ORIGINAL

West Virginia Tobacco Cessation Quitline Consulting Services

Consultant Pricing Proposal

November 13, 2013

Submitted by:

WVMI
3001 Chesterfield Place
Charleston, WV

WVMI Quality Insights

11/08/13 04:11:27 PM
West Virginia Purchasing Division

WVMI
West Virginia
Medical Institute

3001 Chesterfield Place
Charleston, West Virginia 25304
Phone 304.346.9864
Toll Free 1.800.642.8686
Fax 304.346.9863
www.wvmi.org

November 13, 2013

Roberta A. Wagner
State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Re: Solicitation Number EHP14047
Evaluation and Reporting Consulting Services for the West Virginia Tobacco Cessation Quitline

Dear Ms. Wagner:

The West Virginia Medical Institute (WVMI) is pleased to submit the enclosed Cost Proposal in response to the referenced Request for Quotation (RFQ).

WVMI is in agreement with all proposed terms and conditions included in the RFQ. The proposed hourly rate of $150.00 reflects WVMI's best estimate to perform the work outlined in the RFQ. WVMI agrees to extend the same prices, terms, and conditions offered herein to other government entities per Paragraph 48 of the General Terms and Conditions.

The officials authorized to conduct discussions in regard to this proposal and to sign all related documents are:

John C. Wiesendanger
Chief Executive Officer
304-346-9864 Extension 2297
304-346-9863 Facsimile
jwiesend@wvmi.org

Kathleen D. Merrill
Chief Financial Officer
304-346-9864 Extension 2228
304-346-9863 Facsimile
kmerrill@wvmi.org

If you have questions or need further information, please feel free to contact me.

Sincerely,

Kathleen D. Merrill
Chief Financial Officer

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Use or disclosure of data contained on this page is subject to the restriction on the cover sheet of this proposal or quotation.

EHP14047 CONSULTINT PRICING PAGE

Consultant Hourly Rate for WVDTP:

Item	Est. Hours/Month	Rate/hour	Extended Price A
Cessation Quitline Consulting Services (See Item 4.1 through 4.4)	50	$ 150.00	$ 7,500.00

* Travel costs shall be included in hourly rate

Consultant Hourly Rate for Medicaid:

Item	Est. Hours/Month	Rate/hour	Extended Price B
Cessation Quitline Consulting Services (See Item 4.1 through 4.4)	50	$ 150.00	$ 7,500.00

* Travel costs shall be included in hourly rate

Overall Total (Extended Price A+B) $ 15,000.00

Note: Quantities (hours) listed are estimates and are for evaluation purposes only. Actual hours are not guaranteed or implied.

* Award will be based on the lowest overall total bid meeting specifications.

Bidder/Vendor Information:

Name: West Virginia Medical Institute, Inc.

Address: 3001 Chesterfield Place

Charleston, WV 25304

Attention: Kathleen Merrill, Chief Financial Officer

Phone: (304) 346-9864, Extension 2228

Fax: (304) 346-9863

E-Mail: kmerrill@wvmi.org

BASIS OF ESTIMATE:

The West Virginia Medical Institute's (WVMI's) Consulting Pricing Proposal has been prepared according to the instructions provided in the Request for Quotation (RFQ), Solicitation Number EHP14047 – Quitline Consulting Services, and the responses to questions included in Addendum No. 1. The pricing is predicated upon the terms and conditions included in the RFQ.

PERIOD OF PERFORMANCE:

The contract term is for an initial one (1) year period with a renewal term of two (2) successive one (1) year periods. The period of performance for the initial contract term is from January 1, 2014 to December 31, 2014.

HOURLY RATES:

The proposed hourly rates are fully burdened and based on WVMI's best estimate of the effort to complete the deliverables in the RFQ. In accordance with the instructions contained in the RFQ, travel expenses have been calculated into the hourly rate quoted.

ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE:

WVMI agrees to extend the same prices, terms and conditions offered in this contract bid to Other Government Entities per Paragraph 48 of the General Terms and Conditions contained in the RFQ.

Questions may be directed to Kathleen Merrill, chief financial officer, at 304-346-9864, extension 2228, or kmerrill@wvmi.org.

RFQ No. EHP14047

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: West Virginia Medical Institute

Authorized Signature: Kathleen D Morrell Date: 11/08/13

State of West Virginia

County of Kanawha, to-wit:

Taken, subscribed, and sworn to before me this 8th day of November, 20 13.

My Commission expires November 13, 20 16.

AFFIX SEAL HERE

NOTARY PUBLIC OFFICIAL SEAL
STACEY D. KING
State of West Virginia
My Commission Expires Nov. 13, 2016
5406 Luray Lane, Charleston, WV 25313

NOTARY PUBLIC Stacey D. King

Rev. 07/12

State of West Virginia
VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code***, §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code***, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**
____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. **Application is made for 2.5% resident vendor preference for the reason checked:**
____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident vendor preference for the reason checked:**
✓ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. **Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:**
____ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. **Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with *West Virginia Code* §5A-3-59 and *West Virginia Code of State Rules.***
____ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: West Virginia Medical Institute, Inc. **Signed:** Kathleen D. Merrill

Date: November 13, 2013 **Title:** Chief Financial Officer

STATE OF WEST VIRGINIA
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON STREET, EAST
POST OFFICE BOX 50130
CHARLESTON, WEST VIRGINIA 25305-0130
09/30/2013

Received
OCT 03 2013
Business Dept.

KATHLEEN MERRILL
WV MEDICAL INSTITUTE INC
3001 CHESTERFIELD PL

CHARLESTON WV 25304

THIS IS TO CONFIRM RECEIPT OF YOUR VENDOR REGISTRATION FEE. PAYMENT OF THE FEE ENABLES YOU TO PARTICIPATE IN THE PURCHASING DIVISION'S COMPETITIVE BID PROCESS AND ENTITLES YOU TO A ONE-YEAR SUBSCRIPTION TO THE WEST VIRGINIA PURCHASING BULLETIN. A NEW ISSUE OF THE WEST VIRGINIA PURCHASING BULLETIN IS POSTED ON OUR WEB SITE EACH WEEK. BID OPPORTUNITIES ESTIMATED AT $25,000 OR MORE ARE ADVERTISED IN THIS PUBLICATION. WE ENCOURAGE YOU TO LOG ON AND VIEW THE BULLETIN EVERY FRIDAY SO AS NOT TO MISS IMPORTANT BIDDING OPPORTUNITIES. OUR WEB ADDRESS IS:

HTTP://WWW.STATE.WV.US/ADMIN/PURCHASE

IN ORDER TO ACCESS THE WEST VIRGINIA PURCHASING BULLETIN, YOU WILL NEED YOUR VENDOR NUMBER, GROUP NUMBER (IF ANY), AND YOUR PASSWORD WHICH ARE PRINTED BELOW. YOUR ACCESS WILL BECOME EFFECTIVE ON THE FIRST MONDAY AFTER 09/30/2013, STATE HOLIDAYS EXCLUDED.

HELPFUL TIPS: YOUR COMPUTER-GENERATED VENDOR NUMBER BEGINS WITH AN ASTERISK, BUT DO NOT USE THE ASTERISK WHEN LOGGING IN. ALSO, OUR LOGIN SCRIPT IS CASE SENSITIVE. THEREFORE, IF YOUR VENDOR NUMBER CONTAINS A CHARACTER LIKE A, B, OR C, PLEASE TYPE IT IN UPPER CASE.

IF YOU HAVE QUESTIONS, FEEL FREE TO CONTACT US AT 304-558-2311 OR JEANNE.B.BARNHART@WV.GOV. THANK YOU.

SINCERELY YOURS,

Jeanne Barnhart

VENDOR REGISTRATION

VENDOR NUMBER : *709043422
GROUP NUMBER :
PASSWORD : 42800

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: EHP14047

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

West Virginia Medical Institute, Inc.

Company

Kathleen D. Merrill

Authorized Signature

November 13, 2013

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Revised 6/8/2012

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

West Virginia Medical Institute, Inc.
(Company)

Kathleen D. Merrill
(Authorized Signature)

Kathleen D. Merrill, Chief Financial Officer
(Representative Name, Title)

304-346-9864 x 2228 304-346-9863
(Phone Number) (Fax Number)

November 13, 2013
(Date)

Revised 6/15/2012

10. **CONTRACT MANAGER:** During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: John Marks
Telephone Number: 304-346-9864 x 2271
Fax Number: 304-346-9863
Email Address: jmarks@wvmi.org

Proposal for Consulting Services: Evaluation and Reporting for the WV Tobacco Quitline Program – EHP14047

Submitted to:

West Virginia Department of Administration
Purchasing Division
Attention: Roberta Wagner
2019 Washington Street East
Charleston, WV 25305-0130

By:

The West Virginia Medical Institute (WVMI)
3001 Chesterfield Place
Charleston, WV 25311

November 13, 2013

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Executive Summary

The West Virginia Medical Institute (WVMI) provides quality improvement, utilization management, program evaluation, analysis and reporting services to federal, state, and local governmental agencies. In this capacity, we are pleased to offer this response to solicitation EHP 14047 issued by the West Virginia Department of Administration, Purchasing Division. The Purchasing Division, on behalf of the Division of Tobacco Prevention (DTP) of the Bureau for Public Health, Bureau for Medical Services (BMS), seeks a vendor to provide consulting services specific to the evaluation and reporting for the West Virginia Tobacco Cessation Quitline. This project will assist BMS and DTP in their collective efforts to maximize the access, use and effectiveness of the State's Tobacco Cessation Quitline. Findings from the evaluation should enhance the overall operation of the program and identify opportunities for service and performance improvement.

According to the WV Department of Health and Human Resources (DHHR), tobacco use is the leading cause of preventable deaths in West Virginia, killing an estimated 3800 people annually. West Virginia's Tobacco Quitline program began in 2000 as a jointly sponsored and supported program of the BMS and the West Virginia Public Employees Insurance Agency (PEIA). In 2002, the BPH joined in sponsoring the program, thus providing a statewide tobacco cessation service to all citizens of West Virginia. Over the years, West Virginia's Tobacco Cessation Quitline has been a significant resource and integral component of the State's comprehensive tobacco control program. As the Quitline evaluation vendor for this program, WVMI will be committed to supporting this decade-plus effort to enhance the overall health status and well-being of West Virginians.

As a project consultant, WVMI, working in full cooperation with the BMS and DTP, will review Quitline protocols and perform an evaluation that includes, but is not limited to, Quitline caller satisfaction, quit rates and the Department's return on investment (ROI) in the program. WVMI will prepare a comprehensive annual report that includes goals, project tasks/activities, enrollment and related demographic data.

WVMI will reference/utilize the North American Quitline Consortium (NAQC) standards, guidelines and protocols in conducting our evaluation. The NCQA represents a national "gold standard" in providing leadership and direction on various performance improvement opportunities, methods and techniques focused on improving a Quitline's performance. We will also reference, and incorporate as appropriate, materials published by the Centers for Disease Control and Prevention (CDC), Office of Smoking and Health. Finally, we will collaborate with the West Virginia University Evaluation Oversight and Coordination Center, the current Tobacco Cessation Quitline vendor and related stakeholders throughout the state in order to ensure our work remains relevant, consistent and complementary to activities currently underway.

WVMI will support this project with the technical and subject matter expertise of our analytical, program evaluation and operations staff. We will assign project coordination, management

and contract oversight responsibility to John Marks, WVMI's Director of State Services. Gary Rezek, WVMI Analyst/Statistician, Helen Cowie, Informatics Analyst, Karen Hannah, WVMI Epidemiologist, and Jill Manna, WVMI's Corporate Director of Analytical Resources will carry out all technical and analytical responsibilities. Collectively, this team makes WVMI exceptionally qualified to fulfill all program evaluation, analytical and reporting requirements specified by the Department.

Introduction

WVMI has been an active participant in the West Virginia healthcare community for nearly 40 years, and has long been recognized as a champion for improved quality in the provision of healthcare in the state. WVMI has worked with nearly every hospital, nursing home and home health agency in West Virginia, collaborating with them to improve health care quality. Our work with the West Virginia physician community has had a significant positive impact on enhancing the internal operations and workflow of their respective practices. This has allowed these practices to better organize, coordinate, manage and deliver quality health care services to their patients.

During this time, WVMI has also been a trusted resource for many of our State agencies, including the West Virginia Bureau for Medical Services and Bureau for Public Health. WVMI has provided utilization management services to BMS for over 20 years. We have provided these services both as a direct contractor to the Bureau and as a subcontractor to APS Healthcare. The utilization management services provided by WVMI have assisted the Bureau in it management and operation of the State's Medicaid program.

While our service to West Virginia has never wavered, we have also grown to serve or region and the nation. WVMI is now part of a family of five mission-based organizations known as WVMI & Quality Insights. The other companies are Quality Insights of Pennsylvania, Quality Insights of Delaware, Quality Insights Renal Network, and the Mid-Atlantic Renal Coalition. Each is dedicated to improving health and health care.

