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Governor

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
**HEALTH CARE AUTHORITY**

D. Parker Haddix  
Chairman

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Garry D. Black  
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December 6, 1999

Dear State Health Plan Summit Participant:

Thank you for your participation in the development of the 2000-2002 State Health Plan. You have expressed so very well your suggestions and comments about the Plan, and we have listened. The enclosed policies have been revised to reflect your comments and suggestions and those comments received through the six week public comment process. Once the Governor has approved the Plan, we will provide you with a copy.

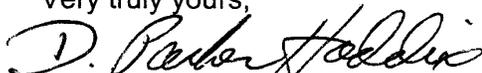
The 2000-2002 State Health Plan contains a focused strategy based on an understanding of our population, the needs of our people, and our beliefs and values about health care. The document contains both descriptive and prescriptive information. Data and information have been included to describe our State, the health of our residents and the health care resources available to them, including information about the financing of health care. In addition, it contains prescriptive, strategic decisions-sometimes boldly, other times incrementally- to develop and shape the State's health care resources, in order to meet current and future needs and demands. The priority issues, which have been developed for use by the public and private health care providers and consumers, affect each of us, regardless of whether we use, provide, purchase, or regulate health care in West Virginia.

Just as the current health status of our residents and our health care system did not occur overnight, we do not expect changes to occur overnight. At any rate, the process has begun to incrementally address some of the State's more challenging and pressing issues, such as care for the uninsured, the elderly, disabled, rural, and other special-needs groups. Beginning in January 2000, through mid 2002, the Certificate of Need Standards will be revised.

As an agency of State government, the HCA strives to be good stewards of public trust and public resources. We wanted to provide opportunities for you to have input into the development of the 2000-2002 State Health Plan in order to have an action-oriented, efficient and effective document. If you have any questions or comments about the State Health Plan please feel free to contact us.

Thank you for your interest and participation in improving the health and health care of the citizens of West Virginia.

Very truly yours,

  
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Enclosures

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## **CHAPTER 4**

### **ISSUE SUMMARIES AND POLICY RECOMMENDATIONS**

Chapter Four includes the executive summaries of the papers contributed by the State Health Plan authors examining, in depth, each of the nine strategic issues identified through the planning process, as well as the recommended policies developed around each issue. While not a comprehensive list of issues and policies, the areas selected represent a baseline perspective on where we stand, what we know, and what we can do to bring about desired changes in the state's health care resources.

The issues were chosen as a result of a survey sent to approximately 300 people in the state and further defined by an advisory group composed of business representatives, payors, regulators, consumers, providers, and unions. The nine issues that are addressed are access, accountability, at-risk populations, coordinated health-related information networks, financing and cost control, promotion of a coordinated health care system, public health, quality of care, and rural health.

The policy recommendations reflect regulatory and allocation decisions involving health care facilities, services, workforce, technology, data, and funding. The scope of the policies covers six major areas: legislation, regulation, taxation, collection and reporting of data and information, funding of public programs, and purchase of health care services. Each recommendation has been further assessed and ranked by urgency of implementation (Phases 1 through 3) and value (A through D) to the system as a whole. The intent is to reinforce and strengthen the health care infrastructure, while focusing resources on the collection, analysis, and reporting of health care information to improve health status and the quality of life.

The selection of the issues and policies was made with the full recognition that there are many other important areas that impact health status and the health care system. Some areas have not been included herein because they are addressed in the Healthy People 2010 initiative or are adequately addressed by other agencies in the state at the present time. Future State Health Plans will address additional issues.

## **I. Promotion of a Coordinated Health Care System**

### **Issue Summary**

There is growing recognition that market reform is needed if the health care infrastructure that West Virginians depend upon is to be preserved, much less improved. Today's health care environment places a premium on efficient organization and delivery of care, demonstrated quality, and improved access at a reasonable cost. Consolidation, integration, and closures are some of the market-driven responses to tighter reimbursement policies and to the shift from the high-cost inpatient care setting to the less expensive outpatient setting. These forces, plus population and economic dynamics in the state, are such that stresses on the health care system are likely to continue to increase. Hence, there is a strong need to organize the health care system to be more efficient and more responsive to the full array of community needs.

One feasible approach to addressing this need is the move toward integrated health care networks, which can provide a continuum of care as efficiently and effectively as possible. Coordinated community-oriented delivery systems, integrated both horizontally and vertically, can improve operating efficiencies and quality without sacrificing access to care. There is a relatively large number of small hospitals, long-term care centers, primary care centers, clinics, public health departments, and personal care homes around the state. Operating efficiency, as well as improvements in quality, access, and the array and sophistication of services available, is more likely to be achieved if these often disparate services are linked in integrated, well-coordinated systems of care. Collaborative efforts of public and private health care officials will be needed to determine how best to move quickly in this direction, with as little disruption as possible.

Many of the steps necessary to permit, and then encourage, the formation of health care networks have been identified and are being discussed among industry officials and policy makers. Because of the nature of the existing state health care infrastructure, which contains a large public provider component, the system's substantial reliance on public payments, and the state's comparatively large underinsured and uninsured populations, initial leadership and guidance should come from public officials.

One important characteristic of a coordinated health care system is an integrated health information system. The electronic patient record is an unusually important, if not essential, component of an integrated health care system. Consideration should be given to using planning and regulatory tools to promote public-private community-based coalitions to pursue health service coordination where this is feasible. The West Virginia Health Care Authority (WVHCA), working with other interested parties, should promote the gradual implementation of electronic records and linkage across health provider settings.

## **Promotion of a Coordinated Health Care System**

### **Policy Recommendations**

- Use planning and licensing, certificate of need, and reimbursement incentives to promote the system coordination and integration. Build monitoring and enforcement mechanisms into the process. (A1)
- Incorporate prospective planning by developing and issuing an assessment of service-specific needs statewide annually, as an update of the State Health Plan. (B2)

## II. Access

### Issue Summary

Rugged, mountainous terrain, a limited highway system that makes travel comparatively difficult, a low population density reflected by many small, scattered pockets of population, plus a large proportion of medically underserved residents — all these describe a state where ready access to health care is a major problem. Adding to this challenge are low family income levels, high poverty rates, low education levels, relatively poor health status generally, a comparatively old (and aging) population, and low levels of private health insurance coverage.

Access to health care is defined as the ability to afford, to reach, and to pay for care when it is needed. The essential resource base, i.e., the personnel, facilities, and the equipment necessary to provide adequate care, simply does not exist in many West Virginia communities. Where resources are readily available, the problem may be the inability to reach or to afford the services. In other cases, the limitation may be a lack of knowledge of the need to seek care or how to do so effectively. These circumstances reflect deeply entrenched economic and social problems that will change only gradually, over a number of years. Near-term approaches that may be productive likely involve steps to ensure the stability, efficiency, and operational flexibility of the existing health care system, in particular the small rural hospitals, the local health departments, and the primary care centers.

