

Tuesday, February 8, 2005
9:00 – 11:00 AM
Room 120C
Portland, State Office Building
800 Oregon St NE
Portland, Oregon



Meeting Notes

- I. Attendees: Matt Carlson, John McConnel, David Labbey, Johnathon Ater, Terri Hammond, Dana Selover, Jim Dameron, Rajiv Sharma, Liz Baxter, Lola Ready, Carol Mesrack, Roy Gabriel, Jenny Pathak, Pat Emmerson, Jessica Letteney, Willi Horner-Johnson, Rajeshwari Deshmukh, Kris Gowen, Rebecca Ramsay, Nancy Siegel, Julie English, Kirsten Jensen, Nancy Vuckovic, Jean Schnady, Gretchen Morley, Angela Kemple, Amanda Garcia-Snell, Rachel Solotavoff, Kathryn Broderick, Andrew Epstein, Nancy Clarke, David Hickam, Marilyn Hudson, Carl Foreman, Karen Eden, Ron Tayler, Clara J. Murray, Dennis Deck, Meika Ludwick, Jeanene Smith, Elizabeth Baxter, Tina Edlund, Lisa Krois, Robert Lowe, Judith Hibbard, Jen Devoe, Janne Boone, Jessica Miller
- II. Brief update of OHREC activities
 - Children's Access Survey will be in the field approximately March 2005. This survey is designed to assess parental barriers to insuring their children.
 - OHP Cohort Study is currently in the field with results expected approximately March or April 2005. This study revisits the previous cohort looking at a follow-up self-report of their insurance status, health status and perceived access to care.
- III. Presentation: "Evaluating the Impact of a Public Performance Report on Hospitals and on Consumers" presented by Judith Hibbard, Professor of Health Policy in the Department of Planning, Public Policy and Management at the University of Oregon.
- IV. Presentation: "Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: The Emergency Department Perspective" Robert A. Lowe, MD, MPH, Director, Center for Policy and Research in Emergency Medicine at OHSU.
- V. Wrap Up



NEXT MEETING

Tuesday, March 8, 2005

9:00 – 11:00 AM

Rooms 111 & 112

Clackamas Community College

Advanced Technology Center

29353 SW Town Center Loop E

Wilsonville, Oregon

"Women's Health in Oregon: Moving the Legislative Agenda with Evidence"

presented by Michelle Berlin MD, MPH, Director, Center of Excellence in Women's Health, Oregon Health & Science University.

A report of the **Oregon Federally Certified Rural Health Clinics** presented by The Oregon Office of Rural Health.



Evaluating the Impact of a Public Performance Report on Hospitals and on Consumers

Judith H. Hibbard

University of Oregon

Dept of Planning, Public Policy, & Management

Assumptions About How Public Reports Can Affect Quality Improvement



- 1 consumers can drive improvements through informed choice [market share]
- 2 concerns about public image can motivate improvements [reputation]
- 3 the feedback about own performance might be sufficient to motivate improvements [feedback]



What is the Consumer Role?

- Pathway 1: [market share]
 - Use comparative Performance information to make a hospital choice
- Pathway 2: [reputation]
 - Observe that there are differences
 - Be able to identify high and low performing hospitals
 - Remember them
 - Talk to others about the high and low performers
- Pathway 3: [feedback]
 - No role for consumers

Evaluation of the QualityCounts Hospital Report



- The Alliance produced and disseminated a report on 24 hospitals in S. Central WI
- Report rated hospitals on complications and deaths
- administrative data-- risk adjusted
- Public report widely disseminated
 - Employees of The Alliance member companies
 - Inserted in Newspaper
 - Newspaper stories
 - Community groups/ library/Website

What the symbols mean:

⊕ Fewer mistakes, complications and deaths than expected

○ Average number of mistakes, complications and deaths

⊖ More mistakes, complications and deaths than expected

Regional Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital A	⊕	⊕	⊕	⊕	○
Hospital B	⊕	⊕	⊕	○	○
Hospital C	⊕	⊕	⊕	○	⊖
Hospital D	⊕	⊖	⊕	⊖	*
Community Hospitals	Surgery	Non-Surgery	Hip/Knee	Cardiac	Maternity
Hospital F	⊕	⊕	⊕	○	⊕
Hospital G	⊕	⊕	⊕	⊕	○
Hospital H	⊕	⊕	⊕	○	○
Hospital I	⊕	⊕	⊕	○	○
Hospital J	⊕	⊕	⊕	○	○
Hospital K	⊕	⊕	⊕	○	○
Hospital L	⊕	⊕	⊕	⊕	⊖
Hospital M	⊕	⊕	○	○	*
Hospital N	⊕	⊕	⊕	○	⊖
Hospital O	⊕	⊕	⊕	⊖	○
Hospital P	○	⊕	⊕	○	*
Hospital Q	⊕	○	○	○	*

Impact of report on Hospitals: Experimental Design

115 Eligible Hospitals
in Wisconsin

24 Alliance service
area (Hospitals In
Public Report)

91 Non-Alliance
Hospitals

Random Assignment

46 No
Report
Hospitals

45 Private
Report
Hospitals*

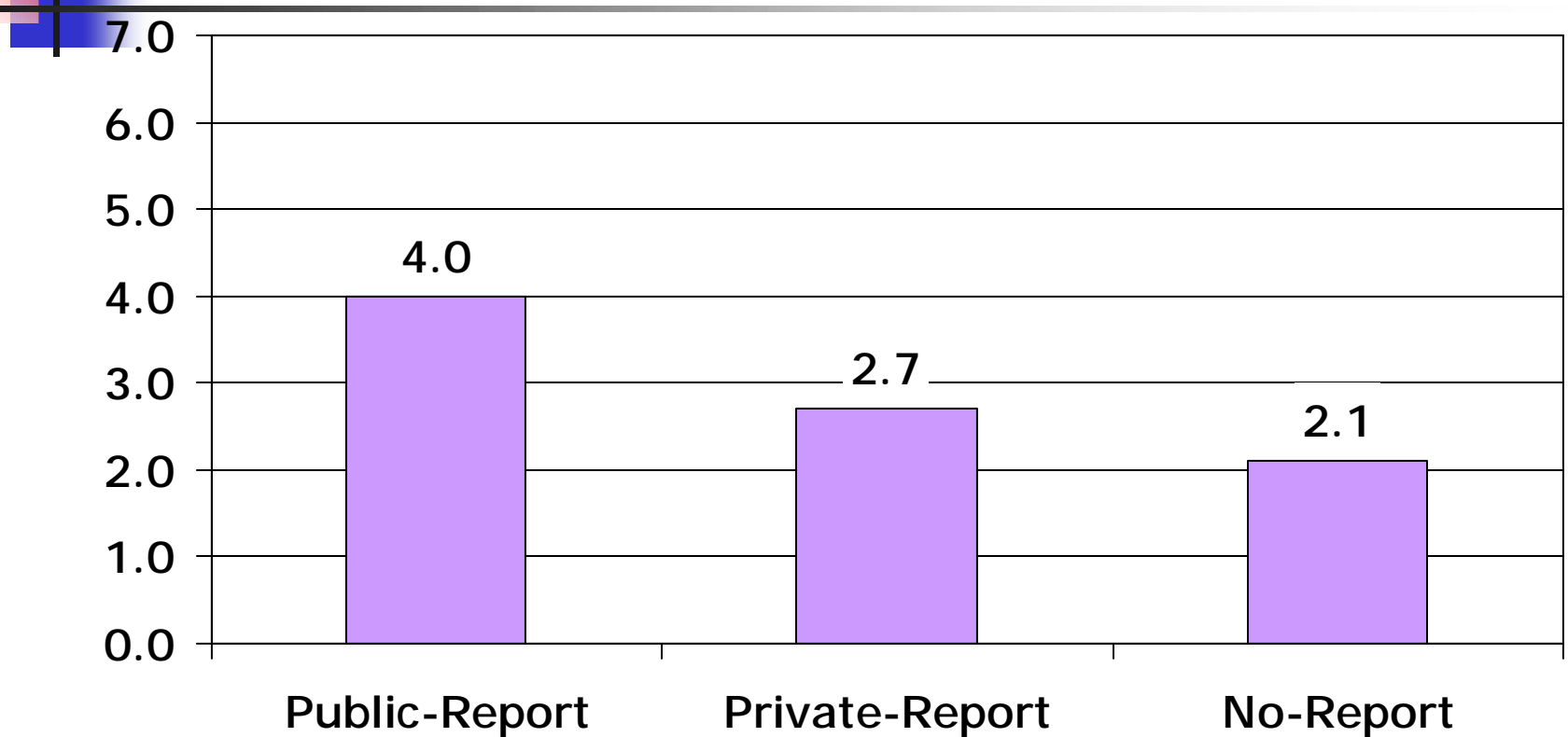
* Three hospitals were lost to closure and two hospitals were ineligible due to overlapping administrative structures



Research Questions:

- Does Making Performance Public Increase:
 - QI efforts within areas reported upon? Are QI efforts greatest among those with lower performance scores?
 - To what degree do 'private reports' stimulate QI activities?
 - Actual improvements in care?

