Minutes
Initiation Work Group, HSCRC
Friday, October 26, 2007
9:00 – 11:00 am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Beverly Collins, CareFirst BlueCross BlueShield; Dr. Charles Reuland, Johns Hopkins Medicine; Ms. Barbara Epke, LifeBridge Health; Ms. Kathy Talbot, MedStar Health; Ms. Pamela Barclay, MHCC; Ms. Mariana Lesher for Dr. Christian Jensen, Delmarva Foundation (Maryland QIO); and Dr. Vahe Kazandjian, and Mr. Frank Pipesh, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Mr. Steve Ports, and Ms. Marva West Tan, HSCRC.

IWG Members on conference call: Dr. Kathryn Montgomery, University of Maryland School of Nursing; Ms. Renee Webster, OHQ, Dr. Donald Steinwachs, John Hopkins Bloomberg School of Public Health.

Interested Parties Present: Mr. Don Hillier, former HSCRC Commissioner; Ms. Ing-Jye Cheng and Ms. Traci Phillips, MHA; Ms. Carol Christmyer and Ms. Deborah Rajca, Maryland Health Care Commission; Ms. Kristen Geissler, Navigant Consulting; Ms. Mary Whittaker, Greater Baltimore Medical Center; Ms. Ann Hoffman and Mr. John Adair, Johns Hopkins Health System; Mr. Kevin Kelbly, Carroll Hospital Center; Ms. Jan Bahner; MedStar Health; Ms. Bobbi Rogers, HSTRM; Dr. Cynthia Saunders, HSCRC.

Interested Parties on Conference Call:; Ms. Cindy Hancock, Fort Washington Medical Center.; Mr. Gerry Macks, MedStar Health; Ms. Sylvia Daniels, University of Maryland Medical Center; Ms. Shirley Knelly, Anne Arundel Medical Center; Ms. Rena Litten, WMHS; Mr. Hal Cohen, HCI for CareFirst and Kaiser Permanente; Ms. Deneen Richmond, Holy Cross Hospital; Dr Scott Spier, MD Mercy;. (There may have been other unannounced callers.)

I. **Welcome and Introductions:** Mr. Steve Ports welcomed the work group and asked telephone participants, the Work Group and others in attendance to introduce themselves. Mr. Ports noted that Dr. Hall regretted her inability to attend due to the funeral of a friend. Mr. Robert Murray, Executive Director, was also unable to attend due to meeting in Annapolis. The minutes of the September 21, 2007 meeting were approved with one correction. (Another correction was received subsequent to the meeting.)

II. **Proposal to Address Stakeholder Confidentiality and Transparency Concerns:** Mr. Ports noted that in response to a suggestion made at the last meeting, staff met with Ing-Jye Cheng and Hal Cohen to discuss potential approaches to achieve greater transparency for stakeholders given the confidentiality constraints of the Data Use Agreement (DUA) with the QIO. Three options were discussed including: increasing the IWG membership, creating a subcommittee to the IWG, and a recommendation that third parties who want access to patient level data to negotiate their own DUA with the QIO. HSCRC leadership elected to create a subcommittee and to offer some advice or assistance to those third parties who decide to pursue a separate DUA. Mr. Ports then reviewed the Subcommittee Charge and Parameters included in the agenda packet. He noted that there will be six members, three

representing the hospital industry (this includes one representative from the Maryland Hospital Association), two representing payers, and a Department of Health & Mental Hygiene quality and policy representative. HSCRC staff will work with MHA to identify the two hospital representatives. Ms. Barclay asked if there were criteria for membership. Mr. Ports said that he planned to include clinical and financial experts but had not developed additional criteria at this time. Ms. Barclay also asked if the IWG could refer items to the Subcommittee for input and Mr. Ports agreed. There was some further discussion of the purpose of the subcommittee. There seemed to be consensus that the subcommittee might provide a good communication channel for additional input to the development of the methodology as long as it did not delay the work of the IWG.

III. **Update Timeline:** Dr. Kazandjian and Mr. Ports discussed the timeline, Quality Based Reimbursement Initiative, Timetable for key activities and decision points, which summarizes the key issues to be resolved between now and early May 2008, in order to be on schedule for completion of a methodology and implementation of baseline data collection in FY 2009. Dr. Kazandjian reviewed the development steps. Mr. Ports reiterated that FY 2009 will be the year for baseline data collection, FY 2010 will be the first year that rewards are introduced into the rate system, and in FY 2011, when there are two years for comparison, rewards and incentives for improvement will be implemented.

