Minutes

Quality-Based Reimbursement initiative
Evaluation Work Group Meeting
March 23, 2009
9:00 AM to 10:30 AM

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

EWG Members present: Don S. Hillier, Former Chairman, HSCRC (Vice Chair); Barbara Epke, MPH, MA, LifeBridge Health System; Robert Brooks, MD, Delmarva Fundation; Pam Barclay, MHCC; Robert Murray, Steve Ports, and Dianne Feeney, HSCRC.

EWG Members on by conference call: Charles Reuland, ScD, Johns Hopkins Health System;; Wendy Kronmiller, JD, OHCQ, DHMH; Beverly Collins, MD, CareFirst BCBS

Interested parties present: Vahe Kazandjian, PhD, CPS**,** Grant Ritter, PhD, Brandeis University; Theressa Lee, Deme Umo and Carol Christmyer, MHCC; Beverly Miller, MHA; Donna Ryan, St. Joseph Medical Center; Hal Cohen, PhD.; Jean Acuna, Mercy Medical Center; Zahid Butt, MD, Medisolv; Claudine Williams, HSCRC.

Interested parties on by conference call: Nikolas Mathes and Karol Wicker, CPS; Rob Carroll, Shore Health System; Sylvia Daniel, University of Maryland Medical System; Suvana Sundaram, Holy Cross Hospital; Jerry Macks, Medstar Health; Shirley Knelly and Anastasia Brown, Anne Arundel Medical Center; San Keller and Sophia Chan, American Institutes for Research.

- ***Welcome and introduction of EWG members and other participants-*** Don Hillier 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 January 30, 2009 meeting minutes –***A motion to approve the minutes was made and seconded with unanimous approval.

- ***Update on timing of analysis of CY 2008 process measures data***- Dianne Feeney stated that a request had been made to the Delmarva Foundation for the first three quarters of CY 2008 process measures data, noting there was some delay with getting the data with staffing changes at the Iowa Foundation for Medical Care, the CMS process measures data contractor. Ms. Feeney added the purpose of request for the first three quarters was to model the benchmark and threshold numbers, and that the fourth quarter of data would not be available until the latter part of May, with the final benchmark and threshold values for hospitals for the 2008 performance year becoming available in the early part of June at the earliest.

- ***Analytic tool in development for hospital use-*** Dr. Vahe Kazandjian noted that

Donna Ryan at St. Joseph had shared the tool she had developed for their internal use which has helped CPS in their development of a statewide tool to help hospitals calculate their QBR scores in an expeditious, timely manner. Dr. Kazandjian added that hospitals would be able to compare their scores with the statewide numbers, and that other hospitals' data would be de-identified and confidential. In addition, HSCRC staff would be provided an administrator account to view all data, and this work to build the platform would be continue over the next few weeks with the tool release thereafter. Dr. Kazandjian noted he would get with Dianne at HSCRC on the values for the formulas to be embedded in the tool so the tool development can be completed.

- ***Update on reporting of PCI , SCIP and Children's Asthma Care (CAC) measures to be added to MHCC's Hospital Performance Evaluation Guide (HPEG)-*** Pam Barclay quickly reviewed the measures and schedule for adding them to the HPEG as listed in the Maryland Register Corrected Notice and the "Hospital Compare and Maryland Inpatient Hospital Quality Measures" comparison table. Dr. Brooks asked whether the SCIP measure updates would bring Maryland up to date with the specifications CMS is using, i.e., antibiotics discontinued 48hrs post cardiac surgery, and Ms. Barclay that Maryland would be up to date and synchronized with CMS.

