

NAHDO QUALITY REPORTING WORKGROUP

August 16, 2007 Workgroup Call minutes

The list of participants:

Name:

Organization or Location:

- Gulzar H. Shah	Director of Research, NAHDO
- Denise Love	Executive Director of Research, NAHDO
- Binitha Kunnel	Oklahoma
- John Bott –	The Alliance (Wisconsin)
- Keely Cofrin	Utah Department of Health
- Ed Walsh	Arizona DOH
- Mike Martin,	Utah Department of Health
- Charles Wentzel	PHC4
- Connie Roland	PHC4
- Mike Burni	PHC4
- Nancy Linn	New Jersey DOH and Human Services
- Tracy Sigurd	
- Susan Schow	Maine
- Bruce Burns	Texas Healthcare Information Collection, Austin, TX
- Dan Lima and Others	Washington State DOH
- Sean Kolmer,	Oregon DOH
- Michael Pine	Michael Pine and Associates
- Pat Merryweather	Illinois Hospital Association
- Pat Jones	Vermont Department of BISHCA

(18 calls lines were used)

PAT Congratulated Denise for election to the NQF. Denise asked participants to send their stories about the benefit of having the state involvement in consumer. Denise has been a constructive critic of NQF for not having representation of states. Denise is the vice chair of the one of the NQF Work Groups-- Public / Community Health Agencies Council.

Utah's New Consumer Report: "2007 Utah Facility Comparison Report on Gallbladder Removal for Adult Inpatients and Outpatients":

In August, 2007, Utah's Office of Healthcare Statistics (OHCS) released their new consumer report. Mike Martin and staff from the Utah Office of Health Care Statistics presented the highlights of this report titled "2007 Utah Facility Comparison Report on Gallbladder Removal for Adult Inpatients and Outpatients.

Mike mentioned that the report was available on their website at:

<http://health.utah.gov/myhealthcare/> ; media link: http://www.sltrib.com/news/ci_6532916

Keely Cofrin has assumed the Director of the Healthcare Statistics, replacing Wu Xu.

Mike first discussed the management process of these reports: OHCS has an advisory committee to guide the development of these consumer reports.

Why gal bladder?

After meeting with state QI; last year for topics; gal bladder removal was selected because it is high volume, and requires outpatient data. OHCS used the outpatient data; The statistics on this indicator will be relevant to decision making.

Measures selected:

For this report, 4 measures were selected -- 3 on facility charges, one on utilization. Measures for average facility charge are All Patient Refined Diagnosis Related Groups (APR-DRGs) for similar, though not identical, kinds of gallbladder procedures in this report's quality of care section. This report shows average facility charge for minor and moderate severity of illness levels combined and average facility charge for major and extreme severity of illness levels combined. APR-DRGs and severity of illness levels apply to inpatients but not to outpatients.

To define the main measure of the report, AHRQ's IQI Definition was used. AHRQ IQI 23 Laparoscopic Cholecystectomy, includes ICD-9-CM procedure code 51.23 (laparoscopic gallbladder removal) and ICD-9-CM procedure code 51.22 (gallbladder removal or open gallbladder removal) on inpatients with uncomplicated cholecystitis (inflammation of the gallbladder) and/or cholelithiasis (gallstones)

Originally IQI 23 stated that a higher rate of laproscopic procedures was desirable. Surgeons were opposed to reporting lap open procedures, so did not report this but instead reported a different measure.

Exclusions: the high outlier cases for both charge and length of stay are excluded from calculation of facility inpatient average charges

How did Utah Compare with the Nation: Utah overall had a higher rate (82.5%) than similar adult inpatients nationwide (75.1%). Utah overall means all Utah facilities combined.

The OHCD received positive feedback on this report. Some media attention was also noted.

Lesson learned:

1. For this kind of topics where procedures are frequently performed in the outpatient setting, one must use outpatient data;
2. Have a physician review your report before release, when topics with clinical relevance are addressed.

3. Do your research: know what gall bladder removal is and what research shows about it?
4. Mike was given a suggestion by a national level reporter to that reporting volume by surgeon will be very useful – we don't need to name the surgeons

Oregon's Consumer Website

Sean Kolmer, OHPR Research and Data Manager was the next presenter who shared highlights from this new web site presentation.

