Minutes
Initiation Work Group, HSCRC
Monday, Sept 29, 2006
9 am-10:30 am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Trudy Hall, Chair and HSCRC Commissioner; Dr. Beverly Collins, Carefirst; Ms. Rene Demski for Dr. Charles Reuland, Johns Hopkins Medicine; Ms. Deneen Richmond, Delmarva Foundation; Dr. Kathryn L. Montgomery, University of Maryland School of Nursing (by telephone) Ms. Marybeth Farquhar, AHRQ; Dr. Dr. Vahé Kazandjian, Ms. Nicole Silverman, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; and Ms Renee Webster, OHCQ; HSCRC: Mr. Robert Murray and Ms. Marva West Tan.
On conference call: Ms. Joan Gelrud and Ms. Joanne Koterwas, St. Mary's Hospital; Mr. Gerald Macks, Medstar Health; Mr. Jeffrey Gebhardt, AHRQ (There may have been other persons on the audio conference. who were not identified.)
Interested Parties Present: Ms. Kathy Talbot and Ms. Jan Bahner, Medstar Health; Ms. Sylvia Daniels, University of Maryland Medical Center; Ms. Ing-Jye Cheng, MHA; Ms. Kristin Geissler, Mercy Medical Center; Ms. Charlotte Thompson, HSCRC; Mr. Craig Weller, Delmarva Foundation, Mr. Jim Miller, DHMH – OPF, Ms. Carol Christmyer and Ms. Deborah Ra

1. Welcome and Approval of Minutes- Dr. Hall welcomed the Work Group and attendees on the audio conference. Other Initiation Work Group members, guests and interested parties on the telephone introduced themselves. The minutes from the September 29, 2006 meeting were approved as distributed. (Corrections regarding a title and an affiliation provided following the meeting are posted in corrected minutes on the HSCRC Web site.)
2. Status of Data Acquisition – Ms. Tan noted that she is still working with the Delmarva Foundation , whose staff have been very helpful, to access the Medicare Clinical Data Warehouse for core diagnostic measurement data. The CMS data request process is very time consuming. She also noted that both the Institute of Medicine and MedPac have recently issued some new reports about pay for performance. The Executive Summary of the IOM report was included with meeting handouts.
3. Continuing Initial Statistical Analysis and Composite Score Construction- Dr. Kazandjian noted that this is the first meeting in which the group is addressing the details of constructing a composite measure. He also requested that the members provide comments in follow-up to the presentation to Ms. Tan. He noted that one of the comments following the last meeting was regarding a reference to the word, "gaming," during the discussion. He wanted to make clear that this reference was in regard to potential situations in published accounts and in no way reflected a comment on the current data analysis. He also noted that the data to be discussed today was from a subset of Maryland hospitals and may not extrapolate to all hospitals. He reminded everyone that the selected measures set will need to evolve over time. As performance levels approach 100% for certain measures, the measurement results will no longer provide data useful in compiling a composite measure and new measures will need to be introduced. This is a successful outcome as it indicates that desired improvements have occurred. Dr. Kazandjian said that the discussion today will be on possible models and moves the project from theoretical discussion toward the working model. He introduced Dr. Ritter for his presentation.

   Dr. Ritter reviewed his slide presentation (Please see Dr. Ritter's attachment for content). He introduced his presentation by noting that this is a discussion of composite score construction for a pay-for-performance program. While multiple scores from different categories might be desirable for other purposes, one composite score, sometimes referred to as a composite of composites, is desirable to make decisions regarding rewards for pay-for-performance. He noted, regarding exclusion rates mentioned on page 4 of slides, that Maryland's exclusion rates for certain measures seem to be about the same as national data, but the result is that certain psychometric techniques can not be used with the existing exclusion rates. For example, there are six AMI measures in the sample set, but on average, only two measures are reported on for any given

patient. He described the appropriateness and opportunity models; and pointed out the opportunity model data results on slides 6-8. Slide 9 reflects the MedPac recommendations for a well conceived composite score construction. Possible composite weighting schemes are listed on slide 10. Factor analysis does not seem applicable to the current data. Regarding weighting by clinical importance, Dr. Ritter noted that this approach may be more useful in the future as more data emerges regarding how outcomes, such as post discharge mortality or readmissions, are related to compliance with specific process measures. Alternatively, a panel of experts could provide their opinion about relative importance of specific measures. Regarding slide 11, Dr. Ritter analyzed the data using three different weighting schemes. He noted that the hospitals should feel comfortable that these three schemes result in relatively similar ranking results. The final slides 14-17 present an analysis regarding the adequacy of variation across hospitals. The rule of thumb is that there should be 7 times the variation across hospitals as it is within hospitals (the F value). The results, on a year's worth of data, are that there is reason to believe that there are discernible differences among the hospitals. Dr. Kazandjian noted that slides 11 and 17 are comforting in that the options we are pursuing are discriminating enough, through well established methods, to make decisions. He then asked for questions.

