

**Office for Health Policy & Research
Health Policy Commission
Quality & Transparency Work Group**

2005 Meeting Notes

March 9, 2005 4-6pm 600 NE Grand Ave, Portland

April 13, 2005 3-5pm 4000 Kruse Way PI, Lake Oswego

May 11, 2005 3-5pm 800 NE Oregon St, Portland

June 8, 2005 3-5pm 800 NE Oregon St, Portland

August 10 , 2005, 3-5pm 600 NE Grand Ave, Portland

September 14, 2005 3-5pm 800 NE Oregon St, Portland

October 12, 2005 3-5pm 827 NE Oregon St, Portland

November 21, 2005 3-5pm 800 NE Oregon St, Portland

Quality and Transparency Work Group Meeting Notes
Oregon Health Policy Commission
March 9, 2005
Metro Building Room 370A
600 NE Grand Ave
Portland, Oregon

Members Present:

Vickie Gates (co-chair), Ralph Prows, Ken Rutledge, Keith Marton, John McConnell, Nancy Clarke, Geoff Brown

Members calling in (and lost due to equipment failure):

Michael Geheb, Michael Leahy, Joel Ario

Members Excused:

Bill Kramer, Jonathan Ater (co-chair), Ron Potts, Doug Walta, Glenn Rodriguez, Gil Munoz

Guests:

John Lee, Health Cost Committee, Oregon Business Council
Tate Williams, Health Forum, Oregon Health News
Jeanene Smith, Deputy Administrator, Office for Oregon Health Policy & Research
Diana Jones, Public Employees Benefit Board
Shelley Bain, Senior Policy Analyst, Oregon Insurance Division (for Joel Ario)
Tina Edlund, Data & Research Manager, Office for Oregon Health Policy & Research
Janne Boone, Health Policy Analyst, Office for Oregon Health Policy & Research

Staff:

Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order 4:16pm

I. Discussion of proposed work plan (Handout #III) (Tape Side A, 038)

- Vickie Gates: this work group was born of the Commission's ongoing concern about the availability of meaningful quality and cost data. Specifically, the Commission would like to see a data clearinghouse/website at the state level, a public/private collaborative to create a mechanism to improve the information available to consumers; this group will flesh out those ideas, deal with the technical issues and act as a convener of stakeholders. The membership of this group has the experience and expertise to address these issues; we can add to the membership as the need for more specific expertise arises.
- Question: What is the scope of Goal #5 ("Review and achieve substantial implementation of the recommendations of the Electronic Health Records (EHR)

taskforce (expected in early 2005)”? Public reporting as well as issues around connectivity.

- Nancy Clarke (tape location 079): The report contains about a dozen recommendations framing how state government can work with the private sector to foster EHR adoption and system connectivity. How the state can serve as leader/convener for creating pilot projects (Regional Health Information Organizations), and discussions on cost, technology/architecture, and governance; Regarding leadership, the report recommends naming and empowering a coordinator who answers to the Governor and to the Office for Oregon Health Policy and Research (OHPR).
- Ken Rutledge: He has been working with State Senator Monnes-Anderson on behalf of hospitals. She expressed interest in the past in EHR efforts and possible supportive legislation.
- Ralph Prows suggests that we add language to the work plan to clarify how Goal #5 ties in to the larger work group effort
- Vickie closes discussion on work plan by stating that it will be a working document that can change as the work progresses.

In response to requests from the Legislature and other stakeholders about OHPR’s capabilities in producing quality-related information, we begin with an inventory of what we currently have, which is hospital data. We will rely on work group members to contribute ideas and information to build on this initial step.

II. Presentation of Hospital Data Available to OHPR Now, Tina Edlund, Janne Boone (Handout #IV)

Note: Please refer to handout for presentation content. The following notes capture commentary not found in the text of the presentation

- Data presented today represents work that OHPR began in September 2004. Previously, OHPR did not have the risk adjustment approaches necessary to process the raw data into meaningful information on cost, quality, and volume by DRG. Now, the office can provide these numbers to the stakeholders who request them.
- OHPR has statutory authority to collect hospital discharge data, which it has been doing since 1982.
- In the future, OHPR would welcome help from this workgroup in making technical decisions about how to present data (i.e. how to deal with outliers (extreme values), trimming, top-coating, etc).
- Tina provided some examples of where input and decisions on display are needed. On slide entitled “Charge Report Example (CABG)” the two blue shaded cells. These were determined to be higher than average charges because they were more than two standard deviations above the mean. The far right-hand column of the table shows “Adjusted Average Charge”, adjusted based on direct standardization as an example (normally, we would use some kind of modeling technique). Peer

groups here are split by hospital types (these can be sorted a variety of ways, geographically, overall expense, etc)

- Next steps: consult with work group about selection of procedures/conditions, technical issues, display of information, hospital review

Discussion

- Ken Ruttledge: hospitals are launching a website modeled after Wisconsin's "Price-point" model hopefully within the month. Charges would be provided by DRG, based on peer grouping. Consumers can look at a single hospital or a group of hospitals for number of discharges for a given procedure, average length of stay, average charge per day, median charge, percent of charges received by each category of payor, charity care data, etc. Each set of data will have an explanatory/qualifying blurb.

Next step for hospitals is to partner with other groups to lend the effort credibility.

Quality: begin with CMS processes (heart attack measures, congestive heart failure, pneumonia) but keep the data more current/timely. Wisconsin has chosen 5 initial "safety indicators. Hospitals now have to decide what information to put on the Oregon site, as well as implement a system for auditing the numbers. Some hospitals have purchased access to sophisticated software that calculates risk adjustment, mortality and complication rates on all DRG's, shows expected number/rate of mortalities, looks at national norm, variations from the norm and the statistical significance of those. We must ensure that the information made available is valuable to the public and is framed in a such way that they understand the information's limitations and what it is, and what it is not, actually telling them.

