Statewide Quality Advisory Committee (SQAC) Meeting
Monday, April 22, 2013
3:00 – 5:00 p.m.
MEETING MINUTES

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

Chair: Áron Boros (CHIA)

Committee Attendees: Dianne Anderson, Dr. Richard Lopez, Amy Whitcomb Slemmer, Dr. Ann Lawthers (designated by Dr. Julian Harris), Dr. James Feldman, Dr. Michael Sherman, Jon Hurst, Kim Haddad (non-voting

Committee Members Participating by Phone: Dolores Mitchell, Dr. Dana Gelb Safran

Committee Members Not Present: Dr. Madeleine Biondolillo (non-voting)

Other Attendees: Miriam Drapkin (CHIA), Lori Cavanaugh (CHIA)

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1. Chair Boros welcomed the Committee and asked the Committee members to introduce themselves. Dr. Michael Sherman and Kim Haddad are two new additions to the Committee.
2. Chair Boros also introduced Lori Cavanaugh, the new Deputy Executive Director for Health Systems Performance at CHIA.
3. Chair Boros gave an overview of the meeting agenda and asked the Committee to approve two sets of Meeting Minutes – one set from the February 25, 2013 meeting and one from the November 9, 2012 meeting.
    a. Chair Boros asked Dr. Sherman to abstain from voting on the minutes, as he did not formally participate in those meetings. Dr. Sherman did not disagree.
    b. Motion to approve the minutes from November 9, 2012 passed unanimously.
    c. Motion to approve the minutes from February 25, 2013 passed unanimously.
4. Chair Boros spoke about the SQAC's Mission Statement for this year. He thanked the Committee members for their discussion of the statement in February and said that Committee members' suggestions had been incorporated into a revised Mission Statement.
    a. Motion to approve and adopt the Mission Statement passed unanimously.
5. Chair Boros gave an overview of the Statewide Quality Measure Set (SQMS) regulation.
    a. The SQAC made recommendations for the SQMS last year.
    b. CHIA plans to implement the SQMS in three phases:
        i. Regulatory framework
        ii. Specify the data collection mechanism
        iii. Collect and report out data. Chair Boros also mentioned that these data will support the work of other state agencies, such as the Division of Insurance (DOI).
6. Chair Boros asked Miriam Drapkin to lead the discussion on the SQMS regulation.

7. Miriam Drapkin noted that the public comment period for the SQMS regulation would close on Monday, April 22, 2013 at 5pm.
8. Miriam Drapkin introduced the timeline and gave an overview of the SQMS regulation development in three parts.
    a. Skilled Nursing Facility (SNF) and Home Health Agency (HHA) measures
        i. CHIA does not anticipate additional data collection for SNF and HHA measures because these entities are already required to report the applicable quality measures in the SQMS to CMS.
        ii. Dr. Richard Lopez asked when the SNFs and HHAs data would be updated in 2014.
            1. Miriam Drapkin responded that she thought SNF and HHA data would be updated again in spring of 2014, but would need to confirm that.
        iii. CHIA expects to release a final rule for SNF and HHA measures in early September, and that the final rule would be followed by a calculation of SNF and HHA performance on the SQMS measures. Miriam said that SNFs and HHAs would have 30 days to validate the data and review their performance before it is made available more broadly.
    b. Hospital Measures
        i. CHIA is committed to requiring of acute hospitals the least amount of new data as possible.
        ii. CHIA plans to develop an Administrative Bulletin and Data Submission Manual this summer. Miriam Drapkin said there would be window of at least 30 days for provider and stakeholder feedback on the Administrative Bulletins and Data Submission Manual before CHIA issues a final rule in the fall. She said that after data is collected, providers will have at least 30 days to validate their data and review their performance. She also noted that CHIA anticipates that the data would be available in the first quarter of 2014.
    c. Registered Provider Organizations (RPOs)
        i. CHIA is waiting for guidance from the Health Policy Commission (HPC), as they have been tasked with defining RPOs. As such, there is no firm timeline for this group at the moment.
        ii. Chair Boros provided a broad description of the types of entities that would be considered RPOs: hospitals or hospital systems, physician organizations, and other smaller entities such as community health centers that accept downside risk.
            a. Dolores Mitchell asked if Accountable Care Organizations (ACOs) meet that definition. Chair Boros said that ACOs may meet that definition but other considerations for an RPO include revenue stream and patient population.
            b. Dianne Anderson asked for a clarification on RPOs and if risk-sharing is a criterion. Chair Boros said that it is unknown and the statute has broad criteria for RPOs. He added that the HPC will hold a regulatory process that will include a public comment period.
            c. Dr. Michael Sherman asked if the provider types named are mutually exclusive. Dr. Sherman said that there are fully integrated ACOs and partnership ACOs and contracts across

multiple provider systems. Chair Boros said that Chapter 224 definition of a "provider entity" references a patient panel greater than 15,000, commercial/TPA revenue of more than $25 million, and whether the entity accepts downside risk via alternative payment methods.

