



Summary of Work and Recommendations for Plan Development

West Virginia Health Care Authority Quality and Utilization Advisory Group Summary of Work and Recommendations for Plan Development

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INTRODUCTION

In 1997, the West Virginia Legislature passed Senate Bill 458, directing the Health Care Authority (HCA) to establish a Utilization Review and Quality Assurance Program. The purpose of this program was to avoid unnecessary or inappropriate utilization of health care services and to ensure high quality health care in the state. To achieve this objective, the Bill provided for the:

- (a) Coordination of the Utilization Review and Quality Assurance Program with peer review programs presently established in state agencies, hospital services and health services corporations, hospitals or other organizations;
- (b) Monitoring of problem areas, imposition of sanctions and provision of incentives as necessary to ensure high quality and appropriate services; and
- (c) Establishment of a Quality Assurance Advisory Group to facilitate program development.

In response to this directive, the HCA established a Quality and Utilization Advisory Group comprised of physicians, managed care leaders, hospital executives, advocacy groups, legislators, public health directors, state agency leaders and consumers. The group was selected based upon their experience and demonstrated leadership in the West Virginia health care delivery system and their perceived ability to provide continued leadership to achieve the objectives set forth by Senate Bill 458.

Responding to the Directive: The Process

On April 20, 1999, the Quality and Utilization Advisory Group (QUAG) first met to review their mission and goals and to formulate a high level plan to pursue the desired outcomes of Senate Bill 458 (Attachment I). The diversity of backgrounds, experiences and vantage points of the QUAG incited highly interactive and spirited discussion as the group processed through the broad scope and difficulty of the task before them. The strategy for approaching the work was to divide the QUAG in to three sub-teams with a focus that mirrored the legislation: Necessity of Admissions, Quality of Care, and Length of Stay. At the conclusion of the initial kick-off session on April 20, members of the QUAG provided the staff of the West Virginia Health Care Authority with an indication of interest regarding personal participation on one or more sub-teams. The staff of HCA reviewed the information provided and the three sub-teams were formed, providing QUAG members with an opportunity to participate on one or more of the sub-teams. The three sub-teams were given a charter (Attachment II) and met in a facilitated forum to develop recommendations to the full QUAG regarding how the QUAG should approach fulfilling the mission of Senate Bill 458. Participation by the QUAG members on the sub-teams was high and very interactive. The format for the recommendations was structured to address the following topics and questions.

- What Questions Do We Propose to Answer?
- What Issues If Addressed Would Be of Greatest Interest and Have the Greatest Impact in West Virginia?
- What Should Be the Scope of the Effort to Address These Issues?
- What Should Be the High Level Approach to Addressing These Issues?
- What Are the Proposed Steps That Are Needed to Move Forward?

Meeting notices and minutes from sub-team meetings were posted on the HCA website and all QUAG members were invited to comment.

The full QUAG met on July 29, 1999 to review and comment on the work of the sub-teams. (Attachment III) From this meeting a number of common themes evolved, giving the participants and staff of HCA a potential framework for addressing the challenges set forth in Senate Bill 458. This QUAG forum provided valuable input to the West Virginia Health Care Authority as they prepared the following plan recommendations.

THE QUALITY AND UTILIZATION ADVISORY GROUP PLAN

MISSION:

The mission of the Quality and Utilization Advisory Group is set forth in Senate Bill 458: to develop a plan to avoid unnecessary or inappropriate utilization of health care services and to ensure high quality health care.

This mission is consistent with the proposed State Health Plan and supports the mission of many of the health care programs and grants in both the public and private sectors. This consistency of purpose provides a foundation for achieving results through a strategy of coordination, an

approach supported by the words of the Bill, "The Board shall coordinate this program with utilization review and peer review programs presently established in state agencies, hospital services and health service organizations, hospitals or other organizations."

GOALS:

From the Mission the following goals were developed and adopted by the HCA and the QUAG:

1. Establish a Quality Advisory Group.
2. Establish a Utilization Review and Quality Assurance Program.
3. Coordinate the Project with Established Utilization and Quality Programs.
4. Develop a Plan for the Review of Key Program Attributes.
5. Monitor Identification of Program Areas.
6. Ensure High Quality and Appropriate Services and Utilization through Incentives/Sanctions.

A phased approach to goal achievement was adopted, with an initial focus on developing an approach to program development.

KEY QUAG DISCUSSION POINTS AND COMMON THEMES:

In the QUAG sessions as well as the small sub-team meetings, participants identified and discussed the broad scope of the Bill, often searching for additional guidance relative to legislative intent. The participants also recognized that addressing the issues of quality and utilization posed a difficult challenge, but accepting such challenge represented purposeful work critical to the residents of the state. The QUAG recognized the various vantage points of those involved in understanding and influencing healthcare service delivery in the state and the need for buy-in to system changes as appropriate.

