

Appendix G.—Health Systems Agency of Northern Virginia

The Health Systems Agency (HSA) of Northern Virginia, now in its seventh year of operation, represents an interesting case of the role of HSAS in encouraging competition and the provision of information. This appendix provides a brief summary of the role of health planning agencies in encouraging competition and consumer choice, with specific examples from the northern Virginia agency.

HSAS primarily function as planning and regulatory agencies and have seldom viewed promoting competition as a primary mission. Although the 1979 amendments (Public Law 96-79) to the National Health Planning and Resources Development Act (Public Law 93-641) called on State and local Planning agencies—HSAS and State Health Planning and Development Agencies (SHPDAs)—to make the encouragement of competition one of their priorities in their review activities and in their community development efforts, many agencies have viewed this charge with hesitation and question.

In a recent survey on this subject, several agencies reported that without changing the present reimbursement system, little could be achieved in terms of increased competition (175). Other agencies argued that the tools available to planning agencies are so limited that little can be expected. Since the 1979 amendments, approximately 30 percent of State and local health planning agencies reported that they have changed their certificate-of-need (CON) review criteria to promote competition.

In another survey conducted by the Intergovernmental Health Policy Project (131), **8 out of 45 States responded that they had changed their CON program to foster competition. Types of changes that have occurred include comparative reviews of applications; exclusions for health maintenance organizations (HMOS); dual choice for State employees; revisions in CON review criteria, administrative procedures, and dollar thresholds; procompetitive insurance laws; and better public information about the market.**

The HSA of Northern Virginia conducted several activities in which price competition among health care providers was supported. In 1980, the HSA focused attention on end-stage renal disease services. At that time, a proprietary corporation, run by subsidiaries of National Medical Care, Inc. (NMC), operated all of northern Virginia's outpatient maintenance kidney dialysis services. The HSA of Northern Virginia attempted to (80):

- increase the number of physicians from which kidney disease patients could choose in the existing outpatient facilities;
- confront restrictive policies that limited medical staff privileges to physicians' owning or operating the NMC dialysis facilities (new policies were set to allow any qualified physician to treat a dialysis patient);
- encourage the development of new independent dialysis services to reduce the domination of a single proprietary corporation; and
- encourage new services to base their charges on the cost of providing services instead of the higher Medicare fee, thereby promoting price competition.

To date, the HSA of Northern Virginia reports that over one-half of the maintenance dialysis facilities have changed their closed medical staff policies and that NMC'S market share has decreased with the development of new and competing dialysis services.

An example of health planning activities aimed at increasing consumer knowledge about health care services was the Northern Virginia HSA'S development of the *Northern Virginia Directory of Physicians, 1979 (194)*. According to Mark Epstein, the Assistant Director of the Northern Virginia HSA, consumers were experiencing difficulties in choosing physicians in such a transient area. As a result, the HSA decided to compile a physician directory and contacted the Northern Virginia Medical Society for assistance in designing the questionnaire and in encouraging area physicians to participate. Because of the State Medical Practices Act restriction on physicians' advertising, the medical society initially did not get involved. The Northern Virginia HSA then successfully persuaded legislators to change the State law so that physicians were permitted to advertise. This cleared the way for the medical society's and individual physicians' involvement (80).

In the directory, the following types of information were collected:

- **Introductory information.** —Type of practice (fee-for-service or prepaid group practice, solo or group), type of support services in office, sex of physician.
- **Availability.** —Appointment only, accepts new patients, office hours, phone consultations, house calls, waiting room time, language spoken, access

to transportation services and parking, handicapped accessibility.

- **Practice information.** —Tests available in office (complete blood count, etc.), fee and time for results, tests available in building.
- **Education, certification, and affiliation of physician.** —Schools graduated from, specialty certification, hospital affiliation.
- **Fees and billing.** —Standard fees; use of usual, customary and reasonable charges, credit card policies; complaints; billing policies. (Note: no specific fees were included in the directory.)
- **Health insurance.** —Blue Cross/Blue Shield, Medicare, Medicaid, Medicare fee schedule as payment in full, computes patients' insurance forms at no charge, bills insurance directly and waits for payment.
- **Counties covered.**
- **Health maintenance organization information.** —practice information, availability, staff support service.

The *Northern Virginia Directory of Physicians*, while comprehensive in description, does not provide actual physician fees, quality rankings, or comparisons of services. Over 12,000 directories were disseminated to the public at no cost. Owing to staffing limitations and budget cutbacks, it is questionable whether the directory will be updated. With the assistance of the Fairfax County Office on Aging, the HSA has also prepared a directory of nursing home services in northern Virginia.

