Statewide Quality Advisory Committee (SQAC) Meeting
Tuesday, July 24, 2012
3:00-5:30 p.m.
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: Diane Anderson, Dr. Richard Lopez, Amy Whitcomb Slemmer, Ann Lawthers (for Dr. Julian Harris), Dana Gelb Safran, Dr. James Feldman, Jon Hurst, Dolores Mitchell, Miriam Drapkin (for Commissioner Áron Boros)

Committee Members Not Present: Áron Boros, Dr. Julian Harris

Other Attendees: Dr. Madeleine Biondolillo (DPH), Iyah Romm (DPH)

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1. Approval of minutes from SQAC meeting on May 18, 2012
    a. Motion to approve meeting minutes passed
2. Approval of minutes from SQAC meeting on June 14, 2012
    a. Motion to approve meeting minutes passed
3. Co-Chair Auerbach introduces Co-Chair Boros' designee, Miriam Drapkin and Committee members introduce themselves
4. The Committee discussed the goals and process for Meeting 7.
    a. Co-Chair Auerbach reminded the Committee that it had collected over 200 quality measures that met the priority, practicality and validity standards. Co-Chair Auerbach reminded the committee that the purpose of the meeting is to narrow the list of quality measures to those that most strongly meet the Committee's priority characteristics.
    b. Dr. Madeleine Biondolillo described the process by which the Committee might select the strongest quality measures:
        i. View and discuss the table (handout) outlining each proposed and mandated quality measure and its supporting information
        ii. Identify from the table (handout) quality measures that are suitable for the various purposes listed
        iii. Select approximately 15 quality measures for each healthcare setting
        iv. In this way the committee will have selected 45 quality measures for inclusion in the Standard Quality Measure Set by meeting's end.
    c. A committee member asked the Co-Chairs if the proposed quality measures had been cross-matched with those that the Measure Applications Partnerships (MAP) had recommended. The committee member advised that the measures recommended by SQAC align with MAP's recommendations.

d. A committee member sought clarification that today the goal is to select approximately 15 quality measures for each of the three priority settings, in order to develop the "DPH Quality Measure Focus List." Iyah Romm confirmed that that is the goal of Meeting 7, and reminded the Committee that they will NOT select/strike a mandated measure, but choose measures in addition to the set of mandated measures.
e. A committee member sought clarification on the three priority care settings for which the committee will select quality measures. Iyah Romm confirmed: hospital, post-acute (home health, skilled nursing facility), Community Health Centers.
f. Co-Chair Auerbach reminded the Committee that 15 measures is an arbitrary goal; the Committee should seek to identify the strongest measures.
g. A committee member asked if "P4P" referred to any and all P4P or the state's P4P programs and if the measures would be required in the P4P programs. Miriam Drapkin answered that the intention is for the Committee to identify some measures that are particularly good for P4P programs.
h. Co-Chair Auerbach stated that quality measures selected by the SQAC will be used for specific legislative tasks rather than as a mandate to carriers. Iyah Romm added that the SQAC is piloting the experience of creating a standard set of quality measures to be used across multiple settings.
i. A committee member noted that outcome measures for hospitals were currently absent from the mandated quality measures set, and proposed that the Committee proceed with the selection of measures with that in mind.

5. Co-Chair Auerbach proposed that the Committee proceed by selecting measures. Co-Chair Auerbach proposed that the Committee start by identifying any adjustments to the Committee's stratification of the **mandated measures** into "moderate" and "strong" recommendations.
    a. Miriam Drapkin proposed to remove AMI-3 because it is no longer collected by CMS. The Committee agreed to this change.
    b. A committee member proposed to move "Adult BMI Assessment" (1-moderate under HEDIS) to the "strong recommendation" pool because of the rise of obesity. A committee member asked why this measure had been downgraded to moderate. Miriam Drapkin responded that it was downgraded because it required a medical record review. A committee member responded that she believed that in a recent MAP meeting, the MAP committee did not recommend using this measure. A committee member responded that if MAP didn't recommend it, she would withdrawal her proposal to upgrade the measure to strong.
    c. A committee member proposed that "Well-child visits" (12-moderate under HEDIS) be moved to the strong pool because it is the only measure for small children and would be valuable. Co-Chair Auerbach asked why it had been downgraded to moderate. Iyah Romm responded that it had been downgraded because it requires a medical record review. A committee member asked if claims could be used to calculate this measure. A committee member said that this is a difficult measure for MassHealth to monitor because of the MassHealth process of enrolling young children. Miriam Drapkin responded that this measure is collected by MHQP, which is a strong recommendation to move from the moderate to strong measure pool.
    d. Co-Chair Auerbach asked if the Committee was comfortable with the decisions to remove the obesity measure and move well-baby visits to the strong pool, knowing that it is difficult for MassHealth.