To proceed with an effort to address quality and utilization, a number of key ideas were identified, discussed and reinforced in small and large group discussion:

1. The outcomes must clearly be defined within the standards of health care.
2. Mechanisms must be in place to measure and report outcomes.
3. The program must establish clear roles for those involved and impacted by recommendations, achieve buy-in from those involved and have identifiable consequences.
4. The challenges of health care delivery in West Virginia, including access to care must be incorporated as information is analyzed and recommendations for change are made.
5. Improvement initiatives should be focused on areas that are important to West Virginians.
6. Cost must be incorporated in the focus on quality.
7. Perhaps length of stay and necessity of admissions should not be separate and distinct focus areas, but should instead be addressed within the penumbra of quality.
8. A plan to address health care quality and utilization must be developed using a phased approach.

RECOMMENDED APPROACH TO PLAN DEVELOPMENT

Based upon the input received from the Quality and Utilization Advisory Group, The West Virginia Health Care Authority recommends the Program be developed and implemented in five (5) phases:

Phase I: Identification of Quality Indicators and Benchmarking of Other State Programs

Phase II: Design of Systems for Data Collection and Analysis

Phase III: Data Analysis and Reporting

Phase IV: Development of Targets and Benchmarks, Measurement Systems and Improvement Initiatives

Phase V: Development of a system for incentives and sanctions in support of quality improvement and reporting initiatives.

The overall approach to Program development centers around the following strategies:

Adopt a narrow focus in the beginning, and expand that focus as the program gains experience and success.

Initially build on existing quality efforts within the state, then expand to new initiatives based upon need and impact within West Virginia.

Define quality of care as inclusive of important indicators of utilization such as length of stay and necessity of admissions.

Consider cost when evaluating current practices around the state and developing new strategies for improvement.

Consider population based methodologies when developing programs.

In support of these strategies, the following program development recommendations are made:

Recommendation 1:

Adopt a disease/injury state focus with an initial target of four key areas that are important and can have the greatest impact in West Virginia. The recommended areas for focus are:

- Diabetes
- Cardiovascular Disease
- Low Back Injury
- End of Life

These areas represent health concerns that are well documented as being significant for West Virginia. In addition, each of these areas is being addressed through other initiatives within the State and thus this strategy represents a key opportunity for coordination of effort for enhanced results.

Action: Identify other focused initiatives in the state, and form a sub-team of representatives of

those initiatives to coordinate program structure, data collection and reporting, and improvement interventions.

Recommendation 2:

Identify the Quality Indicators for the selected disease/injury states using such resources as the HCUP Quality Indicators, HEDIS, JCAHO, NCQA, ORYX, etc. Incorporate indicators on length of stay and necessity of admissions as appropriate.

Action: Hire an HCA research associate to identify quality indicators.

Recommendation 3:

Benchmark quality programs within other states to gain understanding of their program outcomes and the strengths and difficulties of the process.

Action: Research associate will identify programs in other states and sub-team of QUAG will review data from benchmarking efforts.

Recommendation 4:

Using selected quality indicators, design data collection systems and data sources working in collaboration with:

Other West Virginia studies in progress, i.e. WV Disease Management Plan, WVMI, West Virginia University, Marshall University, Bureau of Public Health, and health insurance plans; The database development initiatives of the Data Advisory Group; State Health Plan Initiative; and The CHRIS initiative in progress at HCA.

Action: Identify other quality initiatives within West Virginia focused on the selected disease/injury states, and form a sub-team of representatives from those initiatives; collaborate around data collection and reporting.

Recommendation 5:

Establish a private/public partnership to:

Recommend quality standards and best practices.

Analyze and monitor quality data, and measure and report quality outcomes.

Design and implement quality improvement breakthrough projects and initiatives to positively influence quality outcomes.

Engage in on-going benchmarking with other states to understand the problems occurring in their quality systems and compare inpatient and outpatient experiences.

Analyze existing West Virginia data to understand variations among facilities, communities and high risk populations.

Identify and provide recommendations regarding high impact quality improvement initiatives.

Action: Approach members of the QUAG regarding acceptance of a continuing role. Add other key resources to achieve partnership profile.

Recommendation 6:

Using a population - based approach develop quality targets and benchmarks for best practices, adopting a systems approach for measuring and improving performance. The development of such targets and benchmarks should consider:

Over-utilization of Services

Under-utilization of Services

Access to Services

Disparities of outcomes across communities, geographic areas, delivery systems and health issues

Costs associated with multiple strategies for target achievement

Healthy behaviors and practices

The initial focus of reporting should be population based versus provider based.

Action: Form task forces, with representation from all parties having accountabilities within the system to recommend system targets and benchmarks.