The Office of Oregon Health Policy and Research's new website, was made public August 2, and publishes the payments for selected health care conditions or procedures in Oregon's acute-care hospitals during 2005:

<https://oregon.gov/DAS/OHPPR/comparehospitalcosts.shtml>

The data were provided to the state by commercial health insurance carriers with earned premiums in excess of \$50 million in Oregon. The media report links are available through iHealthbeat article summary:

<http://www.ihealthbeat.org/articles/2007/8/3/Oregon-Launches-Hospital-Price-Comparison-Web-Site.aspx>

OHPR, in combination with Insurance division of Oregon, reported payment data for the inpatient claims – had 50 million dollar worth of claims

There are 82 procedures and conditions they are reporting on – they were considered. A Technical Workgroups was formed which helped decide on various issues related to report. The OHPR staff had meeting with insurance carriers and the hospital association. The report was shared with them and their feedback was accommodated before going live and public on Aug. 02, 2007.

The unique feature of this report is that the report used a much desirable cost measure “actual payment” rather than just charges.

The response has been positive; press has picked up on the report, clearly understanding the limitations of the data being presented. They are excited about feedback they are getting. One of the lessons learned is that transparent healthcare system will benefit consumers. The Hospital Association have been very supportive of the process

Denise mentioned about the NAHDO's map of state reports; asked for help in updating...

Discussion and questions:

Q: Mike Burni in PHC4: How do you know that insurers were appreciative? What was the source of feedback?

A: They drove the whole thing. The data came from them, not from hospitals. They were the ones who gave the data.

Q: Do you know the process of pairing of the data between hospitals and insurers?

A: Hospitals received the aggregated claim data from insurers. Hospital did not see individual level insurer data.

Q: 97% of hospitals are as expected in quality. Have you thought of how to increase variation in quality?

A: We are looking for ways and talking about other indicators...

Q: Does high volume means high cost or the other way around?

A: John Bott: The Alliance reports quality and cost; we rank first by quality and for ties, we then rank by cost; This is not public but mock up of the report is available to public for look up.

Q: Charles Wintzel : for small number as low as 2 you are computing volume and cost? But some people say up to 15:

A: Small number was a concern but 2 was a number every one agreed upon. The group started with 5 and moved down to 2.

CMS Payment Policies---an update: Pat Merryweather

Pat Merryweather updated the workgroup on the latest CMS policies that have significant implications for data, documentation, coding, and payments---and for health data organizations that collect and use hospital discharge data.

Pat mentioned that the final Medicare rules were leased a week ago. They focused on the reserve amount.

Pat mentioned that CMS had proposed use of MS-DRGs after the POA is collected. They were unsure about the impact of the implementation of the MS-DRG. The newly proposed MS-DRG system requires implementation of POA codes, and its adoption will be very resource intensive. There is flurry of concerns about 3M system. Medicare created their own system : they are expanding from ??? 3M APRDRGs to 745 MSDRGs. Uses three tier approach; it will change the grouping of services. This will be a significant change for anyone using the DRGs.

Another change is POA will Oct. 01 , 2007. Apr. 2008 will start rejecting claims if not on claims. POA variable is not specified in current HIPAA, there is work around it in K-3 segment. Oct. 01, 2008, CMS will start reducing payments. Everyone anticipating two areas. Wrong Surgery: CMS does not want to pay for it. Three serious preventable events. Eventually, 8 areas are targeted

MRSA: hospital lose money on MRSA cases, MRSA is in the V-CODE listing not in the other ICD-9. So you are anywhere from 8-13 conditions that will be added Oct. 08. The approach they are taking may not result in reduction in payment; but remains to be seen. Oct 01 2008 will also mark the value-based purchase program by CMS. Additionally, Hospital Quality Alliance will come up with the outpatient measurements rules. 5 Heart attack patient measures for stabilization and transfer – but no specification of these measures yet. This will use CPT2 coding.

The current CMS measures are on processes but not on quality measures. CMS is opening a possibility of use of administrative data by proposing the kind of measures they are proposing.

Q: Drs are not doing very well with CPT1 ? How would they fair with CPT2 ?

A: There was a pilot project on physicians by CMS. The results of this will be available in March.

Rap-up:

Denise encouraged participants to attend the Oct 18-19, 2007 NAHDO Annual Conference in San Diego. She also discussed the roundtable session at NAHDO MTG:

Readmissions by Wu

Implementation Issue at the request of Mississippi

Data linking session by Gulzar Shah

Nest call Sept. 20