATION
Robert Gibbs, Chairperson Des Moines	Consumer
Shirley Henderson, Vice Chairperson Cedar Rapids	Heritage Area Agency on Aging
John Alsip, Ph.D. West Des Moines	Iowa Foundation for Medical Care
Susan L. Beck, D.O. Des Moines	Iowa Osteopathic Medical Association
Dennis Bock Eastern Star Masonic Home Boone	Iowa Association Of Homes For The Aging
Perry J. Chapin Des Moines	So. Central Iowa Federation of Labor
Donna Gabriel Clinton	American Association of Retired Persons
Mary Hellerstedt Des Moines	Blue Cross/Blue Shield of Iowa
Peter Hilsenrath, Ph.D. College of Medicine Iowa City	University of Iowa
Sister Helen Huewe Mercy Health Center Dubuque	Iowa Hospital Association
Frederick O. Lorenz, Ph.D. Ames	Iowa State University
Kay Montgomery, R.N. Iowa Methodist Medical Center Des Moines	Iowa Nurses' Association

(continued)

HEALTH CARE UTILIZATION TASK FORCE MEMBERS (continued)

REPRESENTATIVE	ORGANIZATION
Richard J. Morrow, Ph.D. Division of Pharmacy Sciences Des Moines	Drake University
Mary C. Nelson Iowa Power Des Moines	Iowa Association of Business and Industry
R. Bruce Trimble, M.D. Mason City	Iowa Medical Society
Julie Van Gorp Des Moines	Consumer

CONTENTS

Introduction

The Health Care Utilization Task Force was created under the **Laws Of The Seventy-Third General Assembly, 1989 Session,** of the State of Iowa, Chapter 304, Division X, Section 1002-2. Contained in the Omnibus Health Bill (Senate File 538), the Iowa Health Data Commission was required to "contract for a health care utilization study to review, identify, and address issues related to the utilization of health care services in the state by comparing national data with Iowa data."

The Commission was directed to appoint a representative task force to oversee and review the study which, according to Session law, was to complete the following tasks:

(1) Collect and analyze existing research on the medical efficacy of certain medical procedures and study potential overutilization of the procedures in the state, and prepare a summary of procedures for which there is a significant level of usage in the state and for which substantial evidence from nationwide data suggests there is overutilization on a national level.

(2) Use information collected by the health data commission to evaluate variations in the utilization of diagnostic-related groups and assess the effects of the variations on patient outcomes and health care costs.

(3) Utilize findings developed under this section and analysis of actions taken in other states to identify protocols used in other states for the usage of procedures identified as having high coefficients of variation and as being subject to overutilization.

(4) Make recommendations to the commission and the representative task force regarding the use and potential application of the study findings by health care providers, educators, purchasers, governmental entities, insurers, consumers, and other interested constituencies.

b. The task force shall complete all of the following tasks:

(1) Make recommendations to appropriate agencies and organizations regarding protocol development and implementation, physician education, second opinions for procedures, and reimbursement limitations on procedures which have been identified as subject to overutilization.

(2) Make recommendations regarding other means of reducing health care costs by utilizing health care services more effectively.

(3) Report its findings related to the duties established by this paragraph to the commission, the governor, and the general assembly on or before January 1, in the years 1991, 1992, and 1993.

Task Force Membership

The Health Care Utilization Task Force had its first meeting in October of 1989. Sixteen members were recruited from the following representative groups and organizations: The Iowa Foundation for Medical Care, Iowa Osteopathic Medical Association, Iowa Association Of Homes For The Aging, So. Central Iowa Federation of Labor, University of Iowa, American Association of Retired Persons, insurance, Iowa Hospital Association, Iowa State University, Iowa Nurses Association, Drake University, Iowa Association of Business and Industry, Iowa Medical Society, area agency on aging, and two consumer representatives. Robert Gibbs, a consumer representative, retired, and past president of the Iowa Pharmacists Association, was appointed chairperson; and Shirley Henderson of the Cedar Rapids Area Agency on Aging was selected as vice chairperson. (See page ii for a List of Task Force Members.)

Early Focus on Long-Term Care Data

The Iowa Health Data Commission is required under 145.3(4) "e" and "f" of the **Code of Iowa** to collect long-term care information. As part of the special study mentioned earlier, the Commission included long-term care data gathering.

The Iowa Foundation for Medical Care (IFMC) was chosen through the bid process as the contractor for the study project. The contractor received direction from the Commission and its staff and from the members of the Health Care Utilization Task Force. The final report prepared by the Iowa Foundation for Medical Care was approved by the task force. (See Supplement I for **A Review of Cost, Utilization, and Quality Data Relating to Long Term Care Facilities** as presented to the Commission, Governor, and Iowa Legislature. A copy is available on request.)

