# Transparency Advisory Group

Meeting Minutes

April 19, 2016

**Attendees:**

Charles Hawley, OHCS
Sterling Petersen, OHCS
Emily Varner, OHCS
Elizabeth Brand, UDOH
Dr. Sarah Woolsey, HealthInsight
Jeff Black, HealthInsight
Brock Stoner, HealthInsight
Bri Marshall, HealthInsight

**Via Adobe Connect / Teleconference:**

Aimee Whetman, HCA Physician Services
Andrew Stitt, HealthInsight
Angie Draper, UBMC
Clinda Lasater, Moab Regional
COE Meetings
James Sanders, U of U
Jan Orton, Intermountain
Jesse Liddell, Select Health
Jim Bradshaw, IMC
Jim Murray, Select Health
JoAnn Banks, IHC
Lynette Hansen, Molina
Natasha Chapman, Promise
Rita Hanover, HealthInsight
Scott Horne
Sherrie Pandya, Kane County Hospital
Debbie Spafford
Vida Frost
Will Garrison, Wowza

**UtahHealthScape Updates & Wowza mockup**

- Proposed Modules: Doctors, Clinics, Hospitals, Nursing Homes & Home Health
- Planning on revamp to website thanks to Cycle III
- Make it mobile device friendly. Simplify information people look up.
- High level information that we plan on showing for doctors, clinics, hospitals, nursing homes and home health include awards and badge information, primary and secondary specialty, languages spoken by staff, affiliations and more.
- Question: All data shown there comes from CMS sources?
  - No, the badge info comes from other sources. We need to be careful about what we come up with; it's hard to show comprehensive information for some of the badges. Extended hours badge is hard to keep up with for example with existing workforce and funding. It's an open question to the group – what badge info should we continue to share? We need sources that are easy to keep up to date & are comprehensive for any information that we present. We will come to you with some suggestions in upcoming settings.
- Some impetus for some of the decisions we've made is that our research clearly shows consumers look for specific entity types or specific facility types. Part of impetus for breaking up information into modules is based around that. New UHS will be broken into sections that are hospital specific and nursing home specific, etc. See above list.
- Showing prototype that's still in progress but functional to high degree.

- Another thing we've learned in research is that consumers don't actually believe they have a choice and don't believe that there's a decision they can make.
- The goal we have is to create something that's more of evaluation tool to answer their question of should I be worried or am I going to be ok? We're trying to answer question quickly but in a context that also presents opportunity for them to realize there may be a decision they can make.
- Once they perform search & see results page – all the hospitals in Utah. Those pieces of data that will be associated with different entities.
- Broken into carefully chosen hierarchy.
  - Entity is first, so is hospital #1.
  - Secondary to that is patient experience or readmissions.
  - When we go deeper we get into profiles, the shoppable measures, measures people make decisions based on. The maternity care going to be shoppable measure. (price)
  - The hierarchy below that is the detail measure.
- One thing to get input about is the cost data specifically. Showed example of Vaginal Delivery cost for American Fork Hospital profile. Example of evaluation tool – comparative with nearby hospitals. Not giving them context to see opportunity to make decision. A big challenge is we know consumers want to see one number but we know costs are a range so we're trying to figure out a smart & simple way to visualize the number they're looking for but also to let them know this is a range.
- Question: First 2 quality measures they chose, curious about those?
  - We know patient experience is far and away an attractive measure to consumers. They love seeing it & are drawn to it way before anything else. A big part of this, you have to understand consumers mind is trying to give them what they think they're looking for and then allowing them the opportunity to go deeper. We want to put upfront what the user thinks they've searched for so they feel like they found what they're looking for and then can discover more information. Patient Experience a strong one to put up front in the hierarchy. If they found what they're looking for, then they can dig deeper
- We've separated the data that is quality metrics that cover entire hospital. So patient experience & rate of readmissions is really about hospitals. This remains a discussion as to the best measure.
- Other measures are more specific to condition. Didn't want to weight everything equally & create false proxies.
- Want to start with those two key things.
  - Pt experience measure is rolled up hospital wide kind of measures.
  - Rate of readmission more general across hospital. We need a general measure. Friendly to consumer.
- Then when you get to cost data, the shoppable – Maternity care.
- We can start adding more additions like knee or hip replacements, the scheduled procedures that often times offer more choices will be next level because they are data points that are influenced more by choice.

- From our experience & research, they really aren't that helpful in helping individuals making choices but might be valuable to different people for other reasons.