Collectively, WVMI & Quality Insights' offers 400-plus employees and contractors with diverse experience and training in health care delivery, continuous quality improvement, medical record abstraction, epidemiology, data analysis, and program evaluation and information technology. Each discipline is critical to provision of our core services: health care informatics, health information technology implementation, clinical quality measures development, and quality improvement consultation.

We have a full complement of senior-level staff to provide the consulting expertise necessary to conduct the Tobacco Cessation Quitline program evaluation required by the BMS and DTP. Based on the breadth and depth of our service capabilities we are confident we can exceed the performance requirements set forth for this project.

As a result of our experiences, the work we have performed on a number of related research and analytical projects, and our corporate resources, our team is uniquely qualified to undertake this project.

Relevant Experience

WVMI has successfully administered a large number of state and federal government projects (see Appendix 3 for a listing of current projects). At the heart of many of those projects is data collection, analysis and reporting—core competencies for effective program evaluation. Examples of national and state level work include the following:

- **Veterans Health Administration External Peer Review Program**. Since 1991, WVMI has measured the performance of every Veteran's Health Administration facility in the country. This involves developing performance evaluation criteria, abstracting information from 300,000 medical records per year, and creating meaningful reports the VHA can use to improve its quality.

- **Medicare Quality Improvement Organization for Three States.** WVMI & Quality Insights affiliates help health care providers in all settings perform route cause analysis, implement interventions to improve quality, and measure improvements in quality. We evaluate performance at the individual provider level and program wide. We perform ongoing evaluation of these programs using a detailed, custom-built performance dashboard.

  As part of our QIO work, we employ a strong and active analytic department, which has initiated multiple projects. These projects include analysis of healthcare utilization among Medicare-Medicaid duel eligible beneficiaries; flu and pneumococcal immunization rates by demographic status; 30-day readmission rates in Medicare and long-term care beneficiaries; and many other analytic projects involving state and national Medicaid and Medicare data. We have produced multiple analytic reports for all of these projects, which have met or exceeded the requirements of the federal Centers for Medicare & Medicaid Services (CMS). We have published outcomes from several of these reports in national peer-reviewed journals.

- **Home Health Quality Improvement National Campaign.** WVMI coordinates a national campaign that is helping more than 5,000 home health agencies improve quality. As part of this program, WVMI employs extensive data analysis to provide participants with monthly reports of performance.

  We also develop and analyze the efficacy of multiple interventions designed to improve health outcomes for Medicare beneficiaries that receive Home Health Care services. We evaluate the success and utility of each intervention with surveys sent to a sample of participating agencies. We use the results of these surveys to improve the efficacy and reach of future educational materials. Each set of interventions undergoes rigorous

quantitative and qualitative analysis, based on both changes in rates of national quality indicators and on perceptions of front-line home health care workers.

The campaign also assesses the impact of the program, culminating in a periodic comprehensive report of process and outcome measures. For example, the 2010 report used sophisticated analytical techniques to show a measurable reduction in the acute care hospitalization rate for agencies who participated in the campaign.

- **Measure and Instrument Development and Support Contractor.** WVMI, through its Quality Insights affiliate, has been responsible for developing and maintaining national clinical quality measures related to e-health. This involves extensive research, testing and reporting. It also involves performing ongoing evaluation of the measures to determine usefulness and accuracy.

At the state level, WVMI has:

- Recently performed an assessment of the West Virginia Health Information Network's implementation. We performed document reviews and structured interviews, and we conducted a survey of participants to assess all phases of implementation.

- Assisted the West Virginia Local Health Inc. to conduct a statewide survey of local health departments. The project was funded by the CDC and conducted in collaboration with the Bureau for Public Health, Division of Immunization Services. The purpose of the survey was to assess local health department's readiness to bill for various immunization and related clinical services departments render. We used survey results in the development of a strategic plan detailing measures local health departments should undertake to enhance or expand their billing capabilities.

- Previously collaborated with the West Virginia Diabetes Prevention and Control Program to conduct a statewide public education campaign designed to raise awareness about important diabetes tests and exams. Program assessment included conducting a statewide survey, which led to a published paper exploring whether mass media affect Medicare Beneficiaries'' use of Diabetes Services.

Approach and Methodology

WVMI understands the importance of focusing an evaluation on answering questions most pertinent to the client. This evaluation will be based on the goals of the Quitline program and include both a process and outcome evaluation. To assure client satisfaction with the evaluation and resulting annual report, we will communicate regularly with the client throughout the conduct of the evaluation, making adjustments, if needed, based upon our mutual understanding of the purpose of the evaluation. Early in this process, we will meet with DTP and the West Virginia University's evaluation oversight and coordinating unit to discuss the

Quitline program. This discussion will: include a review of program goals for the annual period; reach agreement on questions to be answered by the evaluation; review the proposed evaluation plan; further focus the evaluation plan as warranted by client priorities; discuss the data sources and procedures that will be used to answer the evaluation questions; develop a firm understanding of the respective contractor (partner) roles; and finalize the timeline and milestones for completion of the project.

Based on the solicitation, we anticipate the client will be interested in answering the following process, utilization, and outcome questions:

Process

1. To what extent were Quitline protocols, activities and tasks completed as planned?

Utilization

2. What was the volume and reach of Quitline utilization?
    a. Number of incoming calls
    b. Number of enrollees in the Quitline program
    c. Demographics of Quitline enrollees: age, sex, race, ethnicity, geographic location, education, type of tobacco use, referral source, insurance coverage
3. What is the reach into target populations?
    a. Percentage of tobacco users who enroll in the program? By any tobacco use? By type of tobacco used (cigarettes, smokeless)? By sub-populations of special interest to the client?
    b. What is the relationship between promotional efforts and reach?
4. What services are utilized by enrollees in the Quitline program?
5. Do enrollees who use various types of services differ from one another – e.g. based on age, gender, etc.?
6. Were there changes in utilization over time?

Outcomes

7. What was the effectiveness of the Quitline? For all applicable recipients of service? For sub-groups of special interest to the client?
    a. Number of quit attempts at 7 and 12 month follow-up
    b. Number who quit tobacco use at 7 and 12 month follow-up
8. What was the level of satisfaction with the Quitline program? For all applicable recipients of service? For sub-groups of special interest to the client?
    a. With program overall

b. With components of the program – include assessment of the degree to which enrollees found components of the program (e.g., educational materials) useful

9. What was the return on investment (ROI)?

We are thoroughly familiar with standards developed by the North American Quitline Consortium (NAQC), and will use these standards to guide the evaluation. NAQC has created a Minimal Data Set (MDS)[1] for use by its members. The organization also provides definitions for quit rates using the responder (number quit divided by the number of all tobacco users seeking treatment who register for services, consent to the evaluation, and receive the minimal evidence-based treatment) and intent to quit methods (number quit divided by the number of all tobacco users seeking treatment who register for services and consent to the evaluation).[2] We will employ both definitions in the program evaluation. Intent to quit will provide the more conservative measure of quit rate.

We will use NAQC standards to determine the penetration of the program into target populations. Measures that we will include in the evaluation are call volume, the number of callers completing intake questions, the number of enrollees in the Quitline, and the number that receive evidence-based services offered by the Quitline. As recommended, we will calculate treatment reach as, "the number in the target population who received Quitline evidence-based treatment divided by the total number in the target population". We will also calculate reach into sub-populations of the larger target population, as data are available. We will use the Behavioral Risk Factor Surveillance System data to estimate target population numbers, such as the number of tobacco users in West Virginia. In addition, we will examine call volume and enrollment numbers in relation to any marketing/communication campaigns of interest to the client. Finally, we will compare the reach of the WV Quitline to goals established by the CDC and included in NAQC technical documents.[3]

The data the WV Quitline collects in the conduct of its routine business will support the above analyses. These data contain consumer-level information related to reasons for calling the Quitline, tobacco use, caller characteristics, and services received. Since not all callers enroll in the program, we will identify the enrollees based on algorithms established in the past to distinguish enrollees from non-enrollees. This will allow historical comparisons. Data elements collected with each call, using standardized formats in the MDS, will allow us to conduct a

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[1] North American Quitline Consortium. MDS for Evaluating Quitlines – Technical Documents. Available at http://www.naquitline.org/?page=technical. Accessed 11/4/2013.

[2] North American Quitline Consortium. NAQC Issue Paper: Measuring Quit Rates. 2009. Available at http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/docs/naqc_issuepaper_measuringquit.pdf. Accessed 10/15/2013.

[3] North American Quitline Consortium. NAQC Issue Paper: Measuring Reach of Quitline Programs. 2009. Available at http://www.naquitline.org/resource/resmgr/docs/naqc_issuepaper_measuringrea.pdf. Accessed 10/15/2013.

descriptive analysis and answer questions related to the characteristics of enrollees in the Quitline program and the type of services they use. We will examine the services used by Quitline enrollees by demographic and other characteristics of interest to the customer. To the extent that historical data are available to calculate performance measures in the same way each year, we will trend utilization data over time and examined any changes that have occurred.

Perhaps the most important components of the evaluation will be the number of enrollees who quit using tobacco, as measured through quit rates, and the extent to which quit rates can be attributed to services received from the WV Quitline. Per specifications in the solicitation, and as recommended by the NAQC, responder and intent to quit methods will be used to measure quit attempts and quit rates at seven and twelve month follow-up. These methods provide guidance on the denominators to be used. Also of importance are ways in which to measure the numerator in these quit rates. The NAQC recommends using 30-day point-prevalence abstinence rates in the numerator. We propose to follow this is the approach.

However, simple quit rates will not indicate whether enrollees achieved abstinence due to the Quitline, or would have quit in its absence. Randomized assignments of callers to treatment and control groups are not practical when the goal is to offer services to all appropriate candidates. One solution is to compare quit rates for different levels of services. We will explore this approach with the client. The NAQC, through the MDS, has been working to gather comparable data across quit lines for comparison purposes. We will use these comparisons only if comparable benchmarks are available for other Quitlines.

We propose to estimate quit rates for the population of WV Quitline users through random sampling. The sample size will be determined in consultation with the customer and will be partially dependent upon whether there is a desire to measure overall quit rates or quit rates within major classifications of enrollees – e.g., by insurance coverage. The latter case would require a stratified random sampling approach. We propose sampling a sufficient number of enrollees to estimate quit rates with +/- 5% margin of error and a 95% confidence interval for the "intent to treat" methodology. However, we will also review methods used in past evaluations for ease of comparison over time. We will work with the client and the West Virginia University's evaluation oversight and coordinating unit to finalize the sampling methodology. We will work with the WV Tobacco Cessation Quitline vendor to obtain the necessary telephone samples.

Another outcome the DTP may wish to evaluate is satisfaction with Quitline services. If the DTP does not collect satisfaction data as a routine part of providing Quitline services, WVMI may include questions related to satisfaction and usefulness of services in the surveys fielded to determine quit rates. To the extent reasonable, we will ask survey satisfaction questions in the same way as in past years to facilitate trending over time. We will work with the client to identify any new questions they wish to add to the survey. If not already a component of a satisfaction questionnaire, we recommend gathering the enrollee opinions about the degree of helpfulness of the Quitline in their achievement of abstinence from tobacco. Regardless of

whether satisfaction data is available through routine service delivery or sampling, we will calculate satisfaction with, and usefulness of, the overall program and component parts for all enrollees and groups of special interest to the client.

We propose to measure ROI as "savings from Quitline services divided by expenditures." To measure savings from Quitline services, we will multiply the number of abstinent enrollees by estimated savings per enrollee. We will obtain estimates of savings per enrollee from studies readily available in the literature, some of which are specific to West Virginia. Savings generally are derived from avoiding productivity losses, premature death, and direct medical expenditures related to tobacco use. To get the denominator for our ROI measure, we will gather total program cost data from the West Virginia Department of Health and Human Resources, Bureau for Public Health, Division of Tobacco Prevention and the Bureau for Medical Services. Because we will be estimating the number of abstinent enrollees from sampling, we will provide both a point estimate and range of potential ROI.

Process and Reporting

For this project, WVMI has proposed a work team and process tailored to meet all performance requirements as set forth by the BMS and DTP. To ensure our work remains relevant, timely and complete, WVMI will submit monthly reports in a style and format mutually agreeable to both parties, to the BMS and DTP program managers. Following the submission of each monthly report, we propose a brief project status call to address any critical findings, outcomes or observations our team has identified. The call will afford all parties the opportunity to regularly assess the project's progress, identify any issues/barriers that may influence the work plan and implement mutually agreed upon modifications if necessary.

An example of possible report formats is included as Appendix 1.

Project Personnel/Staffing

WVMI offers a wealth of individual and organizational experience directly related to this project. Personnel assigned to the project have relevant program management, evaluation, analytical and/or reporting experience.

The following table summarizes staff expertise related to the proposed project.