Practical steps that might be taken to improve access in the near term include:

- Developing a systematic program to ensure that the state and its residents obtain all federal health aid and support for which they are eligible.
- Expanding and developing Medicaid waiver programs where cost effective.
- Encouraging indigenous coordinated systems of care.
- Undertaking necessary planning studies to establish benchmarks for use in planning and in system monitoring and evaluation.

Because there is necessarily such a strong reliance on the public health system and on both direct and indirect public support of the private health care system (e.g., critical access hospitals), responsibility and accountability for initiating efforts to maintain and improve access rest primarily with public officials and programs. The most effective way to encourage other key interested parties to share this responsibility, and to accept some measure of accountability, is to establish a collaborative, population-based planning process that can assess fully the current health care delivery system, public and private, and how it operates. This will entail a series of sequential analytical planning studies to establish baseline operations and measures and to document the current linkages among services and facilities. The results of these studies should become the foundation for policy formation, with true accountability likely to evolve from the process.

## Access

### Policy Recommendations

- Improve health care coverage by (1) increasing access to insurance and managed care to the currently uninsured, including persons in need of end-of-life care, long term care, and behavioral health services; (2) identifying barriers to successful implementation of the Physician Assured Access Services (PAAS) program; (3) modifying insurance and managed care regulations that give priority to existing health care providers in rural areas; (4) supporting and expanding the Mountain Trust Fund; and (5) fully implementing the Children’s Health Insurance Program. (A1)
- Require collaboration at the state, regional, and local levels to address complementary roles of various agencies in promoting public/private partnerships targeting infrastructure for access to health care. Collaboration and planning within local communities are essential to ensure the maximization of all resources. For example, communities could use facilities such as schools for clinics. (A1)
- Develop methods to define, measure, and track health indicators aimed at measuring access to needed health care. Develop data-sharing agreements and protocols with neighboring states in order to address the issue of migration for care. Track, analyze, and report finances, quality, utilization, outcomes, and health status information to determine relationships between outcomes, cost, and access. (A2)
- Improve access to health care providers by (1) supporting programs targeting physician recruitment and retention; (2) supporting communities to “grow their own”; (3) supporting programs that will train residents and students in rural, underserved areas, and (4) promoting the development of provider networks in rural areas. (A2)
- Improve access to transportation to services, especially in rural areas, by (1) supporting social services agencies in developing transportation programs for the elderly and other needy groups; (2) examining the feasibility of using school buses for transportation to health services, and (3) assisting communities in maintaining emergency/medical transport systems. (A2)
- Promote access to health care services by alternative methods, including offering nontraditional hours of operation, services, and providers. (B2)
- Promote community collaboration to provide inventories of essential transportation services within each community. (B2)
- Provide community input to mission and service of health care system. (B2)
- Promote collaboration of state agencies to assure and strengthen the safety net (core level of services), including community health centers. (B2)

### **III. Financing and Cost**

#### **Issue Summary**

The levels of hospital costs and charges in West Virginia compare favorably with those in the South Atlantic Region and the United States, with West Virginia having lower cost per outpatient visit and charge per outpatient visit than all neighboring states and being second only to Maryland in charge per inpatient discharge. There are, however, concerns about the fairness of the payment system, access for individuals who lack health insurance or have inadequate insurance, and the preservation of health care providers that act as a “safety net” for the uninsured and underinsured. Only about 40% to 45% of West Virginians have private health insurance at any given time, because many residents are employed by small employers who are unable to obtain health insurance for their employees. The Mountain State has a high percentage of workers employed by small businesses — of the 39,000 businesses located in the state, 95% employ fewer than 50 people.

In addition to the uninsured and underinsured “working poor,” many West Virginians are dependent on public health insurance programs. About 18% of the population are Medicare enrollees and nearly 20% are Medicaid recipients. Because of this, dependence on federal programs and monies is particularly strong. Medicare patients and revenues account for nearly half (48%) of all hospital volume and receipts and nearly 40% of primary care center volume statewide. Because about three out of four Medicaid dollars are federal matching monies, a substantial majority (60% to 65%) of health system revenues in the state are directly or indirectly federal. Dependence on Medicare will only increase as the state's population ages and as more of the small rural hospitals are designated as “critical access,” making them eligible for cost-based reimbursement.

One area of concern about the state's dependence on Medicare monies is the impact of the Balanced Budget Act of 1997. The Balanced Budget Act was passed as a result of continued increases in health care spending by the federal government and as an attempt to control what Medicare was being required to pay out to providers, but there is growing recognition that these cuts may have gone too far too fast. According to some studies, Medicare spending changes could cause total hospital profit margins to drop below zero by 2002, from their current median level of just over 4 percent. Because of this, a plan currently being considered in both the House and the Senate would restore nearly \$15 billion dollars to the Medicare program over the next 10 years. The state, however, must be prepared to face future challenges such as the Balanced Budget Act as it plans for health care financing in the years to come.

Although state health officials have made a concerted effort to encourage the expansion of managed care, there is very little commercial managed care in West Virginia. Given the problems being experienced elsewhere with managed care in more attractive markets, and the recent widespread disenrollment of Medicare recipients by several plans nationally, it is difficult to see where or how growth will accelerate any time soon.

Most of the positive market changes many associate with managed care (e.g., lower hospital use rates, substitution of outpatient care for inpatient care, and less unnecessary capital spending) are not dependent on high managed care penetration levels. Reduction in inpatient use, the shift from inpatient surgery to outpatient surgery, and the introduction of more efficient operations and practices are likely to continue apace, even if managed care levels do not rise.

## **Financing and Cost**

### **Policy Recommendations**

- Enable employees of small businesses, self-employed individuals, and uninsured persons to obtain health insurance. (A1)
- Make efficient use of new tobacco settlement revenues to support health and health-related projects. (A1)
- Determine the existing public and private health care providers sources and uses of revenue and assess the current and future impact of federal reimbursement changes on West Virginia health care providers. (A1)
- Provide incentives for preventive care and wellness by lowering co-pays for people who meet their personal health care goals. (A1)
- Address the adequacy of existing public payments, particularly Medicaid, including whether West Virginia is taking maximum advantage of the favorable federal/state match for Medicaid expenditures. (A1)
- Address the uninsured population's needs. (A1)
- Develop policies to impact the role of the consumer as the purchaser of health care services. (A1)
- Expand managed care principles, where feasible, through the formation of provider-sponsored organizations and networks. (B2)
- Provide adequate reimbursement for health care providers to encourage use of technologies to improve health care. (B2)
- Assure adequate continuum of care resources by health care providers and payors to meet the needs of elderly and disabled persons. (B2)

## IV. Accountability

### Issue Summary

Accountability, an important non-clinical element of the health care system, provides a structural incentive for all parties to perform as effectively and efficiently as possible. It also makes the identification of problems that otherwise may be unnoticed or misunderstood more likely. Ultimately, a health care system that incorporates a high degree of accountability is likely to have better outcomes, better satisfied clients and providers of care, and more realistic expectations among all interested parties.