Why Collect Long-Term Care Data?

The 1980 Census found 13.3 percent of Iowa's population was 65 years of age or over, and six percent were age 75 or older. Nationally, the state had the fourth highest percentage of people who were 65 or over and had the second highest percentage population of those 75 or older. Projections for 1990 indicate that the population proportion that is 65 years of age has increased to 15 percent in Iowa and that the percentage of those 75 years of age has now exceeded seven percent. It is expected that the state's older population will continue to grow in the future and that it will become older.

In 1980 there were 31,400 Iowa nursing home residents, the majority of whom were 65 or over. This number decreased to around 29,700 in 1990; however, current facility residents tend to be older and in poorer health, requiring more intensive and expensive care.

Additionally, many elderly Iowans are remaining in their own homes either by help provided from family members and others or as the result of receiving services provided by home health agencies, adult day care centers, and other community facilities and programs.

Ramifications

Because the elderly have a high degree of health care usage--primarily due to chronic illness--and because they require particularly expensive medical resources to maintain life in the last year, the aging of Iowa will continue to have a strong economic impact on the state for years to come.

Government, policy makers, and community leaders must therefore begin making decisions on how the elderly will be cared for. Planning is necessary to ensure having the proper number and placement of facilities, the availability of health care professionals, and the development of needed programs. Financing will be an important concern.

Currently, about 50 percent of those in Iowa nursing facilities are covered under Medicaid, which has implications for state budget dollars; for example, will this percentage stay the same or increase? Another consideration is the trend in recent years to pass laws which allow a spouse in a nursing home to transfer income and resources to one's spouse who remains at home. This could result in an increase in actual numbers of those on Medicaid, or it could mean a quicker transition time from being a private-pay patient to becoming a Medicaid-covered individual.

Questions

There are many other questions that need to be answered. These include:

- Should there be an increase or a decrease in the number of nursing home beds available in the state?
- Should development of proprietary facilities be encouraged or discouraged?
- Should alternative forms of living arrangements be developed for retirees?
- Should a way be found to cover expenses that are incurred outside of nursing facilities to enable more people to stay in their own homes for a longer period of time? (Authorities agree that the vast majority of elderly care now occurs in the home, but few of these expenses are currently covered by private insurance or Medicare, placing a hardship on the elderly and their families.)

To help arrive at answers to some of the questions that have been posed, the state needs to achieve a complete overview of cost, utilization, and quality for both facility-based and adult day care as well as home health care. To do this, there is a need for a uniform, comprehensive data collection system throughout the state, with the data organized in useful formats.

Long-Term Care Study

As the selected contractor for the Iowa Health Data Commission study, the Iowa Foundation for Medical Care inventoried long-term care data being collected nationally, identified Iowa sources for similar data elements, and examined the possibility of a single Iowa repository for that data.

1. National Data Inventory and Results

A national survey was undertaken to identify the most commonly and frequently collected long-term care data elements. All 50 states were contacted through a phone survey that asked what data they collected and their reasons for collection.

Findings: The most commonly and frequently collected data elements described the **population covered, level of data collected, collection period,** and **demographics** as well as **facility, utilization,** and **financial** and **staffing aspects.** Data on privately financed services, quality of care, and non-facility health care, such as that provided in the home, was scarce.

2. Iowa Data Inventory and Results

The data collected in Iowa was divided into three groups: Group one contained ten reports and studies that were completed since 1984 that were relevant to long-term care services. Group two consisted of infrequently collected data. Group three was comprised of data elements collected consistently, frequently, and which coincided with national data sources. This group contained 16 reports from seven agencies.

Findings: When the data elements in Group 3 were compiled and collated, new insights into long-term care utilization emerged. These included:

- **Small facilities have higher per-diem costs than large facilities in all but proprietary settings.**
- **Room and board costs are less than the direct health care costs in all long-term care settings except for government facilities.**

Summary Points

- Consumers and policy makers need access to analyzed data to facilitate evaluation and decision making.
- Data is available but needs to be better organized to increase its usefulness.
- Little data on long-term care exists outside of facility-related information.
- Most data is based on Medicaid patients, with little information being available on private-pay patients.

Recommendations

(1) **Extract those data elements which are frequently and commonly collected nationally from existing Iowa reports.**
(2) **Appoint a single agency empowered to monitor the data submission and process it according to the needs of agencies, policy makers, providers and consumers.**
(3) **Assemble the data into a single document. This would provide a consistent, easily repeatable format that would help in facility comparisons. (A variety of reports could be developed from this single source document.)**
(4) **Develop consumer documents that would either direct the consumer to more specific data via a general brochure or possibly provide actual comparative data.**
(5) **Consider collecting data on private-pay facility patients, home health care, and community-based services to complement the comprehensive facility data already being collected.**

The complete report on long term care, prepared by the Iowa Foundation for Medical Care and approved by the Health Care Utilization Task Force, was presented to the Iowa Health Data Commission prior to the end of the fiscal year. With that task completed, the group turned its attention to utilization of procedures.

