Minutes
Initiation Work Group, HSCRC
Monday, March 27, 2006
8:30am-10am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Trudy Hall, Chair and HSCRC Commissioner; Ms. Barbara Epke, VP, Lifebridge Health; Ms. Marybeth Farquhar, AHRQ; Dr. Beverly Collins, CareFirst BCBS; Ms. Renee Webster, OHCQ; Dr. Charles Reuland, Johns Hopkins Medicine; Dr. Donald Steinwachs, Johns Hopkins Bloomberg School of Public Health; Dr. Linda Hickman, Chester River Hospital Center; Dr. Vahé Kazandjian, Dr. Nikolas Matthes, Mr. Frank Pipesh, Ms. Nicole Silverman and Ms. Karol Wicker, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Dr. Laura Morlock, Johns Hopkins Bloomberg School of Public Health; HSCRC: Mr. Robert Murray, Mr. Steve Ports and Ms. Marva West Tan. **On conference call**: Dr. Kathryn Montgomery, University of Maryland School of Nursing; Dr. Maulik Joshi, Delmarva Foundation; Ms. Barbara Hirsch, Kaiser Foundation; Mr. Gerald Macks and Mr. Joseph Smith, MedStar; Dr. Norbert Goldfield, Medical Director and Elizabeth C. McCullough, 3M.

Interested Parties Present: Mr. Don Hillier, former Commission Chairman, Ms. Traci Phillips, MHA; Ms. Wendy Kronmiller, Office of Healthcare Quality; Ms. Mary Mussman and Ms Grace Zaczek, DHMH; Ms. Sylvia Daniels, University of Maryland Medical Center; Dr. Luis Mispireta, University of Maryland Hospital; Ms. Kristin Geissler, Mercy Medical Center; Mr. Rodney Taylor and Ms. Carol Christmyer, MHCC; Ms. Brigid Krizek, Patient Safety Fellow.

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1. Welcome and Approval of Minutes- Ms. Tan welcomed the Work Group and attendees on the audio conference. The minutes from the Feb. 27, 2006 meeting were approved as distributed.
2. Proposed Measure Set and Developing Composite Measures – Ms. Tan noted that there was a busy agenda with two guests: Dr. Grant Ritter, Brandeis University, to discuss developing composite measures, and Dr. Norbert Goldfield, Medical Director, 3M to discuss risk adjustment in APR-DRGS.
   Dr. Kazandjian made a brief recapitulation of some issues previously discussed and provided some updates. He noted that the list of measures in the Feb 27 minutes included the measures that the group agreed to test and noted some issues remained to be resolved including data sources. He suggested that the group not revisit the list at this meeting. Ms. Epke responded that she would like to revisit the list at some point, especially issues regarding data collection for certain measures at the hospitals. Dr. Kazandjian agreed that the list is not cast in stone. Dr. Kazandjian reported that HSCRC, Center for Performance Sciences and MHCC representatives met to discuss accessing existing sources of data and noted that Delmarva Foundation has access to hospital data collected to meet CMS and JCAHO requirements which is now shared with MHCC. The tripartite group is exploring contractual issues regarding sharing data for the Quality Initiative. Dr. Kazandjian reiterated that the Initiation Work Group should regularly revisit the fact that the purpose and structure of quality-based reimbursement and public reporting programs are different; complementary but not identical. He also noted that we are not at the point to state the criteria for selection of the pilot hospitals. Further analysis of the characteristics of the selected measures must be done before the types of hospitals needed for the pilot can be specified. Dr. Kazandjian then introduced Dr. Grant Ritter, Brandeis University.

   Dr. Ritter noted that from the perspective of someone with quantitative input into this process there were two key questions to be answered? What analysis needs to be done? And what decisions need to be made to move from the selected measures to a final composite score? And what role do statistics play in this process? If the goal is to identify real quality, then the

challenge is to distinguish between random fluctuations and true differences in quality between the hospitals. Looking at the measures, there is still a way to go to development of a composite measure. Dr. Ritter saw three areas where statistics could play a role.