The State of West Virginia, as a major payer for health services, needs to move expeditiously to implement methods to accurately measure what it is buying with its scarce health care dollars. The availability of reliable outcome measures could have a significant impact on the health care system by directing resources to those providers and programs best able to demonstrate their effectiveness. In addition, absent the development of effectiveness of care measures tied to the key objectives of the State Health Plan, West Virginia's progress toward achieving those objectives will not be known and cannot be demonstrated to the legislature or the residents of the state. However, public accountability for health care system performance in West Virginia, as elsewhere, is fragmented and somewhat haphazard. Near-term, the best approach to improving accountability appears to be the development, incrementally, of an integrated health information system that supports performance measurement and improvement statewide. It should be expanded gradually into a comprehensive system that includes, at the least, all licensed services and programs.

The traditional framework for measurement has three dimensions:

1. Structure — the characteristic of the care setting;
2. Process — what is done for patients, and
3. Outcomes — how patients respond to care.

Essential features of such a framework include establishing best practices benchmarks across all service settings, monitoring feedback to providers of care and to those served, and developing specific measures/indicators for high at-risk populations chosen for special focus.

Rather than attempt to develop and use unique measures, West Virginia can benefit from the experiences of other states and organizations in selecting accountability measures. Health system officials should monitor and participate, as appropriate, in ongoing performance measurement development initiatives nationwide. Any system adopted should ensure that benchmark accountability measures address identified at-risk populations, access, and vulnerable populations. Consideration should be given to Agency for Health Care Policy & Research Healthcare Cost and Utilization Project (AHCPR HCUP) Quality Indicators, Health Employer Data & Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS), and Foundation for Accountability (FAACT) guidelines, as well as other national initiatives and clinically accepted guidelines that have shown promise. Within West Virginia, the West Virginia Medical Institute has many sets of indicators that are used in different programs such as Medicare, Medicaid, and the Veterans Health Agency. It is imperative, however, that all data used in measuring performance must be credible and the confidentiality of patient and provide-specific data must be protected.

Ultimately, improvements in accountability and performance measurement are tied to having better, more complete, comparable, and timely information. West Virginia already has several longitudinal health databases that can be used to enhance accountability. The development of CHRIS, now under way at WVHCA, should be viewed as the initial step in developing the integrated system needed. All interested parties should be invited to participate in developing a core set of accountability measures.

## **Accountability**

### **Policy Recommendations**

- Establish a set of population-based baseline indicators/performance measures and develop a standard definition for accountability. (A1)
- Extend certificate-of-need data collection to include ongoing tracking of actual performance for the listed health services (to allow for a reconciliation between projections and outcomes) and to measure quality indicators and access to care by the medically indigent population. Augment current operational reporting to more fully inform the public and legislature about the quality of care and financial performance of the state's key health care providers and insurers. (A1)
- Encourage the development of a comprehensive disease management program. Track and evaluate the Bureau for Public Health and the Bureau for Medical Services' disease state management program for diabetes. (B2)
- Develop a core set of measures to improve performance in a cost-effective manner. (B2)

## V. Quality of Care

### Issue Summary

The inauguration of a new millennium will include a focus on “quality renewal” as the result of multiple changes occurring within American industry and throughout the health care system. Quality is an abstract construct that can be viewed from different perspectives. In fact, each person will potentially have a different description of quality based on his or her own professional and educational experience. Recent reports from the Institute of Medicine and a presidential advisory commission have both concluded that health care quality is an endemic problem that must be addressed in the context of a systems approach if improvement is to occur. Quality as used here is thus defined as “the improvement of clinical, financial, functional, and organizational outcomes.” It refers to the **management of processes** rather than the **management of practitioners**.

The three general areas of concern within a systemic treatment of quality of care are underuse of services by those in need, overuse of services by many, and avoidable medical errors, all of which are present in West Virginia. With the exception of avoidable errors, which are not publicly documented or reported, there is considerable evidence in the state of the other two areas, i.e., higher-than-expected use of some services and underuse that may result from limited access, as well as considerable variation in use among similar populations that does not appear to be related to underlying differences in health status.

Analyses of morbidity and mortality within the state reveal substantial disparities among selected populations, indicating that health care quality in West Virginia varies considerably within and across communities, delivery systems, geographic areas, and health problems. These differences may be associated with a number of demographic, economic, environmental, personal behavior, health provider, and health system variables. Strategies for improving quality must therefore include a mix of techniques involving provider interventions, patient-oriented interventions, and health-system-oriented interventions. It is also necessary to recognize that many of the determinants of community and personal health are not individual-specific, but rather reflect characteristics and factors found in the larger environment, e.g., crime, poverty, and employment levels, air and water purity levels, vocational and community safety, and accident-prevention programs.

A fuller picture of the health care quality in West Virginia awaits the development of a more complete integrated health information system. In the meantime, much can be learned from: (1) a fuller use of existing hospital discharge data by linking hospital data with birth and death records, workers’ compensation data, and highway accident/crash data; (2) analyzing variations in treatments and physician practice patterns; and (3) examining more closely preventable hospital admissions, for example, asthma and diabetes-related conditions that could have been prevented through changes in the primary care delivery system.

The problem facing health care officials in West Virginia, as elsewhere, is how to maintain and improve quality in a cost-effective manner, without sacrificing access or unduly burdening any element of the delivery system. Quality of care issues refer to both health care providers and consumers. Underaccess may be related to geography, finances, gender, or ethnicity. In addition, health care providers may overuse certain medical interventions. Assessing and improving health care quality is a continuous process. Over time, the state needs to expand the analyses to include examination of care provided in settings for which little or no data now exist. Planning and regulatory changes may be required to ensure that providers and other data sources collect and report data elements needed to support quality improvement activities.

## Quality of Care

### Policy Recommendations

- Establish a clearinghouse for data collection. (A1)
- Establish an advisory group on quality as a private/public partnership of health care stakeholders to develop and implement a quality plan, establish statewide standards, identify and select national benchmarks, monitor selected quality outcomes, and create a forum for measuring and reporting quality. (A1)
- Determine the definition for quality, to be accomplished by the advisory group on quality. The parameters of this definition will include measurement of health care services against established standards, consumer expectations, and improvement in health status. The term standards includes established targets, appropriateness criteria, or guidelines. (B2)
- Establish conservative objectives and timetables for the advisory group on quality to develop strategies ensuring linkages among financing, care management, and community-based care that will (1) assess the resources available to provider organizations to improve quality performance; (2) assess the experiences of other states to provide insight into the practical and technical problems occurring in their health care systems; (3) perform small area variation studies using existing hospital data to identify variations among facilities, communities, and high-risk populations; (4) identify and select high-risk populations to study by using valid, reliable, tested measures such as AHCPR HCUP Quality Indicators and HEDIS, and (5) use a systems approach to measure quality using the structure, process, and outcome process. (B2)

## VI. At-Risk Populations

### Issue Summary

West Virginia's demography is extraordinary, so atypical that understanding recent and expected population dynamics is critical to identifying health risks. There was an actual decrease in population in 1997. This remarkable development resulted from the combination of low fertility and birth rates and a high and rising death rate. West Virginia's population is aging rapidly, relative to those of most other states and the nation as a whole.

