

Draft Meeting Summary
Cardiac Services Advisory Committee
Tuesday, August 20, 2019
Maryland Health Care Commission
4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:

Anna Aycock	Josemartin Ilaó
Jamie Brown, M.D. (phone)	Richard Pomerantz, M.D.
Blair Eig, M.D.	Rawn Salenger, M.D.
Kristen Fletcher (phone)	Jerry Segal, M.D.
Chris Haas, M.D. (phone)	Stuart Seides, M.D. (phone)
James Recabo (phone)	John Wang, M.D.
Paul Massimiano, M.D.	Stafford Warren, M.D.

MHCC Staff Attendees:

Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Suellen Wideman, Assistant Attorney General
Courtney Carta, Chief, Hospital Quality Performance

Other Attendees:

Terry Haber, Executive Director, Maryland Cardiac Surgery Quality Initiative
Jeanne Ruff (substitute for CSAC member, Steve Hearne, M.D.)

Introductions and Review of April 2019 Meeting

Eileen Fleck welcomed Cardiac Services Advisory Committee (CSAC) members and asked attendees to introduce themselves. Ms. Fleck next noted that Lisa Myers, the representative for the Maryland Emergency Medical Services System (MIEMSS) left the agency, and Anna Aycock has been nominated by MIEMSS to replace Ms. Myers as member of the CSAC. Ms. Fleck also noted that Jim Ridge, the representative for Carroll Hospital Center retired, and Heather Green has been nominated to replace him. The Commission needs to officially approve their nominations, which MHCC staff will request at the next Commission meeting in September.

Ms. Fleck explained that the goal of the meeting is for Maryland Health Care Commission (MHCC) staff to have recommendations from CSAC members on measures to use for public reporting. She noted that at the last meeting CSAC members agreed on criteria to use for evaluating potential measures for public reporting, and those criteria are included in a handout. She read the criteria to CSAC members and asked for confirmation that the list is acceptable. The criteria list included the following: unlikely to result in risk aversion by surgeons or interventionalists; unlikely to be misinterpreted or misunderstood by consumers; useful for decision-making by consumers; endorsed by the National Quality Forum, Society of Thoracic Surgeons, American College of Cardiology, or other appropriate organization with expertise in

public reporting; cost-effective with respect to implementation by MHCC and providers; and the data or source information underlying the measure can and will be routinely audited. No one disagreed with this list.

Consideration of Specific Potential Measures for Public Reporting

Ms. Fleck explained that the agenda includes several measures that MHCC staff concluded should be further discussed based on feedback from CSAC members and the criteria agreed upon. She let CSAC members know that it would also be fine to propose additional measures to discuss. The first measure that Ms. Fleck suggested CSAC members discuss was the Society of Thoracic Surgeons' (STS) composite star rating for isolated CABG cases. She noted that CSAC members had previously discussed this measure. Some members expressed reservations, and some members expressed support for the measure. For the short electronic survey conducted by MHCC staff, respondents primarily either supported the measure or were neutral on the use of it. Ms. Fleck stated that the measure definitely meets the criteria selected by CSAC members. However, she also acknowledged that some questions have been raised about the utility of the information for consumers. Some members believe that it is best for a patient to rely on a physician's recommendation regarding which surgeon to choose, rather than relying on a star rating. Ms. Fleck agreed that point is valid. The composite star rating for CABG would not be useful in every situation. Ms. Fleck requested additional feedback from CSAC members.

Stuart Seides, M.D. asked whether the information has sufficient discriminate value because the purpose is to help the public make better decisions about which hospital to choose for cardiac procedures. The STS composite measure for CABG is structured so that most programs are rated as two-star programs; only a small number of programs are rated as three-star or one-star programs. He is a fan of the STS database, and his hospital uses it. However, for a consumer, he questioned whether there sufficient information to discriminate among programs. Rawn Salenger, M.D. responded that there is sufficient information. Hospitals cannot be ranked with certainty regarding who is best. If you try to discriminate more, then you wind up trying to rank hospitals without valid statistical information to support those rankings. That is why STS takes the approach of evaluating hospitals with a three-star rating system. Although there are differences among programs rated as two-star programs, the programs cannot be reliably ranked.

Paul Massimiano, M.D. commented that Dr. Seides made a valid point at the April CSAC meeting. Most consumers are driven by the recommendations of cardiologists. The other information that should be provided to consumers is information that will be helpful. The STS data is the best source of that information. It can give consumers some confidence that a program meets standards of quality. The STS composite star rating for CABG meets the criteria discussed.

