

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
- Adrian Henderson	AHCA, Florida
- Sara Sheppard	AHCA, Florida
- Teresa Henna	Mississippi
- Charles Wentzel	PHC4
- Ed Walsh	Arizona DOH
- Bruce Burns	Texas Healthcare Information Collection, Austin, TX

Denise Love welcomed the participants and stated the purpose of the call. She mentioned that the National Physicist Coalition wants help to find out from states doing quality reporting, what are some of the facilitators and barriers of hospital data collection, editing/improvement and reporting.

Accordingly, NHADO would like to have the following questions answered:

1. What specific actions do you think states need to take to improve the effectiveness of data collection and disclosure activities?
2. What, if anything, can consumer and purchaser organizations do to support your efforts to improve the effectiveness of state collection and disclosure activities?
3. What are facilitators of state quality reporting and reports? Inhibitors?

Facilitators:

Advisory Board: Having an advisory Board plays an important role in facilitating data collection and reporting. The board ought to be influential in the community, representing all classes of stakeholders, including data stewards, consumers, purchaser coalitions and business community. Florida AHCA had an advisory board. The board was really helpful in providing guidance in all aspects. For instance they help decide how the performance data will be displayed, what methodology will be used to assess performance, where to look for other data improvement efforts like tracking hospital readmissions. Previously, hospital readmissions were tracked for all discharges. FL is now working with 3M to refine that. 3M will tell us how to make it condition-specific?

Pennsylvania Hospital Cost Containment Council (PHC4) gets a great support from their advisory board as well. A 1/3rd of the board members are hospitals; 1/3rd consumers, and the remaining 1/3rd purchasers.

How do you keep them engaged in the beginning years? First few years is collection and analysis without having any reporting, so that time is crucial. Show the other states's reports saying what other states are doing to Mississippi

Work closely with hospitals: Hospitals are the original owners of the data and have a lot to do with data quality. Hospitals are an important stakeholder in the process, and they can provide important feedback on methodology. Getting their buy-in on the methodology would also mean less resistance from them on public reporting. They are looking at the methodology for readmissions. FL has had the support of consumers and purchasers. It has helped definitely. Hospitals in Florida use standard ways of submitting their data, which is web-based submission currently. Previously they used to send it on the disk.

Q: Do you (FL) have online reporting?

A: Yes it is web-based

Having support from the right champion(s): Finding a champion or a group of champions across each category of the stakeholders is often a crucial facilitator. For example, in Texas, a major stake holder from the business community has been a facilitator in fighting back the push back from facilities. It has been a big plus because they can petition the legislators; whereas Government agencies are prohibited from lobbying the political leaders.

Get a head start on Federal Regulations—e.g. POA: CMS's requirement to report present on Admission (POA) is to be implemented by Oct 2008. It would be helpful to plan ahead to make preparations so that Feds' deadline is met. AHCA is working on collection of present on admission in the quarter-2 data of 2007. This head start will help assure the proper "reaction-time" is allowed to all involved. Initially data are not likely to be perfect; it will take some time before the data accuracy is close to perfect. Present on admission will help us assess quality of care. One of the reason for setting an earlier deadline for POA and requesting it before the Fed's (CMS) requirement, is that we do not put undue hardship on the facility.

Cross the threshold of resistance: In the initial stages of public reporting, the state agencies may have to face several inhibitors/blockages. Not giving up at this stage and being successful in promoting the value of data reporting among the stakeholders, can be a great facilitator for subsequent reporting efforts. The more valuable info you produce, people want more of it, creating snowball effect.

Inhibitors:

Industry push-back:

Lack of funding: Reporting may not be possible if the state agency maintaining hospital discharge data lacks resources. E.g., Arizona had 3 people working on discharge data. Resources are extremely stretched given the staff's involvement in other data tasks. This office has asked administration for an additional position, every year this request gets turned down. This year it looked good but did not finally go through? If an additional person was available to help with the reporting, they may have done a lot more reporting than their current level.

Complicated Methodology/Politically incorrect Data display formats: The data design display should make sense to the consumer. The methodology should be sound but it should not be too complicated, it should not be complicated beyond consumers' understanding and regardless of its sophistication, it should still make sense to consumers. All aspects of the methodology should make sense to the users of the report -- how risk adjustments were performed; what is proper way of querying, proper interpretation, and proper readable/comprehensible displaying. The reports should also contain proper disclaimers.

Local politics: Local politics can be a big inhibitor. On the other hand, favorable local politics can boost up the data improvement and reporting efforts. All states that do public reporting, there are always some galvanizing events locally that bring people together to get them to report.

Perception of Value and Demand for Information: How great the demand is, is another factor. If the stakeholders are not aware of the value of the information, because such value has not been promoted, there can be a great demand to shift resources to another competing priority.

Timeliness of the Data: Data timeliness continues to be an issue. While most agencies are behind by a couple years on data collection, real time data have greater relevance and value. For example, like most other states, in Arizona, the data collection, validation and update is a long process. It takes then 9 months between data collection and getting the reports out. They have to send reports back and forth, for allowing hospitals to check them and verify then. Hospitals often submit un-edited data and use state agency as their cleansing system. In Florida as well, they have the same system of verification, and edits. There are regulations in place about allowing hospitals time to edit. In addition, it is a training issue in FL?

Training hospitals and building their capacity for data cleaning can help. FL is putting together guides regarding what should they submit to the State agency. It would spell out things they need to do to facilitate their faster data submissions.

Additional audits by state are very helpful in data cleaning. For instance one of the hospitals had valid codes but because of the wrong mapping, they were incorrect codes. Arizona is working with 3M for severity adjustment. Their licensing allows use on only historic data. The data has to be at least 5 months old before the adjustment can be processed.

Resources at Hospitals: Providers perform so many multiple duties, they have a high turnover. Hospital has to have someone trained in data and the value of data. State agencies can help by providing useful feedback to the hospitals and other providers. If they send good data (under 5% error rate), as an incentive, we send them market share report.

Data Cost: States have to charge a certain amount in data sales, and price it accordingly to keep them going. That is for public as well as research data. Some stakeholders such as purchasers may not want to pay the data price. The prices of hospital discharge data vary dramatically across states. Florida reduced their price from \$600 to \$100 this year. With healthcare transparency and allow equal access, the price was reduced. The customers are loving it. The volume is still same but it will go up after the word is out. In contrast, Pennsylvania data are expensive -- \$9,000 for non-profit; \$33,000 commercial

Denise reminded about the NAHDO conference and thanked all.