6. Co-Chair Auerbach proposed that the Committee proceed by identifying any adjustments to the committee's stratification of the **proposed measures** into "moderate" and "strong" recommendations.
    a. A committee member proposed that "Screening for Clinical Depression" (46-moderate) be moved to the strong recommendation pool. Iyah Romm asked if MassHealth collects this measure, and a committee member responded no. Miriam Drapkin noted that it is intended to be used to measure meaningful use in the future.
    b. A committee member proposed to move "CTM-3" (45-moderate) to the strong pool because it has been identified as NQF priority, but it requires patient reporting.
    c. A committee member proposed to move "Unhealthy Alcohol Use: Screening & Brief Counseling" (48-moderate) to the strong pool, as it is under consideration by the NQF and had support from DPH and MassHealth.
    d. A committee member asked why not include "CAHPS Clinician & Group Survey" (14- and 15-moderate) since ACES is already in the measure set. A committee member responded that 14-moderate is duplicative because ACES is in the mandatory measure set and it encompasses CAHPS. A committee member then responded that some organizations, especially those seeking NCQA recognition as medical homes are required to do the CAHPS and the ACES would not suffice. She suggested including 14- and 15-moderate in the state-wide set in addition to the ACES. Miriam Drapkin proposed to research this issue further offline.
    e. A committee member noted that some of the measures she had proposed were not evaluated in the Strong/Moderate stratification by the staff but also wanted to ask other Committee members to keep those measures in mind because they are being used by the GIC.
    f. Madeleine Biondolillo reminded the Committee that the agreed process for proposing measures was that Committee members provide to staff background information on each measure they recommended for SQAC consideration; if measures were not evaluated, it was because staff did not receive information from Committee members.
    g. A committee member stated that knowing more about the variation that will arise from the measure and the measure's areas for improvement would be helpful in selecting measures for the SQMS.
    h. A committee member proposed that in the next year, the Committee might try to consolidate and organize measures by related areas or conditions. Madeleine Biondolillo agreed and noted that quality measurement is a rapidly growing field and the expectation is that the SQAC will reconvene annually.
7. Co-Chair Auerbach proposed that committee proceeds by discussing 1-33 strong and 5, 14, 15, 45, 46, 48 moderate, as well as the 88 unevaluated measures. Co-Chair Auerbach recommended that the committee spends 30-minutes discussing which measures should move to the second phase (selecting 45 measures).
    a. A committee member proposed that 3-9 strong (7 measures) move to next round. Miriam Drapkin stated that they apply to post-acute settings and are all currently reported. Co-Chair Auerbach stated 3-9 approved to move to the next phase.
    b. A committee member stated that 10-strong is important for measuring patient experience. A committee member stated that it is included in the mandatory ACES measure.
    c. A committee member stated that 31-strong is intended for use in both ambulatory and inpatient settings.

