Minutes
Initiation Work Group, HSCRC
Friday, January 25, 2007
9:00 – 10:00 AM
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Charles Reuland, Johns Hopkins School of Public Health; Ms. Pamela Barclay, MHCC; Dr. Vahe Kazandjian, Dr. Nikolas Matthes, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Ms. Renee Webster, OHQ; Ms. Barbara Epke, LifeBridge Health; Ms. Kathy Talbot, Medstar Health; Dr. Trudy Ruth Hall, Mr. Steve Ports, and Mr. Robert Murray, HSCRC.

IWG Members on conference call: Ms. Beverly Collins, CareFirst; Ms. Joan Gelrud, St. Mary's Hospital; Ms. Mariana Lesher, Delmarva Foundation.

Interested Parties Present: Ms. Traci Phillips, Mr. Paul Sokolowski, and Yong Chen, MHA; Mr. Greg Vasas, CareFirst; Mr. Hal Cohen, CareFirst; Mr. Don Hillier, former HSCRC Chairman; Mr. Samuel Ogundo, Center for Performance Sciences; Ms. Mary Whittaker, GBMC; Ms. Kristen Geissler, Navigant; Mr. Deme Umo, Ms. Deborah Rajca, and Ms. Carol Christmyer, MHCC; Ms. Jean Acung, Mercy; Ms. Joan Hall, Suburban; Ms. Allison Lipitz, Johns Hopkins; Mr. Craig Weller, Delmarva Foundtion.

Interested Parties on Conference Call: Mr. Frank Pipesh and Ms. Karol Wicker, Center for Performance Sciences.

I. Welcome and Introductions: Dr. Trudy Hall welcomed the work group and asked telephone participants to introduce themselves. Dr. Hall inquired as to whether there were any changes to the minutes from the previous work group meeting. No changes were suggested, and the minutes were unanimously approved.

II. Summary of the January 15, 2008 Meeting of the IWG Subcommittee: Mr. Steve Ports summarized the events of the January 15, 20008 IWG Subcommittee meeting. He noted that there was significant discussion about how the transfer of patients between hospitals was reflected in the data. During the subcommittee meeting, Ms. Mariana Lesher explained that it varied depending on the measure and the status of the patient whether the data would be reflected in the transfer-out or transfer-in hospital. At the same meeting, Mr. Kirk Stapleton inquired about linking transfer patient data and risk adjustment. Members of the subcommittee explained that it was not usually possible to link patient data in Maryland, because patients are not assigned unique identifiers. They also explained that risk adjustment was not necessary, because all of the measures are process measures.

Mr. Ports also noted that Mr. Hal Cohen inquired as to whether the methodology could adjust for average results if hospitals attempted to perform well on only the easiest measures. Dr. Grant Ritter responded that there were no easy measures and that there was always incentive to perform better. There was also discussion at the subcommittee meeting about how to treat specialized hospitals and whether hospitals reporting on a smaller number of measures tended to outperform hospitals reporting on all or most measures. Mr. Stapleton reported that he had used a "windsorizing" technique to adjust for hospitals with few patients in a measure and

applied confidence intervals. Dr. Vahe Kazandjian replied that these methods are useful for public reporting but may not be useful for a pay-for-performance methodology. No further topics were discussed at the subcommittee meeting.

III. Additional Modeling of Most Recent Maryland Data from the QIO Clinical Data Warehouse using Opportunity Model and Peer Grouping: Dr. Kazandjian began by reminding the work group that the topics to be discussed were 1) whether an opportunity or appropriateness of care model will be used, 2) whether peer grouping will be incorporated into the methodology, 3) how points are to be distributed between attainment and improvement, and 4) the relative importance of statistical concerns versus other considerations.

Dr. Ritter began by discussing the CMS model, which is an opportunity model that uses the alternative topped-off measure methodology discussed at previous meetings. He reported that the data covered two years and included five topped-off measures. He continued by discussing some of the peer group assignments. He noted that the hospitals reporting fewer measures tended to be small rural hospitals. He added that one hospital was missing from the data set because it did not provide data for 2005, although this will not be a problem in the future because all hospitals are currently reporting data. Dr. Ritter finished by reminding the work group of how points were assigned for attainment and improvement in the CMS model.

Dr. Ritter described the results of the CMS model, noting that there was a great deal of improvement over the two years in question, although this may be due to improvements in reporting data. He added that the amount of points awarded for improvement will tend to wane the longer the pay-for-performance model is in place.

Mr. Hal Cohen inquired as to whether attainment points were being awarded on the basis of 2006 data. Mr. Ritter replied that that should not be the case. Mr. Cohen noted that some of the data in Mr. Ritter's presentation looked incorrect. Dr. Ritter observed that he had probably forgotten to treat AMI-3 as a topped-off measure and stated that this was the cause of the discrepencies that Mr. Cohen had found. Dr. Ritter added that he would recalculate these statistics for the work group.

Dr. Ritter returned to his earlier comment that small rural hospitals use only 9 or 10 measures, while the other peer groups tend to use most measures. He noted that peer group was not correlated with improvement or attainment. Dr. Kazandjian reiterated Dr. Ritter's point by stating that there was no overwhelming statistical support for the idea that peer grouping will make the model more fair. Dr. Charlie Reuland noted that it may be necessary to incorporate peer grouping in the event that any measures that require case-mix adjustment are added. Mr. Murray responded that peer grouping might be considered in the future.

Mr. Ports inquired as to the importance of prevalence. Dr. Ritter replied that the CMS model does not take into account patient load and added that it was worth investigating whether case load should be considered. Dr. Reuland noted that measures might be weighted based on a hospital's percentage of discharge. Dr. Kazandjian noted that an alternative to weighting is to rank hospitals based on patient volume.

IV. **Other Business:** Mr. Ports stated that hospital-identified analyses produced pursuant to the deliberations of the HSCRC Initiation Work Group and its subcommittees may be shared with appropriate individuals at Maryland hospitals that have signed the HSCRC authorization form for the sharing of aggregate hospital-identified data. The intent is that constructive input from these individuals may be incorporated. All data must be stamped confidential and preliminary, and a summary of the methodology must accompany the data.

Mr. Cohen inquired as to whether the data may be shared with payors. Mr. Ports replied that the data could not be shared with payors, because they have not signed the consent agreement. Ms. Barbara Epke concurred with Mr. Ports. Mr. Ports stated that he would email a copy of the policy to members of the work group and subcommittee.

Ms. Epke inquired as to whether the work group was going to update the hospitals on its progress. Mr. Murray suggested the work group meet again in two weeks with a list of options to be considered for the model.

V. **Next Meeting Date:** The next meeting of the Initiation Work Group will occur on February 8, 2008 at 10:00 AM.

VI. **Adjournment:** The meeting was adjourned at 10:00 AM.