In addition, the HSA of Northern Virginia collaborated with the Montgomery County (Md.) Department of Health Systems Planning, the District of Columbia SHPDA, and the HSA of Southern Maryland in setting up the Metropolitan Tertiary Care Task Force to study the regionalization of tertiary care services (80). Cardiac surgery and cardiac catheterization were the first technologies to be assessed. The purposes of the study were: 1) to determine the Washington area's capacity to perform cardiac catheterization and cardiac surgery, 2) to assess if this capacity is sufficient to meet the projected demand, and 3) to identify where these services should be located.

HSAs first analyzed the heart disease mortality rates for 1977. Wide variation was found in the heart disease mortality rate per 10,000 population in the four planning areas: D.C.—31.7, Montgomery County—22.5, northern Virginia—17.2, and southern Maryland 16.3. They noted in their report that data on health status are not adequate for predicting the need for cardiac catheterization services for the following reasons (178):

- 1) sufficient data on the incidence of treatable heart disease do not exist; 2) a single patient may require

repeated cardiac catheterizations to perform a variety of tests (there presently are no data on the frequency of repeat catheterizations); and 3) catheterizations to substantiate negative findings are not reflected in heart disease incidence or prevalence data.

Besides the difficulties with health status data, other factors may affect future need for specialized cardiac care services. First, the technology is constantly undergoing change and innovation (e. g., intra-aortic balloon assist and external cardiac assist devices.) The use of beta blockers is another technological innovation that may influence the use of tertiary cardiac care services. In addition, evidence regarding the effectiveness of coronary artery bypass surgery is insufficient to warrant its consideration as a major treatment for prolonging life for heart disease patients.

A technical advisory panel to the Tertiary Care Task Force, made up of Washington D. C., area experts in open-heart surgery and cardiac catheterization, estimated the number of surgical procedures that should be performed to maintain an adequate volume for quality care: 360 open-heart procedures by a single cardiac surgical team in a dedicated operating room and 200 in a multipurpose operating room (178). These recommended utilization rates were then compared with the surgical capacity and estimated number of procedures at the seven Washington area non-Federal hospitals in 1978: Georgetown University Hospital, George Washington University Hospital, Howard University Hospital, Washington Hospital Center, Washington Adventist Hospital, Fairfax Hospital, and Children's Hospital.

The Tertiary Care Task Force found that only three hospitals—Washington Hospital Center, Fairfax Hospital, and Children's Hospital—were operating at a sufficiently high volume to assure quality care, as defined by the expert panel. None of the Federal hospitals (Veterans Administration Hospital, Walter Reed Army Medical Center, National Institutes of Health Clinical Center, and National Naval Medical Center) met the open-heart utilization standards. In other words, the majority of Washington area hospitals were doing less than the recommended number of cardiac procedures.

In addition to examining utilization as a measure of quality (and cost), the task force also studied mortality rates and suggested the following guidelines (178):

1. The mortality rate in the 30-day period following:
 - adult open-heart surgery should not exceed 5 percent for coronary bypass surgery, and 10 percent for all other types of cardiac surgery
 - pediatric heart surgery should not exceed 25 percent for patients under 1 year of age and 10 percent for all other pediatric patients (i.e., patients 1 to 14 years of age)

2. The mortality rate in the 24 hours following cardiac catheterization should not exceed 1 percent for adult patients and 3 percent for pediatric patients.

In 1978, the task force found the highest mortality rates at Children's Hospital (15 percent), Georgetown University (10 percent), Howard University (10 percent), and Washington Adventist Hospital (8 percent) (178). The high mortality rate at Children's Hospital may be due to the already high-risk infants that make up a large proportion of the caseload. At Georgetown, the high mortality rates may be due to the more complex valvular surgery performed there.

These findings, as reported by the Washington press, criticized the heart surgery programs of the low-volume, high-mortality hospitals (42). To improve this situation, the task force recommended more cooperation and referral among area hospitals. It specifically recommended that all pediatric cardiac surgery should

be performed at Children's Hospital, and affiliations among other facilities should be expanded since "the demand does not appear sufficient to sustain six programs" (178). After this critical review of cardiac care by health planning agencies, experts, and the press, the press noted anecdotal reports of people who canceled surgery scheduled in low-volume hospitals (146).

This case illustrates the potential effect of information related to quality of care. Since publication of the initial report in December 1978, several hospitals in the metropolitan area have hired new cardiac specialists and increased their open-heart operations dramatically, bringing them within the acceptable range according to the cardiac guidelines (179). Only one hospital maintains a cardiac program below the acceptable utilization standards. Moreover, the mortality rates at the hospitals with increased volumes have improved, while the hospital with the lowest volume reports the highest mortality rate.