- Peer groups – Dr. Ritter noted that he had worked with HSCRC in the past on peer groups used in rate considerations. For the Quality Initiative, it is important to decide whether to look at all Maryland hospitals simultaneously or to review peer groups? Is quality different for academic medical centers versus rural hospitals? Also would peer grouping help to achieve buy-in to the Quality Initiative from all hospitals?
- Time periods – Dr. Ritter noted that there needs to be a balance between a longer time period which permits collection of more data versus the fact that a longer period may measure historical quality rather than current quality. Some researchers would recommend three years of data which is a non-starter for purposes of the Quality Initiative. The length of time also relates to the sample size. The sample size for each particular diagnostic group needs to be identified. Another consideration is that a shorter time period may be needed for large hospitals to achieve an appropriate sample size. Peer grouping may help with this issue.
- Creating the composite measure -Dr. Ritter noted that there are different ways this could be done. One could combine all of the group level scores by diagnosis or for all of the quality measures and rank the hospitals by total score. The problem with this approach that it assumes that the differences between each ranking are the same which is statistically not likely. Or one could standardize the scores using Z scores. This approach raises the question of weighting and how to weight. The weighting could be by number of patients or by the amount of variation. Are measures with a large amount of variation more important than measures with little variation in results?

Dr. Kazandjian thanked Dr. Ritter for providing a concise overview of the possible typologies and important questions to be answered. He noted the detail remains to be developed. Mr. Murray asked Dr. Ritter to comment on the CMS approach to composite measures. Dr. Ritter said that CMS stays at the diagnosis level and creates a grouping of measure scores by diagnosis, and ranks and rewards at the diagnosis level. And the reward relates only to the particular diagnosis. Dr. Matthes added that the CMS approach is to weight all measures the same and sum up the scores. This approach is very different from the approach Dr. Ritter described as it does not look at variation or peer grouping. Another problem in the CMS approach is that it assumes that the data are normally distributed which they are not. Thus bias is introduced. Dr. Kazandjian noted that it is attractive to look at other programs, but we must remember that the goals of the Maryland program are different; the Maryland approach is not to reward some and punish others but to encourage everyone to improve to a higher level.

Dr. Morlock asked Dr. Ritter what is the minimum size of a peer group? Dr. Ritter noted in the current HSCRC peer grouping, there are five groups with one group of six small rural hospitals and another group of the two academic medical centers augmented by data from other non-Maryland academic medical centers with the remaining groups containing 17-20 hospitals. He has recommended that the six hospital rural group be combined with another group to add more stability. Dr. Kazandjian noted that it is distracting rather than helpful to get into the detail of the current peer grouping because it was established for a different purpose. He noted that analysis of the data associated with the selected measures may yield a self-selection of groups. Dr. Steinwachs asked if Dr. Ritter had considered how these may change over time. As hospital performance improves toward optimal levels, variability changes substantially. What does that mean for the methodology? Perhaps the measures will be rotated as the group has previously discussed.

Ms. Epke thanked Dr. Ritter and asked what are the next steps given the questions to be answered? Dr. Ritter noted that first he must examine the preliminary data, how fast does data come in, expected rate of the data or even look at existing CMS data to begin to answer the questions regarding time period and sample. The question regarding peer grouping is more of

a policy decision than a mathematical issue. Dr. Kazandjian and Dr. Matthes noted that CPS needs to look at the data, experiment with the data and begin to explore these issues in depth. He also noted that feasibility needs to be fitted into a tight and defined time frame for the Quality Initiative.

Selection Criteria for Pilot Hospitals –Dr. Kazandjian noted that the selection criteria are dependent upon the findings from the data, especially the incidence of numerator and denominator data from various hospitals and the frequency needed to test the model. Many of the next steps in the process are very interdependent.

Hospital input and education re pilot- Dr. Kazandjian solicited creative thinking from the group regarding how to inform hospital representatives about the Quality Initiative and the pilot. He noted that hospital input and reaction are essential to achieving hospital buy-in. There may be need for an additional forum to achieve this input. Perhaps input from other entities should also be sought. He repeated that selection of the pilot hospitals will likely be a consequence of the statistical analysis.

Dr. Reuland asked a question about peer grouping and incentives and rewards. He noted that the program envisions incentives to compete well, to achieve a degree of improvement and to achieve targets and peer grouping seems to help with only one of these. Dr Kazandjian responded that the goal of the program is to raise the level of quality throughout the State and to encourage the sharing of best practices. The value or purpose of peer groups is important to meet statistical needs, for fairness and reliability and for process or performance improvement. Considering that process and structure linkages to outcomes may not be generalizable across the state due to differences in hospital resources and technology, sharing best practices within peer groups may be important. Dr. Reuland said that role of peer grouping to the program aspects he listed was still somewhat fuzzy and he suggested that a written document may be needed to explain this relationship to a hospital forum. Ms. Epke noted that a hospital forum was essential and in regard to the selection criteria, she recommended that an inclusionary approach be taken as some hospitals may wish to volunteer to be in the pilot.