These demographic data hold major implications for the demand for and the provision of health services in the state. The age distribution of the West Virginia population is the single most important determinant of community health status and of the types and amount of health care that are likely to be required. Aging West Virginians — the more than one-third of the population now 50 years of age or older — regardless of gender, location, or race, will be the state's largest at-risk population for the next 25 years.

Progress made earlier this decade in improving health indices may have reached a plateau, or may actually be eroding. The number of excess deaths has increased considerably in recent years; there were about 3,500 more deaths in the state in 1997 than would be expected given the age profile of the state's population. Given the high variance from experience elsewhere, and the greater potential of having near-term positive effects from intervention, it appears that half of the ten leading causes of death are worthy of special attention and effort: diabetes, heart disease, chronic obstructive pulmonary disease, suicide, and unintentional injuries.

With limited health care resources, the goal must be to devise strategies to address as many of the major health problems as is practicable, using available health resources as efficiently as possible. These resources must be woven into a better-coordinated, more efficient service network if the need for both acute and chronic care services is to be met in a reasonable, cost-effective manner. Those managing the planning process should generate a list of potential at-risk groups, with an explanation of the rationale for initial selection, as a starting point from which all interested parties would work. There are various sources available from which to make these determinations, among them the **Dartmouth Health Atlas of Health Care** and the goals and objectives for **Healthy People 2010**, which will be released in April 2000.

## **At-Risk Populations**

### **Policy Recommendations**

- Generate an initial list of potential at-risk groups based upon existing data, with an explanation of the rationale for their selection, as a first step in the planning process and a starting point from which all interested parties would work. Invite all interested parties, based upon the data findings — providers of care, policymakers, voluntary services groups, civic organizations, and the citizenry in general — to participate in the determination of which population subgroups will be judged “at-risk,” as this implies special attention and resources for these groups. The interested parties can contribute their knowledge, experience, and a practical sense of what is feasible and workable; their role should be both substantive and advisory. Their involvement is likely to be most productive if they are involved early, as soon as necessary preliminary planning efforts are under way. (A1)
- Performance measurement systems and indicators of quality and accountability should address priority at-risk populations; at-risk populations should be monitored over time. Assess long-term care needs. (B1)
- Redefine end-of-life care as part of the continuum of care. (B2)
- Use cost-effective methods and processes such as benchmarking and computer modeling in order to allocate health care resources as effectively as possible. (C3)

## **VII. Public Health**

### **Issue Summary**

Public health services are in transition nationwide. Eroding state and local economic support, Medicare payment reforms, and market shifts due to the rise of managed care (particularly among Medicaid enrollees) are combining to threaten public health delivery systems as they exist today. This is especially true in West Virginia, where less than one percent of health expenditures goes for public health services, and a comparatively large percentage of the population is rural, poor, uninsured, and aged, and therefore at high risk of health problems addressed by public health services. It remains to be seen what these changes will mean both for the local public health systems and for those who are dependent on them.

The recent change in policy involves a shift from a more balanced mix of public and personal services and activities to a more narrow focus on basic public health services. National public health organizations, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration have already begun a process to define performance-based standards for the refocused public health system. It is expected that these standards and competency measures will become requirements for public health systems nationwide. These requirements will likely become essential for federally funded public health programs.

Most public health services in West Virginia are delivered by the state's 54 local health departments. Collectively, they have assured that the basic public health services of communicable disease prevention and control, community health promotion, and environmental health protection were met. Providing a wide array of population and personal health care services, they recorded more than one million client encounters in 1998. Given that local health departments serve many of those persons most in need, any reform or integrated system formation should take fully into account their value and role in the health system and assure that those receiving personal health care services are not forgotten.

Growth in managed care presents opportunities, as well as challenges, for the public health sector. Public health methods and techniques in documenting the need for, and then providing, primary care and preventive services are becoming more valuable to managed care and the health system generally. Public health departments that have, or can develop, skills and experience in these areas may be able to market their expertise to managed care organizations and health care networks. Many of West Virginia's local health departments are already part of regional, multifacility networks. They need to further explore the possibility of contracting with managed care organizations to provide a wide range of preventive services.

Much is at stake in the "transition" of West Virginia's public health system. It is evident that alternative ways must be found to provide many of the "safety net" personal health services that the public system has historically provided. Health care officials need to encourage managed care plans, health care networks, and other private entities to contract with public health departments to provide basic preventive and primary care services. In addition, they should ensure that private health care entities participate in and help support (defray the costs of) certain of the core public health functions, including assessing and reporting community needs and undertaking cooperative public/private community health promotion activities. Simultaneously, support of public health's unique provision of population-based health services needs to be strengthened. Preparing the state's public health workforce and building the infrastructure essential for delivery of basic public health services to West Virginia residents is the focus of the West Virginia Public Health Transitions Project. In West Virginia, as well as across the country, the financial resources to support the preventive health system have not grown as rapidly as, nor in the amounts needed to capably care for, the state's aging population.

## Public Health

### Policy Recommendations

- West Virginia should target initiatives in cardiovascular disease. These initiatives could include continuing employee wellness programs, reporting the findings, and seeking opportunities to expand wellness programs for all employees. (A1)
- The WVBPB and the West Virginia Department of Education should collaborate in encouraging school policy development and partnerships between the local boards of health and the county boards of education to determine school-specific environmental interventions and measurement indicators that promote healthy eating, a tobacco-free lifestyle, and physical activity among students, faculty, and staff (including the disabled). (A1)
- Target initiatives in cancer control. These initiatives could include (1) the establishment of a cancer coalition, bringing together medicine and other health professions, environmental scientists, existing coalitions and organizations addressing cancers, and other essential partners to develop a comprehensive plan for cancer control in West Virginia and (2) the continued support by the West Virginia State Legislature for cancer screening and treatment through the West Virginia Breast and Cervical Cancer Diagnostic and Treatment Fund. (A1)
- Continue and support financially the strategic process that has laid the groundwork for a strengthened public health system emphasizing the basic public health services of prevention and control of communicable diseases, community health promotion, and environmental health protection. (A1)
- Create and pass legislation to curb tobacco use among the state's children, making tobacco products harder to obtain by causing a significant increase in the retail cost of tobacco products. (A1)
- Develop policies to ensure that private health care entities participate in and help defray the costs of conducting and reporting public health community needs assessments and establish cooperative public/private health promotion activities, by sharing resources wherever possible. (B1)
- Develop organizational structure and capacity at the state level to institutionalize continued public health workforce development. Identify profession-specific competencies needed to enable the workforce to deliver the basic public health services and measure progress toward meeting those competencies. Establish a process to review and revise the job descriptions and qualifications of public health workers to more adequately reflect the developing profession-specific competencies and qualifications and revise pay scales reflective of these newly emerging requirements. Provide funding to support the leadership development of the current public health workforce to provide for more rapid capacity development. (B2)
- Develop policies that encourage managed care plans, health care networks, and other private entities to contract with public health departments to provide basic preventive and primary care services, such as immunizations, home health care, and screening services. (D3)

## VIII. Rural Health

### Issue Summary

The National Rural Health Association notes that rural areas are experiencing “the most profound changes in the health care system in modern times.” Nearly two-thirds (64%) of West Virginians live in rural areas, with more than three-fourths of the state’s 1.8 million residents living in communities of fewer than 2,500 people. All except four of the state’s 55 counties are designated fully or in part as Health Professional Shortage Areas and/or Medically Underserved Areas.