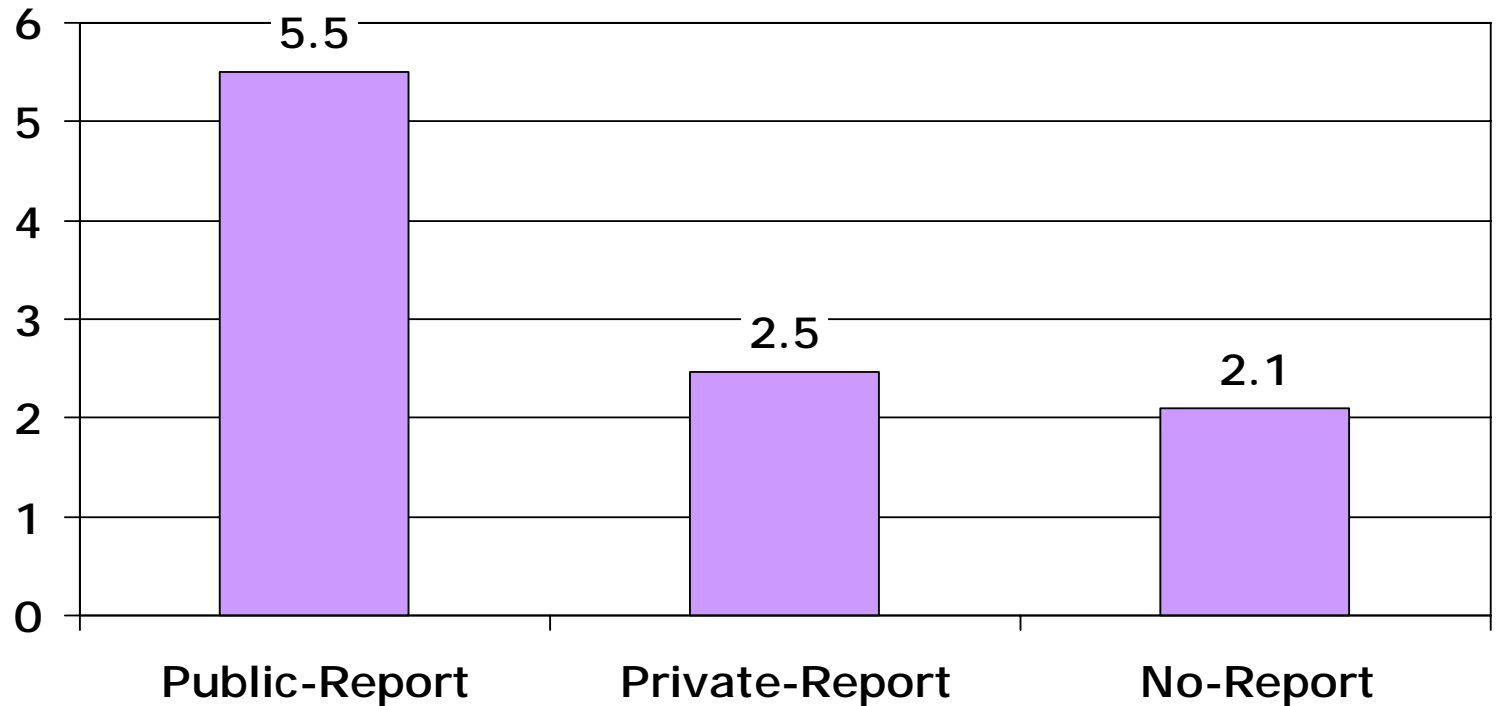
Average number of quality improvement activities to reduce obstetrical complications: **Public report group has more QUALITY IMPROVEMENT** ($p < .01$, $n = 93$)



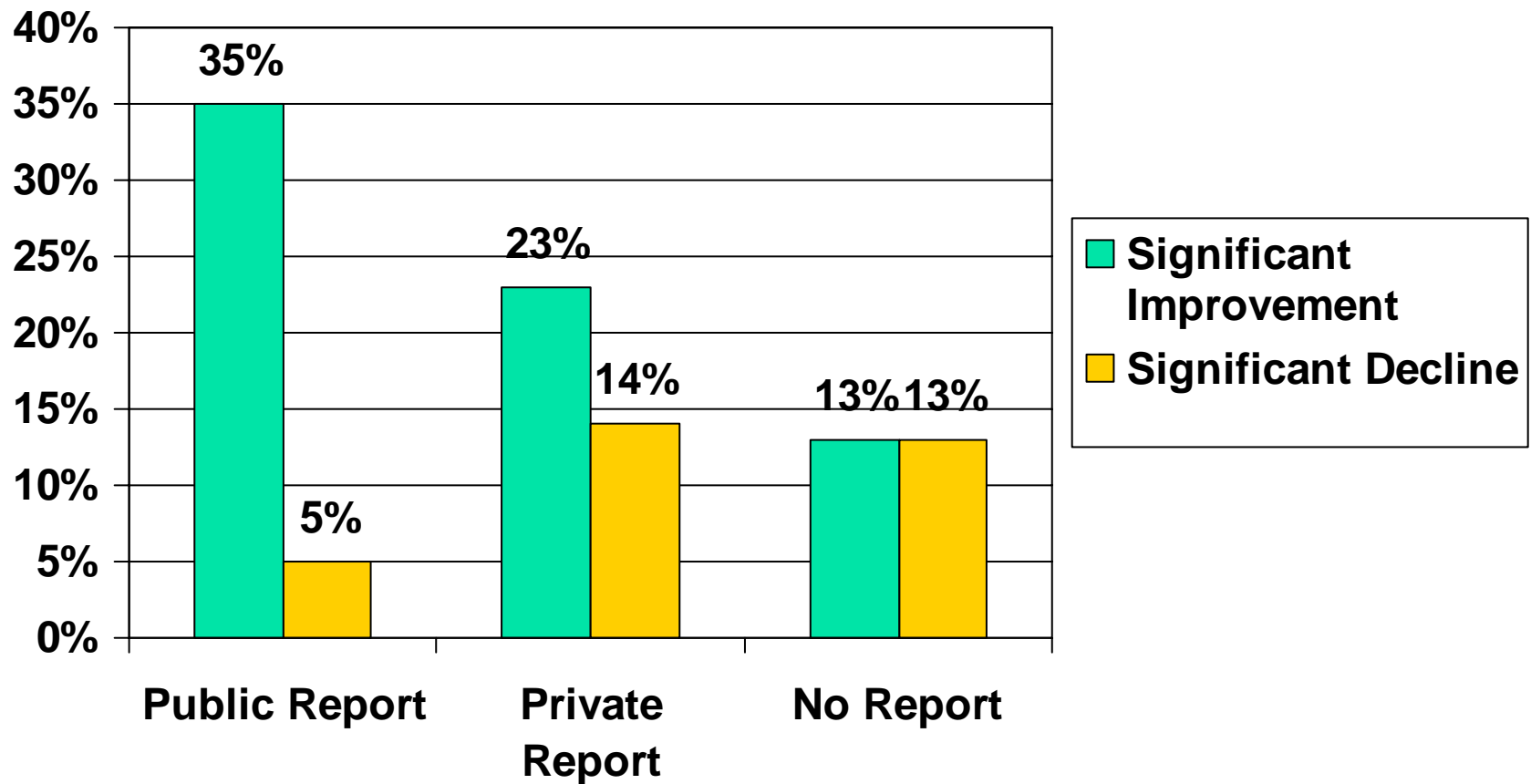
Best practices around c-sections
Best practices around v-bacs
Reducing 3rd or 4th degree laceration

Reducing hemorrhage
Reducing pre-natal complications
Reducing post-surgical complications
Other

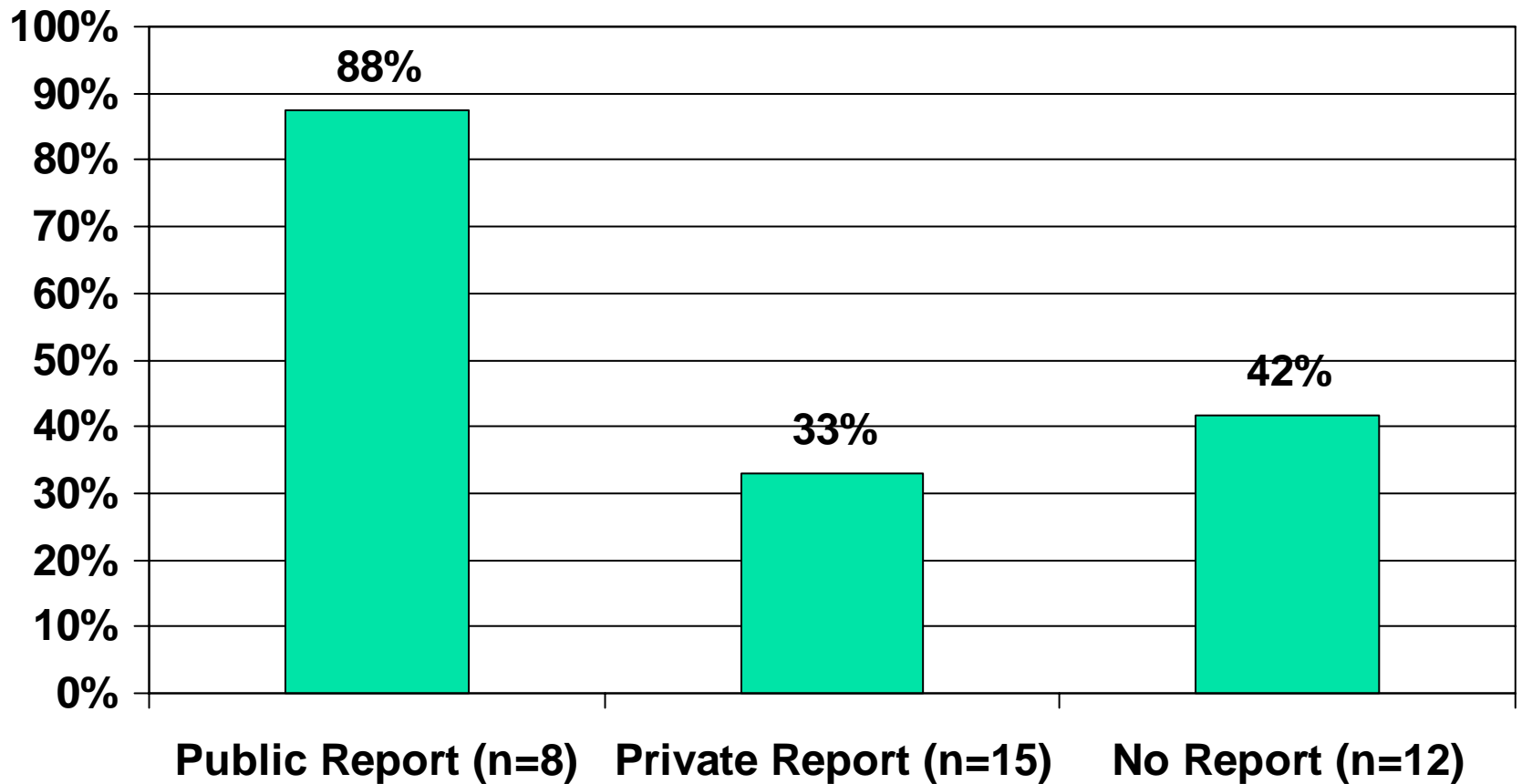
Hospitals with poor OB scores: # of QI activities by experimental condition ($p = .001, n = 34$)



