Minutes
Initiation Work Group, HSCRC
Monday, Aug 8, 2005
8:30 -10:15 am
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.Linda Hickman, Chester River Hospital Center; Ms. Renee Webster, Office of Health Care Quality; Dr. Kathryn Montgomery, University of Maryland School of Nursing; Dr. Charles Reuland, Johns Hopkins Medicine; Ms. Pamela Barclay, MHCC; HSCRC Staff: Mr. Robert Murray, Mr. Mr. Steve Ports and Ms. Marva West Tan. On conference call: Ms. Marybeth Farquhar, AHRQ; Ms. Barbara Hirsch, Kaiser Foundation of the Mid-Atlantic States; Mr. Joseph Smith, MedStar-Union Memorial Hospital; Dr. Maulik Joshi, Delmarva Foundation, Guest Speaker: Dr. Michael Rapp, CMS

Interested Parties Present: Ms. Larry Grosser, HSCRC Commissioner; Mr. Don Hillier, Past Commission Chair, Mr. Katherine Hax, Kaiser Permanente; Ms.Bev Miller, MHA, Dr. Joe Berman, Office of Health Care Quality, Mr. Bruce Kozlowski, MHCC.

1. Welcome and Approval of Minutes- Dr. Hall welcomed the Work Group. The minutes from the July 11, 2005 meeting were approved as distributed.
2. Consensus on Quality Initiative - Dr. Hall noted that, at the last meeting, consensus was achieved on the design features for the quality-based reimbursement project as summarized in the reports of the Steering Committee and Dr. Kazandjian.
3. Guest Speaker from CMS –. Then Dr. Hall introduced Dr. Michael Rapp, Office of Clinical Standards and Quality, CMS, who gave a brief presentation regarding the clinical measures used by CMS in the Hospital Quality Alliance project as well as in the Premier/CMS pay-for-performance demonstration project. Dr. Rapp noted that the hospital quality initiatives were part of a larger CMS strategy addressing quality over a variety of delivery sites and conditions. CMS has several different Web sites where these various initiatives are featured. Dr. Rapp noted that the Hospital Quality Alliance grew out of an earlier voluntary program with an alliance of several national organizations such as AHA, JCAHO and AMA, and the program continues to involve an alliance. Initially a starter set of 10 measures related to heart failure, acute myocardial infarction (AMI) and pneumonia was selected. Subsequently this set was adopted by the pay-for-performance program aspect of the Medicare Modernization Act passed in 2003. Hospitals were required to report these measures in Fiscal Year Oct 1, 2004 in order to get their full market basket update. The incentive is 0.4%. The full update this year is 3.7%. While the incentive is not that large, it did result in a dramatic increase in the number of hospitals willing to report these measures. Seven additional measures were added in April 2005. (All measures are visible on the Hospital Compare Web site.)

   Future plans include adding surgical infection prevention measures this September. All measures currently in use are process measures believed to be related to better outcomes. CMS is considering the possibility of adding outcome measures which are being evaluated through the National Quality Forum (NQF) consensus process as are all measures used by CMS. Future plans include adding measures related to the patient experience of care survey (HCAHPS), more surgical care measures and possibly measures related to the emergency department (ED).

Dr. Rapp noted that implementing measures is complex, difficult and can have unintended consequences. He noted that that some ED physicians ordered antibiotics for a broad range of patients who might have pneumonia in order to meet the pneumonia measure which requires antibiotic given within 4 hours after arrival, This, of course, is not desirable practice as it may lead to antibiotic resistance. Dr. Hall confirmed the occurrence of this practice in a personal anecdote. In the surgical infection prevention measures, the measure relating to prophylactic antibiotic selection was found to be not "durable" and was set aside because organisms and specific antibiotics continue to change. Data collection, data verification, whether to use unverified data or not and data collection tools are all complex items that must be addressed. Working within an alliance to achieve consensus adds another complexity.

Dr. Rapp then considered questions from the Work Group. Mr. Ports asked what process CMS used to select measures. Dr. Rapp suggested use of measures endorsed by NQF which indicates that the measures have been approved through a consensus process as valid and that the technical specifications have been developed. Mr. Ports noted that the starter set of measures has been in use for some time, compliance with some of these measures is up in the 80-90% range and thus, is it still useful to collect these measures or are they being supplemented. Dr. Rapp noted that some measures do currently have high compliance and supplemental or optional measures are under consideration such as the outcome measure of mortality at 30 days following AMI, or angioplasty within 90-120 minutes of arrival for a patient with an AMI. Dr. Rapp said one could question whether it is worthwhile to continue to collect data on a measure with high compliance. Mr. Ports also asked about CMS's data verification process. Dr. Rapp said that contractors perform data verification and that he would provide a name of someone at CMS who worked more closely with this area. Dr. Hall asked how many Maryland hospitals report the CMS measures. Ms. Epke felt that there was 100% participation. Mr. Murray asked that if part of the data collection was to verify that the process measures were correlated with better outcomes. Dr. Rapp replied no, that the correlation was part of the measure development process at NQF and measures would not be used unless they were believed to be correlated with better outcomes. Mr. Murray asked if there was a process to monitor the unintended consequences and use of extra resources. Dr. Rapp said that the QIO monitored practices at the hospital level.