Residents of rural areas in West Virginia differ significantly from the national norms in terms of demography, socioeconomic characteristics, health status and health care needs, and access to care. Demographic and socioeconomic characteristics of the state’s rural population are generally more negative than those found among their counterparts nationally. Actual and perceived health status, personal health risk behaviors, and access to resources are more problematic than in most other rural areas. The lack of roads and the condition of existing roads pose additional problems. Only half of the roads are paved and more than 60 percent of the paved highways are rated fair, poor, or very poor, and poor road conditions are associated with longer times to reach medical care. Even with good roads, health care resources are often limited in the state’s rural areas.

Given these and related conditions and circumstances, the basic question facing health care officials is how to preserve the stability of the existing rural health care infrastructure, while simultaneously working to transform and integrate the private and public health systems. West Virginia has made significant progress in establishing responsive health care systems to serve its rural population. It has developed a network of primary care centers and clinics statewide and has taken steps to stabilize and preserve essential rural hospitals, as well as the viability of local health departments.

Policy makers in West Virginia should make efforts to continue to assist at the local level, gearing programs to the local level and helping develop local health plans. A key component of this effort should be the continuation of support and encouragement in the development of rural health networks. Telemedicine, which provides consultation to six rural areas from hubs in Morgantown and Charleston, is another avenue that holds great promise for the future. Further, the EMS community is evolving to more effectively accommodate rural areas but continues to face financial, organizational, and personnel problems.

A number of additional steps could be taken to gain a better understanding of how health status and the need for and use of health care services, differ between the West Virginia rural population and the rest of the state. Studies are needed to determine:

- age- and gender-specific population-based use rates for rural and other populations;
- the practical effects of the policy of encouraging the conversion of rural hospitals;
- the relationship between facility and program size and volume and treatment outcomes in the state’s small hospitals and service programs, and
- the number of potential unnecessary hospitalizations for ambulatory-sensitive conditions.

## **Rural Health**

### **Policy Recommendations**

- Identify circumstances that are needed to support rural health care and identify the barriers that need to be eliminated. (A1)
- Evaluate payment levels in West Virginia and their impact on rural health providers and make needed changes to the system assuring continued viability of existing providers. (A1)
- Promote the development of new technologies that promote the continuum of care services in rural health. (B2)
- Recognize the importance of medical transportation as a component in a coordinated system of care in rural communities. With more training and medical supervision, EMS personnel can have a larger role in providing care in rural areas. The EMS system should be more integrated into a health care system that is cooperative, shares limited resources, promotes public/private collaboration and cost containment, provides a broad education to EMS providers, and recognizes innovative methods of health care delivery. (B2)

## **IX. Coordinated Health-Related Information Networks**

### **Issue Summary**

Reliable information is the key to understanding community and personal health and the workings of the health care system. The size and complexity of the health care system are such that essential information is now found in many large, disparate databases. The value of individual data sets is increased greatly when they are combined; more sophisticated analyses of the health care system and of community health are possible when data are linked to form an integrated information system.

Fortunately, innovation in information technology and electronic data processing is lowering the cost of data gathering and processing, analysis, and dissemination. Integrated information systems are now feasible, are becoming more practical, and should become less costly, both to develop and to operate. Moreover, it is likely that the cost of not having efficient integrated information systems will soon greatly outweigh the cost of developing and operating them, if that is not actually the case already.

The utility, and hence the value, of the numerous databases in West Virginia are reduced by gaps in the data, limited comparability, lack of comprehensiveness, mismatched timeliness, and inconsistent quality. Under recent legislation, WVHCA will develop a consolidated health-related information system (CHRIS), which will include public and private sector databases. Locating disparate databases in a single location (or a virtual location) moves West Virginia closer to having an integrated statewide health information system.

Regional integrated health information systems are already being developed by two rural provider networks. The Eastern Panhandle Integrated Delivery System (EPIDS), which serves nine counties in eastern West Virginia, and the Southern Virginia Rural Health Network (SVRHN), which serves three counties in southern West Virginia, received federal grants to develop integrated medical information systems. Both networks are vertically integrated, including hospitals, local health departments, primary care centers, social service agencies, physicians, and the services of other entities.

Health officials should monitor data standardization activities in these networks and elsewhere (other states, the federal government, and voluntary standardization organizations), both to take advantage of what is learned and to try to be consistent with developments elsewhere. Experience developing public data clearinghouses and data warehouses is growing, and these sources should be consulted.

Planning policy and decisions should ensure that any health information system developed is designed to ensure that, to the maximum extent practical, population-based data element definition, collection, analysis, publication, and evaluation are built into the system. The value of data from a managed care plan, for example, is greatly depreciated if it cannot be related (linked) to the underlying enrolled population and to the general public.

## Coordinated Health-Related Information Networks

### Policy Recommendations

- Facilitate the adoption of a core set of measures, indicators, and data when establishing the Coordinated Health Related Information System (CHRIS) that will be used for planning, policy setting, performance monitoring, and other systemwide measures utilizing encounter-level detail data. (A1)
- Integrate existing health databases and health information networks to lead to better understanding of the health status and socioeconomic conditions of West Virginia's population and how the health care system is responding to its needs. The plan should also address how existing data are used and provide a rationale for additional data collection. (A1)
- Use data standardization methods from other states, the federal government, and voluntary standardization organizations. West Virginia should take advantage of, and try to be consistent with, other efforts. (B1)
- Implement gradually electronic patient records across health provider settings. This effort will be necessarily long term but is an essential element if there is to be efficient and effective coordination. (A2)
- Require all affected entities to participate in an integrated electronic patient records system in order to obtain data from CHRIS. (B2)
- Seek collaboration between state agencies, universities, and private groups to develop Geographic Information Systems (GIS) infrastructure to benefit all entities, including the consumer. (B2)
- Use medical technology to assess patients in their homes. (C3)

draft

## **CHAPTER 5**

### **IMPLEMENTATION OF THE STATE HEALTH PLAN**

The development of the 2000-2002 State Health Plan required the active involvement of several agencies and organizations throughout West Virginia; so too will the Plan's implementation. The West Virginia Health Care Authority will develop the Implementation Work Plan in early 2000.

The policy recommendations included in the State Health Plan have been developed for eight purposes: (1) reduce the unnecessary utilization of health care; (2) encourage persons to place a higher value on health; (3) provide consumers with the tools necessary to take greater charge of their health; (4) provide for the measurement of outcomes; (5) improve long-term outcomes; (6) identify services to be regionalized; (7) facilitate the development of a responsible marketplace, and (8) address personnel, funding, data, technology, plant and equipment, capital expenditures, cooperation of key groups, and training and education of current and future providers.

