Cabinet for Health and Family Services
Secretary's Advisory Committee on Health Care Transparency

Thursday, January 11, 2007
1 – 3 p.m.
Salato Wildlife Center
Frankfort, Kentucky

AGENDA

I. Welcome

II. Business Items

   a. Roll Call
   b. Approval of Minutes [1]

III. Data Advisory Subcommittee Report

IV. Overview and Presentation of Test Website

V. Review of Additional Implementation Items

   a. Prevention Quality Indicators
   b. Hospital Charge Data

VI. Next Steps

   a. Review of Action Items
   b. Date of Next Meeting

SECRETARY'S ADVISORY COMMITTEE ON HEALTHCARE TRANSPARENCY MEETING
October 6, 2006
1:00 p.m.

MEMBERS PRESENT:

Chris Corbin Office of Health Policy	Paige Franklin KY Hospital Association	William Hacker, MD, Department for Public Health
John Lewis, MD Health Care Excel	Dustin Miller Kentucky Association of Health Plans	Pat Padgett Kentucky Medical Association
Ben Yandell Norton Healthcare	Jan Howell (on behalf of Glenn Jennings) Department for Medicaid Services	

MEMBERS ABSENT:

Larry Bone Four Rivers Health Care Purchasing Alliance	John Burt, EdD Department for Mental Health and Mental Retardation	Victor Cooper, DC Cooper Chiropractic Center
Tom Granatir Humana, Inc.	Frank Jemley Atticus Ventures, LLC	Glenn Jennings Department of Medicaid Services
Bill Tatum Angell-Denham	Marty White Kentucky Medical Association	

STAFF: Cabinet for Health and Family Services, Office of Health Policy
Mark Fazey, Sheena Lewis, Trudi Matthews, Tricia Okeson, Beth Sanderson

Office of Information Technology
Upendar Tulluru

GUESTS: Brennan O'Banion, Department for Public Health
Peter Fairhurst, Kentucky.gov
Bryan Sunderland, Kentucky Chamber of Commerce
Tom Shwab

CALL TO ORDER

Chris Corbin called the meeting to order at the Salato Wildlife Center.

WELCOME AND OPENING REMARKS

Chris introduced Peter Fairhurst, Upendar Tulluru, and Tom Shwab. Peter Fairhurst works with Kentucky Interactive, an organization that contracts with Kentucky to develop and maintain our websites. We have

enlisted the assistance of Kentucky.gov and Peter to work on this project specifically for the Cabinet. Upendar, from the Cabinet's Office of Technology, restructures data extracted from the hospital claims database to allow web-accessible cost, quality, and outcome comparisons among hospitals and with state averages. Tom Shwab works with Chairman Tom Burch of the House Health and Welfare Committee.

APPROVAL OF MINUTES

Minutes from the meeting of March 28, 2006 were approved without change.

DATA ADVISORY SUBCOMMITTEE REPORT

Tricia Okeson provided an update on the Data Advisory Subcommittee. Evolution of data submission from UB 92 to the 837 format was discussed during the August 3 meeting. The next meeting of the Subcommittee is scheduled for Thursday, November 2, 1:30-4:00 PM.

LEGISLATIVE UPDATE

Since the March 28 meeting, Transparency legislation placed in the budget bill, HB 380, has provided the structure and direction as a Cabinet to incorporate some of the ideas presented to and by this committee into information to communicate to the general public. The downside of placing the requirements in a budget bill is that the language expires with the budget. It is important to pursue legislation to make this permanent and maintain the momentum necessary to make the available information accessible and understandable to the overall public. There is still a great deal of flexibility in place in HB 380 that doesn't necessarily limit our ability to communicate this information, but it places more structure around the importance of providing information by relating to accepted standards.

On August 22, President Bush signed an Executive Order promoting and highlighting the importance of Health Care Transparency. Chris referred to the handout distributed prior to the meeting titled ***Better Care, Lower Costs***. Secretary Leavitt highlights four cornerstones of value-based health care: Quality Standards, Price Standards, an Interoperable Health System, and Properly Placed Incentives. Promoting and publicizing quality and price standards through health data transparency are major goals of this committee.

