**Minutes**
**Initiation Work Group, HSCRC**
**Monday, Feb 27, 2006**
**9am-11am**
**Room 100, 4160 Patterson Avenue**
**Baltimore, MD 21215**

**IWG Members Present**: Dr. Trudy Hall, Chair and HSCRC Commissioner; Dr. Maulik Joshi, Delmarva Foundation; Ms. Barbara Epke, VP, Lifebridge Health; Ms. Marybeth Farquhar, AHRQ; Dr. Beverly Collins, CareFirst; Ms. Renee Webster, OHCQ; Dr. Charles Reuland, Johns Hopkins Medicine; Dr. Vahé Kazandjian, Dr. Nikolas Matthes, Mr. Frank Pipesh, Ms. Nicole Silverman and Ms. Karol Wicker, Center for Performance Sciences; Dr. Laura Morlock, Johns Hopkins School of Public Health; HSCRC Staff: Mr. Steve Ports and Ms. Marva West Tan. **On conference call**: Dr. Linda Hickman, Chester River Hospital Center; Dr. Kathryn Montgomery, University of Maryland School of Nursing; Mr. Gerald Macks, MedStar. (Roll not taken. There may have been other people on the conference call.)

**Interested Parties Present**: Mr. Don Hillier, former Commission Chairman, Ms. Ing-Jye Cheng; and Ms. Traci Phillips, MHA; Ms. Charlotte Thompson, HSCRC; Ms. Allison Lipitz, Johns Hopkins University; Dr. Luis Mispireta, University of Maryland Hospital; Ms. Kristin Geissler, Mercy Medical Center; Mr. Rodney Taylor; Ms. Carol Christmyer, and Ms. Dolores Sands, MHCC; Ms. Brigid Krizek, Patient Safety Fellow; Ms. Joanne Koterwas and Ms. Joan Gelrud, St. Mary's Hospital.
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1. Welcome and Approval of Minutes- Dr. Hall welcomed the Work Group and attendees on the audio conference. The minutes from the Jan 27, 2006 meeting were approved as distributed.

**2.** HSCRC Update – Mr. Steve Ports provided a brief update regarding HSCRC's current, interrelated quality strategies which include not only the Quality-based Reimbursement Initiative but also a strategy regarding Health Information Technology/Infrastructure and Electronic Health Records/Interoperability of Health Data or Statewide Switch. Mr. Ports noted that the Quality Initiative Steering Committee envisioned infrastructure support as part of the Quality Initiative reimbursement along with rewards and incentives. HSCRC has approved a two-part HIT study to be conducted by the Maryland Patient Safety Center. The first part will be a literature review to identify those technologies with the best linkages to improved healthcare quality and the second part will be a survey of Maryland hospitals to identify the status of Maryland hospitals regarding implementation of the technologies found to be most closely linked with quality. The study will be followed by HSCRC policy development regarding HIT funding, an application process and a funding awards process. HSCRC's goal is to assure that all Maryland hospitals have the technologies most closely linked with improved healthcare quality by a certain date. Dr. Reuland requested some written material on these strategies. (An electronic file of a draft white paper was emailed to Initiation Work Group members following the meeting.) Dr. Kazandjian introduced Ms. Allison Lipitz from Johns Hopkins University who will be assisting him with part one of the HIT study.

**3.** Goals for the Day- Mr. Ports noted that the goal of the day, with inclusive participation by all, was to review the expanded table of measures and identify measures for the pilot. He urged everyone to express their views and to provide input both on the measures listed on the expanded table or other measures which they felt should be considered. Mr. Ports noted that the HSCRC intent was that participation and input would be encouraged from all stakeholders.

**4.** Expanded Table of Sample Measures Document- Dr. Vahé Kazandjian, CEO, Center for Performance Sciences (CPS), introduced the Center's expanded table of sample measures and he and Dr. Matthes pointed out some features of each measure or group of measures. Dr. Matthes noted some upcoming changes from CMS regarding measures to be used for reporting for the market basket update. (Refer to the Table for content.) Dr. Morlock then presented a set of charts illustrating risk-adjusted mortality rates for some indicators of 2003 inpatient care in Texas Hospitals and another set of tables of 2003 Maryland in-hospital mortality rates for selected diagnoses with observed, risk-adjusted and smoothed rates. These tables were presented for information and as examples of what some other states are doing. (Please contact Ms. Tan if you wish to receive print copies of these tables.) Dr. Morlock noted that she felt that three years of data were desirable when looking at mortality data but noted that this created a tension with use of most current data possible for pay-for-performance. Use of rolling averages may help to overcome some of the data issues. Dr. Morlock noted that coding of mortality data is accurate and available. Dr. Kazandjian noted that APR-DRGs will be implemented in Maryland and that Dr. Goldfield from 3M will attend a future meeting to explain risk adjustment in APR DRGs.