Jose Ilaos speculated that urgent care centers may use the STS information to decide where to send patients for cardiac care, based on a family member's experience. He concluded that providers are appropriately handling patients. Ms. Fleck responded that the urgent care providers should be asked directly about their decision process. She then asked whether the CSAC members who are physicians had heard from patients that they relied on the STS information to choose hospitals. She also asked whether the physicians or other staff for their programs direct patients to the STS web site for comparative information on cardiac surgery programs.

John Wang, M.D. responded that the main times he hears about the STS star ratings are in the CSAC meeting or from hospital administrators, when the hospital performs exceptionally well on the STS star ratings. He expects that most consumers would pick a three-star program over a two-star program. CSAC members are very familiar with the statistics and the clustering of programs as two-star programs. For many other services with reviews and star ratings, consumers pick the service with the better rating. Consumers may take the same approach for cardiac surgery services.

Dr. Massimiano disagreed that patients would approach picking a cardiac surgery program the same way. Surgeons discuss risks with patients. If patients ask about the STS ratings, they would bring it up and ask physicians. If patients are educated enough to be aware of the star ratings and find them, then they probably will read the details about the ratings. He asked Dr. Salenger if patients ever asked him about the STS star ratings. Dr. Salenger responded that he has had patients mention the ranking of his hospital, but it was not in reference to the STS ratings. It may have been the ranking in *U.S. News and World Report* or *Consumer Reports*. He also does not see a problem with a patient choosing a three-star program over a two-star program; the patient is not harmed by that approach. Jerry Segal, M.D. agreed that most patients are directed by a cardiologist to a particular surgeon, and patients can be directed back to physicians if they have questions about the STS star rating information.

Blair Eig, M.D. commented that patients do not use hospital ratings and performance measures for anything. He agreed with Dr. Wang that primarily administrators tout the results of performance metrics and put the results in publications. STS performs the valuable service of collecting data that allows hospitals to identify opportunities for improvement. That is its main function; it is not to provide public performance metrics. If we want to pick a rating system, the STS system is probably the best. Few consumers will use the information though. Most people will rely on doctors, friends, family, or whoever they normally rely upon for health referrals.

Ms. Fleck concluded that there is acceptance of the measure, but it is reluctant and qualified because of questions about the utility for consumers. Dr. Wang responded that there are questions about whether the measure really meets all the criteria agreed upon. It could be misinterpreted or misunderstand and may not be useful for consumers. However, if the mandate is that there has to be public reporting, then the STS composite star rating for CABG is probably as good as it gets for cardiac surgery programs. Ms. Fleck responded that she understands that the vast majority of consumers may not use the information, but if they look at the information, it could be useful as part of their decisions.

Mr. Ilao disagreed that the information is not useful. He asked how providers could use the information to educate patients and allow them to make their own informed decision. He asked specifically about helping patients understand the star ratings. Dr. Wang again commented that the interpretation of the statistical information is challenging, but the STS composite star rating for CABG is probably the best possible measure to use for public reporting.

Dr. Salenger commented that even among themselves they could not agree on the best programs in Maryland. However, consumers can be told that a two-star program is a good program

with competent staff and surgeons. Mr. Ilaio asked if information could be put on the web site that conveys the point just made by Dr. Salenger. Dr. Salenger suggested that a video clip may be more effective than text because more people will click on a video.

Mr. Ilaio commented that the real issue is how public reporting is going to be implemented; it is inevitable that there will be public reporting. Ms. Fleck responded that at this stage, MHCC staff would prefer to focus on picking measures for public reporting rather than implementation of the process because coordination with STS will be required. STS will have to sign off on use of the information by MHCC for public reporting on its web site. Dr. Salenger agreed that the proposed approach makes sense.

Dr. Salenger noted a minor correction to the second bullet point under the second agenda item. It should refer simply to the STS composite star rating for CABG. CABG mortality is a component of the STS composite star ratings. Ms. Fleck agreed with the correction of Dr. Salenger. There is separate star rating system for each component. Ms. Fleck noted that the components of the composite star rating are closely tied to use of the composite star rating for CABG. She asked work group members if the components should also be incorporated in public reporting. Dr. Salenger recommended inclusion of those components because it helps to understand what the composite star rating means. Ms. Fleck noted that there had been a lot of concern about reporting on the risk-adjusted all-cause 30-day operative mortality rate for CABG cases. Including the components of the STS composite star rating for CABG cases would be a way to present that information in the context of the star rating. CSAC members agreed with including the components of the STS composite star rating as part of public reporting.