Chris stated that another important issue that has not been included in what we have discussed here but based upon the data that we have is the insurer pays and patient pays section. Chairman Burch has contacted the Kentucky Hospital Association, Kentucky Chamber of Commerce, and the Kentucky Medical Association, to inquire as to whether there are there are best practices out there from other states

in order to communicate an accurate out of pocket cost to a consumer. Currently, there are no standards in place at a state level to make that information available to consumers.

OVERVIEW OF WEBSITE PROTOTYPE

Chris introduced the website prototype that has been created by Kentucky.gov. He asked the committee for this opportunity to solicit their feedback. There will be a homepage associated with the website that explains the importance of consumer access to health care information and emphasizes why cost, quality, and outcome information are important to a consumer. The information also needs to be placed in a prominent place where a consumer can find it. The second page will be the "search" page, where the user will have the ability to go in and look at information related to a hospital or facility, information related to a procedure, or they could search on information related to a particular quality indicator. Chris stressed that the state will be using the same quality indicators as Kentucky Hospital Association and Norton Healthcare use on their websites. By following the Hospital and Facility Search link, the user would be able to select a hospital from a drop-down list or select a hospital by city, county, or zip code. This takes the user to a hospital or facility profile page which provides the facility name, address, phone number, county, website address, total number of beds, and the total number of hospitalizations. Chris stated that the dates that the number of hospitalizations is captured would be noted and the same timeframe will be maintained for all facilities. Ultimately, a picture of each facility will be included on the site, as well. Procedure information listed on the page will consist of the 25 leading procedures performed at that facility from January 2005 – December 2005.

Procedure Information

The following procedures listed only consist of the leading 25 procedures performed at this facility from **January 2005 - January 2006**.

Procedure	Number of Procedures Performed	Median Age	Median Length of Stay	State Median Length of Stay	Median Charge	State Median Charge
Gastroenterostomy NEC	too few cases	too few cases	too few cases	4 days	too few cases	$12,450
Total Hip Replacement	23	56	4 days	3.5 days	$28,639	$29,500
Total Knee Replacement	41	51	3.5 days	3.5 days	$24,683	$24,200
Vaginal Hysterectomy NEC	29	53	3 days	4 days	$25,125	$28,730

***NOTE THAT THE DATA DISPLAYED IN THIS TABLE IS NOT REAL DATA.**

For example, to get an estimate of the overall comparative information related to a total knee replacement performed at University of Kentucky versus other area hospitals, click the total knee replacement link.

Search Results

The following hospitals or facilities perform the procedure, "**Total Knee Replacement**". Select the name of the hospital or facility to view additional provider detail.

	Hospital / Facility Name	City	Number of Procedures Performed	Median Age	Median Length of Stay	Median Charge
☐ Check to compare	**Statewide Average Statistics**	**N/A**	**22**	**50**	**3.2 days**	**$23,120**
☐ Check to compare		Lexington	33	52	3.5 days	$26,285
☐ Check to compare		Lexington	29	53	3 days	$25,125
☐ Check to compare		Lexington	too few cases	too few cases	too few cases	too few cases
☐ Check to compare		Lexington	41	51	3.5 days	$24,683
Compare - Choose at least two facilities to compare.						

***NOTE THAT THE DATA DISPLAYED IN THIS TABLE IS NOT REAL DATA.**

Ben Yandell asked if the procedures being pulled were principal procedures. Mark stated that he had chosen in this case to use elective surgeries. Ben voiced his concern that we should be careful because the principal procedure might not be the only procedure that the patient had performed.

Several interesting ~~were~~ comments were received:

- Ben Yandell suggested focusing on the way that procedure codes are being incorporated, specifically the primary diagnosis and the relationship between that and the DRG.
- Dustin Miller suggested providing a better explanation of a state median charge to consumers.
- The importance of a glossary was stressed.
- Change date from January 2005 – January 2006 to January 2005 – December 2005.
- Paige Franklin suggested making it clear that these are elective procedures.

Chris stated that the Data Advisory Subcommittee had discussed including a link to a specific area related to indigent care and hospital specific payment procedures, our preference would be to include a link to the hospital so we are not responsible for maintaining it.

Quality Indicator Information

The following quality measures were recorded for this facility from **January 2005 - January 2006**.