- Question: The Patient experience is based on this new star rating that CMS has come up with?
  - Yes – right now it currently isn't using Data point but it will be CMS overall star rating.
- James Sanders said that he was on the last mockup call and thinks it's been improved since last he saw it. His comments are similar to last time. Some facilities wanted to see more socioeconomic demographic adjustments. You see American Fork Hospital with very low readmission rate but it's also a community hospital that's not equipped to handle complex cases, so you would expect their readmission rate would be low. But the other hospitals that deal with more tertiary quaternary care will have higher readmission rates and that won't be reflected here that they are treating more complex patients. Even if vaginal delivery – there is normal newborn deliveries but other types of vaginal deliveries that are more complex. That complex patient will be referred to more tertiary quaternary facility for her delivery. Doesn't feel there's enough sociodemographic adjustment here to make a fair comparison of between community level hospitals and tertiary quaternary hospitals
- Jan Orton - you have comparisons to nearby hospitals but can you also compare to other hospitals that are in your insurance profile? If their insurance is Select Health they might also want to see other hospitals in other areas based on where you live.
- Question: Where are you getting data for cost & how are you sure you're comparing apples to apples?
  - Data we supplied to Wowza from APCD.
  - Comparison of cases – we did understand that might be a problem. The cost is based on APDRG risk groupers for minor and moderate risk of vaginal deliveries. Can get more technical details as needed. Tools designed to make like comparisons to similar risk groups.
  - APCD – as far as maternity cost goes, we have Medicaid data, most of commercial market and feel like we have good understanding of the cost of deliveries in state
  - Are those Costs adjusted for anesthesia, and other ancillary doctor services – some include, some do not – facilities only.
  - Grouper designed to take into account neonate care. Separates from vaginal deliveries.
  - Have had bit of debate on how to proceed forward. If you go look at maternity cost module on UHS now by geography. The total cost for professional & hospital cost combined was around $7K or 8K. Hospital was 5k & Neonate was 2K roughly. So when you see a number like 4, that is lower than anticipated. We'd like to present neonatal data. The way the grouper works though is interesting. What is the most obviously lowest risk neonate group is not the one grouper uses most often. Instead it uses high birth weight. The general understanding is that it's not uncommon baby is born & something else diagnosed to put them in several risk groups. They're comparable and we're exploring that . Might be able to present both of those.
  - We've talked about ways to present ancillary services – imaging, labs, the professional fees in addition to facility fees. Data we have access to now is limited to just the facility

fee. We could present state averages, or even geographic averages for those other services so you could get a more comprehensive view of total cost
  - If could we start with just facility fee for maternity care alone and come to agreement about how it looks and we're comfortable with mild to moderate risk patient that will be a good place to start and then we can build additional modules
  - Get questions on table but at the moment our goal is to refine this portion, test it heavily and move forward with other things. We can set a session to review the cost decision off line if needed.
- Question: Is it possible to have a slide or checkbox on 4 levels of APDRG severity or is it just the first two levels?
  - Check box to select mild or moderate or highest level of severity for price, the cost. That's how Utah Price Point works. You can select different severity ratings. We have the data. The debate we've had when we try to do geography is always how complex do we want to get before consumers lose sight of what this means. Are they going to understand risk adjustment? We have data necessary to where we could put minor, moderate, major and extreme risk groups APRDG severity on there but not sure if we should.
  - Keep it simple. The simpler the better but at same time it doesn't mean we can't give user the ability to drill down into more & more technically detailed information. At the top level it should be as simple as possible. Consumers very confused by this stuff so the simpler the better. But nothing problematic about letting consumer dig deeper and see more detail. Certainly reasonable & something they can work on it.
- Sarah wants to go back to question of the way cost and range are displayed and the comparison. We've heard people might want to check boxes for plan and hospitals – not just geographic area. What do people think about how cost is being displayed?
  - James: Likes the range – would be good to see that you have the mean and range for facility. Would be good to know what high & low for state are, could put info there what that dollar amount is.
  - Challenge there is if we put dollar amounts near a facility name it's very difficult for us to not risk the consumer associating that dollar amount with that facility.
  - Something to consider incorporating is a simplistic legend that appears above information that has the state range and then letting the data below be facility specific. Understanding that lowest to high value is important but it's tricky problem. What do you think about adding that data point as sort of a pseudo legend on how to read that range?
- Imagine there is space that shows state average that shows high/low – piece of information that's above facilities information that gives clear sense of ranges – wouldn't be labeled as cost in the state – would label lowest dollar amount to highest. Would put content for all the visualizations. Want to be careful about how to visualize so dollar amount isn't associated with hospital. Would be like a frozen header row. We can see in next version.
- Google Reviews. Publically available. Easy to set up. Can talk about whether names should be suppressed or not. Could truncate comments and link out so you can read them outside of

website. Idea is we know that consumers are drawn to this kind of stuff. If we can incorporate it, it will resonate well with visitor. But also want to be sensitive to what people are comfortable with and any privacy concerns. Impetus for doing this, been doing research for years on CAPS and with Yale on anecdotes, especially on mock physician compare site we've been working on for them. Learned a lot over the years about how consumers are influenced by this information. Challenges of incorporating this with other kinds of data, we think this is interesting opportunity because Google Review data already public & already there. IF someone searching for hospital, they'll see some of that google anecdote information before they get to our website. By putting anecdotal data with other types of data we think it's a positive thing.