- Vickie Gates: We must involve all stakeholders in the decision-making to ensure that it is useful to all and credible
- Nancy Clarke: Adds that the *processes* as well as the final products need to be transparent
- Currently submitted hospital discharge data: Comp Data collects discharge data, does follow-ups and edits, and provides it to the State under contract. Hospitals buy data quarterly; statute requires OHPR to receive 13 elements of data annually.
- Ralph Prows asks about proxy for cost based on payment/payer class.

(Tape Side B)

- Keith Marton sees quality/transparency effort on two planes: policy issues and technical issues. Policy issues will probably be decided at the Commission level; specifically, how the two current reporting tools ultimately work together (hospitals which focus on process data; OHPR which focuses on outcomes data). Technical issues will likely be addressed by this work group; specifically, identifying key decision points where there is uncertainty, risk adjustment, etc. (DRG is easy but limited, with little clinical relevance). We should be sure to ask consumers how they would like data to be presented.
- The pace of transparency efforts across the nation has accelerated beyond all expectation; the article in the March 9, 2005 edition of the Journal of the

American Medical Association entitled “The Unintended Consequences of Publicly Reporting Quality Information” cautions that there will unanticipated consequences to transparency.

- Ken Rutledge adds that calculating cost data for consumers is complicated by the fact that hospitals “don’t do retail”, they sell in bulk to Medicare, etc.

III. Next Steps (Side B, 145)

Assignments:

Tina Edlund/ Janne Boone/ Ken Rutledge

- **OHPR will come to the next meeting with:**
 - **A set of technical questions for the group**
 - **Discuss OHPR’s concerns with its data sets (timeliness-where are the lags, recommendations around charge/charge proxy issues)**
 - **Other suggestions for making this a more robust process**
 - **Overview of the 14 other states referenced in the PowerPoint presentation and their best practices (start with two or three for next time)**
 - **What are the proprietary information sources that exist, what do they have, how valid is their product**
 - **Highlight Judith Hibbard’s scorecard work in Wisconsin**
- **Ken Rutledge is to provide an overview of the hospital association’s website plans**
- **The request was made for the materials to be circulated ahead of the meeting if at all possible**

Adjournment 5:45p.m.

Next Meeting Agenda Items:

- **Update on hospitals’ Web Effort, Ken Rutledge**
- **OHPR Questions for the Work Group, Tina Edlund**
- **Inventory of Other States, Tina Edlund**

Handouts:

- I. Agenda**
- II. Roster**
- III. Proposed Work Plan**
- IV. Hospital Data Presentation (Janne Boone)**

Quality and Transparency Work Group Meeting Notes
Oregon Health Policy Commission
April 13, 2005
4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon

Members Present:

Jonathan Ater (co-chair), Vickie Gates (co-chair), Joel Ario, Geoff Brown, Nancy Clarke, Michael Geheb, Bill Kramer, Keith Marton, John McConnell, Gil Munoz, Ron Potts, Ralph Prows, Glenn Rodriguez, Ken Rutledge

Members Excused:

Diana Jones, Michael Leahy, Doug Walta

Guests:

Shelley Bain, Senior Policy Analyst, Oregon Insurance Division
Janne Boone, Policy Analyst, Office for Oregon Health Policy & Research (OHPR)
Tina Edlund, Data & Research Manager, Office for Oregon Health Policy & Research
Bruce Goldberg, MD, Administrator, Office for Oregon Health Policy & Research
Diane Lund, Health Forum, Oregon Health News
Varner Searnan, SEIU
Jeanene Smith, MD, Deputy Administrator, Office for Oregon Health Policy & Research
Rick Wopat, MD, CQO, Samaritan Health Services; Oregon Health Policy Commission, Member

Staff:

Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order 3:07pm

- I. Introductions & Timeline Overview (Handout II)**
- II. Quality/Charge Reporting – Informational Items**
 - A. Oregon Association of Hospitals Health Systems (OAHHS) Submission of Discharge Data to OHPR**

- Tina Edlund: hospital discharge data is collected by hospitals and submitted to CompData; OAHHS sends the final product to OHPR once a year.

- B. Review of Other States' Efforts (Handout IV)**

Discussion

- Ron Potts suggests that the group think about how to display this information on the Web in a way that is meaningful to the public (Colorado's "statistical difference" bubbles are not helpful to the layman) He adds that "analysis of means" might be a useful method

- C. Selection of APR-DRGs for Risk Adjustment (Handout III)**

Discussion

- Michael Geheb says that agreement between the State and the health care industry on a single methodology would be a great service to the public and would be much more efficient for maintenance and communication across institutions and Websites
- Glenn Rodriguez agrees that APR-DRGs are the emerging standard; what about standardization of raw data collection? We should work on normalizing data processing across the industry to improve quality control
- Vickie Gates cautions that the work group needs to be careful and very clear when it talks about data collection & processing
- Glenn Rodriguez thinks that normalization of data collection will happen automatically as the transparency effort gets further along
- Michael Geheb says that we have to anticipate that this effort will have some holes as it gets off the ground, that there will have to be a balancing of the practical implementation issues with maintaining public trust
- Ken Rutledge says we should give the hospitals and others a preview of how their current data collection processes will translate onto the Web and how it will reflect on them (accurately or inaccurately)
- Vickie Gates agrees that this should be a priority
- Glenn Rodriguez adds that for the long term, we need to recognize that new data sets will be emerging as this effort matures, and that we will need to review these and maybe update them as time progresses (more clinically meaningful data). Clarity of our purpose/goal will be important. The first outcome of this reporting won't be consumers using the information to make informed choices, but rather hospitals reacting by implementing internal change to clean up data collection processes.
- Ron Potts notes that there is no way to foresee how the public and providers will react to this newly available data; we will need to be continually mindful of keeping our own processes transparent in order to maintain the trust of all stakeholders
- Michael Geheb: the 1992 New York Department of Health published cardiovascular mortality rates, methodological problems were acknowledged, and it changed the landscape of how cardiovascular medicine was practiced; we need to be very careful about how information is presented.

