Statewide Quality Advisory Committee (SQAC) Meeting
Friday, May 18, 2012
10:00AM – 12:00PM
MEETING MINUTES

Location:
Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116

Co-Chairs: John Auerbach (DPH) and Áron Boros (DHCFP)

Committee Attendees: Dr. James Feldman, Dr. Richard Lopez, Jon Hurst, Amy Whitcomb Slemmer, Dana Gelb Safran, David Smith as a designee for Diane Anderson
Committee Members Not Present: Diane Anderson

Other Attendees: Dr. Constance Horgan (expert presenter), Dr. Deborah Garnick (expert presenter), Dr. Madeleine Biondolillo (DPH), Iyah Romm (DPH), Dr. John Freedman

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1. Approval of minutes from SQAC meeting on March 30, 2012
    - Motion to approve meeting minutes passed
2. Approval of minutes from SQAC meeting on April 12, 2012
    - Motion to approve meeting minutes passed
3. Co-Chair Boros introduced Dr. Madeleine Biondolillo, from the Department of Public Health, to review the care transition measures presented at Meeting 4 by Dr. Amy Boutwell.
    - Dr. Biondolillo reminded the SQAC that the committee's focus in Year 1 is Independent Care Organizations, Accountable Care organizations, and Patient-Centered Medical Homes, and that care transition measures are important in capturing movement through these large systems.
    - Dr. Biondolillo introduced the idea of a measure pilot program for those measures that reflect important care areas, but that do not yet have a strong evidence base.
    - Dr. Biondolillo reviewed Dr. Boutwell's recommendations to the SQAC.
        i. Three measures from the Outcome and Assessment Information Set (OASIS) measure set:
            1. Acute care hospitalization (risk-adjusted): Percentage of patients who had to be admitted to the hospital
            2. Emergent care (risk adjusted): Percentage of patients who had to use a hospital emergency department
            3. Timely Initiation of Care: Percent of patients with timely start or resumption of home health care
        ii. The Three-Item Care Transition Measure (CTM-3)
            1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

iii. Four Nursing Home MDS measures:

1. Percent of Residents who Self-Report Moderate to Severe Pain (short stay)
2. Percent of Residents with Pressure Ulcers that are New or Worsened (short stay)
3. Percent of Residents who Self-Report Moderate to Severe Pain (long stay)
4. Percent of High-Risk Residents with Pressure Ulcers (long stay)

- All of these measures fell into the strong recommendation category, except for the CTM-3, which fell into the moderate recommendation category.
- Co-Chair Boros asked Dr. Biondolillo to elaborate on the idea of a measure pilot program.
- Dr. Biondolillo suggested thinking about two different types of measures:
  i. Measures that are supported by strong evidence, and that align with DPH's regulatory authority
  ii. Measures that aren't fully developed, or that are intended for use at sites that are not accustomed to quality measurement, but that support important, up-and-coming areas for quality measurement
- A Committee member asked if it would be possible to review the information that was used to place each measure into the strong, moderate, weak, or no recommendation category. The Committee member also expressed concern about a measure pilot program, and asked if all measures in the SQMS will be equally available to the Division of Insurance to use to tier insurance products.
- Iyah Romm stated that the care transition measures are new for everyone, and that many of these measures are already being collected. He also stated that the measure validity and practicality ratings could be shared with the Committee.
- Co-Chair Auerbach stated that there would likely be a process for differentiating between measures that should be used for insurance product tiering, and those that should only be piloted.
- A Committee member questioned the practicality of including in the SQMS quality measures that are already being reported, emphasizing the need for measures that looked at accountability of care, and coordination of care across settings, not just measures that evaluate quality in long term care settings.
- Dr. Biondolillo stated that the goal of a pilot program would be to find composite measures that can evaluate quality across systems of care. She suggested that synthesizing and highlighting measures that are already being would encourage coordination of care. Looking at the measures together would advance systemness.
- Iyah Romm suggested the possibility of developing programs at DPH that would support providers' attempts to improve systemness.