d. A committee member added that 12 and 13 moderate are pediatric and therefore valuable. The committee member added that 31-strong is HEDIS and intended for use among a range of patients. A committee member proposed that if a measure can be used in an ambulatory or inpatient setting, the committee should decide if it will focus on the negative or positive scenarios (patient is admitted or not). A committee member stated that all PQI measures are ambulatory outcome sensitive measures
e. Miriam Drapkin proposed 42-moderate for consideration.
f. Iyah Romm proposed including 45, 46, 48 moderate.
g. A committee member proposed including 29-moderate 47-moderate and 12, 13, and 14 strong (related to asthma care). Iyah Romm stated: PQIs are not currently reported but could be calculated via discharge data; 2-moderate is not currently reported; 41-moderate can be calculated with reported data, though this measure is not currently collected. Co-Chair Auerbach proposed to remove 2-moderate from consideration. The Committee agreed.
h. Iyah Romm stated that 9-moderate and 48-moderate require data that is not currently reported. Co-Chair Auerbach proposed to remove these measures from consideration.
i. A committee member proposed 11-moderate. Iyah Romm stated that this measure is currently reported. The Committee agreed to not include this measure.
j. Co-Chair Auerbach stated that 41-moderate is calculable and 42-moderate is not. Miriam Drapkin proposed that 42-moderate (Hospice and Palliative Care – Treatment Preferences) should be retained because of the lack of measures related to end of life care. A committee member agreed with Miriam Drapkin regarding 42-moderate. The Committee agreed to include these measures.
k. Co-Chair Auerbach reminded the committee that the following measures had been removed from consideration: 1, 2, 9, 14, 22.
l. A committee member proposed that 9-moderate and 22-moderate be retained to represent behavioral health measures.
m. Co-Chair Auerbach stated that three measures are to be retained, although they are not currently reports: 9-moderate and 22-moderate (behavioral health) and 42-moderate (end of life care). A committee member stated that there was no doubt these measures were important but proposed holding them as possible measures until completing the evaluation of the “strong” measures.
n. A committee member stated that 46-moderate should be considered. Co-Chair Auerbach stated that there are now 4 measures for possible consideration (9, 22, 42 and 46 moderate).
o. A committee member proposed 29-moderate be considered. A committee member proposed that 29-moderate is problematic because it’s an “all or nothing” measure. The Committee declined to include this measure.
p. Iyah Romm reminded the committee of the following: 45-moderate has been agreed upon as a measure to advance to next phase of consideration; 46-moderate is not currently collected because it is in CAHPS; 47-moderate is grouped with the possible measures.
q. Miriam Drapkin reminded the committee that all PSI measures can be calculated from discharge data.
r. A committee member stated that 12-14 strong are part of MassHealth’s P4P program and pediatric measures, which there are not many of. The Committee agreed to add 12-14 to the list of proposed SQMS measures

s. A committee member mentioned that he was uncomfortable with the process as it had evolved throughout the meeting; before the committee weighed consideration of measures by validity, practicality, priority characteristics and in this meeting the committee seemed not to weigh the reporting burden and the health area/condition heavily enough. Co-Chair Auerbach acknowledged the member's statement and noted that each of the measures was evaluated in previous meetings by how well it met the validity, practicality and priority criteria.
t. A committee member asked the committee why 27-strong (Computerized physician order entry standard) is no longer under consideration. Iyah Romm stated that the Committee might consider this measure in future years. A committee member stated that she respectfully disagreed and proposed that 27-strong (CPOE) be prioritized before 48-moderate (Unhealthy alcohol use counseling). The Committee agreed to include both measures.
u. Miriam Drapkin stated that she scanned the set of measures the Committee recommended to move to the next phase of consideration, and that the Committee was close to the goal of 45 measures.
v. Co-Chair Auerbach reminded the Committee that it agreed to move 36 measures (including 7 possible measures) to the next phase of consideration.
w. Miriam Drapkin proposed that the Committee move all 36 on to the next phase of consideration; that staff put together additional research and materials to allow the Committee to further narrow the list of measures in the next meeting. Miriam Drapkin stated that materials will be sent out by the end of the week and asked that the Committee take a look at the pool of measures that have been recommended to move to the next phase of consideration.
x. A committee member suggested that the Committee look into whether CPT codes could be used in place of chart reviews, in regards to the measures that are not currently reported. A committee member stated that claims review may be another viable alternative to medical record reviews.

8. Co-Chair Auerbach thanked the committee for their time.

The meeting was adjourned.

Next meeting:

August 10
Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116