Minutes
Initiation Work Group, HSCRC
Monday, July 11, 2005
8:30 -10am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Trudy Hall, Chair and HSCRC Commissioner; Ms. Barbara Epke, Lifebridge Health and Sinai Hospital; Dr. Donald Steinwachs, Johns Hopkins Bloomberg School of Public Health; Mr. Joseph Smith, MedStar-Union Memorial Hospital; Dr. Jon Shematek, CareFirst Blue Cross Blue Shield; Lekisha Daniel, MHCC; Dr. Maulik Joshi, Delmarva Foundation; Linda Hickman, Chester River Hospital Center; Renee Webster, Office of Health Care Quality; HSCRC Staff: Steve Ports and Marva West Tan. On conference call: Dr. Kathryn Montgomery, University of Maryland School of Nursing; Dr. Charles Reuland, Johns Hopkins Medicine; Marybeth Farquhar, AHRQ; Ms. Barbara Hirsch, Kaiser Foundation of the Mid-Atlantic States.

Interested Parties Present: Larry Grosser, HSCRC Commissioner; Dr. Fadia Shaya, University of Maryland School of Pharmacy; Katherine Hax, Kaiser Permanente; Ing-Jye Cheng, MHA.

1. Welcome and Approval of Minutes- Dr. Hall welcomed the Work Group. The minutes from the June 6, 2005 meeting were approved as distributed.
2. Consultant's Report- Mr. Ports introduced Dr. Vahé Kazandjian from the Center for Performance Sciences. Dr. Kazandjian presented a summary of his report "Designing a Methodology for Recognizing Quality at Maryland Hospitals" which had previously been presented and endorsed in concept by the HSCRC Commission. Some of the key concepts of the report emphasized by Dr. Kazandjian and comments from the Work Group are summarized below.

Dr. Kazandjian noted that he was pleased to attend the Work Group meeting for a number of reasons, including that the Group was moving ahead on developing a quality-based reimbursement tailored to the realities of Maryland. He noted the central themes of the document: quality and performance, how quality could be measured given the state of knowledge in the field, the concepts of rewarding, incentivizing and supporting quality and the use of both quantitative and qualitative measures- the "what" and the "why." Maryland could have a unique program using these concepts to reach a common goal of improving quality in the entire community of providers.

Dr. Kazandjian then turned to a discussion of some of the more qualitative measures including infrastructure and culture. He noted that earlier discussions of infrastructure tended to be in terms of computer technology but that thinking had evolved. Infrastructure will continue to be an important dimension particularly regarding communication. Dr. Kazandjian recommended that the quantitative measures using existing data sources be supplemented by some more intrusive data gathering, such as interviews, relating to qualitative measures. He felt that qualitative data may be essential to understanding why one organization is performing better than others.

Dr. Kazandjian noted that people are often impatient about getting to outcome measures but he recommended that outcomes not be part of initial measurement until other things are in place and carefully measured. His report prioritizes outcomes as a later phase of the project with the initial emphasis on rewards and incentives for quality and performance. The project

name switch from "pay-for-performance" to "quality-based reimbursement" reflects this emphasis.

Mr. Ports asked Dr. Kazandjian to explain what he meant by a productivity measure. Dr. Kazandjian said this could refer to production efficiency or production effectiveness: these are the types of measures found on report cards such as the Maryland Hospital Performance Evaluation Guide. These productions of a service are well defined as in a protocol or a pathway of care. The highest level of these is called evidence-based medicine when production efficiency and effectiveness will result in a predictable outcome. Evidence–based medicine in its purest form reflects a strong correlation between process and outcome, not causality but correlation. Dr. Kazandjian said that he was not referring to industrial type productivity measures; however these could apply such as the relationship of ICU nurse-patient staffing ratio to safety. He further noted that "process of care" or "process of service" could be used in place of the term "productivity."

Referring to a prior statement, Mr. Ports said that he usually considered readmissions an outcome rather than a productivity measure. Dr. Kazandjian noted that at the level of "what"- readmission is an outcome- but at the level of "why "– readmission may be related to failed processes. He noted that this example reflects that there is no such thing as a pure outcome without the context of the related processes. Dr. Kazandjian felt that this back and forth relationship between process and outcome should be used to encourage continuous quality improvement among Maryland hospitals, otherwise a false sense of safety upon reaching a certain threshold may be conveyed. Ms. Epke agreed but felt that this is an area that gets very murky and complex. Dr. Kazandjian agreed that definitions need to be crisp and measures should not be exotic but "tried and true" measures. Ms. Epke agreed but felt that it also might be time to introduce some new measures and new diagnostic or procedure areas.