- A Committee member asked if the criteria used to evaluate measures would evolve over time, perhaps not requiring measures to be NQF-endorsed. He asked if the SQAC mandate would be broader in subsequent years.
- Co-Chair Auerbach said that the SQAC should try and push itself beyond the members' comfort level, and try to balance evidence-based measures with measures that are breaking new ground in areas that deserve more attention. He also stated that legislative changes could abolish the SQAC, so the committee should not take on more than it can accomplish in the near future.
- Co-Chair Boros asked the committee members to look at the recommended care transition measures, and speak to whether or not the number of measures was appropriate.
- A Committee member stated that there should be more care transition measures in the SQMS. Because post-acute care accounts for 20-30% of Medicare spending, there should be more of a balance in the SQMS between acute and post-acute measures. He supported the measures in the Strong Recommendation category, but felt that there may be more dimensions of post-acute care that should be addressed. The Committee Member also asked for a brief recap of the CTM-3 measure.
- Dr. Biondolillo provided a recap of the CTM-3 measure, and stated that many pilots have found the measure to be valid, but that it did not meet practicality requirements because it is not consistently collected in the appropriate sites of care. She stated that this measure was a proxy for systemness.
- Co-Chair Auerbach stated that the SQAC has not yet done a public solicitation for non-hospital quality measure nominations, and that doing so may expand the scope of post-acute quality measures.
- A Committee member pointed out that the OASIS and MDS care transition measures are already reported to CMS, and are used for reimbursement adjustment and regulation sanctions. The member expressed support for the number of nominated care transition measures and did not feel that more were needed at this time, but that as the SQAC expands its focus to systemness, more measures will be considered.
- A Committee member pointed out that the care transition measures lack a focus on patient experience and staff responsiveness, given that pain measures could drive post-acute facilities to select patients with lower pain, rather than try to manage their pain. Measures that focus on pain management, rather than pain level, may be less likely to create this perverse incentive.
- A Committee member agreed that there were very few measures that looked at patient engagement or experience, and expressed support for the CTM-3 measures.

4. Co-Chair Boros introduced Dr. Constance Horgan and Dr. Deborah Garnick from Brandeis University to give a talk on Quality Measurement for Behavioral Health
    - Drs. Horgan and Garnick provided background on behavioral health quality measurement. They outlined the key stakeholders and initiatives, and explained which behavioral health quality measures are already being collected through existing programs. They discussed the four BH quality measures that are already included in the SQMS, which are part of the HEDIS measure set. These four measures are:

i. Initiation and Engagement of Alcohol and other Drug Dependence Treatment
ii. Antidepressant medication management
iii. Follow-up care for children prescribed ADHD medication
iv. Follow-Up After Hospitalization for Mental Illness

- The presenters also outlined the BH measures that will be included in the HEDIS 2013 measure set for Medicaid adults. Drs. Horgan and Garnick pointed out that the BH measures that are included in the SQMS focus on patients who are already being treated for BH issues. Therefore, they recommended three measures for use in health centers that emphasize screening and prevention. These three measures are:
    i. Adult Screening and Brief Intervention: Percent of patients, aged 18 and over who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method and who received brief counseling if identified as an unhealthy alcohol user.
    ii. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention: Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
    iii. Depression Screening in Primary Care Using a Validated Instrument, Including Documentation of a Follow-up Plan: Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
- Co-Chair Boros asked about the burden on providers that population screening measures—in this case for depression—could create.
- Dr. Garnick stated that questions of practicality are part of the NQF-endorsement process, and that measures which have been endorsed meet practicality requirements.
- Dr. Horgan stated that the screening does not have to be performed at an annual physical, but is quick and could be undertaken when the patient comes in for another health issue. She also said that not every patient who screens positive needs detoxification or in-patient services. This measure is simple and NQF-endorsed.
- A Committee member pointed out that the NQF endorsement process also looks at the population prevalence of a disease, and ensures that the prevalence is high enough to warrant universal screening before endorsing a measure.
- Co-Chair Auerbach stated that he felt screening measures were important and easy to implement, but asked about the next steps for patients who screened positive for depression or alcohol/tobacco use.
- A Committee member stated that, often, implementing a screening program brings the prevalence of a disease or behavior to light, and that once the severity of the disease/behavior is recognized, interventions are developed. Screening measures are also relatively easy to incorporate into physician

workflow, and that since most morbidities in our population are lifestyle based, and that screening measures target behavioral health, prevention and lifestyle.

- A Committee member spoke to the importance of keeping screening measures from becoming just another "checkbox" that providers perform quickly. Doctors should be encouraged to hit targets, not just check boxes.
- The presenters also recommended four measures for future consideration, which were not yet endorsed by the NQF:
    i. Adult alcohol Use Brief Intervention provided in a hospital setting
    ii. Medication Assisted Treatment
    iii. Screening for Drug Dependence
    iv. Prescription Monitoring Measure (not yet developed)

5. Iyah Romm presented the next steps to the committee, including the SQAC timeline, and asked the Committee members to consider a set of questions related to the creation and use of the SQMS in preparation for the next SQAC meeting.

The Meeting was adjourned.

Next meeting:

Thursday, June 14th, 2012, 4pm-6pm

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