- ***HCAHPS overview and discussion-*** San Keller, PhD introduced herself as a health services researcher since 1988, with 10 years of Consumer Assessment of Healthcare Providers and Systems (CAHPS) experience, noting that she had authored the Hospital CAHPS development report and several others on Hospital CAHPS (HCAHPS), and is currently consulting with the Veteran's Health Administration to design a system to incorporate Hospital CAHPS in its management compensation structure. Dr. Keller provided an overview and details of the HCAHPS instrument, including the definition, history of development, components, validity testing results, the documentation available on HCAHPS, data collection procedures, case mix adjustment and analysis information, CMS plan for public reporting of HCAHPS, and resources for technical support on HCAHPS. Dr. Keller, clarified that the HCAHPS ratings correlate with ratings of "health" where "health" is an individual's assessment of their overall health, and that there is abundant literature in this area. Grant Ritter, PhD, noted that there was enormous geographic variation with HCAHPS result, with West Coast patients having lower scores, the Midwest having higher scores, etc. and asked if there was regional adjustment to account for this. Dr. Keller responded that she believed there was regional adjustment. Dr. Ritter asked about adjustment for size of facility as larger, urban, possibly teaching hospitals tended to have lower scores, and Dr. Keller responded she did not think there would be adjustment as the hospital size may be rightly associated with perceptions of care. Dr. Ritter asked whether mixing in the global measures with the eight more focused measures may be using the global measures twice. Dr. Keller responded that the individual measures were only explaining 40% of the variance in the global measures, so the global measures were measuring still other aspects of care. Mr. Hillier asked if the HCAHPS measures had been correlated with results of other measures such as the process measures. Nikolas Mathis responded that a statistician from Rand had presented results at an Academy Health meeting at the

end of last year that revealed a weak correlation of the HCAHPS measures with other measures of quality and this was determined to a be a positive finding as the HCAHPS measures address an alternate or different dimension of quality. Dr. Reuland asked whether it was known why CMS publicly reports mortality data if there are statistical differences, but this is not the case for the other Hospital Compare measures. Dr. Keller responded that she thought it was because consumers have difficulty with explanations of statistical differences, confidence intervals, etc. Dr. Kazandjian asked when the interviews with patients took place. Dr. Keller responded the interview period with 48hrs to 6wks post discharge, adding that biases were likely looked at in the case mix models. Dr. Kazandjian cited other literature that patients saying they had good communication with nurses would also score their pain management well, even if the pain management was not clinically correct, as the kindness of the nurses made them generally feel better. Dr. Kazandjian added that, rather than statistical significance, he would look at multi co-linear relationships between these items as pain management, and problems in this area, may be masked by the influence of the communication with nurses item. Ms. Barclay noted that MHCC was thinking about reporting by medical, surgical, and obstetric patient groupings, rather than reporting the patients all together. Ms. Epke noted HCAHPS brings a set of other complications that needs further analysis and deliberations and that the data were not, in her view, of priority over additional process measures and outcome measures that should be discussed and determined first. Ms. Feeney noted that additional analysis on Maryland HCAHPS data on regional variation and other questions would benefit the group for further discussion.

- ***Combining opportunity and appropriateness models-*** Dr. Kazandjian provided introductory remarks, noting that the appropriateness model is patient focused and clinically oriented, and the opportunity model more process oriented, and that a hybrid approach may work well on a continuum as we also move toward outcomes for the QBR. Dr. Ritter noted that, as previously presented, the process measures were becoming topped off, and the appropriateness model provides an option to distinguish hospitals in light of the topped off phenomenon. Dr. Ritter presented hospital specific data, illustrating the following:

    - Scores using 25% appropriateness, and 75% opportunity.
    - Scores using 50% appropriateness, and 50% opportunity.
    - Scores using 75% appropriateness, and 25% opportunity.

  Dr. Ritter noted that hospitals that have scored well on opportunity also score well on appropriateness. Ms. Epke noted there was significant point spread for some hospitals, depending on the blended model, adding that using the appropriateness model would not give credit for important clinical measures. Dr. Kazandjian suggested that going with a conservative approach using a lesser proportion of appropriateness could be a good way to start. Ms. Feeney asked that members of the EWG provide their input on which hybrid approach via email, and that she would provide the hospital scores via email to members not able to attend the meeting in person.
- ***Adjournment-*** The meeting was adjourned at 10:35AM.