III. Quality/Charge Reporting – Items for Feedback

A. Establishing a subcommittee

Discussion

- Tina Edlund & Janne Boone envision one group for technical statistical discussions and then another group for display decisions. **Subgroups will organize and work electronically between regular work group meetings.**
- Vickie Gates wants our product to do a lot better job than other states have done in explaining the data we present and making it meaningful to the public
- Bill Kramer suggests 3 subgroups: statistical, clinical, communications; there is agreement on this. Members will email Tina Edlund if they would like to participate or have someone on their staff they would like to participate.

Tape Side B

IV. Overview of OAHHS Hospital Data Reporting Website, Kevin Earls

- This is modeled after the Wisconsin Hospital Association's Website
- Two ways to use PricePoint: "Basic Query" & "Comprehensive Query"
- Basic Query: geared toward the public
- Comprehensive Query: geared toward researchers
- Michael Geheb says that with regard to financial vs. clinical data set reporting, there needs to be some discussion and consensus on the clinical data as it emerges (financial data has been reported for a long time, and it needs much less discussion); however, that necessary discussion should not slow the posting of the first wave of information
- Site will be up Monday
- Bruce Goldberg asks that this group decide whether to use this charge data or risk adjusted charge info for the state's Website
- Glenn Rodriguez notes that we need to be sensitive to vocabulary (i.e. "threatened abortions" listed on the preliminary OAHHS Website would likely alarm the layman)
- Look into "Medical Illiteracy" project

V. Next Steps

- **Assemble subgroups and get them working**

Adjournment 4:55p.m.

Next Meeting Agenda Items:

- **Subgroup will present technical decisions & proposed data presentation format**

Handouts:

- I. Agenda**
- II. Timeline**
- III. Technical Issues & Risk Adjustment Tools, Janne Boone**
- IV. Summary of other states quality & transparency efforts**
- V. 2005 Meeting Calendar**

Quality and Transparency Work Group Meeting Notes
Oregon Health Policy Commission
May 11, 2005
Portland State Office Building Room 120B
800 NE Oregon St, Portland, Oregon

Members Present: Jonathan Ater, Nancy Clarke, Bill Kramer, Keith Marton, John McConnell, Glenn Rodriguez, Doug Walta

Members Excused: Vickie Gates, Joel Ario, Geoff Brown, Michael Geheb, Diana Jones, Michael Leahy, Gil Munoz, Ron Potts, Ralph Prows

Guests: Nancy Bieber (WCD), Jeanene Smith (OHPR), Shelley Bain (ID), Janne Boone (OHPR), Tina Edlund (OHPR), David Pollack (OMHAS)

Staff: Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 3:10p.m.

HOSPITAL DISCHARGE DATA

I. Tina Edlund and Janne Boone of OHPR discussed the recommendations from the clinical, statistics, and communications subgroups.

a. Clinical Indicators – Volume Counts

Recommendations

- Eliminated esophageal resection & pancreatic resection due to too few numbers
- Strokes: hemorrhagic vs. ischemic stroke - two institutions get the disproportionate share of hemorrhagic cases (probably due to referrals). AHRQ believes that the risk adjustment will take care of this, but OHPR will run the numbers before deciding to display this data.
- Add back pediatric heart surgery volumes and mortality and abdominal aortic aneurysm volume and mortality.
- Consider total hip replacement volume as an indicator.

Discussion

- Trauma centers maybe should be displayed separately
- Coronary artery disease – institutions have different criteria for diagnosis which leads to inconsistency in the data that is collected
- There needs to be a very clear indication of when data can lead to a conclusion about quality and when it doesn't (e.g. C-section and VBAC).
Volume of cases does not equal quality of care for these two utilization indicators and they should be displayed that way.
- AAA & carotid indicators: technology is changing rapidly for both of these indicators; we should ensure that **surgical & endovascular are represented.**

- Total hip replacement volume/quality indicators: data variations will likely result from different care practices (patient processing) rather than differences in quality of care
- CHF mortality depends greatly on the population that is being served and the primary care available in the community; for indicators like this, it may be useful to have an extensive amount of qualifiers
- OHPR data is administrative data (hospital discharge data from the UB-92), not clinical process measures

b. Statistics (3:50p.m.)

Recommendations

- Sample data sorted by hi/low urban, hi/low rural total discharges, DRG refined by volume (for consistent peer groups).

Discussion

- Sort by indicators, not by peer groups. Show all data, but indicate that for very small volumes it is not possible to draw statistically meaningful quality conclusions (and put these small institutions under a separate header)
- For CAF & CABG– only compare hospitals that do it either against each other or the national administrative data (observed vs. expected) by above-threshold/below-threshold
- Have different methodology for each category, as there are vastly different variables for each (procedure – national benchmark, volume – pure data, mortality-statewide average/or national averages & utilization – pure data)
- Bar graphs with confidence intervals and national benchmarks are good, especially for the first launch; concerns were expressed about a too simplified display and how that would be interpreted.