A State Health Plan Advisory Group (SHAG) has guided the development of the Plan. This group includes representatives of consumers, providers, purchasers, payors, state government agencies, and other groups to ensure that the State Health Plan reflects the values, issues, and concerns of the state's residents. Initially convened to identify the nine strategic issues, the group's role has broadened as it continues to advise by ranking the importance and timing of each of the policies. Other roles are planned for the group in the future relating to the plan implementation.

Six different authors developed strategic issue papers used for the executive summaries and policies presented in Chapter 4. Edited versions of the authors' issue papers will be published as a supplemental volume to the 2000-2002 State Health Plan in early 2000. The information contained in these papers will be used extensively in the development of a work plan to implement the policies.

#### **POLICY MATRIX**

The policies as presented in this document are state level activities that will be accomplished through legislation, regulation, state agency budgets and program guidelines, and actions by the private sector. Each of the 52 policies developed for the State Health Plan is included in the matrix that follows; all have been ranked in terms of urgency (timing) and value (importance).

**Urgency Scale.** The three point scale used to determine urgency (timing) is

1. (Phase One) Important to do at a very early stage; implementation should receive immediate attention;
2. (Phase Two) Should be incorporated in initial planning, but implementation may occur after items requiring immediate attention, and
3. (Phase Three) Timing is not as critical; the issue is important but its implementation may be delayed.

**Priority Scale.** The scale of importance/priority is

- A. Imperative, of highest priority;
- B. Valuable, solid recommendation;
- C. Less important but of value, and
- D. Not compelling; an important issue but of lower priority than A through C.

## POLICY MATRIX

### Ranking of Policies by Value (A - D) and Urgency (Phase 1 - Phase 3)

Value	Urgency	Issue	Policy
A	1	Promotion of a Coordinated Health Care System	Use planning and licensing, certificate of need, and reimbursement incentives to promote the system coordination and integration. Build monitoring and enforcement mechanisms into the process.
A	1	Access	Improve health care coverage by (1) increasing access to insurance and managed care to the currently uninsured, including persons in need of end-of-life care, long term care, and behavioral health services; (2) identifying barriers to successful implementation of the Physician Assured Access Services (PAAS) program; (3) modifying insurance and managed care regulations that give priority to existing health care providers in rural areas; (4) supporting and expanding the Mountain Trust Fund; and (5) fully implementing the Children's Health Insurance Program.
A	1	Access	Require collaboration at the state, regional, and local levels to address complementary roles of various agencies in promoting public/private partnerships targeting infrastructure for access to health care. Collaboration and planning within local communities are essential to ensure the maximization of all resources. For example, communities could use facilities such as schools for clinics.
A	1	Financing and Cost	Enable employees of small businesses, self-employed individuals, and uninsured persons to obtain health insurance.
A	1	Financing and Cost	Make efficient use of new tobacco settlement revenues to support health and health-related projects.
A	1	Financing and Cost	Determine the existing public and private health care providers sources and uses of revenue and assess the current and future impact of federal reimbursement changes on West Virginia health care providers.
A	1	Financing and Cost	Provide incentives for preventive care and wellness by lowering co-pays for individuals who meet their personal health care goals.
A	1	Financing and Cost	Address the adequacy of existing public payments, particularly Medicaid, including whether West Virginia is taking maximum advantage of the favorable federal/state match for Medicaid expenditures.

A	1	Financing and Cost	Address the uninsured population's needs.
A	1	Financing and Cost	Develop policies to impact the role of the consumer as the purchaser of health care services.
A	1	Accountability	Establish a set of population-based baseline indicators/performance measures and develop a standard definition for accountability.
A	1	Accountability	Extend certificate-of-need data collection to include ongoing tracking of actual performance for the listed health services (to allow for a reconciliation between projections and outcomes) and to measure quality indicators and access to care by the medically indigent population. Augment current operational reporting to more fully inform the public and legislature about the quality of care and financial performance of the state's key health care providers and insurers.
A	1	Quality	Establish a clearinghouse for data collection.
A	1	Quality	Establish an advisory group on quality as a private/public partnership of health care stakeholders to develop and implement a quality plan, establish statewide standards, identify and select national benchmarks, monitor selected quality outcomes, and create a forum for measuring and reporting quality.
A	1	At-Risk Populations	Generate an initial list of potential at-risk groups based upon existing data, with an explanation of the rationale for their selection, as a first step in the planning process and a starting point from which all interested parties would work. Invite all interested parties, based upon the data findings — providers of care, policymakers, voluntary services groups, civic organizations, and the citizenry in general — to participate in the determination of which population subgroups will be judged "at-risk," as this implies special attention and resources for these groups. The interested parties can contribute their knowledge, experience, and a practical sense of what is feasible and workable; their role should be both substantive and advisory. Their involvement is likely to be most productive if they are involved early, as soon as necessary preliminary planning efforts are under way.
A	1	Public Health	Target initiatives in cardiovascular disease. These initiatives could include continuing employee wellness programs, reporting the findings, and seeking opportunities to expand wellness programs for all employees. Promote public/private partnerships that promote heart health.

A	1	Public Health	The WVBPH and the West Virginia Department of Education should collaborate in encouraging school policy development and partnerships between the local boards of health and the county boards of education to determine school-specific environmental interventions and measurement indicators that promote healthy eating, a tobacco-free lifestyle, and physical activity among students, faculty, and staff (including the disabled).
A	1	Public Health	Target initiatives in cancer control. These initiatives could include (1) the establishment of a cancer coalition, bringing together medicine and other health professions, environmental scientists, existing coalitions and organizations addressing cancers, and other essential partners to develop a comprehensive plan for cancer control in West Virginia and (2) the continued support by the West Virginia State Legislature for cancer screening and treatment through the West Virginia Breast and Cervical Cancer Diagnostic and Treatment Fund.
A	1	Public Health	Continue and support financially the strategic process that has laid the groundwork for a strengthened public health system emphasizing the basic public health services of prevention and control of communicable diseases, community health promotion, and environmental health protection.
A	1	Public Health	Create and pass legislation to curb tobacco use among the state's children, making tobacco products harder to obtain by causing a significant increase in the retail cost of tobacco products.
A	1	Rural Health	Identify circumstances that are needed to support rural health care and identify the barriers that need to be eliminated.
A	1	Rural Health	Evaluate payment levels in West Virginia and their impact on rural health providers and make needed changes to the system assuring continued viability of existing providers.
A	1	Coordinated Health-Related Information Networks	Facilitate the adoption of a core set of measures, indicators, and data when establishing the Coordinated Health Related Information System (CHRIS) that will be used for planning, policy setting, performance monitoring, and other systemwide measures utilizing encounter-level detail data.
A	1	Coordinated Health-Related Information Networks	Integrate existing health databases and health information networks to lead to better understanding of the health status and socioeconomic conditions of West Virginia's population and how the health care system is responding to its needs. The plan should also address how existing data are used and provide a rationale for additional data collection.

