

Statewide Quality Advisory Committee (SQAC) Meeting

Monday, September 22, 2014

9:00am - 11:00am

MEETING MINUTES

Location:

Center for Health Information and Analysis (CHIA)
2 Boylston Street, 5th Floor
Boston, MA 02116

Chair: Áron Boros (CHIA)

Committee Attendees: James Feldman, Jon Hurst, Ann Lawthers, Richard Lopez, Iyah Romm (non-voting), Madeleine Biondolillo (non-voting), Dolores Mitchell, Dana Safran, Michael Sherman

Committee Members Attending by Phone: Dianne Anderson

Committee Members Not Present: Kim Haddad (non-voting), Amy Whitcomb Slemmer

Other Attendees: Tim Prinz (The Lewin Group), Kristina Philipson (CHIA)

1. Chair Boros opened the meeting. He explained that at the previous meeting, the Committee had decided which of the publicly-nominated quality measures would go to the Lewin Group for review, and that this meeting would have two main purposes: a) to identify measures that posed challenges for review, and identify any additional information needed prior to deciding on inclusion in the SQMS, and b) to identify which measures could be accepted into or rejected from the SQMS based on the current information available. He introduced Kristina Philipson from CHIA and Tim Prinz from the Lewin Group to discuss the evaluations.
2. Tim Prinz explained that Lewin reviewed 35 measures plus 10 measures from the Leapfrog set. He said that some of the Leapfrog measures were already included in the SQMS, and these were not reviewed. He explained that the Lewin Group began its evaluation with a literature review of information about each of the quality measures. Following this, 4 team members completed their own scoring rubrics on each measure in each of 4 categories: a) ease of measurement; b) reliability and validity; c) field implementation; and d) amenable to targeted improvement. A single consensus score for each domain was reached after discussion between all team members. He said that the 4 reviewers had between 88% and 92% inter-rater reliability, and that there were no instances of large differences of opinion between members.

3. Tim Prinz explained the challenges in assessing Clinical Survey Questionnaires such as the PHQ-9 and AUDIT. He said that while these are useful for providing better care, and there is a growing push to use these as quality measures, the evidence for them used as quality measures to improve care is limited.
 - a. Dana Safran asked whether the issue with the PHQ-9 was in understanding the reliability of the tool as a point-in-time assessment, or in measuring changes over time and ascribing these changes to the quality of care. Tim Prinz said that the PHQ-9 is a reliable tool, but its use as a measure of care quality when used as a process measure (i.e. how frequently do providers use the PHQ-9) is limited. Iyah Romm said that using the PHQ-9 process measure could be useful for many things, but likely not as an outcome measure for provider accountability.
 - b. Chair Boros asked whether the SQAC would recommend putting in the PHQ-9 process measure given the evidence of its strength as a clinical tool and the limited evidence of its use as a quality measure. Michael Sherman and Ann Lawthers recommended accepting this measure into the SQMS.
 - c. Kristina Philipson said that the PHQ-9 already has national support, so including it would make sense.
 - d. Ann Lawthers said that in certain care areas, there may be multiple valuable screening tools. She said that the Committee should not necessarily endorse only one screening tool to the exclusion of all others in these cases, if there was good reason to endorse multiple ones.
 - e. Kristina Phillipson said that AUDIT is already part of a measure included in the SQMS, so it will not be considered for separate inclusion.
 - f. Tim Prinz said that the Columbia Suicide Severity Rating Scale (CSSRS) cannot easily be tracked over time for a given patient, and the “targeted improvement” category is important. Iyah Romm said that the CSSRS is often used as an overlay tool for the PHQ-9, when more information is needed. He brought up the question of parsimony, and said that the SQAC could choose to either make the SQMS comprehensive, or try to prevent overlap between measures.
 - g. Chair Boros asked whether it made sense to endorse some measures without officially including them in the SQMS. Madeleine Biondolillo said that if there is a tool with obvious clinical use, where providers using the tool have seen scores improve, including them in some way could lead to clinical quality improvement and drive good practice. Chair Boros said that CHIA would return at the next meeting with a more thorough understanding of what a subset of measures that are “useful for clinical improvement”, but not included in the SQMS, would look like.