Recommendations:

- **Use statewide averages or national averages instead of peer group average**
- **For the beginning stage of the data launch, OHPR should: 1) Share data first to hospitals only, allowing them time for review and collaboration on best practices; 2) Display data (e.g. bar charts) in a way that does not draw inaccurate conclusions, even if the display is too complex for the average consumer to use; the first users of this data will be hospitals and health professionals; 3) As this effort matures, begin displaying data in simpler form for consumers, being very careful to qualify each conclusion**
- **+/- Displays:**
 - **Drawing quality conclusions for consumers: have 3 types of conclusion – 1. “Conclusion has general consensus”, 2. “Conclusion is disputed”, 3. “Data does not allow for any conclusion”**
 - **Use J Hibbard’s model of not grading institutions with fewer than 30 cases**

Adjourn: 4:50p.m.

Handouts:

Sample table, graph, and symbols

Subgroup Reports: Clinical Indicators, Statistics, and Communications

Quality and Transparency Work Group Meeting Notes
Oregon Health Policy Commission
June 8, 2005
Portland State Office Building Room 120B
800 NE Oregon St, Portland, Oregon

Members Present: Jonathan Ater, Vickie Gates, Geoff Brown, Nancy Clarke, Gwen Dayton, Michael Geheb, Bill Kramer, Michael Leahy, Keith Marton, John McConnell, Glenn Rodriguez, Doug Walta

Members Excused: Joel Ario, Diana Jones, Michael Leahy, Gil Munoz, Ron Potts, Ralph Prows

Guests: Jeff Keim (Regence), Jeanene Smith (OHPR), Steven Reinhart, MD (The Oregon Clinic)

Staff: Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Tape 1 Side A Call to order: 3:15p.m.

HOSPITAL DISCHARGE DATA

I. Update on Agency for Healthcare Research & Quality (AHRQ) Hospital Quality Indicator project - Tina Edlund and Janne Boone, Office for Oregon Health Policy & Research (OHPR)

a. Initial hospital feedback on indicator data

- Possible content of comments posted to Website:
 - Mortality where “Do Not Resuscitate” orders are in place
 - Some small hospitals treat only terminal stroke patients and provide them only comfort care
- Disagreement over whether confidence intervals should be displayed
- Concern over imperfection of AHRQ risk adjustment methods, particularly for special populations (pediatrics)
- Some small hospitals have expressed interest in having their raw data presented even if they fall below the 30-case threshold
- Allow hospitals to see a test Website before it goes live

b. Recommendations from Communications subgroup

- Commentary around each indicator should answer these four questions: Why are we doing these reports? How are these reports produced? What can you find on this site what are the important cautions about the data?
- Should display national averages next to state and hospital numbers
- In addition to showing an indicator with all hospitals listed below it, there should also be a display of each hospital with all its indicators listed below.

Discussion

- Several members like the clean look of the floating-dot display. Tina will talk to Gary Grunkemeier at Providence about his software and his display method in which the size of the dot indicates volume
- Volume, patient mix, elective vs. emergency should all be explained

- There is concern over variation in the definitions used for reporting across institutions as well as the evolution of technology and clinical practices. These things need to be worked through in future iterations of this display.
- Risk methodology is different between institutions and state and federal governments. While ideally we would use risk adjustment methods specific to each condition/procedure, this approach poses practical barriers. The selected risk-adjustment method (APR-DRG/AHRQ) is the most universally used but omits many important variables. To mitigate this in our initial offering, the narrative we provide should explain this explicitly and give references to other data sources
- Future projects should address differences in payer mix, either by including payer mix in the risk adjustment or by examining disparities in the quality of care among payer types.
- When will emerging physiological databases such as Society for Thoracic Surgeons (STS) database be adopted as the standard and replace the hospital administrative data?
- For highly specialized procedures (e.g. pediatric heart surgery), the practitioners should be invited provide input to OHPR on how to frame those indicators
- There are varying degrees of rigor associated with each database. It may be desirable in the future to have “Certified” data that providers can display in addition to the material that is posted on the OHPR site. This may be a reasonable second step to this process.
- Reporting to national or specialized databases can be very costly and time-consuming, so many providers opt not to participate. Washington’s Clinical Outcome Assessment Program (COAP) <http://www.coap.org> has been a valuable tool for collecting data from all cardiac providers. It collects much fewer variables, making it much simpler to fill out and submit the forms. The outcome of this has correlated remarkably well with more sophisticated databases such as the American College of Cardiology database.

Tape 1 Side B

- OHPR display will need to be continually rethought as to risk adjustment methodology, content, and framing commentary. This is the first step in what will be an ongoing process

Recommendations:

- **Commentary framing for indicators:**
 - **Provide links for each indicator to related databases (e.g. Society for Thoracic Surgeons database).**
 - **Provide hospitals with an outline of recommended content for their one page of commentary per indicator on the OHPR Website. Additional content can then be displayed on the hospital’s own Website with a link from one site to the other**
 - **For highly specialized procedures (e.g. pediatric heart surgery), the practitioners should be invited provide input to OHPR on how to**

frame those indicators, including alternative data sources and evolving clinical practices

- The Website will go live on schedule, but hospitals will be allowed to work on their commentary and submit changes through the end of September, and then quarterly.
 - **Preamble:** outlines how this is a first step, a work which will be continually improved upon, that as a society we are working to develop national standards for reporting and that Oregon is on the leading edge. That the public should expect change to the data offered to them as well as to the process used to develop the data. That the purpose is to help patients make informed choices and help providers with quality improvement. That Oregon is the most efficient state in the union in an industry that is very inefficient and that in addition to this, we intend to lead the way in quality improvement as well.
 - Engineer the Website so that visitors are forced to see the preamble and caveats before they can access the data.
- Framing the project for the media:
- OHPR put out press release/ joint press conference with the Oregon Association of Hospitals & Health Systems
 - Bruce Goldberg talk with Don Colburn of the Oregonian for a well-informed story, with workgroup members acting as additional resources to reporters
 - Coordinate with an editorial board