Percent of hospitals with significant Improvements or Declines in OB Performance in the Post-Report Period:

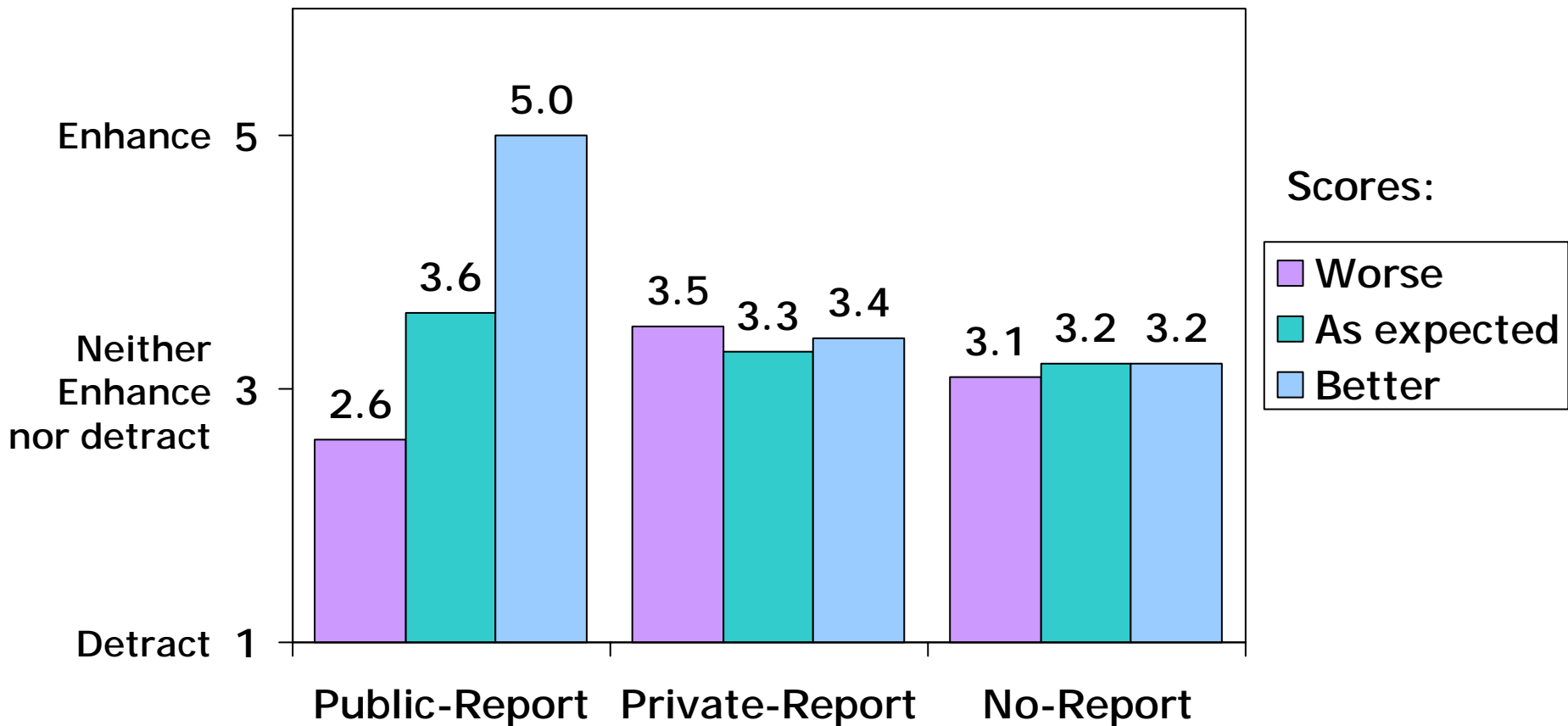


Percentage of hospitals who had poor scores at baseline and who improved their scores in the post-report period



Belief: Likelihood that the report would affect their hospital's public image

(N = 79)



Main effects, $p < .05$, interaction effects, $p < .05$



The stimulus for QI appeared to be concern that the public report would affect their hospital reputation

- The findings indicate that it is all about reputation.



Did the QualityCounts report affect hospital reputations?

In the short term?

In the long term?

Did consumers come away with:

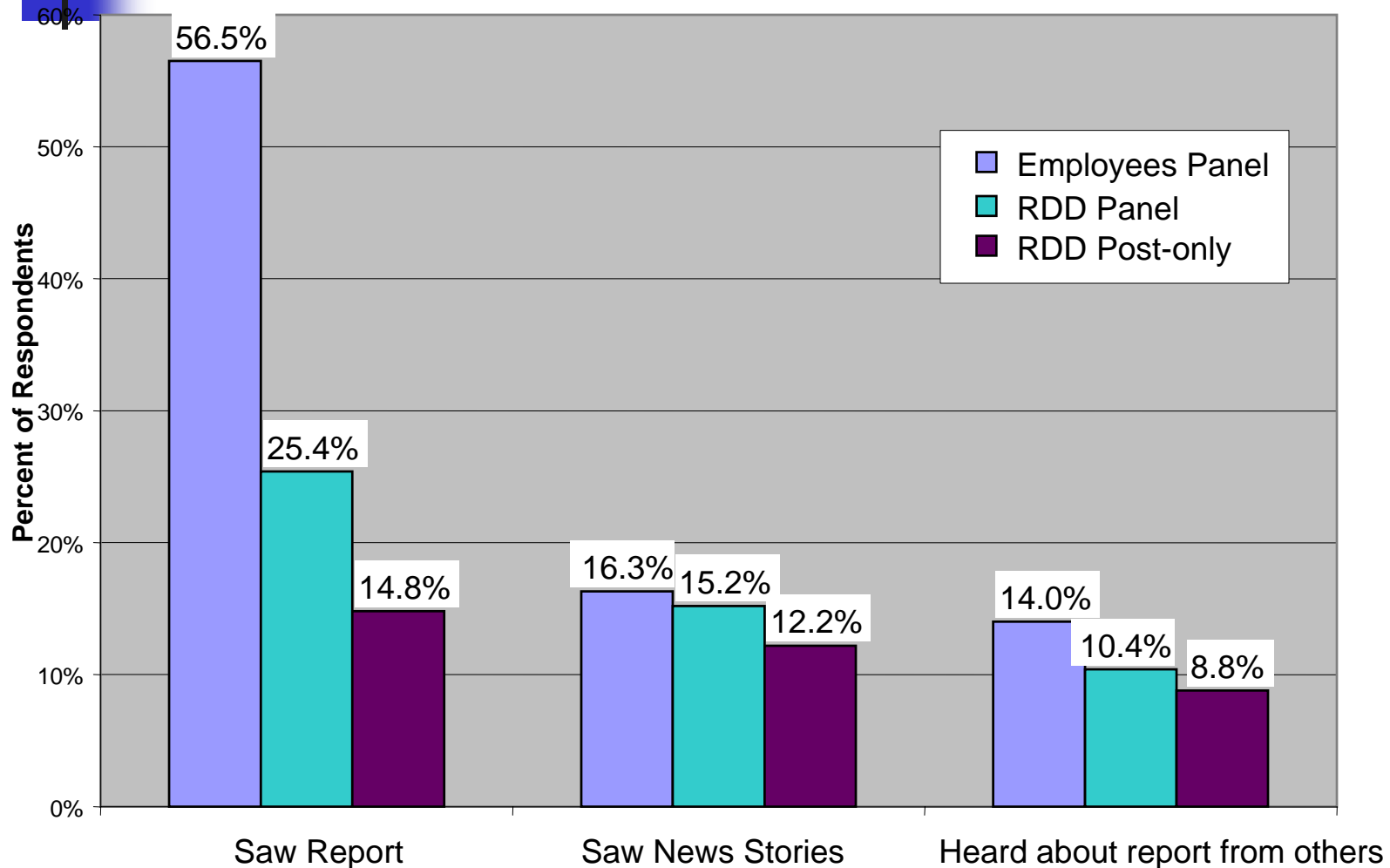
- An overall impression that there are better and worse options?
- Are impressions about which hospitals are better remembered?
- Did they discuss the report with others?



Evaluation of the impact of the report on consumers

- **Surveyed Prior to distribution of report:**
 - Alliance Member Employees
 - Community members (RDD sample)
- **Surveyed after the distribution of report:**
 - Employee panel (N= 93)
 - RDD panel (N= 67)
 - RDD post only (N= 469)
- **Surveyed 2 years later:**
 - New RDD sample (N= 729)

Percentage of Respondents Who Saw the Report, Saw News Stories about the Report, or Heard about the Report from Others.