3. Risk adjustment in APR-DRGs – Dr. Kazandjian then introduced Dr. Norbert Goldfield, Medical Director of Research Group, 3M. (Please refer to attached copies of slides for content of Dr. Goldfield's remarks.) Dr. Goldfield noted, as an aside, that CMS is considering for future rule-making a switch to use of APR-DRGs. He then asked for questions or comments. Dr. Kazandjian asked what can APR-DRGs bring to development of a fair classification or profile for a value-based reimbursement program. Dr. Goldfield gave the example of Alliance of Wisconsin, an employer group, which is using all APR-DRG categories, excluding oncology and rehab, rather than focusing on a few diagnoses to construct a value-based incentive. Dr. Kazandjian then asked, relative to Dr. Goldfield's definition of Value = Maximum Quality/ Lowest Cost, what is maximum quality and is that a relative term. Dr. Goldfield said it is a relative and incremental term, and 3M Research Group's philosophy is that maximum quality relates to outcomes particularly to the AHRQ Quality Indicators, preventable complications and readmissions. He noted that there is panoply of measures available and if the local group wishes to begin with process measures, that is a local decision. He encourages use of outcome measures as a faster way to achieve the goal of maximum quality. Dr. Goldfield agreed with Dr. Kazandjian that improvement of quality occurs at the local level.

Dr. Morlock noted that the AHRQ QI Indicator data are available online and asked as Maryland begins to understand APR-DRGS, has 3 M studied how much change occurs due to coding improvements? Dr. Goldfield said that the Maryland experience is being studied for CMS. Liz McCullough from 3M noted that they are studying trends and changes in case mix

during the Maryland transition to APR-DRGs, first in the academic medical centers and then statewide and noted that first year data are available. She said that the change is not occurring as fast as originally thought and that one-to-three years will be needed until diagnoses are fully coded. Dr. Goldfield noted that incentives speed this process and that improvement is incremental. Mr. Murray stated that Maryland is unique due to the reimbursement structure and that HSCRC has quantified rate of change and has conducted case mix audits and depth of coding audits. There will continue to be plateaus and room for improvement as 3M makes changes in its methodology and HSCRC extends depth of codes accepted. Mr. Murray agreed that it takes about two to three years to make fair and measurable comparisons across hospitals. Dr. Goldfield noted that new codes will be added this year relating to body mass index and stage of chronic kidney disease which will improve the ability of APR-DRGs to stratify based on risk adjustment. He further noted that they are committed to continuous improvement of APR-DRGs.

Dr. Reuland asked a question about the issue of transfers between hospitals within the APR-DRG structure as his medical group is convinced that there are differences in this group of patients. Dr. Goldfield noted that there two issues here; one is the clinical model of APR-DRGs and the other is a decision about other factors such as transfers, readmissions, and outliers that certain groups may wish to exclude. Dr. Goldfield said that he can work with a group to model as the group wishes and they can look at the results and see what is best for them. Dr. Morlock noted that in the AHRQ mortality indicators, there is a separation between AMI with transfer and without transfer, and asked Dr. Goldfield if there were other AHRQ measures that might separate into these categories. Dr. Goldfield said that it depended on the data and local and geographic issues. His personal preference was use the least number of additional factors as possible. But he noted that one could look at the AMI data and see if transfer made a difference. Dr. Kazandjian agreed and said that the CPS approach was that measurement is universal and evaluation or interpretation is local.

Dr. Kazandjian noted that Dr. Goldfield's comments resonated well with the Quality Initiative goal of creating a composite measure and consideration of those variables that should be included or excluded in development of peer groupings. Dr. Goldfield noted that this area went beyond their typical focus but he had had a NIH grant application about creating a user-defined composite measure. He added that for a consumer driven system, one would expect that a 30- year old mother had different interests than a 70- year old man. He also noted that he was planning with Dr. Steinwachs to conduct some research about psychiatric issues and pay for performance. Dr. Kazandjian noted that the current task regarding composite measures is to provide HSCRC with the tools to recalibrate the payment system but it is interesting to contemplate future possibilities. Dr. Kazandjian summarized some main points of Dr. Goldfield's presentation: 1.) an initial overview of the APR-DRG methodology, and 2.) the flexibility of the system for a potential future collaborative effort. Dr. Goldfield responded that he would be happy to consider future joint endeavors.

4. Other Business - Ms. Epke asked that the Measures Matrix distributed with the agenda be updated to reflect the selected measures only to aid hospitals in considering data collection issues. Ms. Tan responded that an updated matrix would be provided.
5. Adjournment- Dr. Hall thanked the whole group for their participation and effort. The next meeting date was confirmed and Dr. Hall adjourned the meeting.

Next Meeting- The next meeting of the Initiation Work Group will be **Friday, April 21, from 8:30-10 am at HSCRC**, 4160 Patterson Avenue, Baltimore, MD 21215 in Meeting Room 100.