Ms. Epke noted that she is interested in the Work Group considering some other evidence-based measures than currently collected by CMS and also that maintaining a high level of compliance with the current measures takes an ongoing effort at the hospital level. She noted that there are many intervening variables between hospitalization and 30 day mortality and HSCRC may wish to consider some other types of outcomes such as interim outcomes, medication outcomes, etc. Dr. Hall asked if HSCRC should be aware of other measures which may have unintended consequences. Dr. Rapp noted that although the assumption is that 100% compliance is the ideal, this may not be the case for every measure due to patient or condition variables. Dr. Hall noted that Ms. Tan had distributed some new information regarding the Surgical Care Improvement Project (SCIP) measures and wondered when they would be implemented. Dr. Rapp noted that SCIP implementation is scheduled for 2007. Ms. Tan asked whether CMS was considering use of any of the NQF patient safety measures that cross over diagnoses and services. Dr. Rapp said that eventually CMS would like to employ measures related to all of the domains of quality identified by the Institute of Medicine but currently is focusing on measures related to under use and efficiency. He also noted that one of the purposes of data collection is providing consumers with information to make decisions based on

quality. Consumers may need more broad-based data in order to be able to use the data for decisions. Currently hospitals are more actively using the data to improve practice. Dr. Reuland asked if there is an appeal process if hospitals feel that the interpretation of their data is not correct and gave an example of a valid exception to a measure. Dr. Rapp noted that the measure management process is being discussed at NQF so that there is a process and accountability to update measure inclusions and exclusions. He noted there is also an appeal process currently. Ms. Epke noted that HSCRC needs to build in an appeal process into their program. Mr. Murray asked whether correlations of large case mix data bases with diagnoses to identify frequency of unindicated processes might give some information on the amount of unintended consequences. This prompted a discussion of the example of antibiotics given to patients with a presumptive diagnosis of pneumonia. Ms. Epke noted that this might be an area where interviews of hospital personnel might be useful. Mr. Ports asked if there are inclusion and exclusion criteria for each measure. Dr. Rapp said yes, all of these are listed on the CMS Web site. Dr. Joshi asked if Dr. Rapp could speak about the composite measures. Dr. Rapp noted that the overall composite measure was frequently talked about but that CMS "was not there yet." Dr. Hall asked what recommendations Dr. Rapp would have for a quality-based reimbursement pilot. Dr. Rapp replied that another group at CMS worked with all of the demonstration projects and referred the group to the Premier/ CMS demonstration Web site. Dr. Hall thanked Dr. Rapp for his presentation.

4. Guest speaker from MHCC - Ms. Tan then introduced Pamela Barclay, Deputy Director, Maryland Health Care Commission, to talk about the development and four-year experience with the Maryland Hospital Performance Evaluation Guide. Ms. Barclay discussed her handout with the Group and concluded with a discussion of "lessons learned" or principles in performance reporting. (Refer to hand out for content.)

   Ms. Barclay then answered questions. Mr. Murray asked how data was submitted from the hospitals and how was data verified. Ms. Barclay noted that MHCC acquires their data from the Delmarva Foundation which obtains it from the CMS clinical data warehouse. There are data verification steps in the process. MHCC uses the same data as CMS uses although it may be presented slightly differently by MHCC. MHCC also collects some unique data from hospitals and uses HSCRC case mix data for some of their structural measures. Mr. Ports asked Ms. Barclay if HSCRC should use patient satisfaction data (HCAPHS) in their initiative and if so, early on or later in the project. Ms. Barclay said she would not recommend use of the patient satisfaction data early on as there are many questions about how does it fit in with other measures, its significance, how to weight it or interpret it. Ms. Barclay said MHCC is not ready yet to use this data for public reporting. Others agreed that this is difficult data to interpret. Ms. Barclay was asked what length of pilot MHCC uses. She said that MHCC uses 6 months or 2 quarters of data. This is usually enough time for even the smaller hospitals to have some cases to report and provides enough data to group and correlate. Dr. Hall thanked Ms. Barclay for her presentation.

5. Other Measures - Due to time limitations, discussion of other measures was postponed until the next meeting. The meeting was adjourned at 10:15 am.

Next Meeting- The fourth meeting of the Initiation Work Group will be Monday, September 12, from 8:30 am -10 am at HSCRC, 4160 Patterson Avenue, Baltimore, MD 21215 in Meeting Room 100.