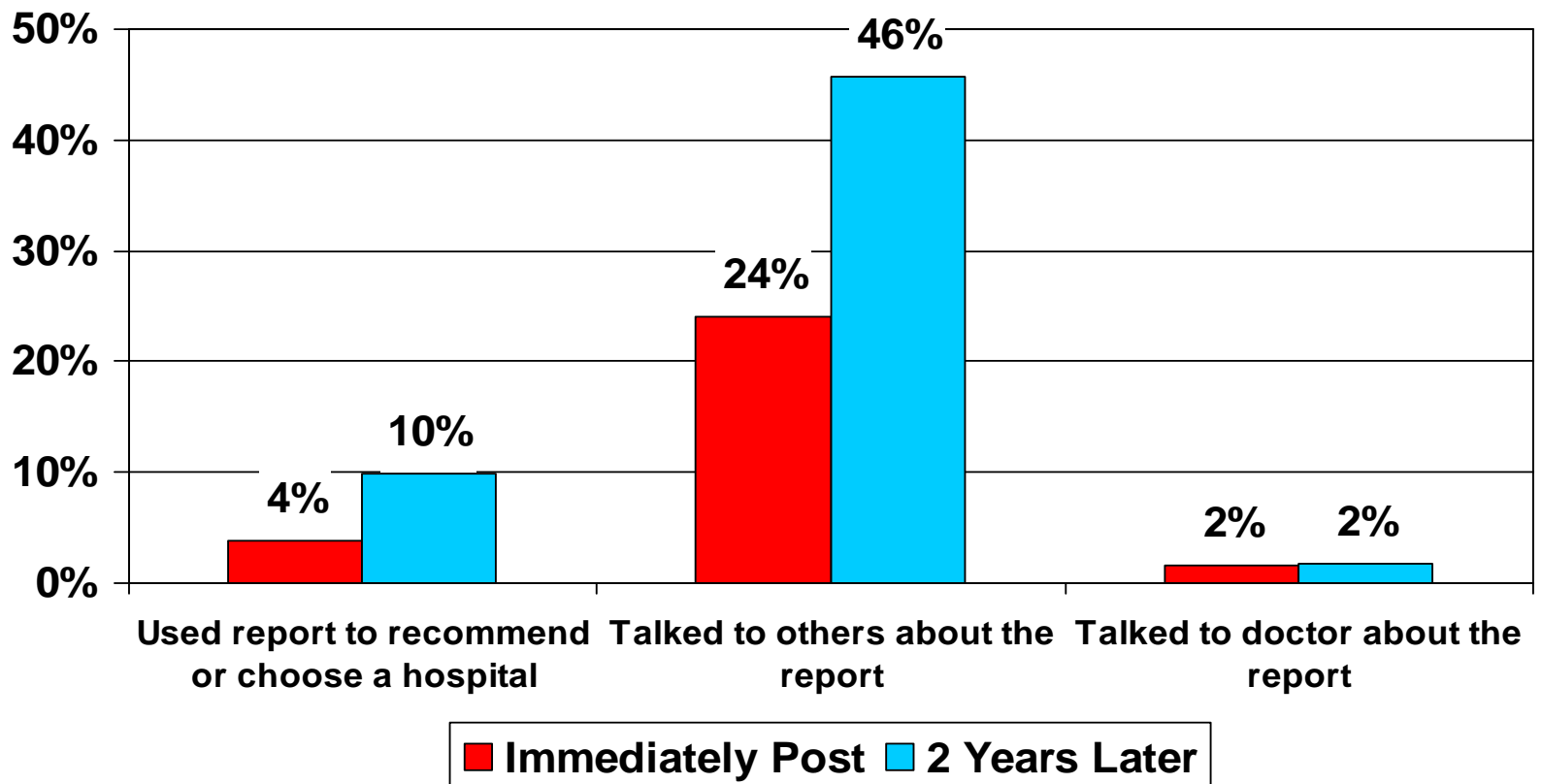


Exposure to the Performance Report

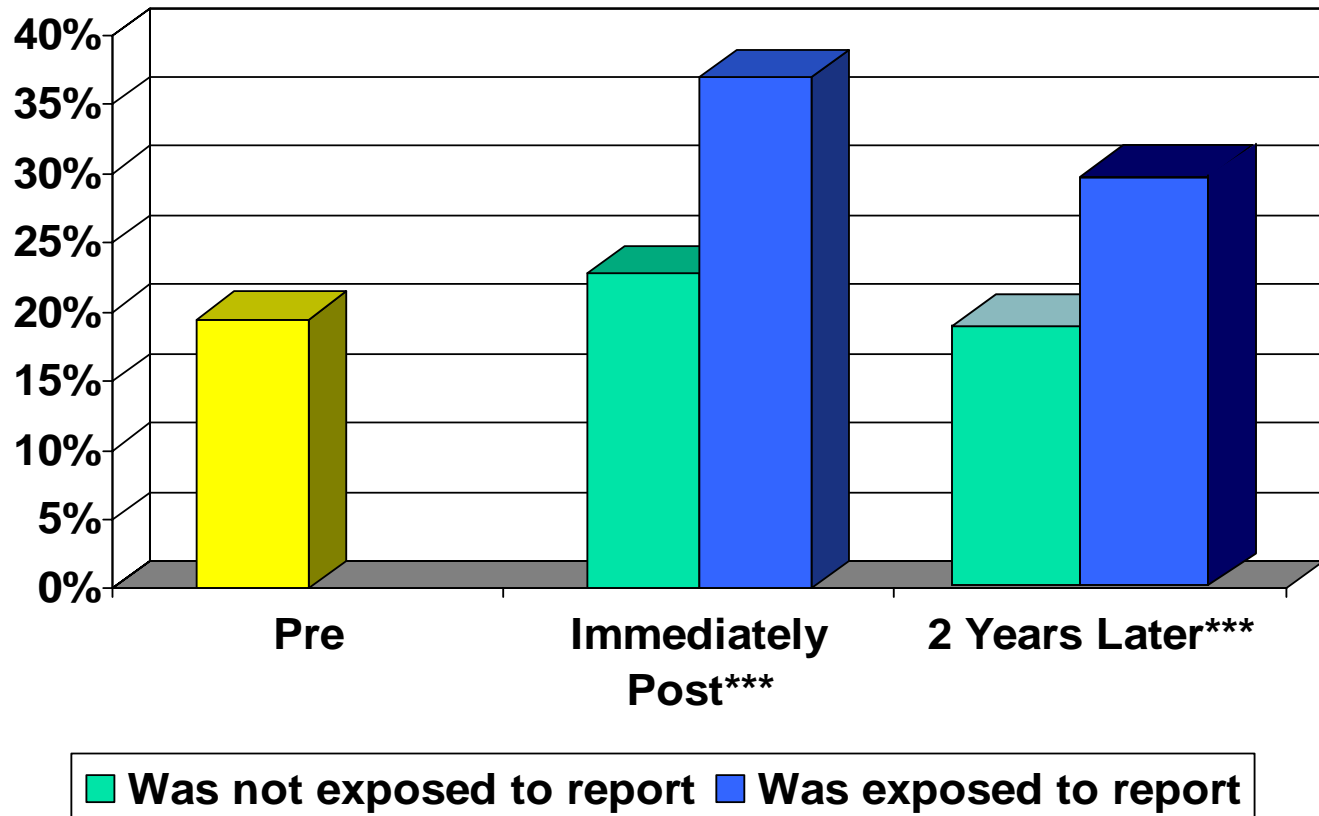
	Remember Seeing Report	Exposed to Report in some way*
Post (RDD only) (n=465)	15%	24%
2 years later (n=729)	6%	14%

* Saw, read about, or heard about the performance report

How the Hospital Report was Used: Immediately after release and 2 years later

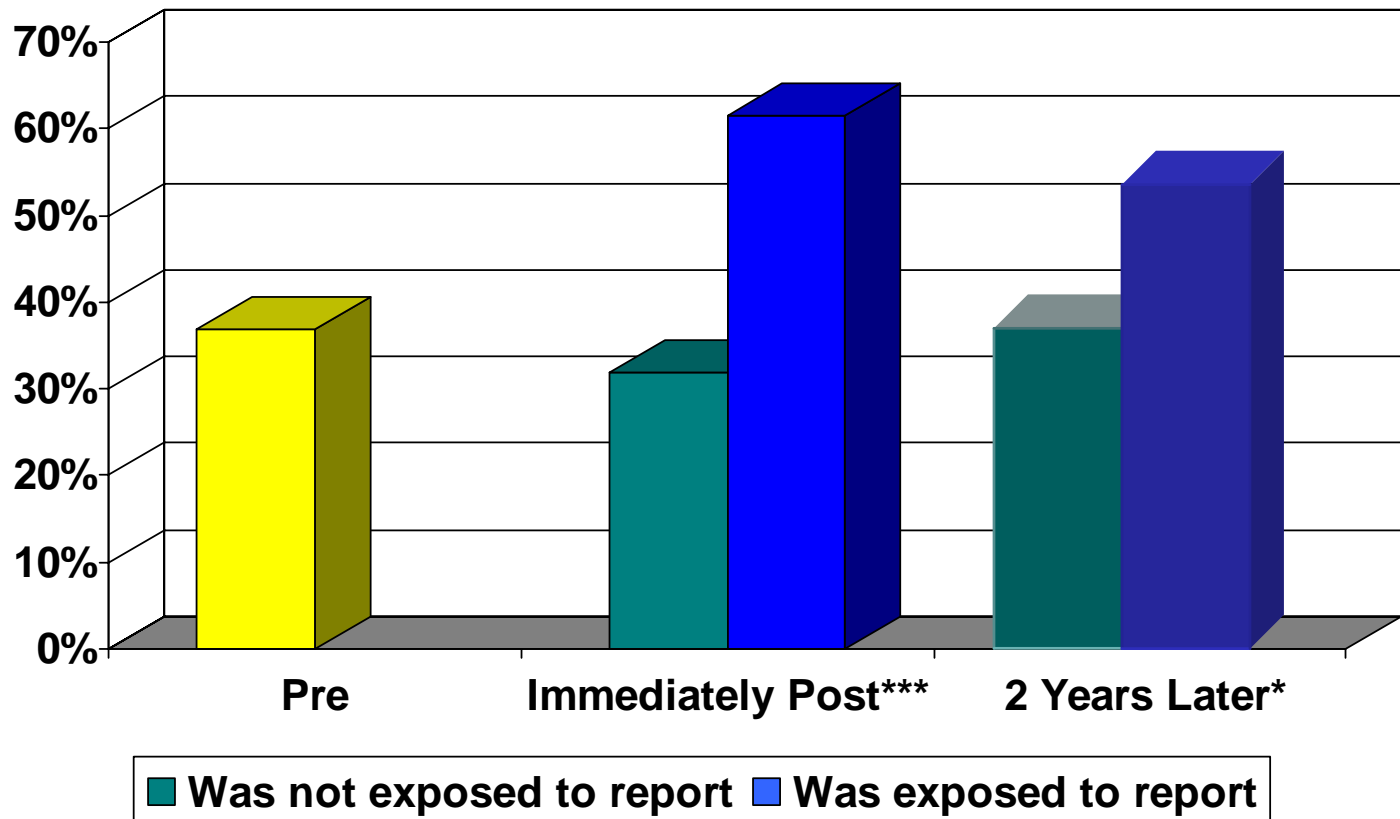


Correctly Identified Highly Rated Hospitals



*** $p < .001$

Correctly Identified Low Rated Hospitals



* $p < .05$, *** $p < .001$



Factors Related to Identifying a highly rated Hospital (Beta Weights)