Recommendation 7:

Establish breakthrough quality groups to pursue quality improvement

Action: Form task forces, with representation from all parties having accountabilities within the system, to review the processes associated with achievement of outcomes, and make recommendations for improvement of such processes and outcomes.

Recommendation 8:

Develop policies for incentives and sanctions that support data reporting and quality improvement.

Action: HCA will lead an effort to formulate and implement specific policies and plans. Such policies and plans should include the development and adoption of quality standards, a provision for evaluating provider performance, and a system of imposing sanctions when appropriate.

CONCLUSION

A continued focus on health care quality and utilization of services is critical to meet the clinical, financial, and health care accessibility needs of West Virginia. This focus has been recognized as a critical need nationally and has been included as a key initiative of the West Virginia State Health Plan. Improvement of the current processes can best be achieved through the

collaboration of all participants within the delivery system. The Health Care Authority continues to be well positioned to facilitate a collaborative effort among all parties to understand and achieve desired outcomes. The Health Care Authority is prepared to accept this role and proceed with specific program development contingent upon appropriate resources being available.

Attachment I

West Virginia Health Care Authority
Quality Utilization Advisory Group Meeting
April 20, 1999 Meeting Notes

Present: See attached list.

Welcome and Introduction

Parker Haddix, Chairman of the Health Care Authority and Chairman of the Quality Utilization Advisory Group, called the meeting to order at 10:05 a.m. Mr. Haddix extended his appreciation to those present, and then identified some of the current Health Care Authority activities to include the State Health Plan, Data Advisory Group, and Interagency Long Term Care Panel. Mr. Haddix then introduced the meeting facilitator, Marsha Boggess with Organization Performance Initiatives Corporation. Advisory Group members were then asked to introduce themselves.

Review of Legislation

Parker Haddix reviewed the sections of West Virginia Senate Bill 458 that created the Quality Utilization Advisory Group, and called for this effort to not duplicate the efforts of other agencies and their activities. The purpose of this legislation and proposed mission and goals are as follows:

- Legislative Purpose Senate Bill 458 §16-29B-23
- Utilization Review and quality assurance; quality assurance advisory group.
- a. In order to avoid unnecessary or inappropriate utilization of health care services and to ensure high quality health care, the board shall establish a utilization review and quality assurance program. The board shall coordinate this program with utilization review and peer review programs presently established in state agencies, hospital services and health service corporations, hospitals or other organizations.
- b. With the assistance of the above-mentioned entities, and after public hearings, the board shall develop a plan for the review, on a sampling basis, of the necessity of admissions, length of stay and quality of care rendered at said hospitals.

Mission

Avoid unnecessary or inappropriate utilization of health care services and to ensure high quality health care.

Goals

1. Create a quality advisory group
2. Establish a Utilization Review and Quality Assurance Program
3. Coordinate the project with established utilization and quality programs
4. Develop a plan for the review of necessity of admissions, length of stay, and quality of care

5. Monitor identification of program areas
6. Ensure high quality and appropriate services and utilization through incentives/ sanctions

Discussion on Communication

Mr. Greg Morris, Health Care Authority Executive Director, asked the advisory group members to complete the survey forms, asking for preferences for the manner of ways to communicate with them (e-mail, fax, telephone, and mail). Another means to communicate will involve the Quality Utilization and Advisory Group website www.hcawv.org/quag. The process used by this advisory group will parallel the activities for the Health Care Authority's Data Advisory Group, since each has a similar size, contains membership of public/private/consumers, and has had work groups to accomplish the work of the group. Each of the Data Advisory Committee's four work groups: Access/Privacy; Components of an Integrated Health Information System; Standards, and Public/Private Partnerships. Each work group has developed recommendations. The activities of the advisory group may be viewed at the following website: www.hcawv.org/dag.

Mr. Morris also indicated travel expenses associated with the Quality Utilization Advisory Group may be reimbursed by the HCA.

Presentation by Dr. Mary Emmett

Dr. Mary Emmett, Director of the CAMCARE Institute Center for Health Services and Outcomes Research, discussed "Quality Measurement: Where Have We Been and Where We Are Going". Dr. Emmett's presentation provided information to develop a context for discussing the topic of quality by providing an overview of those developments that have and are influencing the approach, method and tools for measurement of the past and future issues of quality of care. (The discussion handout is attached.)

Presentation by Dr. George Pickett

Dr. George Pickett, Medical Director of the West Virginia Medical Institute (WVMI), provided information on the WVMI's quality activities at the national and state level. The WVMI was created in 1973 as an external peer review organization. It was first named the Professional Standards Review Organization, and reviewed the experiences of physicians and hospitals. This process involved looking for outliers outside of the normal, bell-shaped curve.

