Minutes
Initiation Work Group, HSCRC
Friday, January 5, 2007
9:00 – 11:00 am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215
Amended 2/5/07

IWG Members Present: Dr. Trudy Hall, Chair**;** Ms. Joan Gelrud, St. Mary's Hospital; Ms. Barbara Epke, LifeBridge Health; Ms. Pamela Barclay, Maryland Health Care Commission; Dr. Charles Reuland, Johns Hopkins Medicine; Dr. Beverly Collins, CareFirst BlueCrossBlueShield, Dr. Vahe Kazandjian and Mr. Frank Pipesh, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Ms. Renee Webster, OHCQ; Mr. Robert Murray, Mr. Steve Ports, and Ms. Marva West Tan, HSCRC.
On Conference Call: Dr. Donald Steinwachs, John Hopkins School of Public Health; Ms. Marybeth Farquhar, AHRQ; Ms. Karol Wicker, Center for Performance Sciences; Mr. Gerald Macks, Medstar Health. (There may have been other unannounced callers).
Interested Parties Present: Ms. Ing-Jye Cheng, MHA; Ms. Carol Christmyer and Ms. Deborah Rajca, Maryland Health Care Commission; Ms. Charlotte Thompson, Health Services Cost Review Commission; Dr. Luis Mispireta, Union Memorial Hospital
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I. **Welcome and Introductions:** Dr. Hall welcomed the attendees and asked telephone participants to identify themselves. Minutes of the December 1, 2006 meeting were approved following several corrections noted by Dr. Collins. (The corrected December minutes are posted on www.hscrc.state.md.us.)

II. **Quality Initiative Reimbursement Modeling and Timeline:** Mr. Robert Murray, HSCRC Executive Director, discussed a timeline that he distributed. (See attached timeline.) This timeline has the same milestones and dates as another timeline distributed at prior meetings but the different format provides more detail of the tasks to be undertaken in the Alpha and Beta Pilots. Mr. Murray stated that staff would develop an option paper outlining reward systems from other pay for performance programs, including the structure and magnitude of rewards, and applicability to an all payer system, as a basis for discussion, probably during the Beta Phase. Work group members indicated that the new format helped clarify the timeline and milestones. Ms. Epke asked whether HIT support would represent new money or a loan, and whether funding would be available to both those hospitals who have and those who have not put HIT infrastructure in place. Mr. Murray said that funding depends on whether the system has been prudent and efficient and can afford to add new money. Funding availability is intended to be equalitarian by supporting a broad range of technologies. Those organizations that have put newer HIT in place will likely be among those facilities that do well on quality measures, thereby reaping financial rewards in that manner. One member asked how the timeline for data matched the activities timeline. Dr. Kazandjian noted that we will be including retrospective data and seeking the appropriate data so that the data timeline will not necessarily match the activities timeline. Dr. Reuland asked if the timeline could be amended to include information about the data to be used during each phase of the process. For example, during Phase II, the data to be used for analysis will be data collected from ____(date) through ____(date).. One attendee asked if the timeline

was adequate to account for delays in data acquisition. Mr. Murray noted the Beta Phase was purposefully long to provide for data acquisition issues.

III. **Review of Comments:** Dr. Kazandjian noted two purposes of the Beta Phase: 1.) to see if the assumptions derived from analysis of the 18 hospitals still hold for a larger sample of all Maryland hospitals and to have a richer data sample, and 2.) to provide enough data to HSCRC staff to develop the financial model. He also noted that data analysis as well as feedback to the institutions will be ongoing, and will not end with the end of the Beta Phase. Ms. Barclay asked how we will deal with changes in measures over time. Dr. Kazandjian noted that this is a factor we have known about from the beginning. Some measures will cease to be useful over time. He noted that he thought of the evolution of different sets of measures similar to use of cohorts. We may start with one cohort of measures, and, then at a certain point, a second cohort of new measures will be introduced while data collection for some of the initial cohort may continue on. Mr. Ports noted that the Steering Committee plan provides for an Evaluation Work Group, which will be charged with looking at new measures, along with other evaluation responsibilities. That group has not yet been appointed. Ms. Epke noted the need for continuous review and constancy with MHCC's Hospital Performance Guide activities.