B	1	At-Risk Populations	Performance measurement systems and indicators of quality and accountability should address priority at-risk populations; at-risk populations should be monitored over time. Assess long-term care needs.
B	1	Public Health	Develop policies to ensure that private health care entities participate in and help defray the costs of conducting and reporting public health community needs assessments and cooperative public/private health promotion activities, by sharing resources wherever possible.
B	1	Coordinated Health-Related Information Networks	Use data standardization methods from other states, the federal government, and voluntary standardization organizations. West Virginia should take advantage of, and try to be consistent with, other efforts.
A	2	Access	Develop methods to define, measure, and track health indicators aimed at measuring access to needed health care. Develop data-sharing agreements and protocols with neighboring states in order to address the issue of migration for care. Track, analyze, and report finances, quality, utilization, outcomes, and health status information to determine relationships between outcomes, cost, and access.
A	2	Access	Improve access to health care providers by (1) supporting programs targeting physician recruitment and retention; (2) supporting communities to “grow their own”; (3) supporting programs that will train residents and students in rural, underserved areas, and (4) promoting the development of provider networks in rural areas.
A	2	Access	Improve access to transportation to services, especially in rural areas, by (1) supporting social services agencies in developing transportation programs for the elderly and other needy groups; (2) examining the feasibility of using school buses for transportation to health services, and (3) assisting communities in maintaining emergency/medical transport systems.
A	2	Coordinated Health-Related Information Networks	Implement gradually electronic patient records across health provider settings. This effort will be necessarily long term but is an essential element if there is to be efficient and effective coordination.
B	2	Promotion of a Coordinated Health Care System	Incorporate prospective planning by developing and issuing an assessment of service-specific needs statewide annually, as an update of the State Health Plan.

B	2	Access	Promote access to health care services by alternative methods, including offering nontraditional hours of operation, services, and providers.
B	2	Access	Promote community collaboration to provide inventories of essential transportation services within each community.
B	2	Access	Provide community input to mission and services of health care system.
B	2	Access	Promote collaboration of state agencies to assure and strengthen the safety net (core level of services), including community health centers.
B	2	Financing and Cost	Expand managed care principles, where feasible, through the formation of provider-sponsored organizations and networks.
B	2	Financing and Cost	Provide adequate reimbursement for health care providers to encourage use of technologies to improve health care.
B	2	Financing and Cost	Assure adequate continuum of care resources by health care providers and payors to meet the needs of elderly and disabled persons.
B	2	Accountability	Encourage the development of a comprehensive disease management program. Track and evaluate the Bureau for Public Health and the Bureau for Medical Services' disease state management program for diabetes.
B	2	Accountability	Develop a core set of measures to improve performance in a cost-effective manner.
B	2	Quality	Determine the definition for quality, to be accomplished by the advisory group on quality. The parameters of this definition will include measurement of health care services against established standards, consumer expectations, and improvement in health status. The term standards includes established targets, appropriateness criteria, or guidelines.

B	2	Quality	Establish conservative objectives and timetables for the advisory group on quality to develop strategies ensuring linkages among financing, care management, and community-based care that will (1) assess the resources available to provider organizations to improve quality performance; (2) assess the experiences of other states to provide insight into the practical and technical problems occurring in their health care systems; (3) perform small area variation studies using existing hospital data to identify variations among facilities, communities, and high-risk populations; (4) identify and select high-risk populations to study by using valid, reliable, tested measures such as AHCPR HCUP Quality Indicators and HEDIS, and (5) use a systems approach to measure quality using the structure, process, and outcome process.
B	2	At-Risk Populations	Redefine end-of-life care as part of the continuum of care.
B	2	Public Health	Develop organizational structure and capacity at the state level to institutionalize continued public health workforce development. Identify profession-specific competencies needed to enable the workforce to deliver the basic public health services and measure progress toward meeting those competencies. Establish a process to review and revise the job descriptions and qualifications of public health workers to more adequately reflect the developing profession-specific competencies and qualifications and revise pay scales reflective of these newly emerging requirements. Provide funding to support the leadership development of the current public health workforce to provide for more rapid capacity development.
B	2	Rural Health	Promote the development of new technologies that promote the continuum of care in rural health.
B	2	Rural Health	Recognize the importance of medical transportation as a component in a coordinated system of care in rural communities. With more training and medical supervision, EMS personnel can have a larger role in providing care in rural areas. The EMS system should be more integrated into a health care system that is cooperative, shares limited resources, promotes public/private collaboration and cost containment, provides a broad education to EMS providers, and recognizes innovative methods of health care delivery.
B	2	Coordinated Health-Related Information Networks	Require all affected entities to participate in an integrated electronic patient record system in order to obtain data from CHRIS.

B	2	Coordinated Health-Related Information Networks	Seek collaboration between state agencies, universities, and private groups to develop Geographic Information Systems (GIS) infrastructure to benefit all entities, including the consumer.
C	3	At-Risk Populations	Use cost-effective methods and processes such as benchmarking and computer modeling in order to allocate health care resources as effectively as possible.
C	3	Coordinated Health-Related Information Networks	Use medical technology to assess patients in their homes.
D	3	Public Health	Develop policies that encourage managed care plans, health care networks, and other private entities to contract with public health departments to provide basic preventive and primary care services, such as immunizations, home health care, and screening services.

**IMPLEMENTATION — STATE HEALTH PLAN ADVISORY GROUP**

Provisions of the Plan must be implemented at several different levels within the state or community. For this reason, the implementation of the Plan will require a great degree of coordination. In order to approach implementation systematically, it will be useful to develop both a detailed project plan and an implementation matrix, which will be used to identify every action identified in the policy recommendations, as well as the necessary state level action steps. The matrix will detail which tasks are to be completed, by whom, and when.

The State Health Plan Advisory Group developed and ranked the policies identified in this chapter. The group will also review the work plan developed by the WVHCA and provide an assessment of the feasibility and plausibility of the resources and activities identified to implement the policies. SHAG will also identify lead agencies responsible for developing and implementing individual work plans for each of the policies and assure the most urgent issues are being addressed. In addition, the group will assist in the establishment of partnerships throughout the state to promote the State Health Plan as a shared responsibility of all interested parties, including the private sector. Finally, they will have a key role in evaluating the effectiveness of the policy recommendations in improving the state’s health care system and the health status of West Virginia’s residents.

**STATE HEALTH PLAN USE BY GOVERNMENT AGENCIES**

State agencies and legislative decision makers share the responsibility of ensuring that laws and regulations protect the public. State agencies are encouraged to develop their policies and plans in congruence with the 2000-2002 State Health Plan. The Plan is intended to provide overall policy direction for the wise expenditures of state resources to achieve the goals of

improving health and assuring access to health care. The Plan establishes health policies to be used to guide the actions of state agencies by (1) establishing a statewide mission, vision, and common policy goals for state agencies; (2) establishing a basis for performance budgeting to measure progress and to show the relationships between budgets and outcomes, and (3) providing a basis for program and priority development, funding requests, and implementation of regulatory functions. Several state agencies and organizations will be involved in developing work plans to implement policy recommendations.