Ms. Fleck next suggested that CSAC members consider 30-day all-cause risk-standardized mortality rates of elective percutaneous coronary intervention (PCI) cases. There was a National Quality Forum (NQF) report re-endorsing use of this quality measure.¹ This quality measure is not currently used for public reporting, but the American College of Cardiology (ACC) plans to use it for public reporting, based on the NQF report. Ms. Fleck asked for feedback on this measure. She asked whether it meets the criteria for public reporting. Stafford Warren, M.D. suggested in-hospital mortality rather than 30-day mortality be considered because it may be difficult to collect data on deaths for some patients. He noted that the elimination of STEMI cases and cases with cardiogenic shock makes sense. Jerry Segal, M.D. commented that salvage cases are a concern and should not be part of the same pool of patients. Dr. Wang commented that it takes a lot of resources to track 30-day mortality potentially. He suggested that in-hospital mortality based on data collected by the ACC would be good. He agreed with Dr. Segal. The surgical turndowns may look like outpatient elective, but they are not really elective cases. It is a reasonable measure. No measure will be perfect.

Ms. Fleck responded that MHCC staff could investigate the labeling of cases. A certain field is used by MHCC staff to separate the primary and elective PCI cases. Dr. Segal commented that there are very strict criteria for primary PCI, but the salvage cases are more difficult to pull out. Physicians should not be penalized for taking those cases. It could vary how many of those patients are treated at different hospitals. Ms. Fleck noted that in the regulations the performance measure had been for 30-day mortality, but then it was recommended that in-hospital mortality be

¹ http://www.qualityforum.org/Publications/2019/01/Cardiovascular_Final_Report_-_Spring_Cycle_2018.aspx

used because it would be easier. It was suggested that in-hospital mortality rates would not be that different than using 30-day all-cause mortality rates. Ms. Fleck asked for additional feedback on the issue. Dr. Warren commented that 30-day mortality rates would be too difficult, but in-hospital mortality rates should be adequate. Dr. Wang noted that 95 percent of patients are released within two days.

Mr. Ilao asked for clarification on why mortality within 30 days should be considered at all. The length of time seemed excessive to him because a physician would not release a patient perceived to be at risk of dying soon. Dr. Eig commented that infections secondary to a procedure are the primary reason why mortality may occur. Some complications can occur associated with a procedure within 30 days that are related to a procedure. Gathering the data for 30-day mortality would be very difficult. Mr. Ilao commented that he did not realize readmission data was reviewed. He agreed that it is acceptable to not use a metric of 30-day mortality for elective PCI cases.

Ms. Fleck noted that there is a national death index to track the information, but it is difficult to access, and there is a long lag with the reporting of the data. It is usually a year later that the data is available. The NQF report includes a detailed assessment of the measure. She concluded that the consensus is support for in-hospital mortality rates. She indicated that MHCC staff would talk with staff at the ACC about their plans for public reporting.

Ms. Fleck next asked CSAC members to consider the PCI metrics with star ratings for process measures, which are part of the voluntary reporting on PCI cases through the ACC. These measures include: use of aspirin to reduce the chance of blood clots after PCI or angioplasty; use of a P2Y12 inhibitor medication to reduce the chance of blood clots after PCI or angioplasty; use of a statin to decrease cholesterol after PCI or angioplasty; and use of all recommended medications to reduce the chance of blood clots and decrease cholesterol after PCI or angioplasty. An example from one hospital was provided as a handout.

Richard Pomerantz M.D. commented that the metrics are all easy ones. The vast majority of programs perform very high on the metrics. Dr. Eig commented that there is nothing wrong with putting the information out there, but it may not be helpful for choosing a program. Dr. Eig noted that it could give reassurance to consumers that PCI programs are performing well with respect to certain aspects of care. Dr. Pomerantz noted that the Centers for Medicare and Medicaid (CMS) retired the use of some of the PCI process measures for medication that had been included in a pay-for-performance program because the measures do not allow for much discernment between PCI programs. The vast majority of hospitals perform very high on the PCI process measures for medications. The information is still collected by CMS though.

Ms. Fleck asked if a different measure for PCI programs would be more useful. There were no suggestions. However, Kristen Fletcher commented that the clinical data collected through the NCDR CathPCI registry is much better than using claims data. Everyone is required to participate in the NCDR CathPCI registry, and the database is national. Compared to the use of claims data, there is more agreement that the results are valid. She suggested that MHCC should not re-invent the wheel. Ms. Fleck agreed that MHCC should not invent a new measure, but

MHCC staff wants to understand if the measures are supported or opposed. MHCC staff also wants to be open to the use of other suggested performance measures.