Health Care Utilization Study

With the beginning of the 1991 state fiscal year, the Health Care Utilization Task Force began overseeing the first part of the utilization study being conducted by the Iowa Foundation for Medical Care, with subcontracting done by the Health Management Information Center. Results of this part of the study will help interested organizations and policy makers to focus their efforts on those procedures with the greatest potential for improving patterns of care. This should help to control health care costs as well as increase patient quality of care.

The ability to analyze utilization of procedures results from past health data collection and studies, including small area analysis, which provides a method of measuring and comparing the uses of medical care by different populations. Small area analysis utilizes such statistical techniques as adjustment for age, sex, and random variation, and compares one group's experience with another. The results of small area analysis have consistently shown that a wide variation exists in the usage of certain procedures, and that these variations appear to be the result of differences in individual medical practice patterns.

One of the beginning tasks of the study was to determine procedures occurring with the greatest frequency in Iowa. The ten most frequent causes for hospital admission were identified as:

- Adult Gastro-Enteritis
- Psychoses
- Adult Pneumonias
- Heart Failure and Shock
- Acute Myocardial Infarction
- Cholecystectomy with Gall Bladder Disease (Procedure)
- Medical Back Problems
- Adult Bronchitis and Asthma
- Substance Dependence Rehabilitation or Detoxification
- Specific Cerebrovascular Disorders

Of these ten most frequent causes for hospital admission, one was a procedure: Cholecystectomy with Gall Bladder Disease.

In the study, data was also analyzed to identify those procedures that accounted for the highest total hospital inpatient days, highest total dollars, and those procedures with high variable admission rates. Procedures with the highest total patient days were:

(1) Other Mental Disorders and Procedures
(2) Major Joint Operations

Procedures that consumed the most dollars were:

(1) Major Joint Operations
(2) Coronary Bypass Procedures
(3) Major Small and Large Bowel Operations
(4) Other Vascular Procedures
(5) Cholecystectomy with Gall Bladder Disease
(6) Other Mental Disorders or Procedures

Procedures with the highest variable admission rates were:

(1) Coronary Bypass Procedures
(2) Chemotherapy and Radiotherapy
(3) Tubal Interruptions for Non-Malignancy
(4) Tonsillectomy and/or Adenoidectomy

The table on the following page provides further information on the procedures identified in the study.

Table 1. Summary of Procedures*

Procedure	#Adms.	Pt. Days	Dollars**	SCV***
Most Frequently Admitted Procedure				
Cholecystectomy with Gall Bladder Disease	5866	40303	29251	79
Procedures with the Highest Total Patient Days				
Other Mental Disorders and Procedures	4989	87437	29129	187
Major Joint Operations	5157	56000	55067	54
Procedures that Consumed the Most Dollars				
Major Joint Operations	5157	56000	55067	54
Coronary Bypass Procedures	2030	28180	44278	930
Major Small and Large Bowel Operations	3095	42724	35622	34
Other Vascular Procedures	3513	31968	33870	216
Cholecystectomy with Gall Bladder Disease	5866	40303	29251	79
Other Mental Disorders and Procedures	4989	87437	29129	187
Procedures with the Highest Variable Admission Rates				
Coronary Bypass Procedures	2030	28180	44278	930
Chemotherapy and Radiotherapy	5061	17053	13377	726
Tubal Interruptions for Non-Malignancy	296	948	790	463
Tonsillectomy and/or Adenoidectomy	2842	3127	3250	317

* For patients hospitalized in Iowa in 1988.
** In millions of dollars.
***The Systematic Component of Variation (SCV) is a measure of variability in admission rates. The higher the value the greater the variability in the use of the procedure.

(See Supplement II for the **Report on Admissions, Patient Days, Dollars and Variation for Non-Maternity Inpatient Hospitalizations in Iowa, 1988** as presented to the Commission, Governor and Iowa Legislature. A copy is available on request.)

Next Step

During 1991, the task force will continue to oversee other portions of the study. This will include looking at the efficacy of the procedures identified during the 1990 study as well as assessing their potential for overutilization. The group will also look at information collected by the Iowa Health Data Commission to evaluate variations in the utilization of diagnostic related groups and to assess the effects of variations on patient outcomes and health care costs.

Concluding Comment

The Health Care Utilization Task Force looks forward to another year of working with the Commission in implementing the Iowa General Assembly's legislation on behalf of the people of the State of Iowa.