American Health Quality Association Technical Conference, February 2003

Roundtable Discussion: What type of drill-down analysis should be done with FATHOM data and how should QIOs use the analysis results to research and monitor HPMP problem areas?

Since several attendees were new to HPMP and FATHOM, a brief description of the contents of FATHOM was provided.

Question: When will FATHOM data be 'shareable' with hospitals? One of the components of quality improvement is to see where you stand in relation to others as a motivation to take action. Sharing FATHOM data with hospitals was seen as a fundamental requirement of getting the job done for HPMP.

Question: What is the time frame for approval of an HPMP project, and will data be outdated once the project is approved?

Concern: Insufficient budget to perform case review to confirm a problem identified through FATHOM.

NM uses the HPMP error case listing report to produce reports of case error rates by hospital and control charts to trend case error rates over time. The SAS code for production of the reports was shared in an earlier presentation. [Note: This type of analysis is practical only for states with smaller numbers of hospitals.]

CT reported that requests for Higher Weighted DRGs (HW DRG) are climbing. They will investigate whether there is any overlap with the target areas in FATHOM.

NC expressed concern over starting with a low payment error rate. They have experienced a very steady rate of HW DRG requests, approximately 30 to 40 per month.

AL has experienced a lot of success with sending their physicians to address the medical staff of hospitals on how to document, what coders do, appropriate admission criteria, etc. They have found a niche in facilitating the relationship of the medical staff with case management, coders, etc.

CT recommended that FATHOM be mined to identify monetary issues that would motivate physicians to pay attention to the data. It is their experience that comparative data, with reasonably large enough denominators, and the dollars involved in the services get the attention of physicians. For example, if a hospital is shown that they are an outlier on length of stay (LOS), and that a reduction in LOS can free up money to hire more nurses, or more equipment, the physicians will be motivated to participate. Some hospitals do not have a process for obtaining a timely discharge summary for a patient. CT law requires that a discharge summary attend a patient who will be discharged to a nursing home, etc. If the physician does not dictate the discharge summary on the day that the patient is ready to leave the hospital, then that patient stays one more night in the hospital resulting in an unnecessarily longer LOS.

CT also recommended looking at the combination of the One Day Stay, Same Day Readmission to Same Facility/Elsewhere, and the Seven Day Readmission target areas as an indicator of premature discharges. Outlier hospitals on the combination of these areas need to work on the communication of medical staff with other staff within their facility.

WA expressed an interest in learning where their state's hospitals compared to other states' hospitals on FATHOM target areas. WA suggested that states find other states with similar problems and join forces to submit a project plan for a project to cover all the states with that problem. WA asked whether an HPMP workgroup could be formed to assist in the discussion of findings from FATHOM data and in the generation of ideas for HPMP projects.