Dr. Kazandjian then moved to the discussion of the recommendations in his report. He first discussed the cohort approach: to take a few hospitals, test a few measures, make necessary adjustments to develop indices which are then part of combined or composite indices. He noted his current research in composite measures.

Dr. Kazandjian suggested that the Work Group take their time to develop the design, assuring that the program is seen as voluntary and of common interest by the providers. He noted that voluntary participation has a strong history in Maryland. He further noted that transparency and clarity suggested a minimalist approach with the hospitals involved in decisions regarding the measures. He continued that pay-for-performance is not a new idea: it has been used in other industries but the achievables are less well defined in health care. He noted that Maryland has the opportunity to blend three existing themes: the financial aspect from HSCRC and the quality and safety aspect carried out by the providers and other organizations, such as the Maryland Patient Safety Center and Delmarva Foundation. HSCRC can provide a benefit to the State through this project by encouraging "all boats to rise."

Dr. Hall then asked for questions or comments. Dr. Steinwachs wondered if there may be need for a new set of data collection from the hospitals on outcomes to supplement the financial data now captured. He suggested some sampling of cases 30 days after discharge to collect data on outcomes as current outcomes data are weak and mainly limited to items such as discharge and readmission. Dr. Kazandjian agreed that there is little work being done on outcomes weeks and months after discharge and that functional status and quality of life are critical outcomes in many chronic conditions. Dr. Kazandjian agreed that it would be interesting and important to have discussions about defining outcomes and how to build an

accountability system. This is why the choice of hospitals, measures and diagnoses for the pilot will be important. Even if this is not the right time to introduce outcomes into the project, it is a right time to discuss outcomes as this is an investment into the future. Dr. Hall noted that we must be careful to look at factors hospitals have control over as there are so many intervening variables in long term outcomes.

Dr. Shaya asked given that not all providers will be above average, how all providers will be motivated to improve and how will targets be set. Dr. Kazandjian answered that his design suggested that there would be a relative position analysis and a relative target analysis for the rewards and incentives. This is not to imply that there are different levels of excellence or tiers of quality. There is one level of excellence but there may be different paths to reaching that goal.

Mr. Ports noted that HSCRC uses peer groups for financial purposes but how would peer groups for quality be derived? Dr. Kazandjian said peer groups could be based on: 1.) national and external data 2.) local peer groups based on performance rather than structural characteristics, and 3.) evidence-based. Dr. Hall noted that we must keep in mind, as we move forward with this project, the great variability in Maryland institutions in size, resources and technology.

Dr. Shematek asked how infrastructure and composite measures would fit into the program and composite scoring. Dr. Kazandjian responded that, so far from the field, composite scoring has not dealt with qualitative aspects. The idea of composite scoring is twofold: to include multiple dimensions of quality and to forecast. Culture and infrastructure are in the "why" category of measurement explaining why a certain production/process took place. Is it possible to incorporate culture and infrastructure into the composite score? Dr. Kazandjian says this is not known but he feels it could be explored. At this point, part of this Initiative could be to understand, document and share better practices, including those related to culture and infrastructure, to bring everyone to a higher level of performance. A related question was if infrastructure and culture would be linked to quality-based reimbursement? Dr. Kazandjian said that culture and infrastructure were linked in the sense that they helped to explain why things did or did not happen.

In response to comments from Dr. Montgomery and Ms. Epke, Dr. Kazandjian noted that if there are five ways to classify severity for the same case presentation, then there needs to be more uniform definitions for the purpose of this project.

Mr. Smith asked who would be in the institutions collecting qualitative data. Dr. Kazandjian concurred that the qualitative aspect is a new idea that needs a cost-benefit analysis to determine if it is worth the effort to collect this data. Dr. Kazandjian believes that it is and that this is already being demonstrated in the area of patient safety. A sampling approach could be used involving selected members of hospital leadership. Dr. Kazandjian noted that this approach has been used in Maryland before as in some of the activities of the Delmarva Foundation. Perhaps this type of qualitative data collection could be sub-contracted to another group but this is beyond the discussion this morning.