	Post	Year 2
Gender	.00	.07
Exposure to report	.19***	.13***
Age /Length of time in the area	.11**	.04
Importance of reputation	-.02	.05
Importance of family recommendation	.03	.00

* $p < .05$, ** $p < .01$, *** $p < .001$



Reports can influence consumers

- Evidence for an impact on consumer perceptions of hospital quality– with diminishing but observable long-term effects
- People talked about the report and influenced the views of others
 - Some indication that social networks plays a role in the recommendation of higher rated hospitals



Implication: Public Reporting Does Work

- It does stimulate quality improvement -
-- primarily through a concern for reputation
- Feedback, and market share were not found to be viable pathways in this study

Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: The Emergency Department Perspective

Oregon Health &
Science University
Center for
Policy & Research
in Emergency Medicine

This draft is intended for review and comments only. It is not intended for citation, quotation, or other use in any form.

Changes in Access to Primary Care for OHP Beneficiaries and the Uninsured: The Emergency Department Perspective

- Robert A Lowe, MD, MPH
- K. John McConnell, PhD
- Rochelle Fu, PhD
- Cody Weathers, BS
- Jill Boyer-Quick, MS
- Annette Adams, MPH
- Beverly Bauman, MD
- Funding from
 - Robert Wood Johnson State Coverage Initiatives Grant (through the Office for Oregon Health Policy and Research)
 - Robert Wood Johnson Foundation Initiatives in Health Care Financing and Organization
 - Emergency Medicine Foundation

The context

- 1990's
 - Oregon Health Plan created
 - Expansion group of ~100,000 Oregonians added to the ~300,000 Oregon Medicaid enrollees
- 2000's
 - Reduction in scope of benefits
 - Premiums
 - Co-payments

Impact of OHP changes?

- Ideal study
 - Prospective cohort
 - Primary data collection
 - Follow OHP beneficiaries and uninsured Oregonians for several years
- But
 - Need for quick data

Opportunity

- Poor access to primary care →
 - Potentially avoidable ED use
 - Potentially preventable ED use
 - More ED use
- ED claims data rapidly available

Objective

- To describe changes in ED use, comparing before vs. after the OHP changes
 - Phase 1: OHSU data
 - Phase 2: representative sample of Oregon EDs
- Uninsured and OHP

Methods

- Study subjects

- OHSU ED visits, August 2001 through June 2004

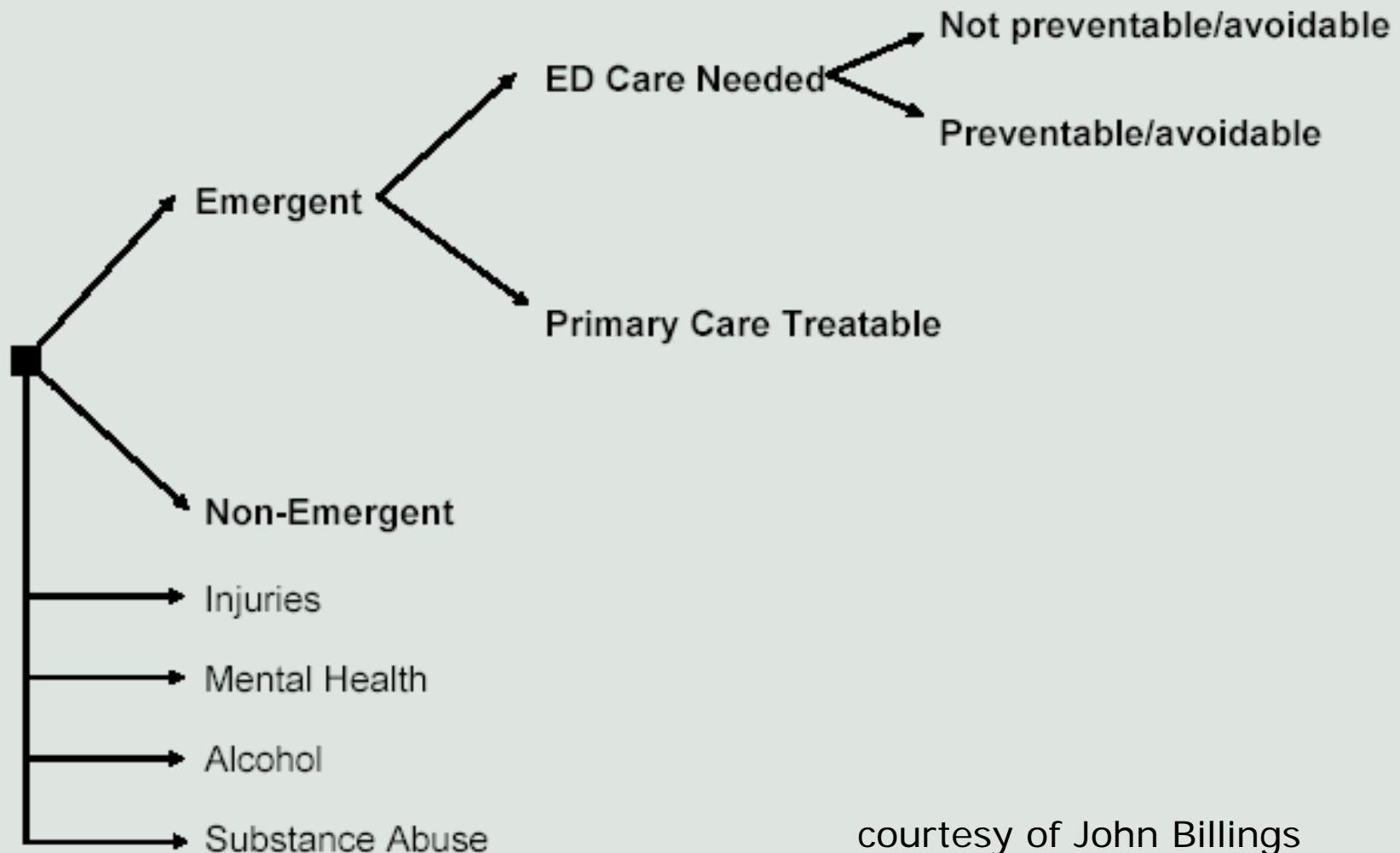
- Variables

- Predictor: before vs after 3/1/2003

- Outcomes

- Overall ED visits
- Behavioral health
- Ambulatory care treatable/potentially preventable
 - Billings algorithm

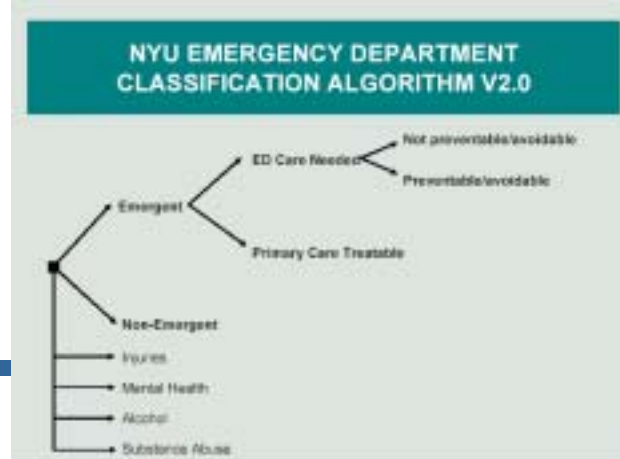
NYU EMERGENCY DEPARTMENT CLASSIFICATION ALGORITHM V2.0



courtesy of John Billings

Billings algorithm

- ICD9 789.0: Abdominal Pain
 - 0% non-emergent
 - 67% emergency, primary care treatable
 - 33% emergency, ED needed
- ICD9 038.1: Staphylococcal septicemia*
 - 0% non-emergent
 - 23% emergency, primary care treatable
 - 77% emergency, ED needed
- ICD9 038.10: Staphylococcal septicemia NOS
 - 0% non-emergent
 - 100% emergency, primary care treatable
 - 0% emergency, ED needed