## **ROLE OF THE PRIVATE SECTOR**

West Virginia will continue to see more profound changes in the delivery and financing of health care. Decision makers in the public and private sectors need to work together to resolve the health care issues facing our state; for this to happen, a common framework for action is necessary. The purpose of the State Health Plan is to enable the health care system to develop in an organized, cost-effective manner with sufficient resources to meet the needs of West Virginians and address both the regulatory and market-oriented forces that affect the supply and demand for health care services. It is the intent of the Plan to allow both public and private entities greater flexibility in working cooperatively in obtaining creative solutions, accepting mutual accountability for sharing risks, responsibilities, and resources, and fostering greater coordination among health care resources to reduce existing fragmentation of services and facilities.

The private sector can use the data, information, vision, goals, and policies herein and in future work plans to make health care decisions, identify needs, assess their organizational capacity to meet these needs, and allocate resources. In addition, the State Health Plan can assist the private sector in controlling health care costs and promoting interagency coordination. Private health care providers, unless otherwise exempt, will continue to obtain a certificate of need before (1) adding or expanding health care services; (2) exceeding the capital expenditure threshold of \$2,000,000; (3) obtaining major medical equipment valued at \$2,000,000 or more; or (4) developing or acquiring new health care facilities.

Specifically, the private sector can use the State Health Plan in the following ways:

- Use population-based planning to determine the appropriate need, supply, and distribution of health care resources to improve the health status of the people who use the health services provided by their organizations.
- Use the State Health Plan policies to reduce fragmentation or duplication of resources and to increase the coordination of health care providers/services to provide greater continuity of care and follow-through.
- Accept the State Health Plan as a shared responsibility among public and private entities and commit to shared risks and resources.
- Partner with other health care providers in their communities to continue to address the root causes of disease, death, and disability.
- Commit to reducing unnecessary health care expenditures.
- Commit to reducing fragmentation and duplication of health care resources.
- Allow consumers to have a greater voice in their health care decisions and in the ways in which health care is delivered and financed in their communities.
- Continue to offer input and technical expertise to government-sponsored task forces and advisory groups in such areas as health care analysis, information management, and clinical studies.

- Increase sensitivity and social responsibility for the implications of selecting or not selecting to serve certain geographic areas or population groups in efforts to control health care costs.
- Link the State Health Plan to the allocation of organizational health care resources.
- Provide accurate and timely data to assist in the measurement of health status and for making decisions, setting priorities, and measuring the effectiveness of activities.
- Acknowledge the need for the coexistence of regulatory and market-oriented approaches so that the concerns of the poor, the working uninsured, and the people with special needs are able to receive necessary health care services.

### **ROLE OF THE WEST VIRGINIA HEALTH CARE AUTHORITY**

The WVHCA will assist in the implementation of the State Health Plan through the agency's health planning responsibilities and by being actively involved in implementing many of the policy recommendations. The Authority shall be responsible for the implementation of the policies relating to coordinating and overseeing state government health data collection, transmitting, reporting, and analysis. As the lead agency responsible for the state's health planning, the WVHCA will provide a structure and staff resources to facilitate the overall coordination and implementation of the State Health Plan.

The Health Care Authority staff will prepare a work plan in early 2000 for adoption by SHAG. In the development of this plan, issue policy implementation strategies identified by the State Health Plan authors and the advisory group will be used. A specific feature of the work plan will address the preparation of a resource allocation framework for each policy, to include anticipated implementation costs and resource requirements for staff, data, technology, financial resources, and other factors. The work plan will include information on key process and structure implementation steps, listing specific requirements and tasks needed to produce the desired outcomes. This document may also define key terms, describe policy intent, identify prerequisites, outline barriers to successful implementation, and identify start and completion dates, necessary resources, strategic success and risk factors, current and future data needed to measure or benchmark accomplishments, and responsible parties. In addition, the implementation plan will address the development of the West Virginia Healthy People 2010 objectives focusing on health promotion and disease prevention, allowing the various health agencies within the state to work together to improve the health of West Virginia residents. The complexity of health care issues requires broad-based collaboration and coordination so that efforts will not be duplicated.

In addition, the WVHCA will assume the following responsibilities:

- Prepare an annual report on the status of policy recommendation implementation based upon input received from the responsible agencies. This report will address accomplishments and collaborative efforts that have occurred to achieve policy implementation and document challenges or limitations encountered as they may relate to funding, as well as policy implementation design, staffing, operations, and other factors.
- Develop an annual report that would include: (1) a summary of regulatory decisions for the previous 12 months; (2) a multiyear schedule for the review and analysis of the appropriateness of maintaining certificate of need controls for all covered services over a seven-year period; and (3) an analysis of the appropriateness of maintaining certificate of need controls on at least two of the covered services/categories each year. This report will assess market changes statewide that may affect the need for continued regulation of selected health care services, facilities, and equipment.

- Prepare a description of the components that should constitute a coordinated health care system, information useful for the development of the revised certificate of need standards. This will involve an assessment of the current needs of the health care system and comparison of these needs with currently available health care resources.
- Establish a task force to study the need for additional nursing facility beds in the state. The study will include a review of the current moratorium on the development of nursing facility beds, the exemption for the conversion of acute care beds to skilled nursing facility beds, the development of a methodology to assess the need for additional beds, and the certification of new beds both by Medicare and Medicaid.

### **CONCLUSION/RECOMMENDATIONS FOR THE FUTURE**

The State Health Plan is both a process and a product. It is a call to action for all of West Virginians to work together as partners to focus thinking and action on creating measurable improvements in health care in our state. The WVHCA anticipates regular and periodic updates to the Plan. Future improvements and refinements will occur to reflect technological changes and additional information obtained about the issues and trends affecting our state residents. The issues addressed in the Plan are complex, challenging, and always changing. Because this document is population-based, the scope reflects the needs of our entire population: infants, children, adults, seniors, and special-needs groups.

The State Health Plan establishes the framework to:

- Improve access to needed health care services.
- Constrain health care costs.
- Determine priorities for addressing statewide health care needs.
- Determine the distribution of health care resources and, where necessary, ration the supply and distribution of these resources.
- Establish goals for the health care system to improve the health of West Virginians and the efficiency and effectiveness of the health care system.
- Provide regulatory oversight and administration of the certificate of need program.
- Provide a public process for decision-making.

Following the adoption of the State Health Plan, it is the intent of the WVHCA to:

- Use the approved State Health Plan for the development of the revised certificate of need standards during 2000-2002.
- Develop an Implementation Plan in early 2000 using information provided by the State Health Plan authors.
- Publish the text of the complete papers submitted by the State Health Plan authors in early 2000.
- Prepare a State Health Plan annual report to discuss changes in the health care system and the status of the health plan policies.
- Revise the State Health Plan every three years.