Assignments:

- **Members:** review narrative draft and get comments to Tina by Monday, June 13
- **Tina Edlund:** send hospitals an outline of possible content for their indicator comment page (links to other data sets, etc)
- **Gretchen Morley:** work with OHPR on coordination with the media
- **OHP staff:** find meeting room for next time that allows us to see and navigate the Website as a group

Next Steps:

- Take the data that is up and available, convene providers, and start to work collaboratively on quality improvement (taking care to build trust in the process by establishing rules for communication and sharing)

Adjourn: 4:56p.m.

Handouts:

Agenda & Timeline

Sample Data Display: By indicator (CHF2) and by hospital

Hospital Review Documents, May 23, 2005

Quality and Transparency Work Group Meeting Notes
Oregon Health Policy Commission
August 10, 2005
Metro Building Room 275
600 NE Grand Ave, Portland

Members Present: Jonathan Ater, Vickie Gates, Geoff Brown, Nancy Clarke, Bill Kramer, Michael Leahy, Keith Marton, Doug Walta

Members Excused: Joel Ario, Diana Jones, Gil Munoz, Ron Potts, Ralph Prows

Guests: Betsy Earls (Kaiser), Laura Flammer (Providence Portland Medical Center), Jennifer Pratt (Matrix Assoc), Tim Stumm (Oregon Assoc of Hospitals & Health Systems)

Presenter: Tina Edlund, Office for Oregon Health Policy & Research

Staff: Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 12:40p.m.

I. Hospital Quality Indicator Web posting (Tina Edlund)

- Tina Edlund would like to assemble a subcommittee which will meet over the next year to decide on additional AHRQ indicators to present on the Web site and to craft a consumer-friendly data display. She asks that each workgroup member give her a name (preferably the quality improvement person from their organization) so that the workgroup has good representation across the hospital community
- For future consideration: take a look at the Dartmouth-Hitchcock Medical Center data display

II. Overview of the Oregon Health Care Quality Corporation's common quality measures project (Nancy Clarke)

- Project objective is to encourage high quality care through use of these measures in value-based purchasing programs
- Scope limited initially to out-patient primary care
- Convene stakeholders to establish common quality measures which are consistent, scientifically sound, clinically meaningful, and congruent with existing national efforts
- How these measures are ultimately used by stakeholders is not part of this project

III. Next Steps

Discussion

- The new subcommittee will work with Tina Edlund to
 - ◆ Refine data
 - ◆ Add indicators
 - ◆ Target our audience (statisticians, providers, group purchasers, consumers)
 - ◆ Move toward an interactive Website
- Define 1-year, 3-year, and 5-year milestones
- Focus on public relations/media outreach which will have a considerable education component

Assignments: Workgroup members please volunteer a quality improvement person from within your individual organizations to take part in the Website subcommittee over the next year.

Possible next agenda items:

- Plan outreach around Quality Indicators Website:
 - ◆ Public relations/media
 - ◆ Educating purchasers and consumers
 - ◆ How to convene providers to discuss available data and quality improvement strategies
- Define milestones for measurement

Adjourn: 2:32p.m.

Handouts:

1. Agenda
2. Q-Corp Project Summary - Draft

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**Quality & Transparency Work Group Meeting Notes
Oregon Health Policy Commission
September 14, 2005
Portland State Office Building Room 120B
800 NE Oregon St, Portland, Oregon**

Members Present: Jonathan Ater, Joel Ario, Geoff Brown, Gwen Dayton, Michael Geheb, Bill Kramer, Michael Leahy, John McConnell, Ralph Prows, Glenn Rodriguez, Brett Sheppard, Doug Walta

Members Excused: Vickie Gates, Nancy Clarke, Diana Jones, Keith Marton, Gil Muñoz, Ron Potts, Jason Snider

Guests: David Rosenfeld (Oregon Health Forum), Shelley Bain (Oregon Insurance Division)

Staff: Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)
Tina Edlund, Data & Research Manager, OHPR
Jeanene Smith, Deputy Administrator, OHPR
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 3:11p.m.

I. State Website (Tina Edlund)

A. Web trends report - 2004 Hospital Quality Indicators Website

- hits to the site have leveled off to about 375 per week; average time on the site per user is 2.5-3.5 minutes; most visitors download reports

B. Proposal: health information clearinghouse Website (Exhibit V)

- Connect citizens to a wide range of information on the cost and quality of health care in the state
- Compare providers, health plans, hospitals on quality and cost
- Provide information about being a wise health consumer and how best to manage one's health

Discussion

- Is this an appropriate role for the State? Does the State have enough credibility with the business community to do this effectively?
- The State can be a neutral party if there is a process in place: 1) to make inclusion of content a "level playing field" and 2) for vetting the data that is presented
- This will not be the only site designed as a single point of entry to health care information in Oregon; however, with the workgroup in place to oversee the content and lend the site credibility, it will be a valuable public resource
- Maintaining site content will be the most onerous part of the project; also, as it gains visibility, there will be more and more parties vying to be included
- Subcommittee should be formed to decide on content criteria

II. Setting goals – a 5-year plan (Exhibits 3 and 4)

Discussion Summary

- **Objective:** Every incremental goal we set needs to further the overarching goal of delivery systems improvement; we need to always keep in mind that transparency is a means to the end of improving the system as a whole, thus any