Table 1: Staff Experience

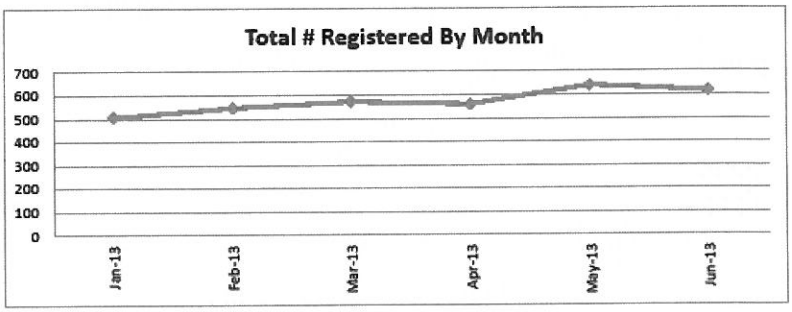
Staff with Major Roles	Education	Years of Experience: Program Eval	Analysis	Technology	Project Mgt.
John Marks, Contract Manager	BA, MSW	26	15		21
Jill A. Manna, Design and Analytical Oversight	BA	10	15	10	10
Karen Hannah, Epidemiologist	BA, MBA	30	35		10
Gary Rezek Analyst/Statistician	BA	15	12		
Helen Cowie, Informatics Analyst	BA, MS, Software Engineering	15	18		

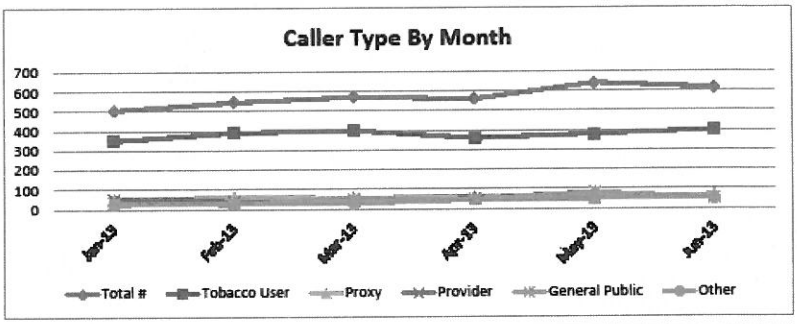
John Marks, WVMI's Director of State Services, will serve as Contract Manager. Gary Rezek and Helen Cowie will serve as the lead analysts assigned to the project; Karen Hannah will serve as the lead epidemiologist. Jill Manna will provide technical/analytical oversight of the work WVMI will perform.

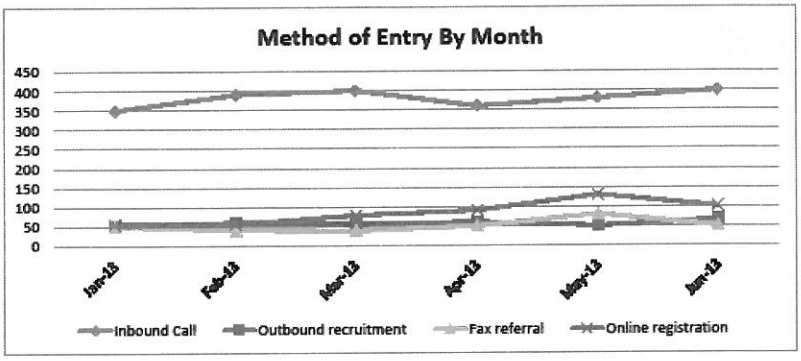
Mr. Rezek, Ms. Cowie, Ms. Hannah and Ms. Manna each have experience and are proficient in data management, surveillance and in the evaluation of data. Our entire analytical team is experienced in Microsoft Excel, Access, Word and Power Point. Each person is knowledgeable of and works with data manipulation software such as SAS and/or SPSS.

Resumes, including staffing qualifications for all members of the project team are included in Appendix 2.

Appendix 1: Examples of Possible Quitline Reports







Appendix 2: Resumes

John L. Marks, Jr.
Director of State Services

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
Fairmont State College, Fairmont, WV	BA, Sociology/Psychology	1972
West Virginia University, Morgantown, WV	MSW, Social WOrk	1974

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV
Director of State Services, 2001-Present

Serves as the Director of State Services for WVMI and is responsible for the financial and operational performance of the company's state services contracts, including pre-authorization and medical management contracts. Additionally, Mr. Marks plays a key role in establishing and servicing WVMI's strategic business partnerships with health-related organizations.

CCO HealthCareSystem, Inc., Charleston, WV
Executive Director, 1999-2001

Developed a strategic plan and implemented strategies to achieve corporate objectives for a physician-hospital organization. Successfully negotiated two payer arrangements on behalf of the network. Led the development and implementation of the network's medical management program. Developed the company's first marketing program.

Carelink Health Plan, Inc., Charleston, WV
Vice President of Provider Relations and Network Development, 1995-1999
Executive Director, 1992-1995

Senior management member of West Virginia's first and only provider-owned-and-operated managed care company. Responsible for the development and execution of the company's network expansion and provider-relations strategy. Accomplishments include expanding the service area from four West Virginia counties to 28. Negotiated service agreements including various risk-sharing arrangements with individual providers and organizations. Project manager of the plan's Medicaid MCO program.

West Virginia Department of Health and Human Resources, Office of Medical Services, Charleston, WV

Director, 1991-1992

Directed the state agency responsible for administering West Virginia's Medicaid program, which had a budget in excess of $600 million and served over 315,000 beneficiaries. Reduced accounts payable to providers by 25%. Improved timeliness of reimbursement to Medicaid providers. Ensured that over 80% of all claims were processed and paid within a 45-day period. Increased fees for certain providers by more than 60%.

King's Daughters' Medical Center, Ashland, KY
Interim President/CEO, 1989

Vice President of Professional Services, 1984-1990

Vice President of Human Resources, 1982-1984

After serving as VP of Human Resources and VP of Professional Services, was requested by Board of Managers to serve as Interim CEO of a hospital with a total budget of $65 million and 950 employees.

PRIOR EXPERIENCE

- *Executive Director*, West Virginia Advocates for the Developmentally Disabled, 1978-1982.
- *Health Care Specialist*, United Mine Workers of America, Health and Retirement Funds, 1977-1982.
- *Program Specialist*, West Virginia Department of Health, 1974-1977.

Jill Manna
Corporate Director of Analytics

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
Bloomsburg University	BA	1992

APPLICABLE EMPLOYMENT EXPERIENCE

Quality Insights of Pennsylvania, Harrisburg, PA
Director of Scientific Support, October 2002-present

Provides analytic supervision and guidance for the WVMI & Quality Insights analytic team. Interprets contract requirements and design applications/analysis to support those requirements. Created a dashboard for management to focus attention on key areas for quality improvement and program evaluation. Provides data analysis, reporting and support for disease management studies. Studies are multi-disciplinary, ranging from acute inpatient, review services, skilled nursing to physician office. The data includes beneficiary, inpatient claims, outpatient claims and survey data. Additionally, serve as the liaison with the acute inpatient provider community as technical and analytic support for a web-based data warehouse.

KePRO, Harrisburg, PA
Supervisor, Health Data Analyst, April 1999-August 2002

Provided data analysis, reporting and support for disease management studies. Also, summarized various data sources for project justification. This included beneficiary, claims, both managed care and fee for service, and pharmacy data. Created various Access based databases for data management and tracking. Supervised a group of three data analysts. Responsible for all data verification on all projects. Conducted database training classes for KePRO employees.

Aetna US Healthcare – USQA, Blue Bell, PA
Business Systems Delivery Specialist, November 1998-Apil 1999

Provided statistical reporting and analysis of various managed care data. Categorized beneficiary data into risk stratifications according to severity.

Keystone Health Plan Central, Camp Hill, PA
Research Associate, Research and Analysis
Senior Product Implementation Coordinator, Actuarial Service, November 1995-November 1998

Provided statistical analysis of managed care health plan financial and utilization data including HEDIS. Coordinated cross-functional departments for product and systems implementation. Prepared financial justification for project validation. Researched and implemented regulatory mandates. Trained new employees on the use of software packages in order to become proficient in job duties. Provided functional and user documentation.

Keystone Peer Review Organization, Harrisburg, PA
Reports Analyst, April 1993-November 1995

Formulated statistical analysis to monitor physician and company processes. Responsible for downloading/uploading of data with the Health Care Financing Administration. Wrote specifications, programs to analyze Management Information Series (MIS) reports for the monitoring of physicians and review coordinators. Duties included: preparation, programming and analysis of health claims data to improve healthcare standards and practices.

OTHER EXPERIENCE AND PROFESSIONAL ACCOMPLISHMENTS

- **Hardware:** IBM and compatibles, HP, RISC 2000
- **Software:** SAS, Access, Excel, Word, PowerPoint, SQL
- **Related Training:** Certificate for 16-week course in Epidemiology

Gary Rezek
Statistician

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
West Virginia State University	B.A. in Sociology	1991

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV
Health Care Data Analyst, 1996 - Present

Assists in development of health care quality measures for use in outpatient care settings. Designs and executes testing protocol for measure scientific acceptability and prepares submission of evidence for National Quality Forum (NQF) for endorsement.

Participates in all aspects of projects designed to measure quality of care of Medicare patients. Uses Medicare claims data to research and develop quality of care indicators for a broad range of clinical topics. Assists in developing data collection instruments and designing and programming data collection applications. Analyzes and performs quality checks on data and creates reports that summarize findings using appropriate graphical presentations and statistics.

CMR Research Associates, Morgantown, WV
Co-founder, 1994 - 1996

Co-founded research company specializing in mail and telephone surveys. Duties included soliciting clients, consultation, proposal writing, project budgeting, project planning and design, data collection and entry, data management, statistical analysis and report writing.

WV University Survey Research Center, Morgantown, WV
Research Associate, 1995 – 1996

Directed research projects for various state agencies and private clientele using telephone and mail surveys. Duties included consultation with current and potential clients, project planning and design, supervision of data collection and data entry, data management and statistical analysis.

OTHER EXPERIENCE AND PROFESSIONAL ACCOMPLISHMENTS

- Base SAS and SAS/Stat 15+ years
- Oracle PL/SQL 15+ years

PUBLICATIONS

- Schade CP, Hannah KL, Rezek G, Brehm JG. ACE inhibitor use and mortality reduction: do controlled trial results equal clinical practice? WV Medical Journal, 2006, 102(1), 304-6.
- Schade CP, Brehm JG, Stephens MK, Rezek G. Beta blocker use in acute myocardial infarction in West Virginia. WV Medical Journal, 2002, 98(2), 56-60.

Karen L. Hannah, M.B.A.
Epidemiologist, Health Care Quality Improvement Program

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
Marshall University	M.B.A. Economics	1985
Marshall University	B.A. Psychology	1976
University of Michigan	Post-graduate classes in epidemiology and biostatistics	1996

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV
Epidemiologist, Health Care Quality Improvement Program, April 2001-present

Currently serves as epidemiologist in WVMI's Health Care Quality Improvement Program (HCQIP). Responsible for the design and evaluation of population-based quality improvement projects using Medicare and Medicaid data, as well as for descriptive and observational studies of health care quality, health status, and health care effectiveness. A principal writer on grants and proposals across contracts.

Health Systems Analyst, Medicaid program, July 1998-April 2001

WV Bureau for Public Health, Office of Maternal and Child Health, Division of Research, Evaluation and Planning, Charleston, WV
Epidemiologist, January 1997-June 1998

WV Bureau for Public Health, Office of Nutrition Services, Women, Infants and Children's Program, Charleston, WV
Nutrition Surveillance Coordinator, July 1995-January 1997

West Virginia Department of Health and Human Resources, West Virginia Women's Commission, Charleston, WV
Research Consultant & Writer, November 1993-July 1995

NARAL, Charleston, WV
Executive Director, 1989-1993

Drake Beam Morin, Republic of Singapore
Psychometrician, 1987-1988
Economics Department, Marshall University, Huntington, WV
Economics Instructor, 1986

OTHER EXPERIENCE AND PROFESSIONAL ACCOMPLISHMENTS
Publications

Books

- *West Virginia Women: In Perspective* West Virginia Women's Commission, Charleston, WV August 1995.

Peer-Reviewed Journal Articles

- Hannah KL, O'Neil M. "Bringing all the players to the table: the West Virginia controlled substance advisory board." W V Med J. ;2010 Jul-Aug;106(4):22-25.

- O'Neil, M, Hannah K. "Understanding the cultures of prescription drug abuse, misuse, addiction and diversion." W V Med J. ;2010 Jul-Aug;106(4):64-70.

- Ruddick P, Hannah K, Schade C, Bellamy G, Brehm J, Lomely, D. "CASE STUDY: Root Cause Analysis Training Helps Reduce Falls in Rural Health Care Facilities. "Root Cause Analysis in Health Care: Tools and Techniques;" Joint Commission Resources, 4th edition, 2010, edited by Richard J. Croteau, M.D., ISBN: 978-1-59940-318-2.