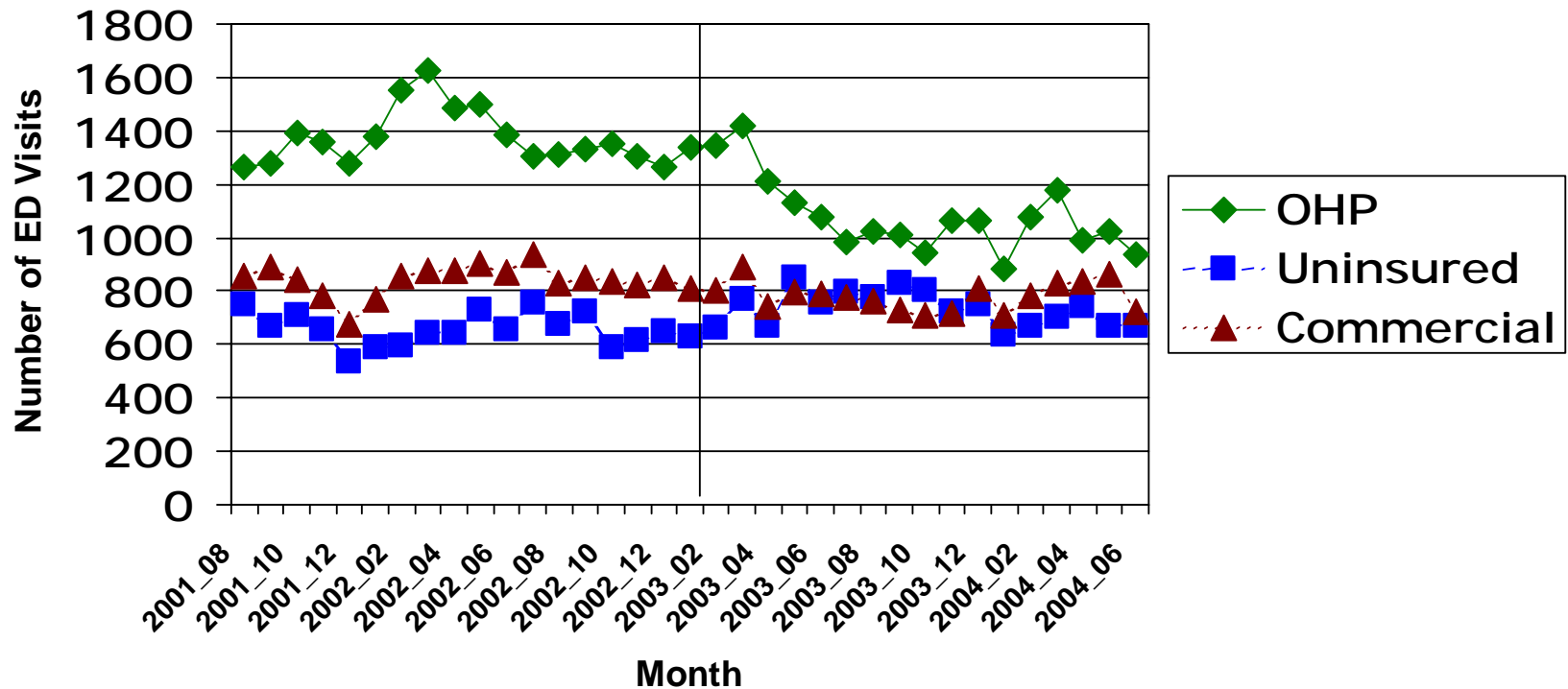


Data analysis

- Numbers of ED visits
 - Not a rate
- Payer mix
 - % of ED visits in each payer category
- Case mix
 - % of visits in a diagnostic group
- Pseudo-rates
 - Would be rates if any OHP enrollee in the 4-county area would come to OHSU if they went to an ED
 - Changes informative if the % who would come to OHSU did not change during the study period

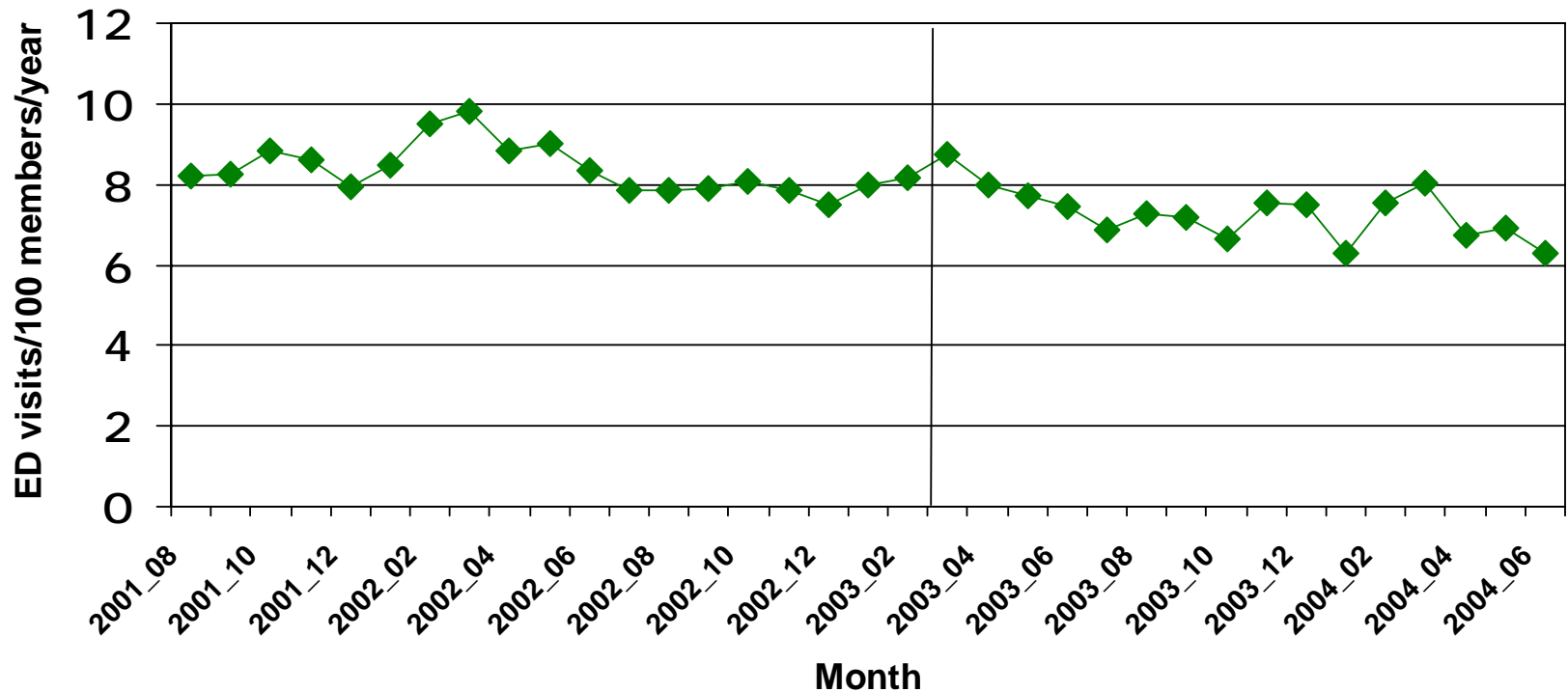
Results

Payer mix: % OHP visits fell, % uninsured rose



- OHP 38% of visits before 3/1/03 → 32% after (RR 0.84, 95% CI 0.83-0.85)
- Uninsured 18% → 22% (RR 1.22, 1.19-1.24)
- Commercial 23% → 23% (RR 1.01, 0.98-1.03)