Dr. Joshi asked Dr. Kazandjian for some comments on what is meant by infrastructure support in addition to technology. Dr. Kazandjian said that infrastructure includes technology but it also includes education, educating leadership, building reporting lines, openness and communication. All of these are necessary for supporting process. While a few months ago there was quite a bit of emphasis on technology such as computerized physician order entry

(CPOE), now there is a growing realization that simple techniques such as better hand washing improve patient safety. Dr. Hall noted that we need to be careful in using the term "infrastructure' as some institutions may think it always means technology whereas she agrees that things such as accountability are critical to quality health care. Steve Ports said that the Commission saw infrastructure support in two ways: 1.) as a quality measure, such as similar to one of the Leapfrog requirements, and 2.) the Commission might decide to set aside money in rates, perhaps in the form of a loan, to an institution that was financially efficient, but lacked the resources to do what it needed to do regarding quality improvement in order to compete for the rewards and incentives. As efficiencies accrued over time to this institution, then it would pay back the system. But any decision regarding infrastructure support would be within the purview of the Commission.

Ms. Epke noted that the infrastructure concept was the most difficult for hospitals to understand as there is a question of how to find enough money to help all Maryland hospitals in a meaningful way. Therefore, the idea of loans makes sense. She also noted that it is difficult to focus on what area of infrastructure to improve first. She agreed that education is critical. She noted that Sinai's current CPOE implementation is already showing benefits regarding medication errors. Ms. Epke also noted that attempting to measure outcomes post discharge is very difficult and expensive to do.

Dr. Hall cautioned that as work proceeds on the Initiative, we must be careful that we do not create a system that encourages hospitals to divert resources to meeting the measures and then other parts of the quality system suffer.

Dr. Hall then noted that the main purpose of the first two meetings of the Initiation Work Group was for the members to get to know each other and to come to some consensus on the key concepts for the Quality Initiative. She then asked Mr. Ports to take the group through some of the main concepts for their endorsement. Mr. Ports reviewed the following concepts from the Steering Committee and/or consultant's report: desirability of implementing a HSCRC quality-based reimbursement initiative, the mission, vision and goals, the concept of three streams of rewards, incentives and infrastructure support, the prioritization of measurement of different dimensions of quality, the plan for one or two pilots, the consultant's recommendation regarding phases and comparison using baseline references. The Initiative Work Group endorsed in general all of these concepts.

In regard to the prioritization of different measures, Dr. Steinwachs suggested that the group consider looking at some limited outcomes during the pilot, perhaps related to target conditions. He felt that we must be prepared to answer the question about whether the other activities made a difference to the patients. He noted that we may already be capturing some limited data on outcomes which could be supplemented in the future by richer findings. In response to a member's comment, Mr. Ports noted that one of the Steering Committee goals is "to become a model for enhancing health care quality in the hospital setting while being consistent with broader quality initiatives." One member noted that hospitals may want to know the expense and impact of being in the pilot. Dr. Hall noted that at prior meetings there had been a discussion that the pilot could not be a tremendous financial and administrative burden to hospitals or they will not want to participate. Ms. Epke agreed and noted a prior discussion about looking at what hospitals already have in progress in meeting regulatory and other requirements. Mr. Ports asked if the group did want to use national data for baseline comparisons or other benchmarking and they agreed. Mr. Smith noted that he was rather pessimistic about the rewards and incentives idea as there was a limited pot of money to be divided. Mr. Ports agreed that the HSCRC must operate within the waiver requirements and

that the usual method to reward hospitals was by scaling within the annual update factor. Dr. Kazandjian. noted that the first step was to find out what resources and efforts were needed to implement the pilot.

Dr. Hall asked the group, in preparation for the next meeting, to review the summary of existing pay for performance programs provided previously by Marva and noted that available measures currently being used by various organizations may be discussed. The RFP for the Technical Consultant for the next phase of the project has been posted and hopefully, the consultant will be available for the September meeting or shortly thereafter. Dr. Hall thanked Dr, Kazandjian for his clear, expert report. There was no other business and Dr. Hall adjourned the meeting at 10 am.

Next Meeting- The third meeting of the Initiation Work Group will be Monday, August 8, from 8:30 am -10 am at HSCRC, 4160 Patterson Avenue, Baltimore, MD 21215 in Meeting Room 100.