- i. Dolores Mitchell said that the SQAC should be careful about characterizing measures that don't make it into the SQMS but are still useful. She said that the state of quality measurement is fluid, and that identifying measures as useful for clinical practice but not reporting on them could send a confusing message. Madeleine Biondolillo said that public reporting drives behavior differently than quality improvement efforts. She said that giving providers a pathway to make measures work in their systems could be useful even before public reporting begins.
4. Kristina Philipson identified challenges with the Leapfrog set which was nominated for inclusion in the SQMS. She said that the set was nominated as a whole, but it is an extensive survey that combines more traditional quality measures with other structural measures. She asked whether the SQAC should consider the Leapfrog Survey as a complete set or as individual components.
- a. Dana Safran said that Leapfrog is a set because of how Leapfrog reports to hospitals, but since the SQMS is used differently, CHIA can consider them as components.
 - b. Kristina Philipson said that these measures are potentially useful for consumers and are very consumer oriented. Dana Safran said that if certain measures in the set are not reliable, these measures would not be useful to consumers, while other more reliable measures in the set could be useful.
 - c. Dana Safran asked about the feasibility of reporting Leapfrog data given the proprietary nature of the survey. Chair Boros said that CHIA is currently in negotiations about getting Leapfrog data, and is unsure whether the data will be available for use.
5. Kristina Philipson explained the challenges with the Hospice Item Set. She said that the measures were new, so there was not a lot of evidence for field implementation. She asked whether CHIA should include the whole set because CMS is planning to public report on them with data collection beginning in January 2014.
- a. Madeleine Biondolillo said that the difference between a 1 in the reliability domain and a 1 in the field implementation domain is large. She said that if a measure is shown to be unreliable, it is more problematic than if it is not widely used. Michael Sherman agreed.
 - b. Iyah Romm said that CMS is requiring them, so they will be widely used unless there is a high rate of noncompliance. Tim Prinz said that the Lewin Score looked at literature surrounding use, and was notably conservative given upcoming CMS public reporting. Dana Safran said low field implementation could mean that providers have not had a chance to use the measures, and asked whether the SQAC could include them in the set but note that reporting would not begin for a certain time period. Madeleine Biondolillo said that if this happens, the SQAC could be explicit about a pathway to reporting.

- c. Ann Lawthers said that she would support including 4 of the 5 measures in the SQMS: a) pain screening; b) pain assessment; c) dyspnea screening; and d) dyspnea treatment. The SQAC agreed.
 - d. Ann Lawthers asked about variances on the ease of measurement category for hospice measures, given the similar write-ups of how the measures are collected and reported.
- 6. Kristina Philipson said that the patient engagement measure evaluation was the same as last year.
 - a. She said that the active patient engagement measure allows self-scoring of a patient's confidence to manage his or her own healthcare and could be useful in facilitating a dialog between patients and providers, but that data collection was not clear enough to report as a quality measure. She said that there is a proprietary tool that focuses on this question for patients recently diagnosed with chronic conditions, but this tool was not nominated for inclusion.
 - b. She said that the shared decision-making measure is a series of questionnaires used at MGH for patients receiving screenings or procedural services. She said that these are helpful patient engagement tools but not statewide quality measures.
 - c. Dana Safran said that there is a Dartmouth measure of decision quality. This measure was not publicly nominated but could be considered for inclusion.
 - i. Dolores Mitchell recommended talking to the Informed Medical Decisions Foundation
 - ii. Iyah Romm recommended seeking out provider perspectives on patient engagement.
 - d. Chair Boros recommended further discussion of patient engagement measures at the next meeting. The SQAC agreed that this discussion should include the Dartmouth measure and the proprietary tool.
- 7. Kristina Philipson identified measures that did not pose challenges for Lewin's preliminary evaluation:
 - a. She said that the 3 behavioral health measures all received good scores.
 - b. She said that the Pediatric Care/Behavioral health measure of depression screening by 18 years of age received a good rating, while the other 2 nominated measures received moderate or weak scores.
 - i. Ann Lawthers asked why the reliability and validity score for Developmental Screening in the first 3 years of life was rated as 0. Tim Prinz said that there are a

number of tools with varying reliability and validity, so scoring this was difficult. Ann Lawthers said that the measure simply asked whether the provider uses a standard tool, and questioned the low rating. Chair Boros recommended following up at the next Committee meeting.