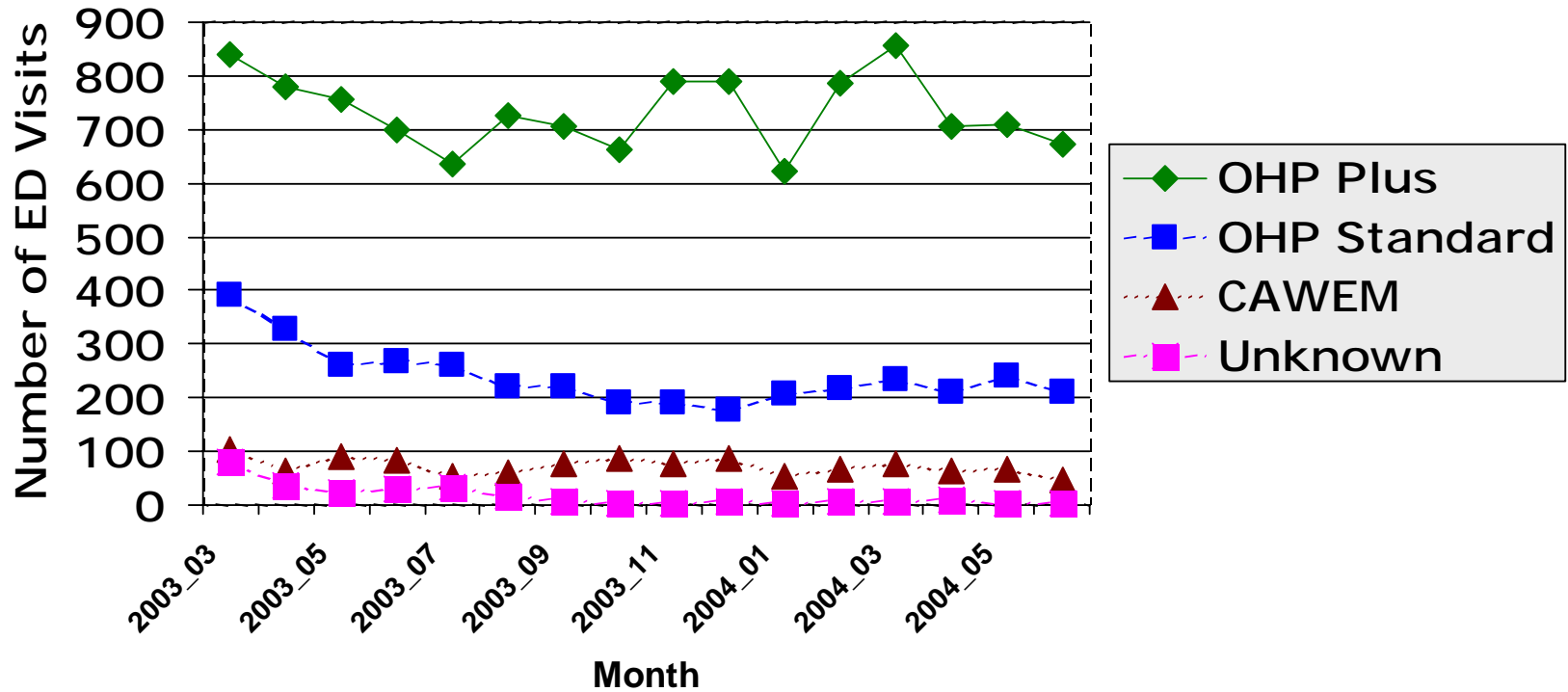
“Rate” of OHP ED visits fell



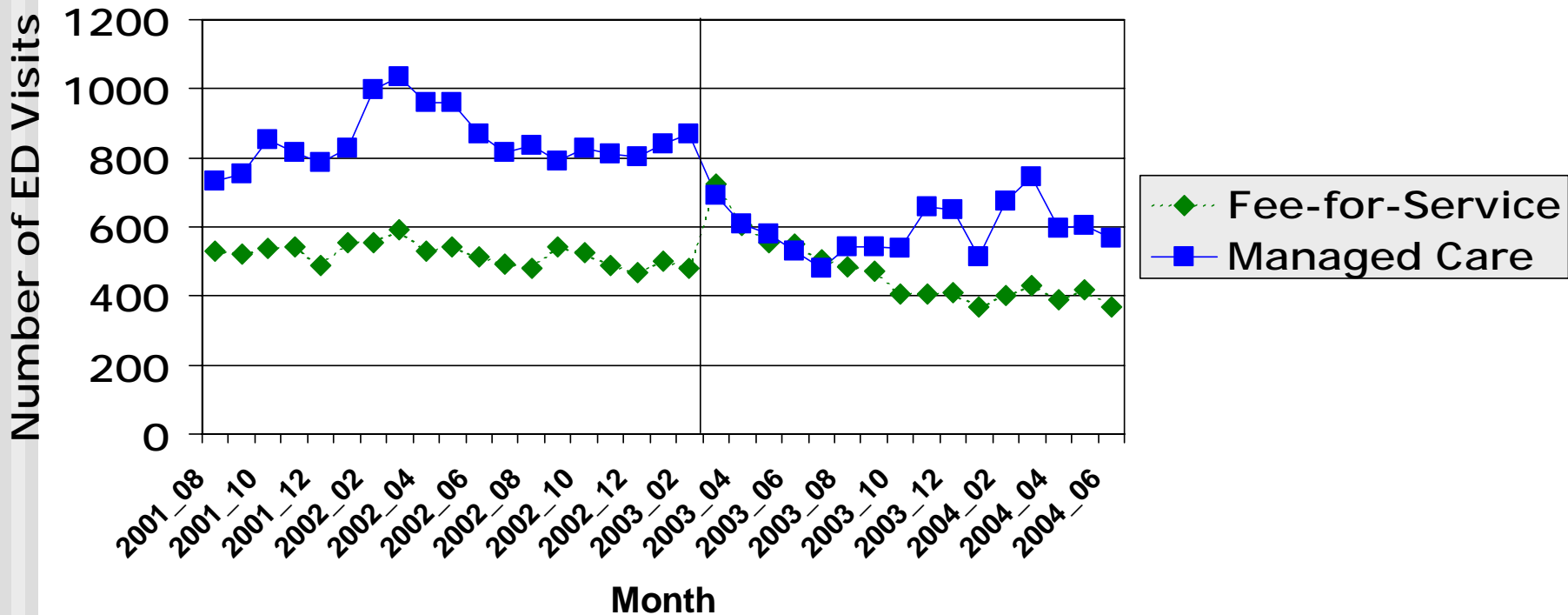
- Rate before 8.4 visits/100 members/year
→ 7.3 after

Payer mix:

% OHP Standard visits fell



Payer mix: % Fee-for-Service increased for OHP



■ FFS 38% → 44% (RR 1.16, 1.13-1.19)

Behavioral health: data limitations

- Alcohol-related ED visits
 - Mean 57/month
- Drug-related ED visits
 - Mean 15/month
- Other psychiatric ED visits
 - Mean 159/month

Behavioral health ED visits: payer-mix changes

■ Alcohol

- OHP 46% of visits before → 32% after (RR 0.69, 0.61-0.78)
- Uninsured 26% of visits before → 37% after (RR 1.41, 1.21-1.65)

■ Drug

- OHP 55% of visits before → 36% after (RR 0.66, 0.53-0.81)
- Uninsured 27% of visits before → 45% after (RR 1.70, 1.28-2.24)

■ Other psychiatric

- OHP 41% of visits before → 31% after (RR 0.76, 0.70-0.82)
- Uninsured 16% of visits before → 23% after (RR 1.48, 1.30-1.67)

Behavioral health ED visits: case-mix changes

■ Alcohol

- 1.9% of OHP visits before → 1.7% after (RR 0.90, 0.77-1.06)
- 2.2% of uninsured before → 2.8% after (RR 1.29, 1.08-1.54)

■ Drug

- 0.6% of OHP visits before → 0.5% after (RR 0.85, 0.63-1.13)
- 0.6% of uninsured before → 0.9% after (RR 1.52, 1.08-2.13)

■ Other psychiatric

- 4.7% of OHP visits before → 4.7% after (RR 0.99, 0.89-1.09)
- 3.8% of uninsured before → 5.1% after (RR 1.33, 1.16-1.53)

Behavioral health visits: Interpretation

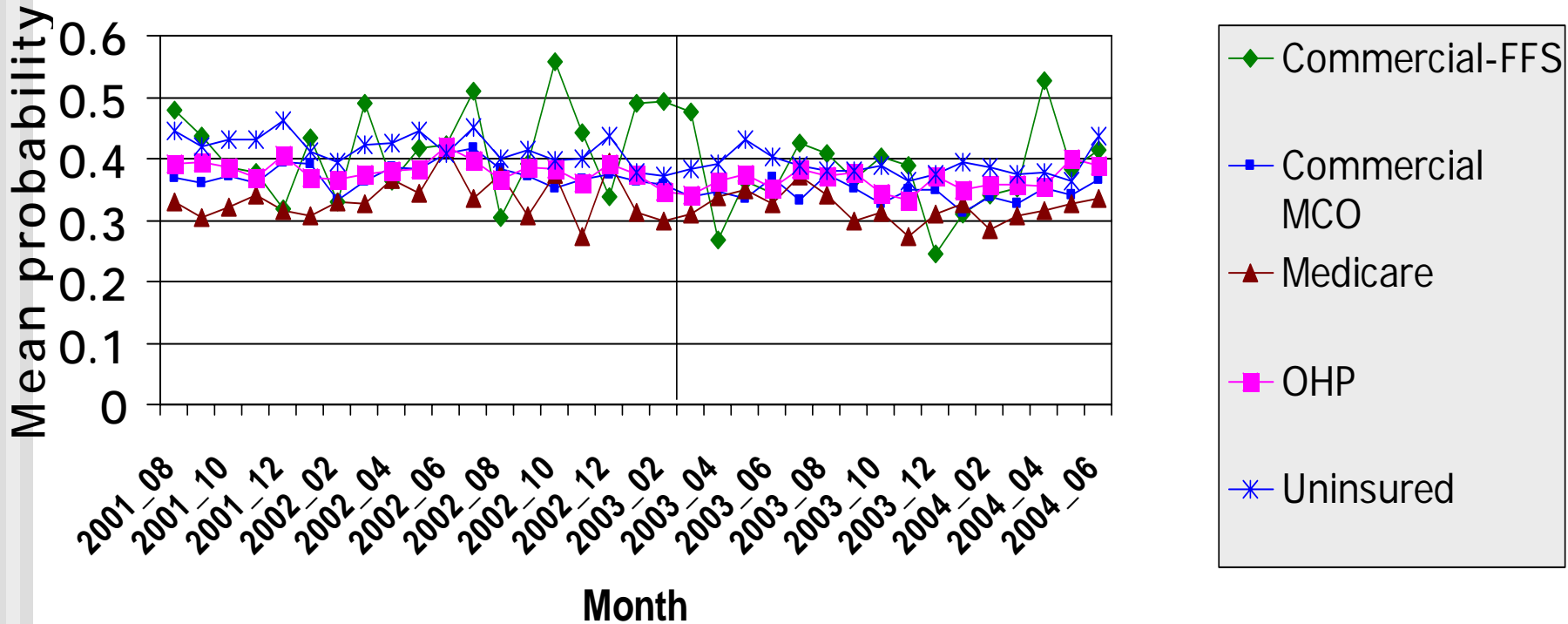
- Payer mix
 - Fall in % of visits covered by OHP
 - Rise in % of visits by uninsured
- Case mix
 - Little change in OHP case-mix
 - Given the drop in number of OHP visits → reduced number of OHP-sponsored behavioral health visits
 - Among ED visits by uninsured patients, rise in % drug-, alcohol-, and psychiatric-related
 - Have OHP enrollees with behavioral health conditions dropped out of OHP and substituted ED for outpatient treatment?