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infrastructure that this effort creates needs to be relevant and useful to the improved/improving system

On Data:

- Billing data vs. clinical data for measuring quality: we should continue publishing administrative data while we work toward clinical data, understanding that implementation of clinical data reporting may make administrative data obsolete.
- 3 kinds of data sets available right now: administrative data set, chart-abstracted data set, and clinical (physiological) data set
- Switch to surgical database? Problem is that the databases that hospitals currently own do not match one another
- *This* group has a lot of influence over which database software providers will buy; several entities purchased 3M's software only because this workgroup is using it.
- We need to move beyond volume measures. There are scientific data sets that have buy-in from practitioners; using this data would lend instant credibility with the provider community and eliminate a lot of resistance to this effort. For example, the American College of Cardiology (ACC) database, the Society of Thoracic Surgeons (STS) database, and the National Surgical Quality Improvement Program (NSQIP) database
- OAHHS has working groups studying electronic data transfer and clinical data collection; Gwen Dayton will connect their efforts, where appropriate, with our own.

Next Steps:

- 1) Web subcommittee will improve the first 12 indicators that are already posted before considering the addition of more Agency for Healthcare Research and Quality (AHRQ) indicators
- 2) Identify areas of emphasis in clinical data
- 3) Find key clinical partners to facilitate broad adoption of data sets (2005 goal)
- 4) Help hospitals identify best practices in the collection of administrative data using the indicators we have currently posted
- 5) Purchasers and pay-for-performance: why doesn't Medicaid take the lead?
- 6) Recommend electronic data-sharing improvements between institutions (some progress can be made even before we reach the age of electronic health records; specifically, test results)
- 7) 2007 legislative session: the timing might be right for a compromise on public reporting of data in which payors and providers contribute the data and the Legislature helps fund purchase of software.
- 8) See 2nd bullet below

III. Outreach

- Site is not ready for consumer outreach
- To purchasers: the Oregon Business Council would like to help employers learn to use quality data for decision-making; the OBC could use a liaison from the workgroup. Perhaps a PowerPoint presentation with a snapshot of what quality data is available now as well as an idea of what data might be available in the future. Purchasers want data that is endorsed by providers.
- OHSU has decided to use NSQIP in future. Michael Geheb offers to contribute funds for getting the data up statewide if the payors and the providers agree to contribute and reconcile their data

Adjourned: 4:50p.m.

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Assignments:

- **Workgroup members:** please let Tina know who from your organization will sit on the Web Subcommittee (ideally your Quality Improvement officer)
- **Ralph Prows and Vickie Gates:** collaborate before the October meeting on a presentation to the workgroup re: Regence's movement toward use of quality measures

Next Meeting: October 12, 2005

Exhibits:

- I. Agenda
- II. August 10 meeting notes draft
- III. 2005-2006 Objectives (from existing work plan)
- IV. Discussion tool: Draft 5-year Plan & Timeline
- V. Sarah Seeking Health Info

DRAFT

**Quality & Transparency Work Group Meeting Notes
Oregon Health Policy Commission
October 12, 2005
827 NE Oregon St, Room 827A, Portland, Oregon**

Members Present: Vickie Gates, Shelley Bain (for Joel Ario), Nancy Clarke, Pam Hedges (for Jason Snider), Diana Jones, Bill Kramer, John McConnell, Ralph Prows, Brett Sheppard

Members Excused: Jonathan Ater, Joel Ario, Geoff Brown, Gwen Dayton, Michael Geheb, Keith Marton, Gil Muñoz, Ron Potts, Glenn Rodriguez

Guests: Zak Ramadan-Jradi, Medical Director, Clinical Performance Measurement, Regence
Beryl Fletcher, Oregon Dental Association
Jennifer Pratt, MatrixAssociates
David Rosenfeld, Oregon Health Forum

Staff: Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)
Tina Edlund, Data & Research Manager, OHPR
Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 3:12p.m.

I. Report on 2005 AHRQ Quality Indicators User Meeting, Maryland (Tina Edlund), Exhibit IV

Discussion

- AHRQ is developing a white paper on lessons learned and on the effects of this data across the states (e.g., improved coding practices)
- Other states employ quality improvement officers to facilitate the use of administrative data for improving administrative processes such as coding; it is noted that Oregon has the Oregon Association of Hospitals & Health Systems and the Oregon Health Care Quality Corporation which could both serve this function for Oregon hospitals and clinics
- Link to AHRQ PowerPoint presentations from the 2005 user meeting:
http://www.qualityindicators.ahrq.gov/usermeeting_presentations_2005.htm

II. Next steps for stage one of hospital quality indicators reporting: Consumers, Other Clinical Databases, & Other Questions Raised

- Tina will get two new subgroups running and she needs more names for the rosters. One group will be made up of providers to tackle the small numbers problem and the consumer-oriented data display, and a second subgroup will consider how to encourage provider agreement on and adoption of common, national databases such as NESQIP and how to address the attendant resource challenges

III. Presentation: Monitoring & Incenting Clinical Quality: Regence's Response to Clinical Indicators (Zak Ramadan-Jradi), Exhibit V

Discussion

- What is the business proposition for the project (return-on-investment)? [Project began as an academic research project. Regence did send letters to providers, giving them a number to call to confer with a registered nurse on using the data to identify areas for improvement in their practices. So far, no providers have made use of this resource.](#)