- Hannah KL et al., "Hospital Administrative Staff vs. Nursing Staff Responses to the AHRQ Hospital Survey on Patient Safety Culture." *Agency for Healthcare Research and Quality, Advances in Patient Safety: New Directions and Alternative Approaches; 2008 (in publication)*

- Ruddick P, Hannah K, Schade C, Bellamy G, Brehm J, Lomely D, "Using Root Cause Analysis to Reduce Falls in Rural Health Care Facilities." *Agency for Healthcare Research and Quality, Advances in Patient Safety: New Directions and Alternative Approaches; 2008 (in publication)*

- Schade CP, Hannah K. "Quality of Ambulatory Care for Diabetes and Lower Extremity Amputation." *Am J Med Qual.2007 Nov-Dec;22(6):410-7*

- Schade CP, Hannah K. "Impact of the 2004 influenza vaccine shortage on repeat immunization rates." *Ann Fam Med. ;2006 Nov-Dec;4(6):541-73*

- Schade CP, Hannah K, Ruddick P, Starling C, Brehm J. "Improving Self-Reporting of Adverse Drug Events in a West Virginia Hospital," *Am J Med Qual. ;2006 Sep-Oct;21(5):335-410*

- Hannah KL, Schade C, Cochran R, Brehm J. "Promoting influenza and pneumococcal

immunization in older adults." *Jt Comm J Qual Patient Saf. 2005 May;31(5):286-93*

- Brehm J, Hannah K, Ruddick P, Schade C. "Physician Supply In Key Medical Specialties In West Virginia Hospitals, 2001-2004." *W V Med J. , 2004 Jul-Aug;100(4):132-5.*

- Schade CP, Hannah K, Rezek G, Brehm J. "ACE Inhibitor Use And Mortality Reduction: Do Controlled Trial Results Equal Clinical Practice?" *W V Med J. ;2006 Jan-Feb;102(1):304-6*

Helen Manuel Cowie
Informatics Analyst

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
West Virginia University	MS, Software Engineering	2002
Charleston Area Medical Center: Clinical Laboratories Categorical Program	Certificate, Clinical Chemistry	1992
West Virginia University	BA, Chemistry	1989

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV
Informatics Analyst, 2001-Present

Responsible for data quality surveillance using SAS for WVMI's major project to assess quality for the Veterans' Health Administration (known as the External Peer Review Program). Performs statistical analysis and reporting of medical record abstractors' performance using assessment and audit data. Conducts inter-rater reliability assessment of data abstraction tools. Responsible for the presentation, statistical analysis, graphical reporting and mapping of data for various state and federal projects which have included VHA special studies, Medicare and Medicaid programs.

Biostatistician, 1999-2001

CAMC Health Education & Research, Charleston, WV
Research Assistant II, 1996-1999

Served as coordinator for Charleston Area Medical Center's inpatient and outpatient satisfaction research where duties included database programming, statistical analysis and reporting. Alos served as project coordinator for Carelink Health Plans member and provider satisfaction research. Provided expert research assistance to Charleston Area Medical Center physicians, faculty, and health-related professionals on various clinical, health services, behavioral, and organizational research studies and projects. Conducted, analyzed, and managed outcomes and satisfaction research studies for the Family Resource Center, a mental health facility.

Charleston Area Medical Center, Charleston, WV
Medical Technologist, 1992-1996

Performed high-complexity, clinical laboratory testing of patient specimens using automated and manual procedures in the areas of clinical chemistry, toxicology, coagulation studies, and therapeutic drug monitoring. Other duties included teaching and in-service instruction,

monitoring of instrumentation quality control, routine instrument maintenance and troubleshooting, and biohazardous and chemical waste management.

Logan Regional Medical Center, Logan, WV
Cardiology and Laboratory Technician, 1989-1991

OTHER EXPERIENCE AND PROFESSIONAL ACTIVITIES

- 1993, Board Registry in Clinical Chemistry by the American Society of Clinical Pathologists
- 2001-2008, Attended 7 Annual SAS Users Group International Conferences
- 1999-2000, Completed over 90 hours of in-class instruction in SAS programming language
- 2000, Attended SAS Enterprise Miner Workshop given by West Virginia University, Department of Statistics, Morgantown, WV
- 2000, Attended Standard Data Processing System (SDPS) Users Group Conference, Des Moines, IA
- 1998, Attended NCQA (National Committee for Quality Assurance) certified vendor training for administering the HEDIS/CAHPS 2.0H Survey, Washington, DC
- 1993-1996, Taught undergraduate Clinical Chemistry topics in laboratory mathematics, proteins and lipids
- 1990-1994, Completed 18 of 36 credit hours toward an MS degree in Industrial Engineering at the West Virginia Graduate College, now known as the Marshall University Graduate College

Appendix 3: Select WVMI & Quality Insights Projects

Client	Project Description	Start Date	End Date
Centers for Medicare & Medicaid Services, Home Health Quality Improvement Initiative (HHQI)	Provides assistance and best practice reference materials to all home health agencies in the United States in a variety of areas.	01/11/2007	07/31/2014
RTI International	Implementation of Technical Assistance for Health Information Technology (HIT) & Health Information Exchange (HIE) in Medicaid & Children's Health Insurance Program (CHIP). WVMI hosted workshops and webinar.	06/01/2011	05/22/2012
WV Health Care Authority	Cardiac Catheterization Lab Audit Project.	07/01/2009	06/30/2012
RTI International	Barriers to HIT Meaningful Use Pilot Study Focus Groups.	09/01/2010	06/30/2012
West Virginia Primary Care Association (WVPCA)	Assistance to WVPCA-member Health Centers to Achieve National Committee for Quality Assurance (NCQA) Recognition as Patient-Centered Medical Homes.	02/22/2011	02/21/2013
Centers for Medicare & Medicaid Services (CMS)	Measure & Instrument Development & Support. Developing and maintaining national quality measures related to electronic health records (EHRs) and e-prescribing.	09/30/2008	09/29/2013
American College of Cardiology	Abstraction Services and Data Analysis.	06/17/2011	12/31/2013
West Virginia Health Improvement Institute (WVHII)	West Virginia Regional Extension Center (REC) for Health Information Technology. Assistance to 500 priority primary care providers in transitioning to EHRs and attaining meaningful use certification.	02/08/2010	02/07/2014
Office of the	Delaware Regional Extension Center	04/06/2010	04/05/2014

Client	Project Description	Start Date	End Date
National Coordinator for Health Information Technology	(REC) for Health Information Technology. Assistance to 1,000 priority primary care providers in transitioning to EHRs and attaining meaningful use certification.		
Office of the National Coordinator for Health Information Technology	Eastern Pennsylvania Regional Extension Center (REC) for Health Information Technology and Western Pennsylvania Regional Extension Center for Health Information Technology. Assistance to 1,000 priority primary care providers in transitioning to EHRs and attaining meaningful use certification.	04/06/2010	04/05/2014
Centers for Medicare & Medicaid Services (QIO)	Quality Improvement Organization projects in West Virginia, Delaware and Pennsylvania. Assistance to providers in working toward CMS goals of better care, better health and lower costs.	08/01/2011	07/31/2014
Department of Veterans Affairs	External Peer Review Program Contractor (EPRPIV). Medical record data abstraction services within VA facilities across the US.	09/30/2009	09/29/2014
APS Healthcare	West Virginia Medicaid Medical Necessity and Utilization Service. Medical review and medical eligibility review services.	12/01/2009	11/30/2014
American College of Cardiology	ACC National Cardiac Data Registry Audit 2012-13.	03/09/2012	03/31/2013
West Virginia Bureau for Public Health	Production of Media Campaign in Collaboration with WV Diabetes Prevention & Control Program.	03/29/2012	03/28/2013
WV Health Care Authority	Cardiac Catheterization Lab Audit Project.	07/01/2012	06/30/2015
WV Local Health Inc.	Survey of WV Local Health Departments, A Capacity Analysis of Billing Capabilities.	03/01/2013	08/31/2013

Appendix 4: Sample Reports and Surveys Produced by WVMI

This Appendix includes the following examples:

- West Virginia Disparities Report
- Home Health Quality Improvement Cardiovascular Risk Report Card
- Home Health Quality Improvement Best Practice Intervention Package Survey Instrument

West Virginia Disparities Report

Introduction

Research demonstrates disparities in health care delivery and status based on race and ethnicity. African Americans, Asian Americans, Hispanics, and Native Americans, suffer disproportionately from chronic disease, cancer, and infectious disease. These racial and ethnic designations define 'Underserved' in this report.

Immunizations and cancer screening have been identified as two key areas where minority Americans experience disparities in health care outcomes compared with whites.

Current federal minority health initiatives, such as the Department of Health and Human Services (HHS)'s Initiative to Eliminate Racial and Ethnic Disparities in Health, HHS's Healthy People 2010 program and the Centers for Disease Control and Prevention (CDC)'s Racial and Ethnic Approaches to Community Health (REACH) 2010 program, have sparked efforts to close the divide in quality rates.

Methods

The data sources for this report are the analytic data files produced by CMS for four prevention topics, influenza immunization, pneumococcal immunization (PPV), colorectal cancer (CRC) screening and breast cancer screening. CMS's Program Progress Reports were used to obtain statewide and national rates.

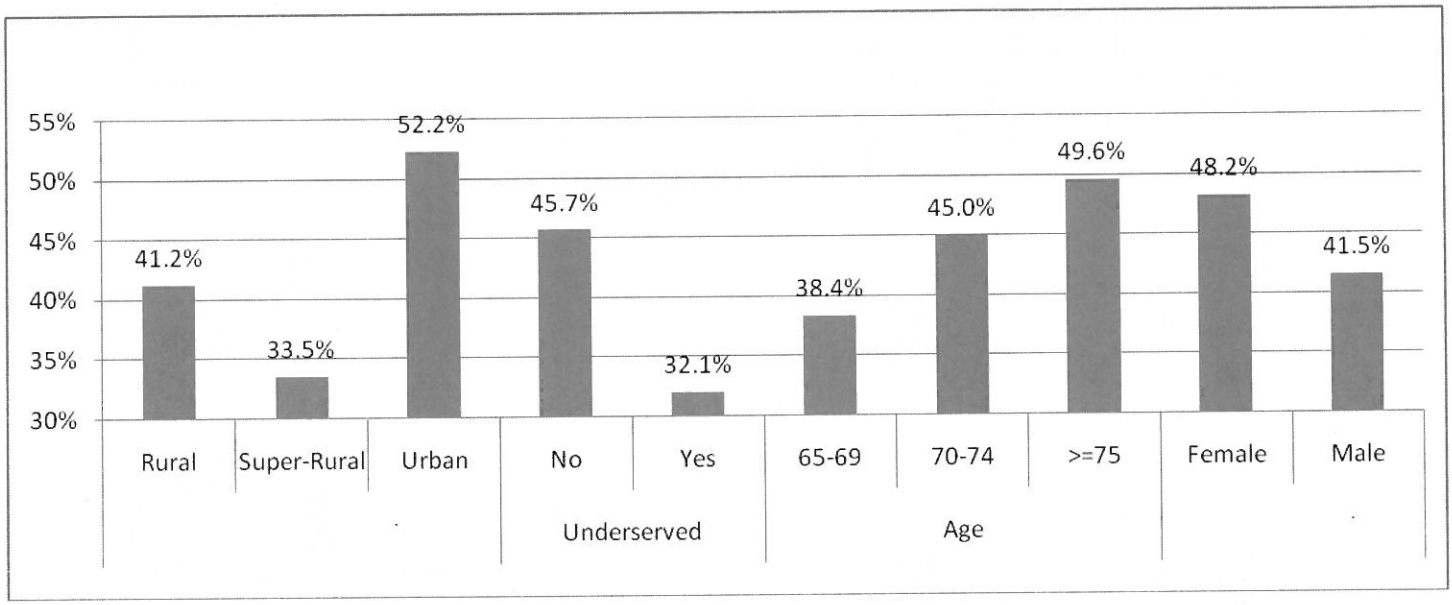
For each of the prevention topics, a map was produced illustrating the density of underserved beneficiaries in the denominator for that topic measure by zip code.

For influenza immunization the baseline rate is based on the 2007-2008 flu season. The baseline period for all other topics is either one year (PPV and CRC) or two years (breast cancer screening) with the period ending 12/31/2007. These rates are compared to rates from the periods ending 3/31/2008 (Q1), 6/30/2008 (Q2) and 9/30/2008 (Q3) for all topics except influenza immunization.