Jeanne Ruff suggested that it should be sufficient to say that the MHCC requires programs to complete a Certificate of Ongoing Performance for PCI and cardiac surgery, and the Commission endorses certain quality metrics, rather than drilling down on exactly what is reported out. She understands that consumers want to know how a Certificate of Ongoing Performance is evaluated. However, recently her hospital had a Joint Commission disease specific re-accreditation survey, and the surveyor had no idea about the requirements of the State for cardiac surgery programs, including both the requirement for a Certificate of Ongoing Performance and the requirements for designation of Cardiac Interventional Centers by MIEMSS. Those requirements and the work of the Maryland Cardiac Surgery Quality Initiative reflect a high level of scrutiny and commitment to quality.

Ms. Fleck responded that some people want more information rather than trusting a blanket statement or a specific endorsement or ranking. For that reason it may be helpful to have more details, even though she keeps hearing that consumers do not pay attention to that information. MHCC staff still wants to have the information available for the small number of consumers that value more detailed information.

Ms. Fletcher agreed with Ms. Ruff. She commented that MHCC staff should be responsible and careful not to confuse consumers with conflicting data. For example, aspirin on arrival may indicate 100 percent compliance based on the NCDR CathPCI registry, but CMS claims data indicates that the same hospital is below average. Ms. Fleck agreed that MHCC should be mindful of data that conflicts. For example, if there are two measures for CABG mortality, but the data sources are different, and the results are inconsistent, then it may confuse consumers. MHCC staff should then choose one measure for its web site to reduce the potential for confusion among consumers.

Mr. Ilaio commented that the medication measures for PCI programs seem a bit redundant and not especially helpful. He suggested that less information may be better. Ms. Fleck asked if having one measure would be sufficient, such as the last measure that refers to use of all recommended medications to reduce the chance of blood clots and decrease cholesterol after PCI or angioplasty. Dr. Warren suggested that only reporting on one measure would be sufficient. Other CSAC members agreed. He then asked about including information on case volume. Ms. Fleck noted that in earlier discussions with CSAC members there was concern about reporting volume information relative to volume standards included in MHCC's regulations. She asked if Dr. Warren's proposal was just to have the volume information without any judgment about it. She also asked CSAC members if that approach would be acceptable. Work group members agreed with the approach proposed by Dr. Warren. Ms. Fleck noted that MHCC staff will coordinate with the ACC on the presentation of the information and will follow-up with the ACC.

Dr. Eig asked about whether other states have their own public reporting of information derived from the data collected by the ACC or STS. Ms. Fleck responded that she was not aware of any other states using the data in that way. She would have to check. She also mentioned that MHCC staff obtains calculations from STS that are used in Certificate of Ongoing Performance

reports. MHCC staff signed an agreement to allow for the use of the STS data in Certificate of Ongoing Performance staff reports.

The next measure that Ms. Fleck asked CSAC members to consider was information on focused reviews. A focused review generally occurs when there are patient outcomes that are concerning or other concerns about quality. It is unique to Maryland and a sensitive issue. It is not something that has been endorsed by other organizations. However, it is relevant to consumers potentially.

Dr. Eig asked whether a focused review with no findings would result in anything reported publicly. Ms. Fleck responded that the results may still be reported. She noted that Prince George's Hospital Center performed less than 100 cardiac surgery cases for two consecutive years and that triggered a focused review. The results were reported to the Commission in a monthly update of activities. It is posted on MHCC's web site and distributed at the public Commission meetings. The conclusion was that the program is a good program, so that may not have been seen as newsworthy.

Dr. Eig commented that the question is whether to focus more attention on the quality measures and the outcomes of focused reviews. Ms. Fleck responded that MHCC should be fair to hospitals. The purpose of the process is to figure out if there is a problem and then a hospital is given an opportunity to improve. In some cases, a hospital may have already started working on the problem. There is a lag in the data though. It could be a year later before improvement shows up in the data. Dr. Eig commented that the lag is concerning and may not fit well with public reporting. The system for investigating issues is trusted. It is good to have backup for hospitals' internal review systems. Dr. Massimiano asked if focused reviews are announced to the public before conducting them. Ms. Fleck responded that MHCC's intention to conduct a focused review is not announced. Dr. Massiamiano then asked whether the results were announced at the completion of the review, and Ms. Fleck confirmed that is correct. Dr. Massimiano commented that he does not see a problem with that process.

