

December 1, 2006

**Mr. Steven Michaud, President
Maine Hospital Association
33 Fuller Road
Augusta, ME. 04330**

Dear Mr. Michaud,

Thank you for your November 13, 2006 correspondence which outlines your concerns on behalf of all Maine Hospitals regarding the Maine Quality Forum's use of hospital quality reports created from administrative data. I would like to start with a general statement about administrative data. Later in the letter I will address your specific concerns.

Maine has been a recognized leader in maintaining administrative databases such as Hospital Discharge database and the All Payer/Paid Claim database. In addition, as you know, Maine has joined New York and California in a leadership position of requiring a present on admission indicator which greatly improves the meaning of codes for co-existing conditions and complications. The Maine Quality Forum and the Maine Hospital Association share the same goal of maximizing the accuracy of administrative database describing healthcare services as a means to our shared goals of improved quality, safety and access. Furthermore, as reimbursement moves from fee for service payment without regard to quality or risk, to payment for volume, quality and assumed risk; it is extremely important that each provider submit as accurate a claim for payment as possible

In your letter you raised questions about our use of screening metrics developed by the Agency for Healthcare Quality and Research and released to the states for the very use we have undertaken. MQF has generated these Patient Safety Indicators (PSI) and Inpatient Quality Indicators (IQI) using AHRQ provided software and methodology. We reviewed the draft reports with the Maine Quality Forum Advisory Council. We then provided the 2004 metrics to Maine hospitals so that they could validate their own data. Many Maine hospitals invested significant energy in this process. One result of the hospitals' investment was improving their own coding quality assessment as well as their own appreciation of their relative performance on these screening metrics to their peers.

As we have analyzed these databases with various algorithms we have encountered coding aberrations. Our practice has been to bring those aberrations to the attention of those responsible. We point out that we are

not coders but simply presenting information that an institution appears to be coding in a unique fashion. It then becomes the obligation of the institution to decide if their coding is accurate.

You raise the issue of the specific Patient Safety Indicator (PSI) #2 entitled “Death in low mortality DRGs”. This is a PSI that is unique in that it is considered a sentinel event PSI. When we reviewed the 2004 data we did identify one institution that was different from all others. We did send a letter to the Department of Health and Human Services that stated

“as we work through data analyses we occasionally recognize aberrations of data that raise the possibility of a quality problem. In this situation we feel the issue is best examined by your division. The enclosures describe death in low mortality DRGs for 2004 derived using AHRQ methodology. These results are not appropriate for public reporting. The results however suggest the need for further examination. The hospital, given my understanding of its service profile, may represent itself this way due to the age of its patients.”

In summary we found an aberration in the data and that was ultimately found to be a hospital problem of miscoding. The hospital’s coding system has now been improved to everyone’s benefit.

Furthermore you point out that the Northeast Healthcare Quality Foundation suggested that we had improperly followed AHRQ instructions in analyzing PSI 2 and presenting the data. I reassure that we did nothing improper. The AHRQ suggestion of partitioning the data by DRGs or in effect looking across patients who shared a major diagnosis was intended to facilitate identifying that portion of the system that failed. Jeff Geppert, speaking for AHRQ stated *“earlier versions of the AHRQ QI software used to report the Death in Low Mortality DRG observed rate stratified by DRG type (e.g., medical, surgical, psychiatric, obstetric). The intent of the PSI #2 stratification was to help hospitals allocate resources to those service areas where there may be opportunities for performance improvement. However, since most hospitals had very few total cases the stratified rates were dropped from the most recent software release”*.

In addition you pointed out that “presence of one death is not a reliable measure of performance”. The issue here was not a single death by itself but a single death in a situation where no death would have been expected. The Maine Quality Forum continues to support PSI 2 as a sentinel event type metric and has not, and does not plan to present this data publicly.

We are presently in the midst of analyzing 2005 data using the AHRQ methodology for PSI and IQI. When those analyses are complete they will

made available to your member institutions. We will continue to be available to provide them with a list of patients included in any indicator that they select. Each hospital will thereby be able to focus their quality improvement efforts on both coding and patient care issues.

Enclosed with this letter you will find Maine Quality Forum Policy Discussion for analysis and plan of use for these AHRQ derived screening metrics as accepted by the MQF Advisory Council.

In your letter you asked us to delay public access to these screening metrics until they have been validated and NQF approved. AHRQ went through a rigorous process in the development of these metrics for their present use. MQF has further asked each hospital in Maine to review their own data for possible errors for the 2004 version of the metrics and will do the same soon for the 2005 version. In addition MQF is jointly working with your own organization to explore participation in AHRQ's continuing process of metric quality improvement for these same metrics. AHRQ has submitted PSI 2 to NQF for consideration as a "never event" metric. AHRQ has also submitted the Pneumonia Inpatient Mortality Rate (IQI 20) for endorsement. The Pneumonia Inpatient Mortality Rate has been endorsed by the Steering Committee and is in process for final NQF endorsement. We should note that MQF has already complied with the Steering Committee's recommendation that each hospital should have an opportunity to confirm their numerator for this and every other metric. We are unaware whether or not any other PSI or IQI indicators might be submitted in response to an appropriate NQF call for metrics as further projects are funded.

In the attached policy discussion we have defined public access for IQI and PSI metrics as available preferentially to sophisticated users. We do not intend to attempt to convert all of these metrics to information digestible by the general public.

As you appropriately point out Maine hospitals on average provide high quality care. I frequently have the opportunity to share with you our joint pride in what Maine providers do for the citizens of Maine. However, at the same time, even though we compare well with other states, we do not compare well with other countries and certainly fall far short of the care we would like to see for ourselves. We both recognize that the short comings are not a lack of effort and often not a lack of skill but unfortunately a failure to invest in and utilize recognized tools that support safety and quality of health care.

I have always maintained that a reputation is built through transparency and accountability. The general public is aware of the short comings of our healthcare system. Any attempt to maintain otherwise serves us no useful

purpose. As Mainers we are proud of the care that we receive and as Mainers we are determined that we will do much better.

Sincerely,

**Dennis Shubert, M.D., Ph.D.
Director, Maine Quality Forum**

Enc. Maine Quality Forum Analysis and Plan

**Cc: Governor John Baldacci
Dr. Robert McAfee, Dirigo Health Board of Directors
Ms. Trish Riley, Governor's Office of Health Policy and Finance
Ms. Karynlee Harrington, Dirigo Health Agency
Ms. Rebecca Colwell, Maine Quality Forum Advisory Council
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