- c. Kristina Philipson said that 4 of the 6 nominated End-of-Life Care and Patient-Centered-Care measures received Strong or Good evaluations.
 - i. Dana Safran said that the previous SQAC meeting had considered the Measuring What Matters set for end of life care, and asked why CHIA had not reviewed these measures. Kristina Philipson said that these were not in the list of official measure nominations received by CHIA. The SQAC recommended considering these measures prior to the next meeting.
 - ii. Kristina Philipson noted some overlap between the measure of Palliative and End of Life Care: Dyspnea Screening & Measurement and the Hospice Item Set. The SQAC agreed that these looked at somewhat different populations.
 - iii. Madeleine Biondolillo said that the CARE and Family Evaluation of Palliative Care measures were important, but seemed difficult to collect. She said that families do tend to respond positively to this measure, but it requires a family survey. Chair Boros recommended future discussion these measures.
 - d. Kristina Philipson said that 10 additional CMS measures were nominated for inclusion even though they did not fit into the SQAC priority domains. She said that these are currently part of the Value-Based Purchasing initiative. Iyah Romm said that the CLABSI and SSI measures have DPH equivalents which are the standard for Massachusetts, and recommended using the DPH scores.
8. Dolores Mitchell asked whether, given current worries about opiate overdose, there were any measures that would look at this area. Iyah Romm said that there is a claims-based measure of back pain patients in the Emergency Department prescribed opioids. Chair Boros said that CHIA would look into this prior to the next Committee meeting.
9. The SQAC voted on inclusion or rejection of measures and identified which measures needed further discussion. Committee decisions were as follows:
- a. Included Measures:
 - i. Clinical Survey Questionnaires:
 - 1. Patient Health Questionnaire: the PHQ-9 (NQF 712)
 - ii. Leapfrog

1. High-risk Newborn Deliveries (PC-03)
 2. Newborn Bilirubin Screening & DVT Prophylaxis in Women Undergoing Cesarean Section
 3. Incidence of Episiotomy
 4. Aortic Valve Replacement
 5. Pancreatic Resection
- iii. Hospice Item Set
1. HIS: Pain Screening
 2. HIS: Pain Assessment
 3. HIS: Dyspnea Screening
 4. HIS: Dyspnea Treatment
- iv. Behavioral Health
1. Post discharge continuing care plan created
 2. Post discharge continuing care plan transmitted to next level of care provider upon discharge
 3. Maternal Depression Screening
- v. Pediatric Care/Behavioral Health
1. Depression screening by 18 years of age
- vi. End-of-Life Care/Patient-Centered Care
1. Proportion admitted to hospice for less than 3 days
 2. Beliefs/Values Addressed (if desired by the patient)
 3. Advance Care Plan
 4. Palliative and End of Life Care: Dyspnea Screening & Management
- vii. Other Measures
1. PC-02 Cesarean Section
 2. Patient Safety Composite

3. Pneumonia 30-day mortality rate
4. Heart failure 30-day mortality rate
5. AMI 30-day mortality rate
6. Hospital-onset methicillin resistant staphylococcus bacteremia aureus (MRSA)
7. Hospital-onset *C. difficile*
8. Catheter-Associated Urinary Tract Infections

b. Rejected Measures

i. Clinical Survey Questionnaires

1. AUDIT: (A vote was not necessary because the measure is already present in the SQMS)

ii. Leapfrog Set

1. Abdominal Aortic Aneurysm Repair-scored “weak”
2. Esophagectomy – scored “weak”

c. Further Discussion Needed

i. Clinical Survey Questionnaires

1. Generalized Anxiety Disorder 7-item (GAD-7)
2. Columbia Suicide Severity Rating Scale

ii. Patient Engagement

1. Use and Quality of Shared Decision-Making (MGH surveys)
2. Active Patient Engagement (J. Wasson, Dartmouth)
3. Dartmouth measure of decision quality
4. Judith Hibbard’s Patient Activation measure. Proprietary tool for patients recently diagnosed with chronic conditions