IV. **Modeling of Maryland Data from the Maryland Clinical Warehouse**: Dr. Grant Ritter presented some additional modeling and data analysis of peer grouping and internal consistency of the quality measures results for the four diagnosis-related groups (Acute Myocardial Infarction (AMI), Pneumonia (PN) Heart Failure (HF), and Surgical Care Improvement Program (SCIP). He considered the data using the appropriateness, opportunity, and graded models. Dr. Ritter reminded the group of the characteristics of the three models:

1. Opportunity model – each measure counts as an ‘opportunity’ and is counted as 1 in the denominator and numerator. The weight is on each opportunity.

2. Graded model – each group of measures (e.g., AMI) is counted as 1 if all measures are met, but ‘partial credit’ for performance on individual measures is also allotted.

3. Appropriateness model – each group of measures is counted as one or zero. If all measures within a group are met, the score is one but the score is zero if any one of the eligible measures in a diagnostic group is not met. (Also called the “all or none” approach.)

The graded and appropriateness models are viewed as more patient –focused models because the weight is on each patient getting the care that is needed.

For the peer group analysis, Dr. Ritter used approximately the same five peer groups that are used in the rate setting methodology except that he combined groups 3 and 5 (hospitals with substantial teaching programs) because group 5 only contains two hospitals. The groups include:

Peer Group 1	Larger rural and smaller suburban – 14 hospitals
Peer Group 2	suburban and urban hospitals with little or no teaching) 6 hospitals
Peer Groups 3 & 5	(hospitals with substantial teaching programs) 10 hospitals
Peer Group 4 (small rural)	 5 hospitals.

Ms. Epke wondered if Group 4 might be too small.

Dr. Ritter then described Composite Score Distributions by Peer Group. Peer Groups 3 & 5 had higher scores for the AMI Composite. For Pneumonia, the small, rural had higher scores. There is more room for improvement overall in pneumonia than AMI. For Heart Failure, the small and rural did a bit better in scores but there is room for improvement overall. For SCIP (formerly SIP), the data are not as comparable due to some data quality issues.

Dr. Ritter then turned to his analysis of internal consistency among the diagnostic – related group measures using Cronbach Coefficient Alpha. He explained that an Alpha score of 0.7 to 0. 95 indicated very good internal consistency. Dr. Kazandjian asked that if a measure is not internally consistent, is this an indication that the measure should not be kept in the final set. Dr. Ritter noted that you do want some variation, whether the measure is kept or not is more of a clinical decision. In response to a question about weighting of the measures, Dr. Ritter noted that the three modeling approaches under consideration already do weight the measures – either by measure or by the patient. Dr. Ritter said that one can do more complicated weighting but methods are not as solid as using a weight of 1, which is practical. CMS also has this topic on the back burner. Dr. Reuland said that he would agree to this issue being on the back burner for awhile as long as a future discussion on weighting is not totally closed. Mr. Cohen also noted that he was agreeable to being silent on peer groups for the time being but that he does have serious questions to raise. Then, there was some consideration of the Alpha scores of various measures. The Alpha for AMI 1 – Aspirin on arrival – is very low, which may indicate a topped out measure. The Alphas for AMI 6 – Beta blocker on arrival, PN 4- Adult smoking cessation, and HF -3-ACEI or ARB for LVSD were also very low, which may be an indication of a data quality or a clinical issue.

Dr. Kazandjian then summarized the presentation noting that the group now has some additional data to consider whether certain measures are to be kept or not. The issue of more complex weighting schemes is on the back burner for the time being. Three composite modeling approaches are under consideration – all are reasonable, consistent and sustainable. It would be useful to have feedback from the group on how important is it for clinicians to use one model or the other. Are patient-based models favored? Mr. Cohen noted that the decision is not one approach or the other. He described a Michigan Blue Cross/ Blue Shield P4P program which is using the appropriateness model for AMI, and the opportunity approach for the other diagnosis groups in 2007 and will move to the appropriateness model for all in the future. Ms. Epke noted that mixing of models from the outset would be difficult. She also suggested that some preliminary recommendations be given to the new IWG subcommittee so that their work is more efficient.

Next Meeting: After discussion it was agreed that the next meeting of the Initiation Work Group would be scheduled for December 7, 2007 from 9 am to 11 am at HSCRC. Mr. Ports then adjourned the meeting.