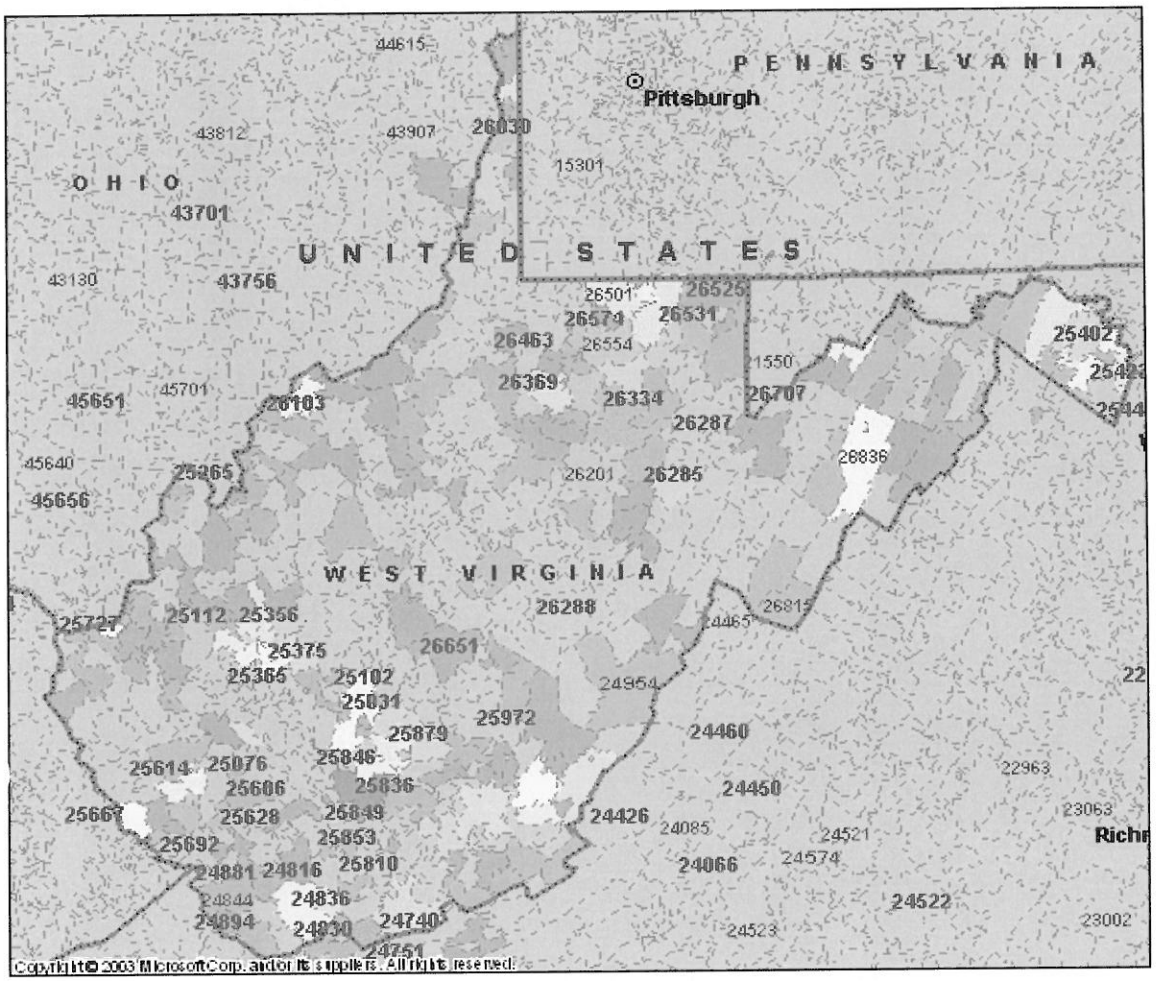
Influenza Immunization

The national rate of flu vaccination for the 2007-2008 flu season, based on CMS claims data, was 49.8%. A substantial disparity exists in the underserved population of West Virginia. The point difference between the underserved and non-underserved populations of 13.6% results in a disparity rate of 29.8%.

2007-2008 Flu Immunization Rates by Categories - West Virginia



Density of Underserved Population for Influenza Immunization



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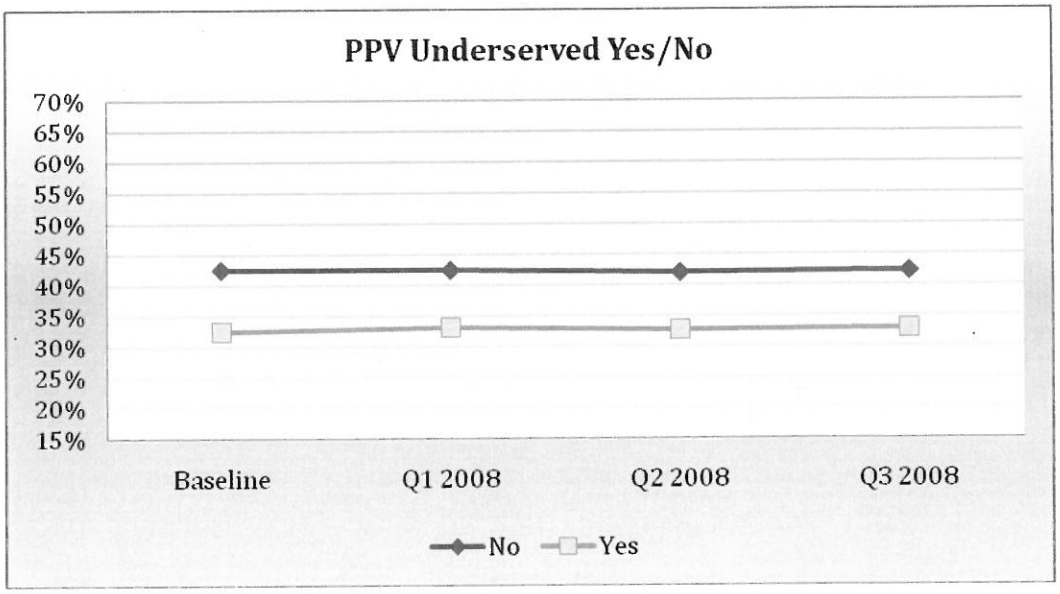
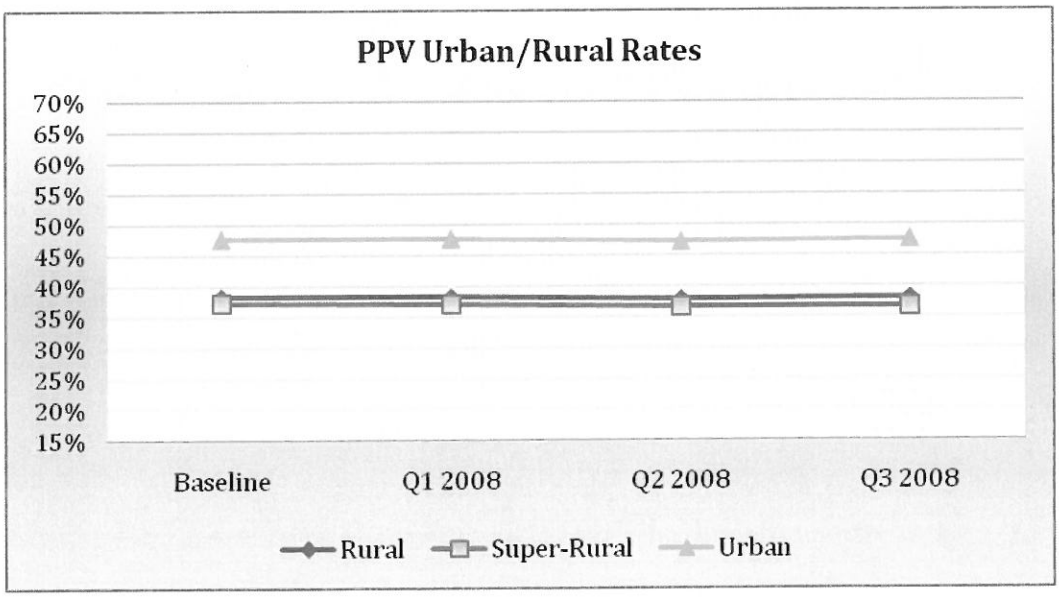
Pneumococcal Immunization

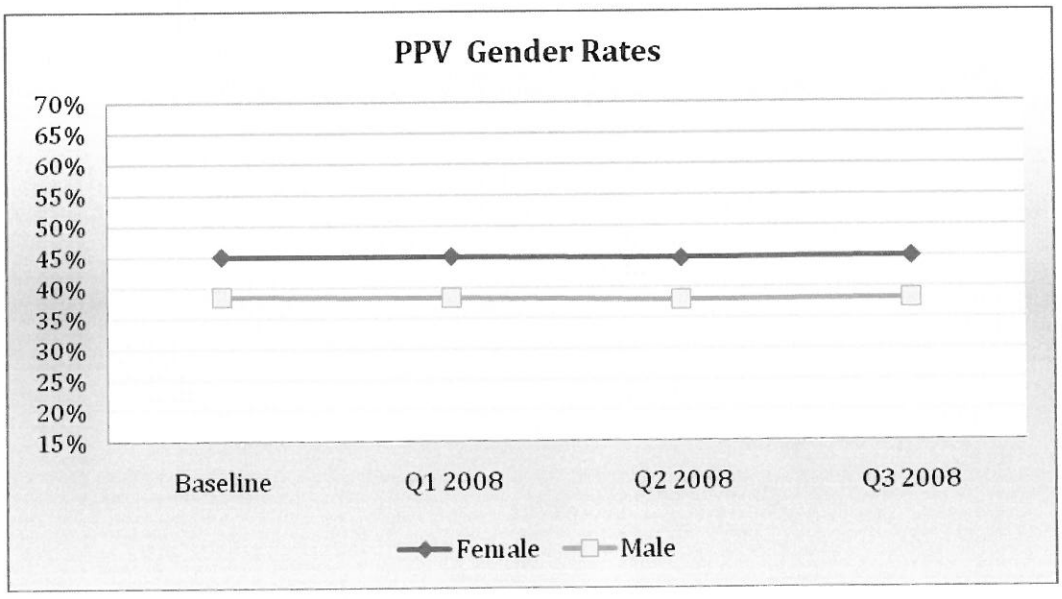
In West Virginia, the proportional disparity rate for the underserved remains virtually unchanged from baseline.
The rate difference for the 3rd quarter is 9.3% resulting in a proportional disparity rate of 22.1%.
Zip codes classified as super-rural and rural show little difference in the rate of pneumococcal vaccination, however those classified as urban have a higher rate that remains stable across quarters.
Rates for males are consistently lower by about 6 percentage points.
Given the lengthy time frame of the pneumococcal vaccination numerator, the age group differences appear to illustrate the cumulative effect of beneficiaries receiving the vaccination over time.

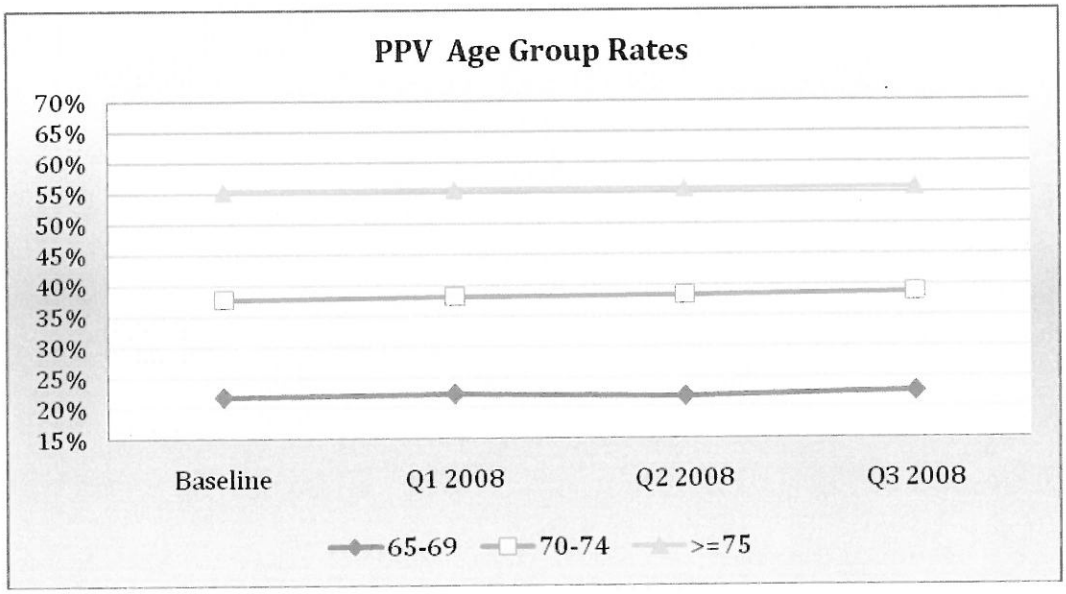
Baseline through Q3 2008 PPV Rates - West Virginia