Dr. Collins asked if there were a minimum number of opportunities needed for analysis, such as 30 opportunities per hospital. Dr. Ritter agreed and noted that it is easier to meet the 30 threshold if opportunities are the unit of measure. Even small hospitals should have no problem meeting this volume level if annualized or one-half year's worth of data are used. Dr. Kazandjian added that the volume is only one criterion for becoming a screen for an index of performance; appropriateness must also be considered.

Mr. Murray asked for a clarification between use of outcome measures to weight clinical importance of process measures versus embedding outcome measures, with process measures, into the construction of the composite score. Dr. Ritter said that he thought in terms of short term versus long term outcomes. Short term, one might use 30 day mortality as one more measure in the composite. Long term, for weighting clinical importance, one might consider which processes are related to the best health, by looking at long term outcomes, e.g., 2 year mortality. Dr. Ritter also noted that some propose a link between better quality and reduced cost so that one might look long term at the post admission cost of care as an indicator of quality. CMS is interested in this approach – the cost offset argument.

Ms. Richmond stated that while we have been discussing the opportunity model, CMS is exploring the appropriateness model at selected hospitals nationally via the QIOs. In Maryland, ten to twelve hospitals have volunteered to participate in this appropriateness model and composite measure project but the data are not being publicly reported currently. This approach may be part of the CMS Hospital Compare public reporting in the future. Dr. Ritter said that both the opportunity and appropriateness models have their champions and it is not clear which CMS will ultimately select. He noted that Maryland has been rather unique in many areas and may select its own approach.

Dr. Kazandjian noted that in discussing "appropriateness," Dr. Ritter's presentation focused on "what you do" and "what happens," and how "well being" can be an adjuster of the process measures. When CMS talks about appropriateness, it are referring to "doing the right thing" or evidence-based medicine. Evidence-based medicine is clearly not a local phenomenon. There are also non-evidence based measures. Due to the uniqueness of Maryland and its rate setting process, there may be non-evidence based measures which Maryland wishes to incorporate into its composite measure. There is room for discussion on this matter.

Next, Ms. Tan introduced Marybeth Farquhar and Jeffrey Gebhardt from AHRQ who generously agreed to a last minute request to present some information regarding AHRQ's work on developing a composite measure. (Please see the attached AHRQ slides for the content of the presentation.) Ms. Farquhar noted that part of the impetus for this project was a request from the Commonwealth Fund and the National Healthcare Disparities Report who wanted an overall or

composite score for their audience, who are consumers and politicians. Ms. Farquhar noted that she also wanted to put the AHRQ Quality Indicators, the composite score methodology and the AHRQ reporting template through the National Quality Forum validation process. More impetus came from the States who are using the AHRQ Quality Indicators for their own public reporting and wanted a composite measure. Ms. Farquhar noted that she was indebted to the AHRQ work group, Stanford and University of California, at Davis, for all the work they contributed. Mr. Gebhardt discussed the methodology, involving creation of a composite of composites, and noted that details of the methodology are available on www.ahrq.gov.

Dr. Kazandjian made some comments. He asked if the word "cohort" used in the presentation was the same as the epidemiological definition. Mr. Gebhardt clarified that in this presentation "cohort" referred to the group of indicators related to a disease, such as the AMI measures. Dr. Kazandjian also asked for a clarification of the use of "forecasting." Will there be a forecasting model, for example, for safety measures? Will there be a signal to predict and avoid adverse events? Mr. Gebhardt noted that the forecasting meant the ability to distinguish between signal and noise. The concept is to develop the ability to distinguish between performance that is persistent over time and should be incentivized and performance that is random and fluctuates over time and should not be rewarded. Dr. Kazandjian noted that AHRQ is also using the term "forecasting" with a somewhat different meaning from the general usage regarding probability. What Mr. Gebhardt seems to be describing is a continuous measure for consistency, rather than a prediction of future behavior. Mr. Gebhardt responded that it is being used as a predictor of future behavior. Ms. Farquhar concluded by noting that the reporting templates will be available publicly in a few days. She said that comments on the presentation were welcome and her contact information is on the slides. Dr. Hall thanked both Mr. Gebhardt and Ms Farquhar for their presentations.

Dr. Hall noted that a great deal of information was presented today for the work group to sift through. Dr. Kazandjian concluded that there are a variety of right ways to approach construction of a composite measure. The approach Maryland selects will be determined by our goals, context and abilities. He noted that one of the challenges we will face in the future is the structural, enabling ability to link process and outcomes. We will need to follow cohorts of patients, in the epidemiological sense, over time, and to measure outcomes such as readmissions. As of today, there are many barriers to following patients after discharge. There is much work from the field that the group will need to consider for application in Maryland. He noted that a look at the safety data, regarding ventilator-related pneumonia, and tackling of peer groupings are issues to address in the near future. We do have an under representation of small and rural hospitals in the current QIP data set being examined, and ways to correct that should be explored. Dr. Kazandjian said that basically we have two models on the table: the patient or condition model and the opportunity approach. The opportunity approach can be expanded with a predictive or forecasting component. He concluded that mid-month meetings with HSCRC staff have been useful to keep the project on track.

Adjournment- Dr. Hall thanked the whole group for their participation and effort. The next meeting date will be Friday, September 29 at 9 am to 10:30 am at HSCRC. Dr. Hall adjourned the meeting.