- Sarah would like to ask the group their feeling on this. This is patient friendly area. As physician not sure I want the Google thing to take up a third of the real estate when I'm trying to communicate quality information that maybe is slightly more scientific when they can go out & get the google stuff elsewhere. Not sure if we want our brand of UHS to include things we don't have sense of what that is other than experience. There's a lot of different ways to get that. Is that something we want to spend time on?
- Jan – think it's a proven fact that those who comment on Google are angry. They're negative and not always appropriate or correct feedback.
- Takes up a lot of real estate. Reason we chose Google over others like Yelp? Not sure if ratings better or not. Ease of access with Google is high and the majority of people are familiar with. Also worth noting that all these concerns are incredibly valid but also if the goal is to give user the thing they are looking for – huge benefit in presenting something we know they want to see will cause them to spend more time on our website and dive into that data. Something we know the research supports but all your concerns are understandable.
- Google review – comments are negative – wheat google gives us – is what's been marked as most helpful reviews. Comments that people have found to be helpful – good way to get away from angry comments.

- Next steps: Taking feedback – we welcome comments.
- From project perspective – we are in process of finalizing quality indicators we calculate using facility encounter data. The 2014 data was just finalized in last few weeks so we're in process of getting measures calculated so we can shift 2014 data to final to HI & Wowza and we'll also share with hospitals as part of as formal review process we need to go through. You'll hear more about data itself in near future.
- Wowza is to come back, take these comments into consideration, decide if we need more mockups or not from things people have commented on and will bring back to this group next month. Also will be sharing with more patient groups. Send comments to Bri if you have more to say offline.
- Question: Does quality data align with cost data? People associate higher cost with higher quality?

- Tabs you see at the top that say vaginal, caesarian, safety –if you click on safety tab you'll see 4 different quality measures for vaginal and a few for caesarian. It will be under different tab – will not be shown together.

- The patient would need to take another step in understanding who is in or out of network so they could see where prices apply – searching by plan vs searching by zip code.
- Think we'll have hard time searching by plan. We don't have plan level detail. Within a carrier, can identify payers – but variation within facility. Without plan detail we'd have a hard time displaying that info.

**APCD & CSD Presentation - See slides**

- Controlled Substance Database (CSD) & APCD
- Department of Health got a CDC grant called Prescription Drug Overdose Prevention for States.
- 4 year project and has 5 main goals
- The first one is Enhance & Maximize CSD as a public health tool. This one directly relates to APCD.
- Some other areas are doing community level interventions, evaluate policy, develop rapid response projects and partner with CDC.
- We will be increasing the number of data systems linked to CSD. Linking CSD to APCD using DOH MPI.
- Will be linking to other data services – death, ED, hospital, inpatient, birth etc.
- Increase and improve proactive reporting.
- Analysis – going to be done using TRUST software developed by U and the VA.
- Part of grant gives us 5 indicators we have to report to CDC on, these are minimum indicators.
  - Looking at percent of patients receiving more than average daily dose of 100MME.
  - Rate of multiple provider episodes – 5 or more prescribers in 6 month period
  - Percent of patients prescribed long acting/extended release opioids
  - Percent of prescribed days overlap between opioid prescriptions
  - Percent of prescribed days overlap between opioid and benzodiazepine prescriptions
- Other indicators we're looking at are looking at provider specialty, preceding medical events, trends in prescribing practices & patient behaviors by payer type
- See slides for more details
- Open to thought & suggestions – send to Charles.
- This is just introductory background to this project. This is goal of TAG to keep people informed. Still figuring out internally what we want to do and how TAG can contribute but wanted to give you a little background on this.
- The interest would be to do some interventions preventative interventions some pharmacy or provider interventions would other potential grants out there that could forward this.

**Clinic Quality Comparison Measures for 2017 see slides**

- Need to decide which ones we should produce for 2016.
- First 5 measures are almost identical to what we saw last year.
- NQF for breast cancer might have changed.
- Bottom 5 measures are new this year but are things we have talked about in the past.
- Will let people take a look at these.
- We did try to use CMS released quality guidance for ACOs, tried to follow that guidance, those measures reflected in those.
- Trying to align with CMS and payer community. Will have conversation about what to do for next year. Will be easier than last year now that we have a process but will get your feedback on what's important.

**Next meeting:**

**TAG**
**May 17th, 2016**
**9:00 – 10:00am MT**
**@ Cannon Health Building**
**288 North 1460 West, Room 125**
**Salt Lake City, UT 84116**