Billings categories by payer

	Commercial	OHP	Uninsured
Non-emergency	.36	.37	.40
Emergency PC treatable	.35	.37	.36
ED needed, potentially avoidable	.09	.09	.09
ED needed, not avoidable	.19	.16	.15

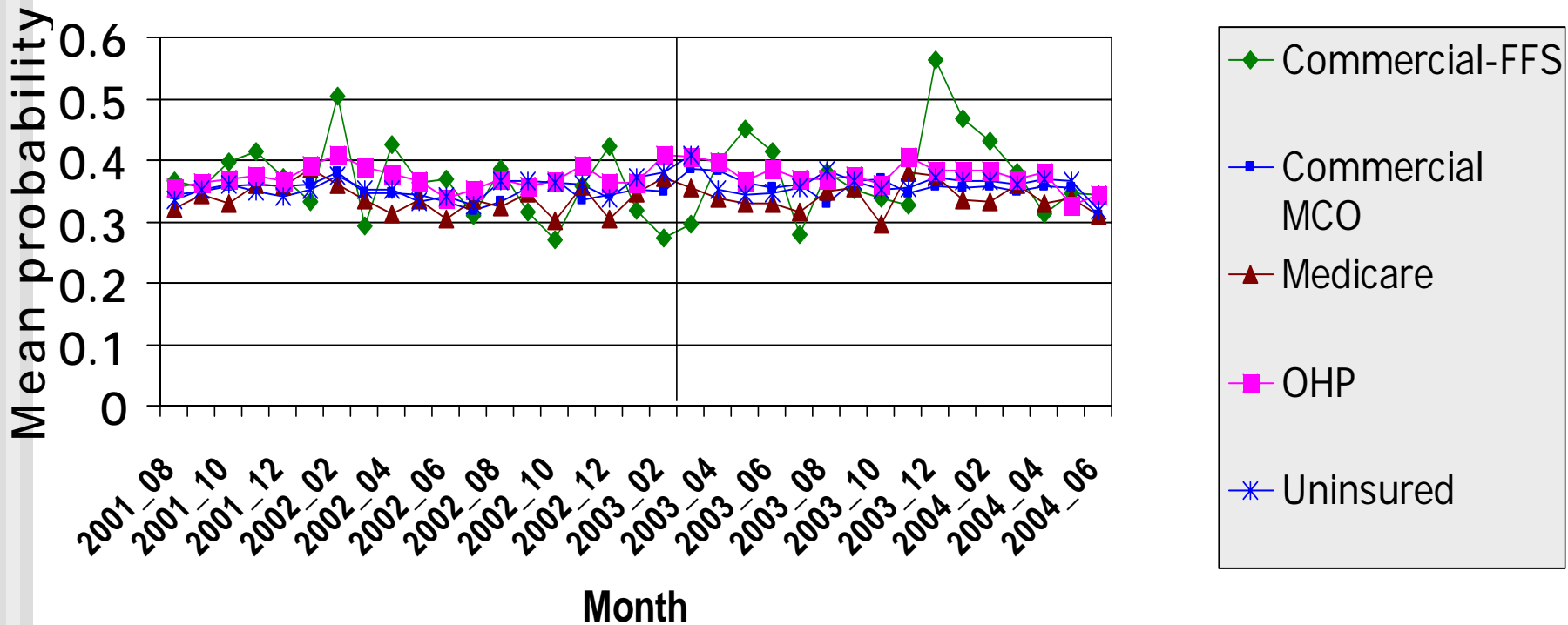
Ambulatory care sensitive ED visits

Non-Emergency



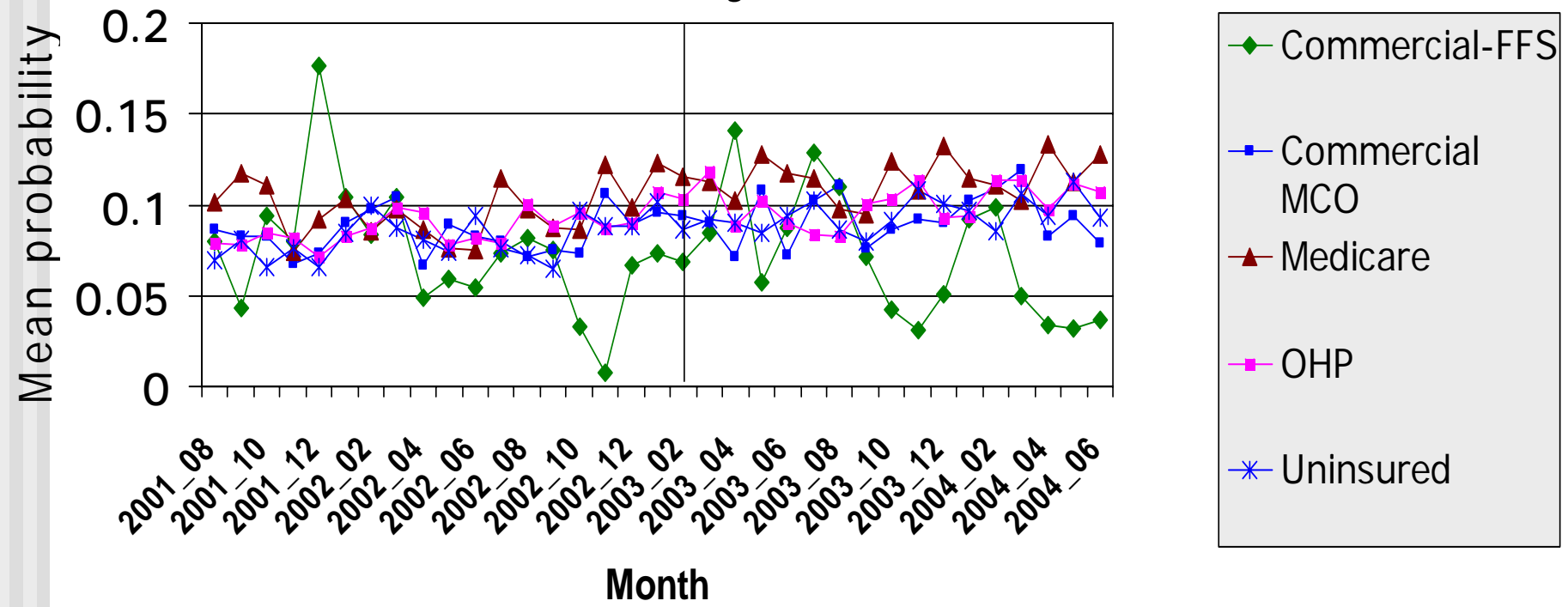
Ambulatory care sensitive ED visits

Emergency/Primary Care Treatable



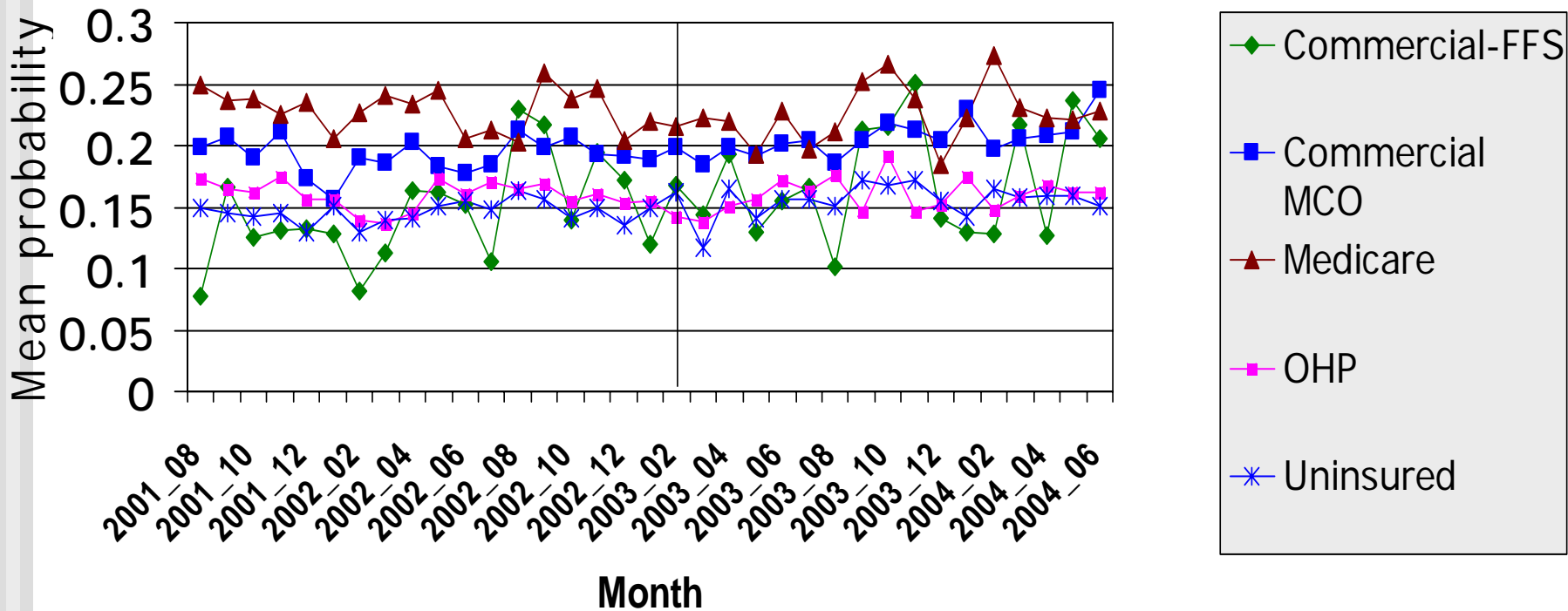
Ambulatory care sensitive ED visits

Emergency, ED Needed
Potentially Preventable



Ambulatory care sensitive ED visits

Emergency, ED Needed
Not Preventable or Avoidable



Summary:

Overall ED visits

- Drop in OHP visits
 - Payer mix
 - Drop in “rate” puzzling
 - Impact of co-payment?
 - Rise in uninsured visits
 - Payer mix

Summary:

Behavioral health ED visits

- Drop in OHP visits; rise in uninsured
- Have OHP enrollees with behavioral health conditions dropped out of OHP and substituted ED for outpatient treatment?
- Limited by under-reporting of drug and alcohol-related diagnoses in billing data

Summary: Ambulatory care sensitive ED visits

- ? Validity of classification system?
- If % emergencies doesn't rise and # of visits falls, are patients with emergency conditions failing to seek care?

Limitations

- Counts not rates
- One ED
- Under-reporting of drug and alcohol diagnoses

Conclusion

- Probably not good news
 - Drop in OHP ED use
 - As % of all ED visits
 - As “rate”
 - Increased ED use by uninsured suggests increased barriers to care
 - Especially for behavioral health problems
 - Worsened payer mix will force increased cost-shifting

Next steps

- Study more EDs
- Historical cohort study of OHP enrollees
 - Case-mix adjusted ED utilization rates