**5.** Dr. Kazandjian noted that there is a distinction between measures for public reporting and pay-for-performance, which is the province of HSCRC. He further noted that HSCRC does have a timetable for the quality initiative, the group has a good list of measures to choose from and he encouraged the work group to identify categories of measures for the first phase. Dr. Hall suggested, that in identifying those categories, positive and negative effects on hospital behavior, unintended consequences, and items under the control of the hospitals are factors to be considered in selection of the measures. Ms. Epke asked if the work group is defining size and scope of the pilot. Dr. Kazandjian said that he characterized this process as prioritization or identification of various cohorts of measures for future consideration. He also noted that not all measures will work in creating a composite measure. Dr. Matthes noted that CPS will analyze the first cohort of measures selected for the statistical properties of the measures and use in a composite measure. Mr. Machs noted that the data upon which rewards and incentives will be based should be as current as possible. Dr. Kazandjian noted that the HSCRC already uses an annual cycle for rate setting and that the aim will be to use data which is a year old, but, at this point, the data is not going to be real time. Mr. Machs expressed concern that this initiative represented a new mission for HSCRC. Mr. Ports responded that HSCRC's original legislative mandate is to create a functional reimbursement system in Maryland to improve hospital efficiency and also to improve hospital effectiveness or quality**.** The Commission, including former Commission Chair Hillier in attendance, have been discussing and planning the quality initiative for some time. Ms. Epke noted that the Work Group should consider the size of the whole package selected, perhaps eliminating for the pilot those measures that are on the cusp of being implemented by CMS and suggested that MHCC could "vet" other measures for consideration for future phases. Dr. Kazandjian noted that as part of quality improvement, the Work Group should consider not only what hospitals are currently doing, but what they should be doing.

The Initiation Work Group, using the CPS expanded table of measures as a basis for discussion, then made a first cut at identification of measures for the pilot, deferring for a later phase of the Quality Initiative the newest measures promulgated by CMS and JCAHO, measures that might be clinically controversial, and measures in which data collection may pose more challenges.

The following measures were tentatively selected for the pilot:

**Clinical Measures**

1. **AMI -1 Aspirin at arrival**
2. **AMI- 2 Aspirin prescribed at discharge**
3. **AMI- 3 Angiotensin converting enzyme inhibitors (ACEI) or angiotensin receptor blockers (ARB) for left ventricular systolic dysfunction (LVSD)**
4. **AMI- 4 Adult smoking cessation advice/counseling**
5. **AMI- 5 Beta blocker prescribed at discharge**
6. **AMI– 6 Beta blocker at arrival**
7. **PN -2 Pneumococcal vaccination**
8. **PN- 3a Blood cultures performed within 24 hours prior to or 24 hours after hospital arrival for patients who were transferred or admitted to the ICU within 24 hours of hospital arrival**
9. **PN -3b Blood culture before first antibiotic – Pneumonia (Questions remain on this measure.)**
10. **PN- 4 Adult smoking cessation advice/counseling**
11. **PN- 5b Pneumonia patients who receive their first dose of antibiotics within 8 hours after arrival in the hospital**
12. **PN- 7 Influenza vaccination**
13. **HF- 1 Discharge instructions**
14. **HF- 2 Left ventricular systolic function (LVSF) assessment**
15. **HF- 3 ACEI or ARB for LVSD**
16. **HF- 4 Adult smoking cessation advice/counseling**
17. **SIP- 1 Prophylactic antibiotic received within one hour prior to surgical incision (by surgery type for 8 procedures.)**
18. **SIP- 2 Prophylactic antibiotic selection for surgical patients (by surgery type for 8 procedures.) (There were some questions about including this complex measure.)**
19. **SIP -3 Prophylactic antibiotics discontinued within 24 hours after surgery end time (48 hours for CABG) (by surgery type for 8 procedures.)**

**Outcome Measures**

20. **Central-line associated bloodstream infections in the ICU**
21. **Ventilator-associated pneumonia in the ICU**
22. **Symptomatic indwelling urinary catheter -associated urinary tract infections (UTIs) in the ICU**

The other measures on the expanded table of measures were temporarily set aside for reconsideration for future phases of the Quality Initiative. Tentative slotting for future phases was:

Patient safety measures are a possibility for Cohort II. The patient safety measures, which reflect the Leapfrog original three "leaps," may be added to the CMS market basket update reporting requirements. Another suggestion was to make the Leapfrog measures more of a hospital commitment than a measure. Also CPOE will be looked at as part of two part HIT study so there will additional analysis of this measure.

AHRQ Inpatient Quality Indicators (mortality rates) need some modeling or simulation and additional analysis before use. These will be studied for Cohort III.

Outcomes measures related to mortality and readmissions were deferred to Cohort IV.

Patient Satisfaction or HCAHPS measures will be part of the CMS market basket update reporting requirements, probably in 2007. The Work Group preferred to defer use of this qualitative measure. Dr. Kazandjian asked that judgment be withheld until the other selected measures are analyzed as different measurement dimensions may be very useful in the adjustments needed in constructing a composite score. Dr. Kazandjian, at several points in the

meeting, reiterated that the epidemiological rather than the clinical view, and the different goals of public reporting and pay-for-performance must be taken into account when considering the overall usefulness of the measures in building a composite measure for a quality-based reimbursement program.

6. Other Business – A suggestion was made regarding the timeline for taking information about the pilot to all Maryland hospitals. Dr. Kazandjian noted at the next meeting that CPS will bring back their analysis regarding the feasibility of use of the group of measures selected today, and once the group is comfortable with the selected cohort, then the composite methodology will be developed. A national expert from Brandeis University will assist with development of the composite methodology and will be invited to the next meeting. In response to a question, Dr. Kazandjian stated that the methodology has not yet been selected and depends on the group of measures chosen. Dr. Matthes notes that CPS staff has been reviewing the CMS composite measure approach which assumes a normal distribution, and that many statistical issues must be taken into consideration. Once the information about the pilot and the desired characteristics of the pilot hospitals have been identified, then information will be distributed to all hospitals, possibly in April. Peer groupings and a mix of different types of hospitals will likely be utilized. Ms. Epke noted that guidance on the characteristics of the hospitals (size, services, location) will be important as most hospitals will likely want to participate in the pilot in order to gain experience with the process.

7. Adjournment- Dr. Hall noted that the group had made great progress today and 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 **Monday, March 27, from 8:30-10 am at HSCRC**, 4160 Patterson Avenue, Baltimore, MD 21215 in Meeting Room 100.