iii. Pediatric Care/Behavioral Health

1. Diagnosis of ADHD in primary care for school-aged children and adolescents (does measurement promote over diagnosis?)
2. Developmental Screening in first 3 years of life (should measure be rated low on reliability and validity because a single tool not specified?)

iv. End-of-Life Care/Patient Centered Care

1. CARE - Consumer Assessments and Reports of End of Life
2. Family Evaluation of Palliative Care
3. (There was a question about why the “Measuring What Matters” measures for end of life were not evaluated by Lewin. Kristina Philipson said she was not aware of the request but will follow up for the next meeting.)

v. Other Measures

1. Central-Line Associated Bloodstream Infection (DPH Equivalent)
2. SSI Surgical Site Infection: SSI colon, SSI-abdominal hysterectomy (DPH Equivalent)

d. No Motion

i. Hospice Item Set

1. HIS: Patients Treated with an Opioid who are Given a Bowel Regimen

10. Kristina Philipson said that subsequent to notifying hospitals of their quality measurement results, a hospital requested that CHIA not report PSI 19, a measure of 3rd and 4th degree obstetric traumas per 1,000 vaginal deliveries without instrument, unless it is paired with a C-section rate and a footnote regarding issues with the measure. She said that she had requested SQAC feedback and heard back from 3 SQAC members who subsequently sought input from subject matter experts. She said that feedback reflected some concerns, but there was not unanimous agreement on the ideal course of action. Based on this, she said that CHIA was planning to continue reporting the measures.

- a. Dr. Feldman reiterated his email comments that there is no specific data citing a direct relationship between c section and third and fourth degree lacerations. He also reiterated that no measure of 3rd and 4th degree lacerations alone has received NQF endorsement.

- b. Dana Safran reiterated her email comments that critique of the measure is largely based on varied definitions of 3rd degree lacerations. However, she said that ACOG has very clear definitions of the varying degrees of laceration.
- 11. Kristina Philipson outlined progress on CHIA's project to evaluate Obstetric Measures as the first specialty-specific addition to the SQMS. She said that CHIA's goals are to determine current use of OB measures for reporting, QI, and tiering; understand relative strengths and weaknesses of measures by use; learn how measures are applied by provider type (MD, NP, PA, other); align state and national OB measures; and identify issues associated with measuring and reporting specialist quality.
 - a. She said that CHIA seeks to complete this project between September 2014 and March 2015 via structured interviews with specialty organizations, and provided the Committee with a list of stakeholders. She said that CHIA had written an initial set of questions for these interviews and had cataloged existing obstetric and perinatal measures. She asked the SQAC for recommendations on additional stakeholders to talk with, and asked whether the review should include perinatal measures or be limited to obstetric measures.
 - i. The SQAC said that the review should include perinatal measures.
 - ii. Iyah Romm recommended talking to Lauren Smith and Charles Homer at NCHQ (National Association for Healthcare Quality).
- 12. Chair Boros said that CHIA has written a letter to DOI with recommendations regarding the use of SQMS by payers for provider tiering. He said that the key points are that payers should draw exclusively from the SQMS when tiering hospitals and physicians in their merged market products; that SQMS updates should be predictable and well in advance of health plan contracting deadlines; that specialist measures can come from outside the SQMS; that in the future, standard specifications for measures may be required, including minimal sample sizes; that CHIA intends to calculate provider performance on the measures and recommends that in the future, these results be used to tier providers on quality; and that CHIA does not have any recommendations regarding tiering methodologies at this time but advises that DOI publish the methodologies used by the carriers with a view to future standardization.
- 13. Chair Boros asked for a motion to approve the minutes from the June 16, 2014 meeting. The minutes were unanimously approved.