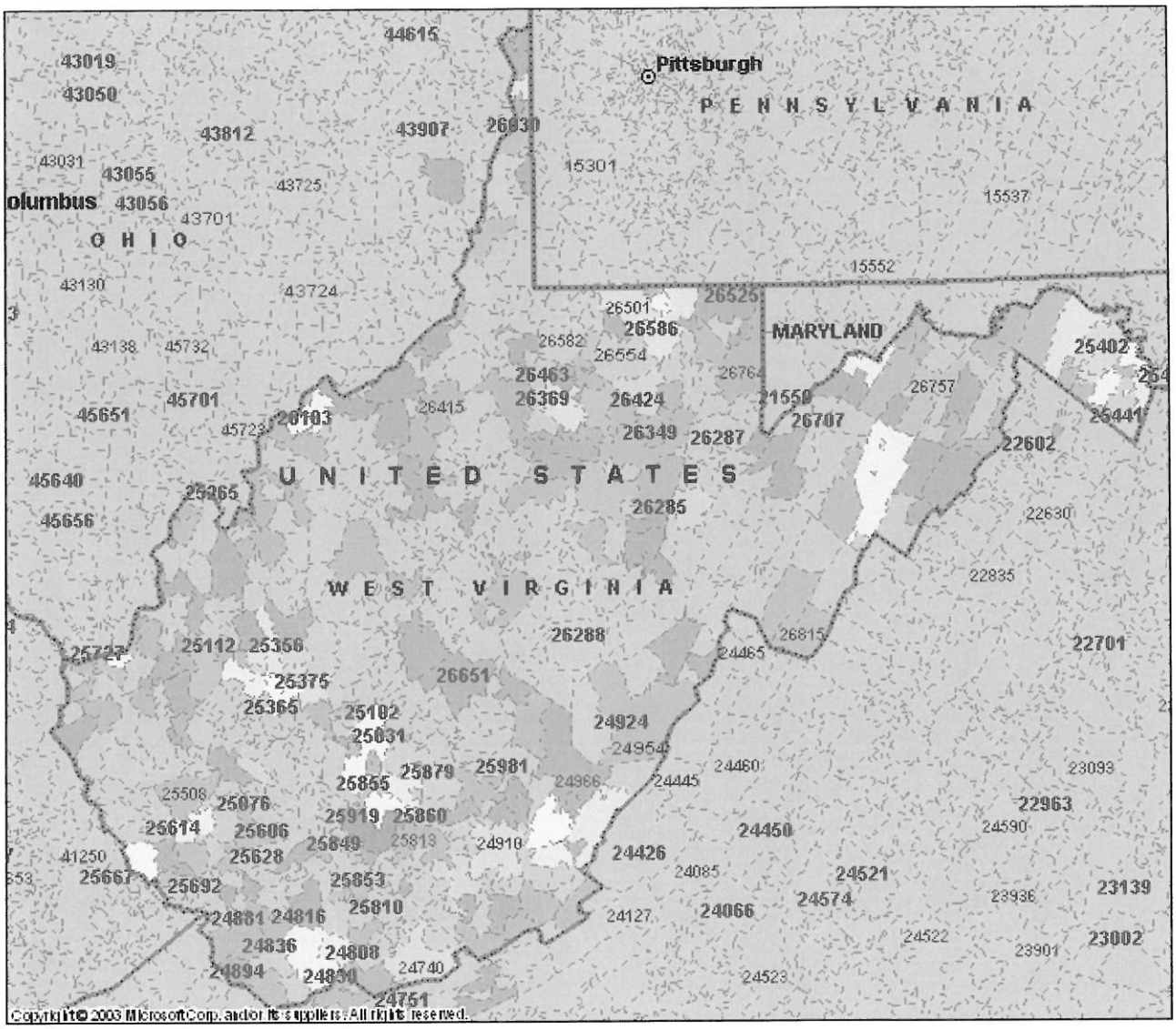


Baseline through Q3 2008 PPV Rates - West Virginia (cont.)





Density of Underserved Population for Pneumococcal Immunization



Underserved Population PPV Beneficiaries

400

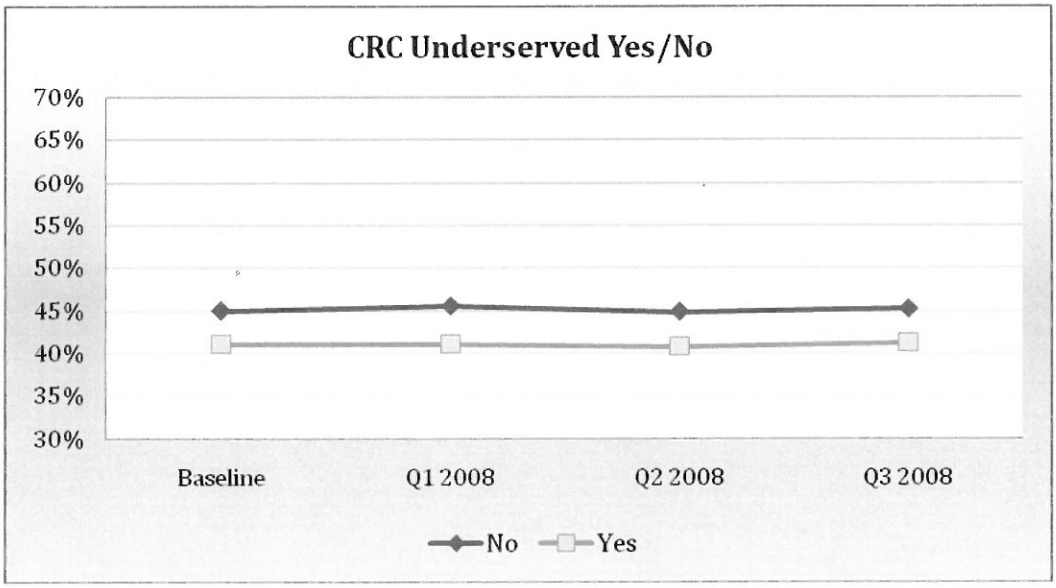
20

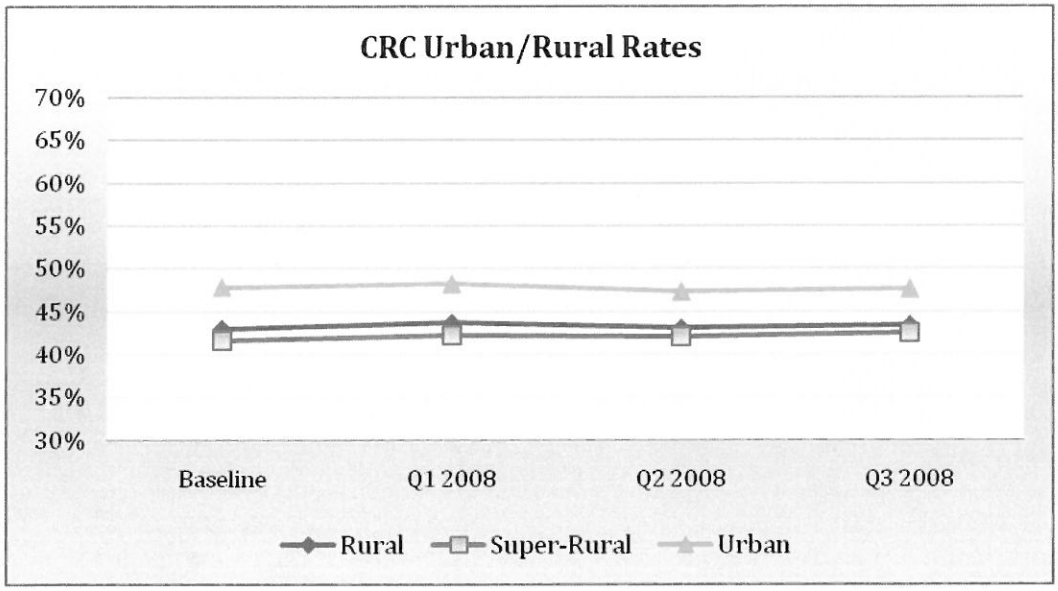
1

Colorectal Cancer Screening

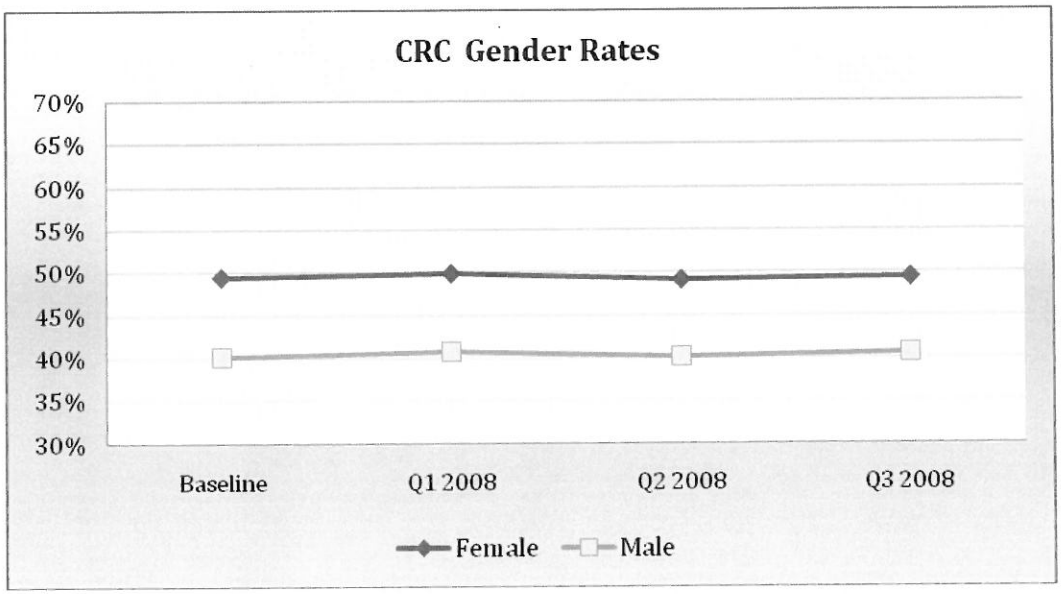
There is variation between groups in the statewide rates for colorectal cancer screening. The rate of disparity for the underserved population remains lower than the non-underserved population and remains stable across all quarters.
Rates for urban zip codes are about 4-5% higher than rural zip codes.
A substantial gender disparity exists for colorectal cancer screening. More females than males obtain a colorectal cancer screening with the difference being about 10%.
The difference in rates for those below and above age 70 may be attributed to a cumulative effect similar to that seen with rates for pneumococcal vaccination but the marked difference between the 65-69 age group and the 70-74 age group would suggest that those over the age of 70 are more likely to receive a colorectal cancer screening.

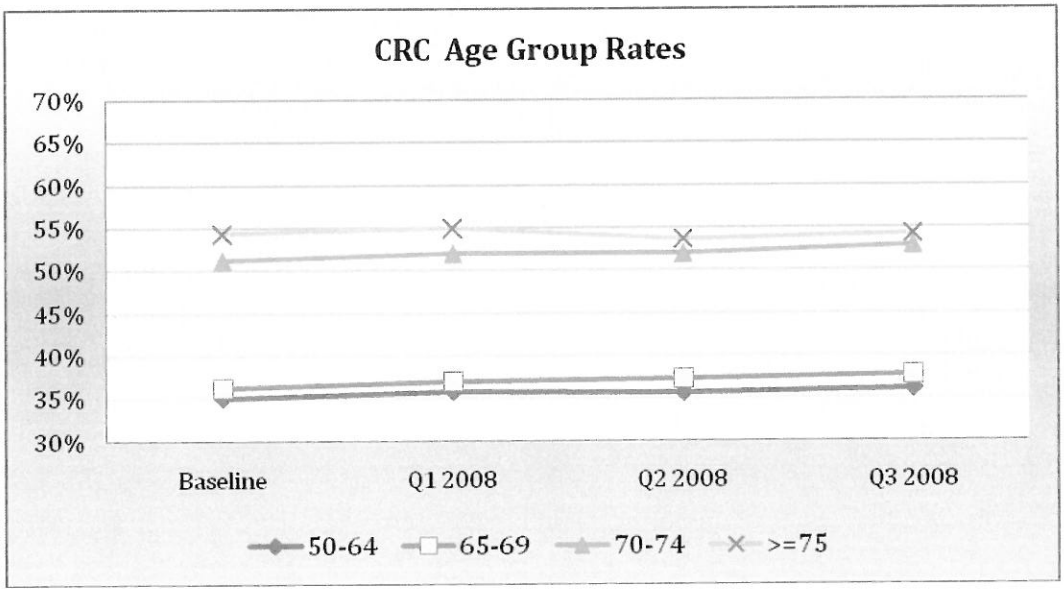
Baseline through Q3 2008 CRC Rates - West Virginia