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- How to prevent overuse of (e.g. PAP smear) in a P4P environment? Right now, the only thing being measured is whether or not a test/procedure has been conducted, not how many times it has been conducted (a provider will get the same score for 1 PAP per biennium as for 4). Outcome is not being measured yet, nor is efficiency of care, so in the short term there is no disincentive for over-utilization. This is something Regence is comfortable with in the initial phases of the project.
- Attribution methodology: Regence is using the team-based medicine approach, based on the individual patient chart (both the referring physician and the specialist receive credit for a given claim.) In comparing providers, Regence compares within specialties (family practitioner to family practitioner, internist to internist.) It is working with the Puget Sound Health Alliance on standardization of attribution methodology across the health care system.
- Normalizing the data: how does Regence treat the data of patients whose membership is not continuous over time and how does the presence or absence of electronic health records affect the claims base? Short of chart audits and outside of a closed system such as Kaiser, we cannot achieve outcome measurement without electronic health records. This was acknowledged at the beginning of the project, and this is why claims data was chosen as a proxy for outcome. Three years is the current minimum period of time at which an electronic health record is recognized to be useful; some providers do have electronic records this long, but most do not.
- Is there a process for alerting a given provider that an indicated test/procedure (e.g. mammogram) is overdue? Right now, to the extent allowed by HIPPA, providers are given a report showing their patient list against the claims data; the program is not currently set up to show providers which patients did not receive recommended screenings, but that is something that can and may be done in a future iteration of the project
- There is no data yet on how providers are using their data to improve their processes or quality of care, and doctors are not engaging yet in any kind of dialogue with Regence around their data
- There is the potential to use this data reporting for disease case management at the local/clinic level. Many providers are still using paper registries; this group may be able to facilitate connecting these providers to electronic disease registries to improve their case management capabilities
- Feelings/attitudes/questions from providers? They ask: why are you doing this reporting? How do you know these numbers are accurate? What can this information be used for and why should we spend time looking at it? Providers say that they are given too much information to read through, so Regence has assembled it in a tiered way that allows providers to choose the level of detail they want. They ask how their clinic compares to a neighboring one. Gastroenterologists have provided feedback on colorectal screening data that led to some adjustments. Providers would like to see outcome vs. process measures and to be more involved in the development process of quality data reporting. Regence is interested in keeping local providers engaged in the process while staying congruent with emerging national standards.
- What reaction has Regence gotten from employers so far? Employers ask “what are quality improvement efforts going to cost me?” “What initiatives can be implemented to ‘move the bar’ on quality?” P4P is one possibility; perhaps, exclude low-performance providers from the plan, etc; for the time being, the purpose of the project is to educate everyone involved about the data, project processes, and the potential for future use and improvements. The project is still too preliminary to talk about concerted quality initiatives.
- The pilot in Oregon, working with the 12 health plans here, is framed as assistance for disease case management, it measures eligibility from a certain coverage date rather than continuous coverage, and emphasizes its use as an alert for needed care. Is Regence’s project at all compatible with this model? Not in its current form; the algorithm would need to be modified, it would require a different attribution method, a rethinking of the eligibility issue, etc. This initial project is only a benchmark for further efforts, not a complete tool for quality initiatives or for disease management.

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- The threshold for a provider to get a report is at least three indicators and a minimum number of Regence members served; rural providers were well represented in this initial effort and emerged as some of the top performers
- Is there an economy of scale for the number of members tracked? The project started with 40 million claim lines and is up to 240 million; Health Benchmark Incorporated (HBI) is contracted to charge per indicator, not per member. Chart audits, however, would add significant cost to the process
- The going rate for this service across the nation with companies similar to HBI is 3 to 6 cents per member per month.
- Does Regence track denied claims as well as accepted claims? It excluded denied claims in the first round of reporting but included them in the most recent round for the obvious reason that regardless of who ends up paying the claim, the health care services were still being provided to the member.

Next Agenda Items

1. Update on Q-Corp project on quality measures for out-patient providers
2. Review of extant quality reporting and P4P efforts in Oregon

Adjourned: 5:06p.m.

Next Meeting: November 9, 2005

Exhibits:

- I. Agenda
- II. September meeting notes DRAFT
- III. Work plan
- IV. AHRQ meeting summary
- V. Regence quality reporting project outline

AHRQ User's Meeting 2005, Summary

Issues/Challenges

Alignment within:

- Hospital Quality Alliance, Ambulatory Quality Alliance and National Quality Forum
- Pay-for-Performance
- Quality Improvement

No gold standard:

- Clinical and administrative and patient experience of care all have strengths and weaknesses
- EHR not a panacea
- Need local data and national benchmarks

AHRQ Initiatives

- National tracking and benchmarks
- Local experience of care (Consumer Assessment of Health Plans Survey (CAHPS) and the Hospital Consumer Assessment of Health Plans Survey (HCAHPS))
- Measuring culture of safety
- Physician measures (Ambulatory Quality Alliance)
- Hospital quality & safety (Inpatient Quality Indicators, Patient Safety Indicators)
 - Introducing Pediatric Module in Dec/Jan
 - What else?
 - Women's health measures?
 - Readmissions?
 - Emergency Department quality?
- Potentially avoidable admissions (Prevention Quality Indicators)

AHRQ Vision

- Develop, maintain and evolve measures
- Strengthen administrative data at federal, state and local levels
 - Enhance administrative data by linking to contextual factors (hospital characteristics, socioeconomic status, "Do not resuscitate" orders, present on admission)
 - Add clinical elements, connect to electronic health records
- Create tools to facilitate use
 - Develop reporting template (Shoshanna Sofear)
- Bring change through strategies and partnerships

On the horizon: identify, categorize and evaluate health care efficiency measures (literature review, create typology for measures, develop criteria: 1-year timeline)



Clinical Performance Measurement

Quality & Transparency Committee - Oregon Health Policy Commission

October 12, 2005

Zak Ramadan-Jradi, MD, MBA

Clinical Performance Measurement



The Problem

The Health Care Industry is Plagued by a “Value Deficit”:

2001: Institute of Medicine report

“An urgent call for fundamental change to close the quality gap”

2003: RAND study

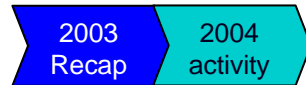
“This study provides the best estimates ever available about the quality of care in the United States. Overall, participants in the study received 55 percent of recommended care.”

