Minutes
Quality-Based Reimbursement initiative
Evaluation Work Group Meeting
August 8, 2008
9:00 AM to 10:30 AM
4160 Patterson Avenue
Baltimore, MD 21215

EWG Members present: Pamela Barclay, MHCC; Robert Brooks, MD, PhD, MBA, Delmarva Foundation for Medical Care, Inc.; Barbara Epke, MPH, MA, LifeBridge Health System; Charles Reuland, ScD, Johns Hopkins Health System**;** Donald M. Steinwachs, PhD, Johns Hopkins Bloomberg School of Public Health; Renee B. Webster, DHMH; Robert Murray, Steve Ports, and Dianne Feeney, HSCRC.

EWG Members on by conference call: George Chedraoui, IBM; Beverly Collins, MD, MBA, CareFirst BlueCross BlueShield; Cynthia Hancock, Fort Washington Medical Center; Julianne R. Howell, PhD, Independent Technical Advisor, CMS.

Interested parties present: Vahe Kazandjian, PhD, Nikolas Matthes, and Samuel Ogunbo, Center for Performance Sciences; Hal Cohen, Hal Cohen, Inc.; Ing-Jye Cheng, MHA; Kristen Geisler, Navigant Consulting.

Interested parties on by conference call: Susan Glover and Debra Illig, Adventist Health Care; Elizabeth McCullough, 3M; Rena Litten, Western Maryland Health System; Gail Thompson, Kaiser Foundation Health Plan of the Mid-Atlantic States; Greg Vasas, CareFirst BlueCross BlueShield; Lydia Isaac, DHMH; Rob Carroll, Shore Health; Renee Dempsey, Johns Hopkins Health System.

- ***Welcome and introduction of EWG members and other participants-*** Steve Ports called the meeting to order and invited EWG members and interested parties joining the meeting in person and by conference call to introduce themselves.

- ***Review and approval of the July 22, 2008 meeting minutes -*** A motion to approve the minutes as submitted was made and seconded with unanimous approval.

- ***New measures discussion (refer to new measures discussion document August 8, 2008 revised draft) –***
    - Changes to the draft new measures discussion document- Dianne Feeney noted changes to the new measures discussion document from the previous draft including: the re-ordering of the measures so that related structure, process, outcome, and patient experience measures are now clustered by clinical topic area; the addition of AHRQ working definitions of healthcare quality and its domains in Appendix A; in Appendix D, the inclusion of the CMS final lists of 12 new "pay for reporting" measures IPPS hospitals will begin reporting in October 2008, and 11 hospital acquired conditions (HAC) for which Medicare will not pay additionally beginning October 2008; and, the addition of a patient safety structure measure that the group should consider, that the hospital

maintain Maryland deemed status by meeting all Medicare Conditions of Participation.

- Hospital deemed status and conditions of QBR Initiative participation- Renee Webster provided an overview of the Office of Healthcare Quality (OHCQ) hospital survey and certification process, noting that it is complaint-driven and that from year to year two to three Maryland hospitals undergo full reviews for not meeting required standards or Medicare Conditions of Participation, thus losing their deemed status. Most hospitals that undergo full surveys have corrected their deficiencies by the time of the survey, and Maryland hospitals have not lost Medicare certification and funding for many years. Examples of reasons for hospitals losing deemed status include such issues as the patient weights not being recorded prior to renal dialysis, patient right violations related to restraint use and disregard for advance directives, and neglect of a patient's nutrition status. Ms. Webster also asked whether the EWG should consider a structural measure related to hospitals that have conditional Joint Commission accreditation status. Robert Brooks noted that the Medicare and Joint Commission standards are similar but not exactly the same, with 95% overlap. Ms. Webster noted that OCHQ does conduct two "look behind" surveys of hospitals that have undergone Joint Commission surveys. Pam Barclay noted the Maryland Hospital Performance Guide does post Joint Commission accreditation status. Vahe Kazandjian commented that perhaps these structural measures could be viewed and serve as stratifiers or adjusters to a QBR measures index, and also noted that one event should not necessarily affect and skew the overall measurement of a hospital. Ms. Webster suggested, for hospitals that loose deemed status, that the group should perhaps consider withholding QBR payments until deemed status is restored. Barbara Epke raised the fact that, to date, the conditions for hospital participation in the QBR Initiative have not been discussed. Robert Murray suggested the group schedule a time soon to discuss the conditions for participation in the QBR Initiative, and Hal Cohen noted that a Michigan hospital pay-for-performance initiative does specify conditions of participation, with hospitals having suspended quality payments until conditions are met. Ms. Epke supported scheduling time soon to have a thoughtful discussion about conditions of QBR participation, including the issue of conditional Joint Commission accreditation.
- CMS new pay for reporting and HACs- Ms. Feeney next turned the group's attention to the CMS final list of 12 new pay for reporting measures for IPPS hospitals and 11 HACs to be implemented on October 1, 2008, suggesting that not considering these measures and HACs now may appear that Maryland hospitals are lagging behind the nation. Beverly Collins clarified that, for the HACs, the coding of the specified conditions as not present on admission in the claims is the method CMS will use to determine whether a higher payment is not justified, voicing concern that a clinical record audit would be required to ensure the coding is consistent with the care during the hospital stay. Donald Steinwachs noted that, if hospitals do not code properly, CMS will also not pay them the additional cost for the care that is not coded. In this instance, unless charts are audited, CMS would not get the data on the quality of care, however. Dr. Steinwachs noted that the CMS approach is for Medicare patients, and that

we need to consider hospital acquired conditions that would be applicable to patients for all payers. Ms. Epke noted that the 7 "non-payment" conditions identified in the newly released MHA policy would apply to all payers. Ms. Feeney noted that the Potentially Preventable Complications (PPC) measure developed by 3M is derived administratively, that it applies to all payers, and that it covers 64 complication types. Dr. Kazandjian expressed the concern that mixing these kinds of measures to formulate an overall index of hospital quality would be difficult and must be carefully crafted. Mr. Murray noted that it is important to address these issues in light of the national Medicare effort. Dr. Kazandjian added that it is important to look at the logic and feasibility of complications measures. Ms. Epke noted the group should focus on the CMS process and related outcome measures, for example, the infection measures. Dr. Brooks noted that the conditions on the list are rare occurrences, and would, therefore, be difficult to express in a rate that is fraught with statistical inaccuracy. Mr. Reuland added that for rare events and mortality outcome measures, the confidence intervals are wide and don't reflect hospital performance differences. Mr. Cohen noted that rare events differentiate care among patients and not hospitals. Dr. Kazandjian noted that it will be important to consider an infrastructure support component of the QBR Initiative. Ms. Feeney noted that the 3M PPC methodology will be presented in detail at the next EWG meeting. Mr. Murray noted that we need to carefully consider the PPC approach and other outcome measures and how they overlap with the current process measures and how they may fit and behave in an index.

- MHCC Hospital associated infection (HAI) measures- Ms. Feeney suggested and Ms. Epke supported next looking at the MHCC infection measures on the horizon. Ms. Barclay provided a brief overview of the new HAI measures to be added to the MHCC Performance Guide (see Appendix C of the draft discussion document). The group agreed it would be helpful to review the detailed specifications for these measures at a subsequent EWG meeting.

- ***Next meeting date and time*** – The group agreed to convene next on Monday, September 8, 9 AM-10:30 AM, and to alternate subsequent meeting dates on Mondays and Fridays to maximize EWG member participation.

- ***Adjournment*** – Mr. Murray adjourned the meeting at 10:30 AM.