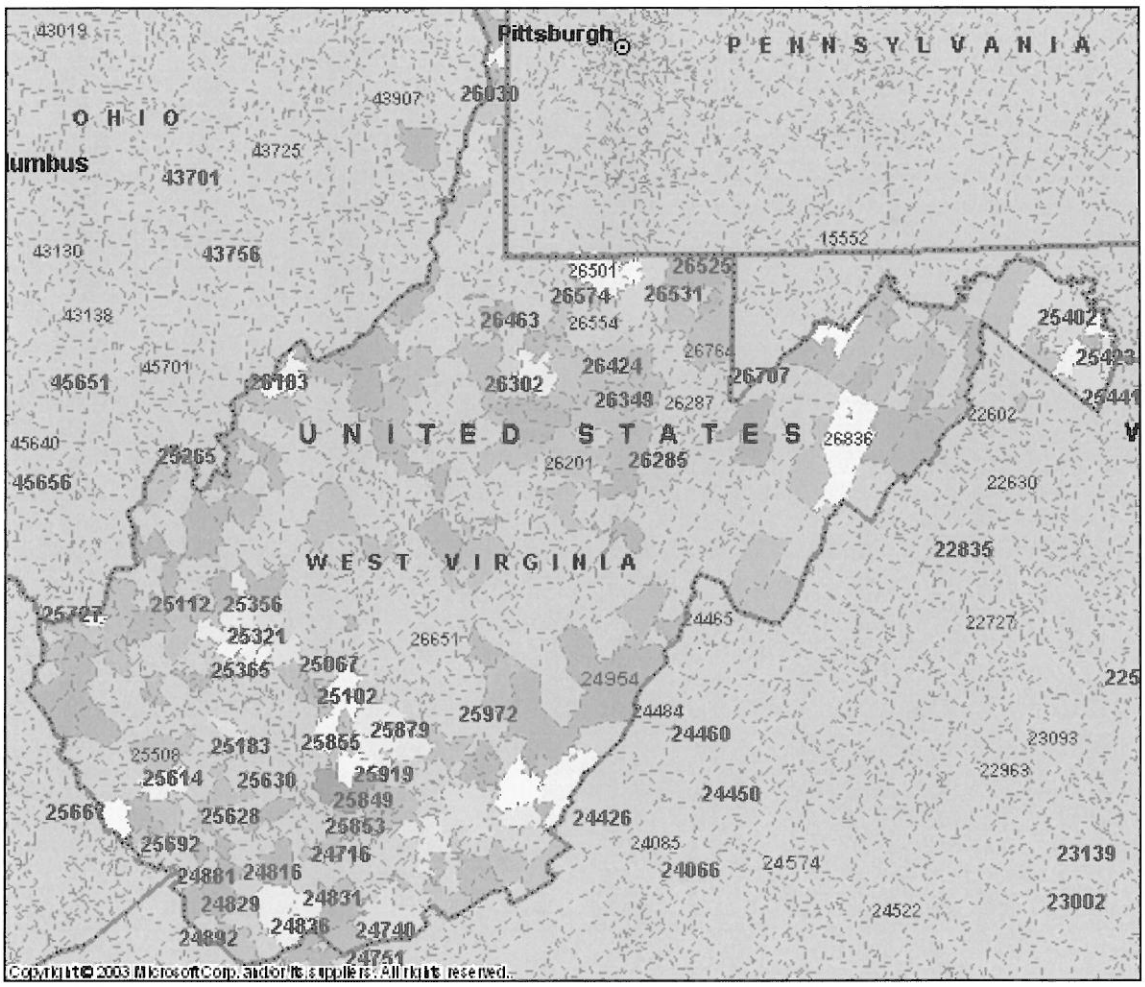


Baseline through Q3 2008 CRC Rates - West Virginia (cont.)





Density of Underserved Population for Colorectal Cancer Screening



Underserved Population CRC Beneficiaries

450

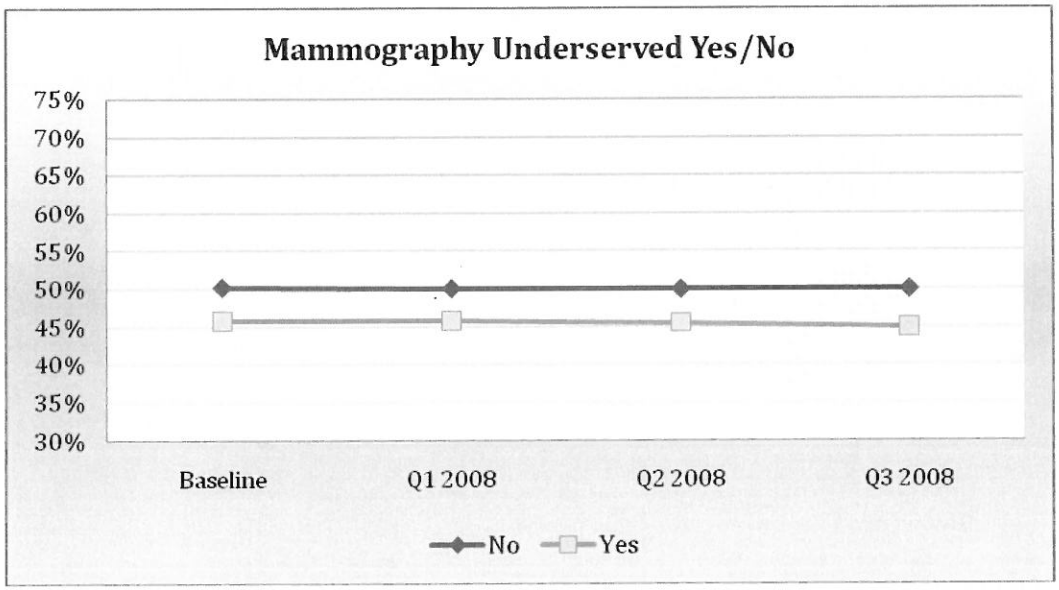
21

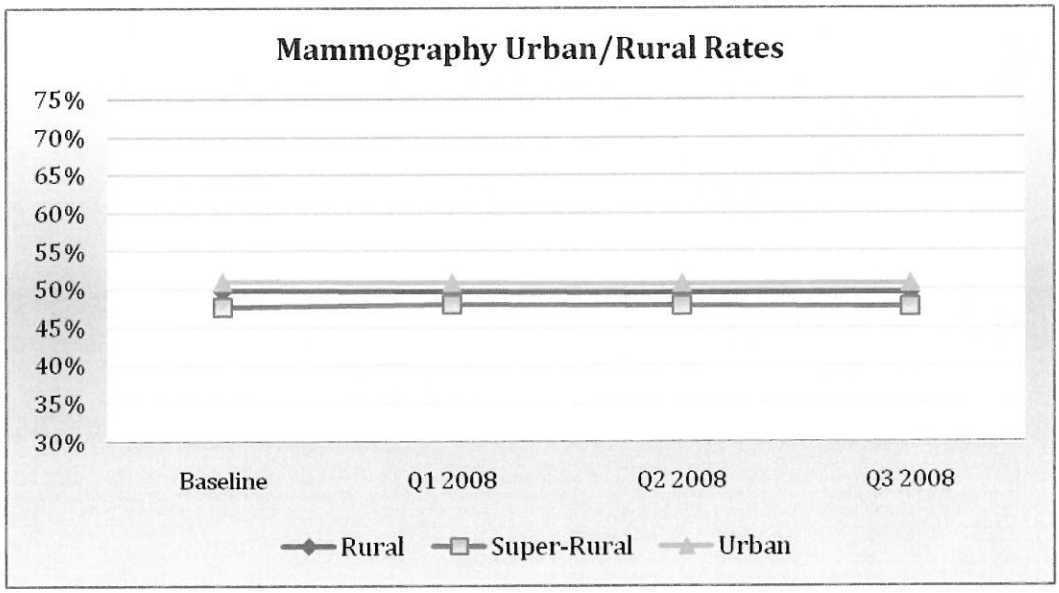
1

Breast Cancer Screening

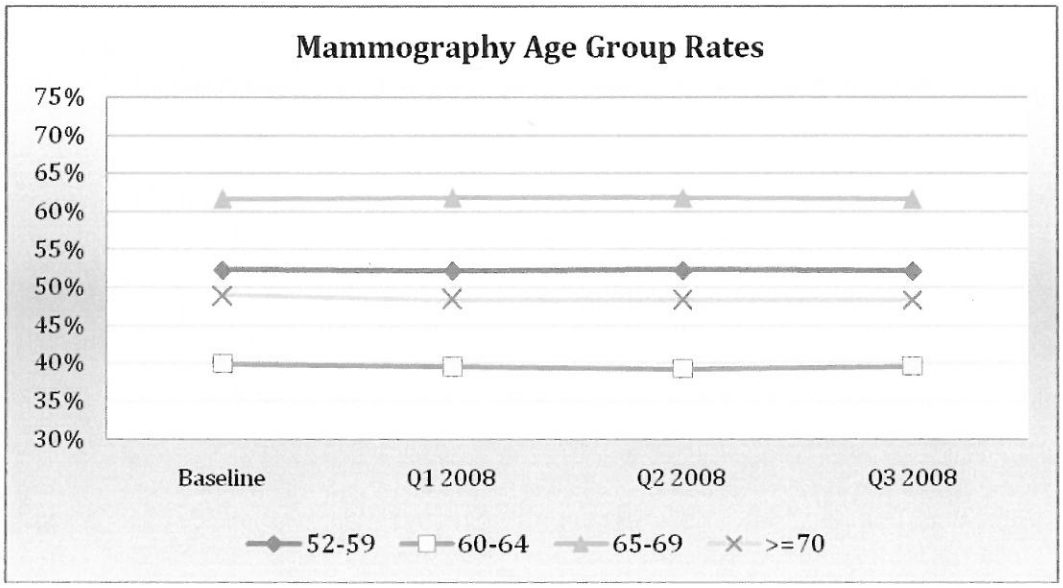
The rate of disparity for the underserved population remains consistently lower across quarters.
Rates for urban, rural and super-rural are more tightly bunched but rates for urban areas are 1-2% higher than rural areas and about 3 % higher than super-rural zip codes in all quarters.
Rates between age groups are markedly different. About 40% of women age 60-64 have received a mammogram while the rate for those between 65 and 69 is about 62%. Those younger than 60 and older than 70 have a similar rate of close to 50%.

Baseline through Q3 2008 Mammogram Rates - West Virginia

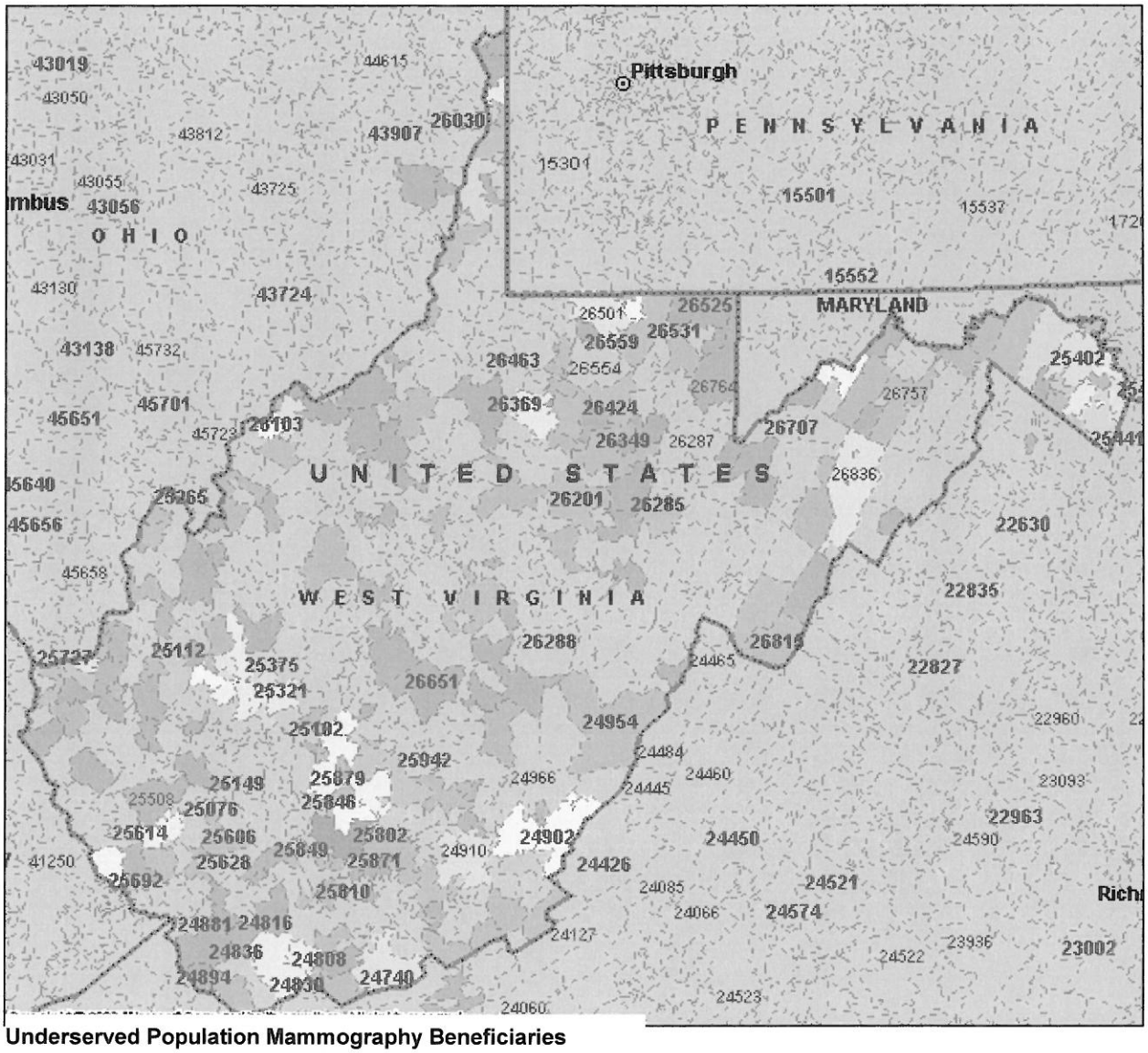




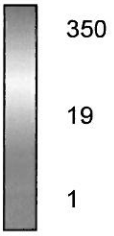
Baseline through Q3 2008 Mammogram Rates - West Virginia (cont.)