Dr. Kazandjian then turned to discussion of the comments received from the hospital community. Some of these comments were already discussed at the prior meeting. He noted that we had looked at two potential candidates of methods (appropriateness and opportunity models) but that no decision had been made at this point about methodology due to incomplete data for analysis. He mentioned that we may decide on a mix or hybrid of methodologies attuned to the Maryland reality. Dr. Kazandjian noted that these methodologies are based on national experience and the literature. Dr. Kazandjian briefly mentioned the feasibility and time allocation issues surrounding examination of clinical relevance of measures. He proposed to begin the project with an emphasis on process measures and as we go into the Beta Phase, begin the analysis, on a parallel track, of clinical appropriateness, beginning with those measures for which there is more immediate consensus. The prioritization, weighting, or calibration of measures can not occur until that time. Dr. Kazandjian noted that it is not yet time for members to indicate a preference or support for one approach over another as important analyses remains to be completed. He stated that analysis to date seem to indicate some statistical comfort with the approach we are taking.

Dr. Mispireta raised some concern from the perspective of clinicians, particularly the desire to have information on outcomes, differences in performance and also the difficulty in motivating performance improvement. Dr. Kazandjian noted that the unit of analysis in this project is the institution or hospital. First, we are looking at the processes or "what," we have not yet looked at the "why" or determinants, such as staffing or performance level, that explain the variation. Dr. Kazandjian added that we will be looking at outcomes in a future phase, while continuing to look at evidence-based practices or processes as well as efficient practice. Dr. Hall concurred with Dr. Mispireta regarding the differences in physician performance.

Ms. Gelrud mentioned the concern that the current process measures do not always reflect scientific advances on a timely basis. She would like us to also think of how to incentivize clinicians for more forward thinking and better practice that may not

be compliant with current measures. Mr. Murray said that perhaps argued for more focus on outcomes. Ms. Epke said that we were not ready to look at outcomes due to difficulties in risk adjustment and other issues, but for now we need to continue to focus on process measures.

IV. Further Discussion in the Construction of Composite Measures: Peer Grouping: Dr. Ritter gave a presentation on peer grouping and linking of hospital performance scores with a dataset of potentially correlated hospital characteristics. (See attached slide presentation.) Dr. Kazandjian noted that these findings indicate that we may need peer grouping for equalitarian reasons, but that we may also need more specification, e.g., types of services, level of NICU. Dr. Kazandjian noted that we should feel good that the early HSCRC vision included both incentives and rewards, an approach that other national pay for performance programs are just now recognizing as important. He also noted that the peer grouping tables with the various percentiles listed could serve as a vetting tool for measures. If the 25 and 90 percentile values become very close, then the sensitivity and usefulness of the measure is in doubt. The dispersion in the statistics at this point is useful from a performance improvement perspective. Dr. Reuland asked if a different set of measures might be useful for different peer groups depending on that gap or dispersion in percentile scores. Dr. Kazandjian said that the current data is suggestive of that conclusion but that we need the full data set of the Beta Phase to make that determination. Ms. Gelrud noted that the peer groupings make the model seem more realistic and equitable.

V. Other Business: Dr. Reuland said that he had learned that the definitions regarding use of ARBs in AMI patients with kidney disease, which he discussed at the last meeting. had been clarified.

VI. Next Meeting and Adjournment: After some discussion with the group, Dr. Hall stated that the next meeting of the Initiation Work Group would be February 9, 2007 from 9am to 11 am at HSCRC. Dr. Kazandjian asked that the group continue to provide comments to Ms. Tan for distribution and discussion. Dr. Hall then adjourned the meeting.