2005: IOM + RAND + Increasing Medical Costs

*Continued lackluster value for employees and their dependents
Frustrated purchasers*



Clinical Process Quality Measurement



The Journey

- Employer driven
- Why a vendor
- Commitment to provider collaboration



Vendor Background: Health Benchmarks, Inc.

- Over 100 evidence-based indicators across multiple specialty areas.
- Indicators are derived algorithmically from claim & administrative data.

Sample Indicators

- ACE inhibitor use in heart failure
- *HbA1c* testing for diabetics
- Asthma controller medication use
- Creatinine check for new *NSAID* use

Sample Specialties

- Cardiology
- Endocrinology
- Allergy/Immunology
- Oncology/Hematology



2005 &
beyond

AQA - NQF - HBI

AQA Measure	AQA Description	Regence 2005	Other Recommending Organizations	NQF Measure	NQF Description
Heart Failure					
11. ACE Inhibitor /ARB Therapy	Percentage of patients with heart failure who also have LVSD who were prescribed ACE inhibitor or ARB therapy.	ok	NQF, AMA PCPI, ACC, AHA	30 - ace HF: ACEI/ARB Therapy	Percentage of patients with heart failure who also have LVSD who were prescribed ACE inhibitor or ARB therapy



Clinical Process Quality Measurement

Lessons learned

- Volume needed for a meaningful measure
- Standardized attribution methodology
- Claim data coding and billing issues
- Measures needed for proceduralists



Reframing the Relationship

- Statistically-valid baseline measurement
- Intensive clinician education and communication programs
- Establish credibility for data-driven collaboration
- Raising the Bar improves health outcomes and lowers cost
- Foundation work must be done first



Questions

Quality & Transparency Work Group Meeting Notes
Oregon Health Policy Commission
November 21, 2005
800 NE Oregon St, Room 120, Portland, Oregon

Members Present: Jonathan Ater, Vickie Gates, Shelley Bain (for Joel Ario), Geoff Brown, Nancy Clarke, Gwen Dayton, Lisa Krois, Bill Kramer, Ron Potts, Ralph Prows, Brett Sheppard, Margaret Wiseman

Members Excused: Joel Ario, Michael Geheb, Keith Marton, John McConnell, Gil Muñoz, Glenn Rodriguez

Guests: Ian Tim, health services consultant

Staff: Hanten Day, Research Analyst, Office for Oregon Health Policy & Research (OHPR)
Tina Edlund, Data & Research Manager, OHPR
Gretchen Morley, Director, Oregon Health Policy Commission
Jessica van Diepen, Assistant, Oregon Health Policy Commission

Call to order: 3:15p.m.

I. Update from Clinical Databases Subcommittee: Review of the National Surgical Quality Improvement Project (NSQIP) – Hanten Day

Discussion

- Additions for the subcommittee roster: Ralph Prows, Margaret Wise, a representative from the Veterans' Administration for the subcommittee (as the VA has a great deal of experience with NSQIP), a representative from OMPRO. Revised roster will be distributed to the workgroup.
- Would the American College of Surgeons be willing to cut a deal in order to have broader representation in Oregon? No small or even medium-sized hospital would be able to afford to allocate this level of resources to participate in NSQIP
- Charge to the subcommittee: address how NSQIP aligns with CMS, JCAHO, and the Surgical Infection Prevention (SIP) and Surgical Care Improvement Project (SCIP) measures. What vehicle might be appropriate in Oregon for putting this together?
- The subcommittee will report back at the workgroup's January meeting.

II. Presentation: Oregon Association of Hospitals & Health Systems' new quality website and state-wide survey results on utilization of clinical databases for quality measurement (Gwen Dayton)

- A. New quality data website**
- B. Clinical Databases Utilization Survey**

III. Update: Oregon Health Care Quality Corporation's Primary Care Quality Measures Project (Nancy Clarke)

- Physician leader interviews are underway; initial findings suggest that there is widely divergent knowledge and receptivity to the idea
- An Expert Committee has been assembled to develop a draft set of principles and measures for broad circulation; there will be numerous opportunities for clinician input.

Discussion

- Administrative data and clinical data measure different things; both have value, and we need to find a way to reach consensus on a common clinical database and reporting methodology
- It is problematic to choose measures without knowing how they will be used
- What can be learned from the ARC process for assessing infrastructure?

IV. Next Steps

- December 14 workgroup meeting is cancelled
- Possible January agenda item: Discussion with the Oregon Business Council and the Oregon Purchasers' Coalition about what kind of health care information they are interested in seeing in the future
- Staff will poll the workgroup members again to try and find a better regular meeting date for 2006.

Adjourned: 4:45p.m.

Possible Next Agenda Items

- 1. Tentative: Oregon Health Care Purchaser's Coalition (Barbara Prowe) and the Oregon Business Council (Bill Kramer)**
- 2. Review of extant quality reporting and P4P efforts in Oregon**

Next Meeting: January 9, 2006

Exhibits:

- I. Agenda**
- II. October meeting notes DRAFT**
- III. Spreadsheet: Utilization of quality-measures databases**
- IV. Q Corp Project Summary**