Density of Underserved Population for Breast Cancer Screening



Underserved Population Mammography Beneficiaries



Underserved Rates and Disparities

West Virginia					
Topic	Measurement Period	Underserved rate	Non-underserved rate	Rate Difference	Rate of Disparity
Influenza Immunization	Baseline	32.1%	45.7%	13.6%	29.8%
Pneumococcal Immunization	Baseline	32.4%	42.5%	10.1%	23.8%
	Q1	33.0%	42.4%	9.4%	22.2%
	Q2	32.6%	41.9%	9.3%	22.2%
	Q3	32.8%	42.2%	9.3%	22.1%
Breast Cancer Screening	Baseline	45.8%	50.3%	4.5%	8.9%
	Q1	45.8%	50.1%	4.3%	8.6%
	Q2	45.5%	50.0%	4.5%	9.0%
	Q3	45.0%	50.1%	5.1%	10.2%
Colorectal Cancer Screening	Baseline	41.1%	45.0%	3.9%	8.7%
	Q1	41.1%	45.5%	4.4%	9.7%
	Q2	40.8%	44.8%	4.0%	9.0%
	Q3	41.2%	45.2%	3.9%	8.7%

Statewide and National Baseline Indicator Rates Q3 2008

West Virginia		
	Statewide Rate	National Rate
Influenza Immunization ('07-'08 season)	45.4%	49.8%
Pneumococcal Immunization	42.0%	45.4%
Breast Cancer Screening	57.9%	60.8%
Colorectal Cancer Screening	45.1%	49.4%

Summary

WVMI/Quality Insights is committed to monitoring the difference in these rates on an ongoing basis. Medicare claims based data and other resources give us the ability to identify target populations and geographic areas with the greatest disparities in preventive services rates.

We will also monitor disparate rates in urban vs. rural areas, gender, and age groups where appropriate. We will use these data to inform our statewide disparities project.

WVMI/Quality Insights will request the CMS analytic files for these data on a quarterly basis and monitor disparities to identify any trends in statewide health care disparities.

Cardiovascular Risk Report Card For All Population

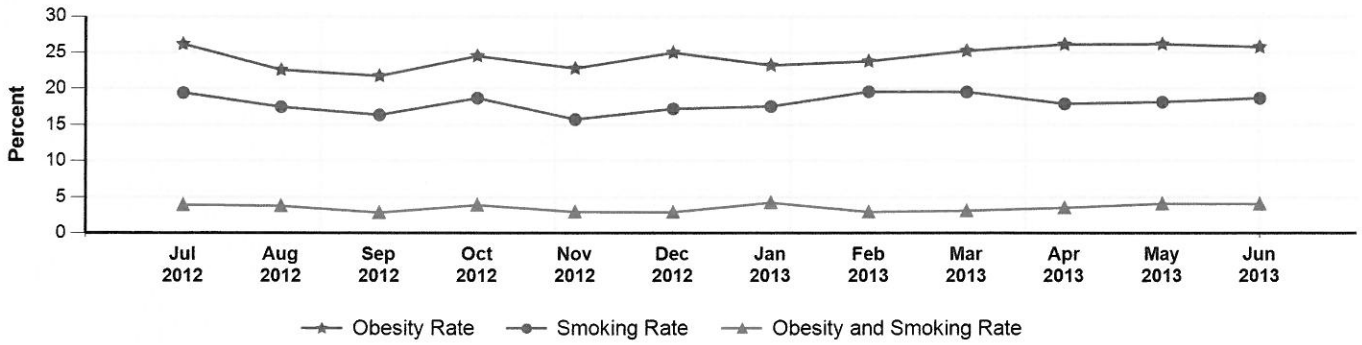
ıe: CV Sample Agency **Medicare#:** 999999

Location: Any City, PA **Report Date:** 08/12/2013

Rate for Obesity, Smoking and Both Obesity and Smoking (All Population)

	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	Jun 2013	Total
Obesity	233	203	182	232	230	222	225	209	226	258	255	222	2697
Smoking	173	157	137	177	159	153	170	172	175	177	177	161	1988
Obesity and Smoking	35	34	24	37	30	26	41	26	28	35	40	35	391
Discharges	890	898	836	946	1008	888	968	878	895	987	974	861	11029
Obesity Rate (%)	26.2	22.6	21.8	24.5	22.8	25.0	23.2	23.8	25.3	26.1	26.2	25.8	24.5
Smoking Rate (%)	19.4	17.5	16.4	18.7	15.8	17.2	17.6	19.6	19.6	17.9	18.2	18.7	18.0
Obesity and Smoking Rate (%)	3.9	3.8	2.9	3.9	3.0	2.9	4.2	3.0	3.1	3.5	4.1	4.1	3.5

Rate for Obesity, Smoking and Both Obesity and Smoking (All Population)



Data Source: Data shown is from the OASIS-C.

HHQI National Campaign *Underserved Population* Best Practice BPIP Survey

Instructions:

This is a voluntary and confidential assessment for agencies participating in the Home Health Quality Improvement (HHQI) National Campaign funded by CMS. Your feedback will be used to assess the overall effectiveness of the HHQI campaign and to assist with future development of quality improvement resources, tools, and initiatives.

This survey will be available until xxxxxx. Your feedback is extremely important and we greatly appreciate your time spent sharing it with us. This survey should take no more than 10 minutes of your time – thank you.

Enter your agency name:_____

Enter your six-digit Medicare provider number (CCN):_____

1. What is the size of your agency?
   - ☐ Large (greater than 699 discharges / year)
   - ☐ Medium (100-699 discharges / year)
   - ☐ Small (less than 100 discharges / year)

2. When did your agency first participate in the HHQI campaign?

   Select year from dropdown: prior to 2010, 2010, 2011, 2012, 2013

3. Did your agency download the HHQI's ***Underserved Population*** Best Practice Improvement Package (BPIP)?
   (If Yes go to #5 - if No go to #4)
   - ☐ Yes
   - ☐ No

4. Please tell us your reasons for not downloading the ***Underserved Populations*** BPIP or associate resources. Please select all that apply:
   - ☐ Determined the contents did not address our agency's specific issues or needs
   - ☐ Thought the materials were too complex for our agency
   - ☐ Tried to download the BPIP, but did not succeed
   - ☐ Found better materials elsewhere
   - ☐ Developed our own materials

☐ Other reason: (specify)

_____

4a. If the contents of the BPIP on Underserved Populations did not address your specific issues or needs, please list them here:

_____

4b. Although your agency did not download the BPIP on Underserved Populations, did you obtain the BPIP a different way, for example, from another agency?

( ) Yes ***[GO TO 5]***

( ) No [***GO TO 11]***

5. Please indicate the frequency that best describes your agency's use of each the following *patient* BPIP tools.

TOOL	**Never**	**With a few patients**	**With many patients**	**With nearly every patient**
"Doctor Reminder Notice" (p. 10)				
"Morisky's Medication Adherence Self-Assessment – MMAS 8-Item" (pp. 51-53)				
Other (please list): _____				

6. Please tell us if you used the Morisky's Medication Adherence Self-Assessment (MMAS-8) prior to reviewing the tool in the ***Underserved Population*** BPIP (pp. 51-53).

☐ Yes

☐ No, but was aware of MMAS-8 tool

☐ No, never heard of MMAS-8 tool

7. Please indicate if your agency has used any of the following *leadership* tools related to ***Underserved Populations*** to facilitate quality improvement efforts.

TOOL	Never	Occasionally	Often	Almost Always
"Engaging Change for Self-Management and Health Disparities" (pp. 12-13)				
"Simple Tips for Creating Health Care Collaboration" (p. 20)				
"Small Home Health Agency Action Tool" (pp. 52-53)				
Other (please list): _____				

8. How did your agency use any of the featured materials in the ***Underserved Population*** BPIP? Please select all that apply:

   ☐ Distributed materials to staff or posted

   ☐ Used materials to set targets or goals for the agency

   ☐ Employed strategies from the BPIP in routinely in patient care

   ☐ Revised one or more agency policies or protocols to incorporate materials

   ☐ Provided face-to-face, teleconference, or electronic educational programs for staff

   ☐ Never used the materials

   [If "Never used" selected, go to Q9; otherwise go to Q10]

9. Please tell us why your agency did not use any of the featured materials in the ***Underserved Population*** BPIP. Please select all that apply:

   ☐ Used other resources from the BPIP, but not the featured tools

   ☐ Used weblinks within BPIP, but not the featured tools

   ☐ Used resources on the BPIP Web page, but not the featured tools

   ☐ Felt featured materials did not address our specific ***Underserved Population*** issues

- ☐ Did not have time to use them at this point, but intend to use some
- ☐ Found better materials elsewhere
- ☐ Developed our own materials
- ☐ Other reason:

  _____

10. Please assess how frequently your agency uses the ***Underserved Population*** BPIP materials. Choose the one best response.
    - ☐ Nearly all the time for the care of every patient
    - ☐ Frequently
    - ☐ Occasionally
    - ☐ One-time activity only
    - ☐ Never

11. Please tell us if your agency uses any of the other supporting resources from the HHQI ***Underserved Populations*** BPIP webpage. Please select all that apply:
    - ☐ Cultural Competency tools or resources (e.g., Culture-Sensitive Assessment Checklist)
    - ☐ Patient Basic Needs Webinar and Clinician Post-Test
    - ☐ Health Literacy tools (e.g., Newest Vital Sign Toolkit or Ice Cream Label)
    - ☐ Teach-Back (e.g., Teach-Back Role Play)
    - ☐ Bulletin Board Templates
    - ☐ "My Plate" Samples
    - ☐ Multimedia resources (e.g., Podcast)
    - ☐ Not using, but plan to use one or more
    - ☐ Not using and no plans to use
    - ☐ Other supporting resources: (specify)

      _____

12. Describe how the ***Underserved Populations*** BPIP or resources have most affected how your agency provides patient care.
    - ☐ We are implementing **actions** to improve the care of populations
    - ☐ We have begun to perform **assessments** of the population issues

- ☐ It has increased our **awareness** of specific population issues
- ☐ No impact at all
- ☐ Additional comments:

(Allow option to enter comments **and** select only one of the responses above)

13. Has your agency conducted staff training on ***Underserved Population*** activities?
    - ☐ We began doing this periodically before we downloaded the package and are still doing it
    - ☐ We started doing this after we downloaded the package
    - ☐ We plan to do this in the next 3 months
    - ☐ We plan to include some component in all agency activities
    - ☐ We have not done this
    - ☐ Other (e.g., if you tried this activity and stopped)
    - ☐ Please describe your agency's staff training activities:

      _____

    (Allow option to enter staff training activities **and** select only one of the responses above)

14. Does your agency collaborate with other providers (e.g., hospitals, community services) to address the needs of the ***Underserved Population*** in your community?
    - ☐ Yes, we did this prior to downloading the BPIP or resources and are still collaborating
    - ☐ Yes, after we downloaded the BPIP or resources
    - ☐ No, but plan to in the next 3 months
    - ☐ No, do not have any plans
    - ☐ Other (e.g., if you tried this activity and stopped) Please describe:

      _____

15. Has your agency integrated the ***Underserved Population*** BPIP materials or resources into your quality performance activities?
    - ☐ Yes
    - ☐ No, but we plan to in the future
    - ☐ No and we have no plans to

16. Has your agency adopted or revised policies or protocols related to the needs of ***Underserved Populations***? (i.e., health literacy, limited English proficiency, etc.)

- ☐ Yes
- ☐ No, but we plan to in the future
- ☐ No and we have no plans to

17. If you have additional comments about the campaign materials or if you have used tools other than those mentioned in the previous questions, please describe below:

    _____

    (Optional)

Thank you for taking the time to complete this survey. Your responses will assist us in making future BPIPs even more responsive to your agency's needs.
(exit to HHQI website)