Quality Indicator	Quality Measure	State Quality Measure Average	Comparison Analysis
Acute myocardial infarction (AMI) mortality	.08	.15	Performs above state average
Hip replacement mortality	.03	.01	Performs below state average
Congestive heart failure (CHF) mortality	.01	.05	Performs above state average
Stroke mortality	.23	.35	Performs above state average
Vaginal birth after cesarean section (VBAC), Uncomplicated	.95	.95	Performs at state average

***NOTE THAT THE DATA DISPLAYED IN THIS TABLE IS NOT REAL DATA.**

On the Quality Indicator Information Section, Dr. John Lewis suggested using "better than" or "worse than" the state average as opposed to the words above or below. Ben stated that Norton's website uses the words "better than" or "worse than". He said that he would like to see something more significant than above and below.

Bryan Sunderland suggested adding a graph or a sliding graph to demonstrate how much above or below average the facility ranks. This would show how noticeable the difference is.

Ben suggested using percentages rather than decimals.

Dr. John Lewis suggested the following change in the introductory wording for the Quality Indicator Information Section "The following risk adjusted quality measures were . . . "

When the user has chosen the acute myocardial infarction (AMI) mortality quality indicator link, the screen brings up all of the search results for all of the organizations that have cases of acute MI. The quality measure, the comparative information and the analysis are similar to the previous page. As we make changes to the previous pages, they will also be incorporated to these pages as well. Paige asked if

we had thought about putting the national average out there, as well. Chris stated that he was more interested in comparing hospitals within the state against their peers. Ben said that though it is just another number it would provide a reference point to show how Kentucky hospitals stack up against other US hospitals.

Bryan Sunderland again mentioned a sliding scale when comparing hospitals. Chris agreed that as much graphical information as possible should be provided to the user.

Chris returned to the main page to the procedure search link. The user would be able to select a procedure from a drop down list and then filter the results based on city, county, or zip code. The link will bring up the same search results shown before with the facility, state average, median age, median LOS, and the median charge. The comments mentioned previously could be incorporated on this page. Dr. Lewis asked if it was going to be possible to determine which physicians performed the procedures. Chris told him that would not be possible.

The last category is the quality indicator section. The site allows the user to search the 30+ inpatient quality indicators that are on the site, filter those indicators by city, county, or zip code and have the same layout as previous pages.

Chris wanted to mention some of the other things being worked on in the prevention quality indicator area. These are a set of indicators that compare the care within a geographic region based upon the reasons people are admitted to the hospital. If there are complications associated with diabetes, it is not the hospital's fault the patient was admitted for diabetes but traces back to the level of care provided by the community or the personal responsibility of the individual to get the appropriate diabetes chronic condition care. While working on prevention quality indicators, we are talking about incorporating our geographic regions into "super ADD districts". There will be a central Kentucky region, Louisville region, western Kentucky region, south-central Bowling Green region, southeastern, and northeastern Kentucky, where the care is centralized and can be compared to other areas. The other category of indicators related to patient safety and further discussion with the Data Advisory Subcommittee about the appropriateness about some of those indicators would be appreciated. A limited number of those would be fair to be used as indicators to determine patient safety but not all of them.

Chris mentioned to the committee the possibility of taking the data and looking back historically to see the changes in quality, charge, or LOS, by facility, and, at the same time, carving that up into other pieces to see if there is a relationship between the Payor of service, quality, and charges vs. the statewide

aggregated data. We have the ability to slice and dice COMPData to Medicaid, Medicare, to commercial insurance, and the other category.

Ben referred to the KHA website and how a private link was sent to members in order for them to view the site before it went live. The site was updated on a daily basis and will be going live soon. Ben encouraged Chris to use this method with the transparency website.

Ben observed that one of the things discussed by the committee early on was cost; however, there has been no resolution as to how we are going to get that out to people. The problem is our ability to drill down into the data is rightfully difficult if not illegal. There is no easy answer without legislative intervention. The alternative would be that the providers share some of the basic discount information that they would feel comfortable with on a volunteer basis.

REVIEW OF TIMELINE

The website should be up and running sometime in November. Chris will make the revised version of the prototype available to both the committee and Data Advisory Subcommittee through a link or a hard copy before it goes live.

NEXT STEPS

The next meeting date is proposed for Friday, January 11, 2007.

ADJOURNMENT

The meeting was adjourned at 2:37 p.m.