By 1983 this external review and analysis shifted to the concept of quality improvement. While the process still involved identifying and addressing outliers, it focused on the systems approach by using data and information to analyze and examine hospitalization and professional practices. The process involved using an epidemiological, population-based approach to look for variations and determine possible reasons for their happening. In the context of a systems review, problems are believed to be the result of issues within the system, not the individual professional or hospital. The systemic review has concern for the misappropriation of resources, as well as profiling patterns of care and looking for variations in what is happening and looking for clues as to why this might be happening.

Quality improvement includes a six-step process: topic identification, study group, design, data collection, analysis and feedback. Dr. Pickett indicated that it is very important to have data

integrity. He stated that sophisticated analytical tools may be used to develop patterns or to find aberrant patterns and could be a fault of an internal program. Sometimes it takes a third party intervention to determine "Are you doing as well as you want to do?" It becomes a system issue, not individual performance issues. Professionals want to get better and they want information on how to build systems.

Overview of Inventory

Cathy Chadwell, Co-Chair of the Quality Utilization and Assurance Advisory Committee, discussed the quality assurance inventory. She reported that committee members were asked to complete an inventory of their organization's quality activities. The objective was to increase the awareness of current WV and US quality/utilization activities. Of the 40 QUAG members who received the survey, 26 responded, with 2 determined not to be applicable, and 12 did not respond. The results were distributed at the meeting. No analysis has been attempted at this time since it is considered a work-in-progress document.

Brainstorming and Sharing Information

Advisory Group members were asked to review the inventory and to determine if other resources could be identified to also include in the inventory. Group discussions identified several groups, including those that collect proprietary information that may not be available for public use. Included in the discussions were JCAHO, NCQA, HEDIS, and payor data sets, University of Maryland Quality Indicator, OASIS-home care, external quality review, employer data, (GE, Steel, Coal accounts). Other resources were identified and includes, epidemiological, health ethics, analytical resources, college of pharmacy (disease management), consumer representatives (are topic specific) NIOSH, physician, community medicine, academic resources, medical society (by specialty) HCFA-OSCAR, CDC, URAC, Picker Patient Satisfaction Surveys, WV Quality Council, American Association of Health Plans, and the Kellogg Foundation Community Voices Project.

Meeting Critique

A critique of the meeting indicated:

- (1) many quality resources are available;
- (2) these resources could take much time to process; and
- (3) advisory groups' activities should follow the mission and goals of the group.

Comments from the group discussions included concerns about short time frames, frustration experienced when information is requested by major funding sources (Medicare/Medicaid), the relationship between this advisory group and the quality issue in the State Health Plan, the availability of the Picker Institute to profile hospital data, the planned roles for the advisory group members, and the difficulties experienced in other states regarding quality activities. A comment was made that this could be viewed as an opportunity to accomplish what other states have not been able to do, because of the size of the state.

To accomplish the goals for the advisory group, three subgroups will be established. Each subgroup will develop recommendations for an approach to developing a plan for reviewing the necessity of admissions, length of stay and quality of care. Advisory Group members were asked

to complete a questionnaire to rank in order their preferences for participating on the subgroups. Each subcommittee will have an organizational meeting by May 25, 1999.

Committee members found the meeting to be helpful, provided great speakers, was well organized, provided an opportunity to see and meet others. Other members expressed concern for the timetable and ambitions, the need for clearer guidelines, the perceived lack of understanding of the legislative intent creating the group, the hope that the group will not experience a blue ribbon syndrome and the need for process agreements for the group.

Follow up activities:

Notes from sub-teams will be distributed to other sub-teams.

HCA staff will contact members to let people know of the subgroup they will participate in and the meeting details.

Information will be posted on the website and by other means of communication.

Subcommittee meetings by May 25, 1999 (HCA staff and MB).

Closing Comments

Parker Haddix indicated that he was encouraged by the participation and understanding of quality issues of the advisory group members, affirmed that the mission of the Health Care Authority is to protect the people of West Virginia, indicated the West Virginia legislature will be apprised of the findings and activities of the advisory group, and requested members to provide information of interest to the group. Mr. Haddix stated that there will be no attempt to obtain proprietary information. He asked for the members to not be discouraged by some of the information discussed that identified some barriers and obstacles, but instead to focus on what can be accomplished by a group of committed members to move forward to protect the people of the State of West Virginia.

Meeting adjourned at 2:50 p.m.

Meeting handouts:

Membership List

Quality Assurance Inventory

Communication Preferences Survey

Dr. Emmett's discussion outline

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
- 5. Recommendations for improvement interventions (need measurement systems)
- 6. Package results and determine how to communicate and how to implement interventions
- 7. On-going effort to measure, compare and publish/take action per recommendations

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