Ms. Fleck asked if there is value in people knowing that a focused review was conducted, the reason for it, and that a problem was corrected. She also asked whether there are concerns that it unfairly casts a shadow over a hospital. Mr. Ilao asked for confirmation that the consequence when a hospital fails to correct a problem is closure of the hospital's cardiac surgery or PCI program. Ms. Fleck agreed that was a possibility. A hospital could be asked to voluntarily close. Mr. Ilao noted that the purpose of the system is not to alarm patients. The lag between notice of a focused review and the reporting of results is an opportunity to improve and potentially beneficial. Ms. Fleck agreed. However, she also noted that there could be situations where a hospital failed to identify a problem or take action in spite of knowing about the problem. Occasionally that happens and then there may be a story in the news about it.

Mr. Ilao commented that he viewed the situation as analogous to a student who is failing. There would not be a big announcement to the class or school. A teacher would work with the student in private to remedy the student's grades. The process that MHCC has set up is sufficient to address problems that may have been overlooked by a hospital's internal review. The hospital is given notice. It is not about alerting a patient, but making sure that hospitals are safe for patients.

Dr. Salenger suggested that the system be one that does not routinely report on focused reviews, unless a threshold is reached where a problem appears to be chronic. Then it should be announced to the public. Routine findings of problems that get corrected do not need to be announced. Consumers may misunderstand the results of routine focused reviews, which is not consistent with the criterion of using measures that are unlikely to be misunderstood.

Dr. Massimiano noted that a focused review is part of the Certificate of Ongoing Performance process. A program that does not meet the requirements for a Certificate of Ongoing Performance will not get one, and a program that meets the requirements will receive a Certificate of Ongoing Performance. That information is public. He agreed with Dr. Salenger that reporting the particulars of a focused review is not necessary. Ms. Fleck responded that the issue is what information is appropriate to share and direct toward consumers. She asked whether the information matters in terms of a consumer's decisions about a hospital or program. Dr. Salenger has suggested that not every focused review should be directed at consumers.

Dr. Massimiano commented that if there was a problem then a hospital would not get a Certificate of Ongoing Performance. Dr. Massimiano agreed with Dr. Salenger that there needs to be a threshold. Mr. Ilaio agreed that it was appropriate to have public notice if a program is considered for closure because of failing to meet standards.

Dr. Warren suggested that MHCC include on its web site a description of the Certificate of Ongoing Performance process and the focused review process. He suggested that information might make consumers more comfortable with the process. Given the lag with the focused review process, it may be more helpful for consumers just to know how the process works generally. Ms. Fleck responded that it seems more helpful to have information about focused reviews that have been conducted rather than general information about the process. However, she understands the reluctance around public reporting related to focused reviews. Dr. Salenger suggested that in extreme situations where there is a chronic problem and a program has failed to improve then the public should know. In that situation, the Commission may be considering closure already or potentially a program may be given more time, and it may then be useful for the public to be aware of the situation. Ms. Fleck asked if anyone had comments on that approach.

Dr. Massimiano suggested that a case-by-case approach may be appropriate; MHCC decides whether to publicly report on a case-by-case basis. Dr. Segal asked about the purpose of reporting the information. Ms. Fleck responded that the purpose would be to give consumers information that may be useful for making a decision about which hospital to choose. It could also be useful to set expectations for hospitals in advance. It may motivate hospitals to make sure that problems are corrected. Dr. Segal commented that every hospital should be concerned about a focused review. Members seem to agree that if a problem is fixed then it does not need to be publicly reported.

Ms. Fleck asked if the scenario of a hospital failing to improve after a focused review was realistic. Dr. Eig commented that the rules are often made for the one percent who are outliers. It has happened elsewhere in the country with cardiac surgery programs. Dr. Salenger agreed that it can happen. Ms. Fleck commented that she could understand that if a process is only internal the

situation could arise, but with an external reviewer getting involved it seems unlikely that a hospital would not improve or successfully address problems identified. Ms. Fleck commented that discussing the issue has been useful.

Next Meeting and Updates

Ms. Fleck noted that she had skipped over the review of the April CSAC meeting summary and asked if anyone had changes. There were no changes, and the work group agreed to finalize the meeting summary. Ms. Fleck asked if anyone wanted to bring up any other issues. There were no comments. Ms. Fleck then asked about the timing of the next meeting. It was suggested that a meeting in November rather than December is preferred. Ms. Fleck thanked everyone for their participation and adjourned the meeting at approximately 8:40 p.m.