9. Chair Boros discussed the Committee's meeting schedule for 2013. He said that there are opportunities for ad-hoc presentations and mentioned other quality measurement efforts, specifically the Quality Alignment Initiative and CHIA's Consumer Website as opportunities for the SQAC.
    a. Chair Boros also explained that the SQAC enabling statute explicitly states that the role of the SQAC is to recommend quality measures for uniform reporting by providers. He said the goals for today are to determine the Committee's priorities for the 2013 SQMS recommendation and to assign related work to Committee staff.
    b. He framed the conversation of Committee work for 2013 by suggesting three possible approaches to this year's SQMS recommendation:
        i. Changes to mandatory measure sets
        ii. Potential alignment with other quality measure sets
        iii. Evaluate whether the SQMS has measurement gaps the Committee is interested in addressing.
10. Chair Boros gave an overview of the changes to the mandatory measure sets. He said that some of them are mechanical and other changes would need Committee feedback.
    a. Ann Lawthers asked if there is or could be a process to identify measures that may be dropped from the SQMS.
        i. Chair Boros responded by saying that yes.
11. Miriam Drapkin outlined the changes to the four Mandated Measure Sets
    a. HCAHPS – the addition of the CTM-3 measures to the HCAHPS measure set were incorporated at the end of last year and included in the SQAC measure recommendations. Further updates are not anticipated this year.
    b. CMS Process Measures – there are three measures that were dropped from this set:
        i. aspirin at arrival (AMI-1),
        ii. beta blocker at time of discharge (AMI-5), and
        iii. hair removal for surgical procedures (SCIP-Inf 6).
        iv. Dolores Mitchell said that they were dropped because they are highly utilized and that high compliance leaves much to be desired. However, she said she is opposed to dropping them altogether.
        v. Dana Gelb Safran said that there is almost universally 100% compliance with these measures. She also agreed with Dolores' comments but said that that the data comes from CMS and if CMS stops collecting it, there will be a burden to collect this data.
        vi. Chair Boros said that because these measures have been dropped from the mandated measure sets, they have also been dropped from the SQMS. Chair Boros noted that the nomination process for including additional quality measures for recommendation is still available. Dolores Mitchell said that the Committee should be mindful about the burden on others to collect and report on these measures.
        vii. Dr. Feldman recalled that last year, there was discussion about not recommending some of the measures from the mandated measure sets

because the measures did not show adequate variation and/or showed a disconnect in care.

viii. Chair Boros said that last year, SQAC categorized some measures as "low recommendation" and noted that the Committee can discuss the measure evaluation process at the next meeting.

c. HEDIS Set – 5 new measures in the 2013 set.
   i. Miriam Drapkin suggested that these five new measures go through the formal evaluation process.
   ii. Ann Lawthers asked if the SQAC would add these measures to the SQAC's 2013 recommended measures. She also said that MassHealth has a policy not to require a measure in its first year, so that there is an appropriate time to evaluate the purpose and efficacy of the measures.
      1. Miriam Drapkin responded that these measures could be added to the 2013 recommendations, which will not be required until 2014. She also noted that the SQAC recommendation is a statement that the measure is worth including in the SQMS, which is distinct from implementation of the SQMS.
      2. Amy Whitcomb Slemmer asked Ann if there is any benefit to a waiting period.
         a. Ann Lawthers responded that it varies. For example, with NCQA's Hemoglobin A1C measure, NCQA applied this measure across the board in the first year and then only applied the measure to a subset in the following year. She said that the efficacy of measures depends on how they are used.
         b. Amy Whitcomb Slemmer said that she thinks it makes sense for some measures but she doesn't want the SQAC to miss an opportunity to advance the use of patient experience and efficacy measures.
      3. Miriam Drapkin stated that there are a number of utilization measures in HEDIS that are used by health plans and that have never been applied to providers. She said she has limited experience with these measures and that the measures are methodologically challenging and perhaps not designed for this application.
         a. Dolores Mitchell said that the SQAC must think through the gaps for resource use and cost when considering measures.
         b. Dianne Anderson asked Miriam if she could be more specific about the resource use for these measures. Miriam Drapkin explained that the measures use codes and DRG Groupers to ascertain utilization bundles.
            i. Dr. Sherman said that he thinks this is the right approach from the perspective of the health plans but thinks there may be other factors to consider.
            ii. Dr. Feldman raised the concern about risk adjustment, appropriate attribution and if the literature supported the use of these measures to evaluate resource use.

iii. Ann Lawthers said she agrees with Dr. Feldman and wanted to know if these measures were designed for health plan use, RPOs or another entity.
iv. Dr. Lopez said that the SQAC may need to change the application of recommendation for these measures to "defer" or "not applicable."
v. Chair Boros said that the SQAC staff will look into the issues that were raised.

4. Miriam Drapkin said that the last group of HEDIS measures is for health plans and the CAHPS survey. She asked if two health plan surveys would be extraneous.
    a. Dolores Mitchell recommended that the SQAC be mindful of the gaps in the SQMS.
    b. Dana Gelb Safran said that these measures relate to call timeliness and if a patient receives a call back when information was needed. She also noted that the Patient-Centered Medical Home (PCMH) and the Massachusetts Health Quality Partners (MHQP) will be using these data.
    c. Chair Boros explained that a way the SQAC could evaluate these measures is by evaluating how the three health plan measures would apply to providers.
5. Miriam Drapkin asked Dana Gelb Safran to give an overview of the Ambulatory Care Experience Survey (ACES). Dana provided a brief history and overview of this measure set.
    a. Miriam Drapkin said that ACES doesn't functionally exist anymore and proposed that CHIA interpret "ACES" to mean it's most current iteration, which is currently the Clinician Group CAHPS survey.
        i. Chair Boros requested a more descriptive explanation.
        ii. Miriam Drapkin said that the ACES measure set is a composite of the Clinician CAHPS and the PCMH/expanded CAHPS, which includes additional settings of care.
        iii. Dr. Lopez and Dr. Safran said that they support Miriam's proposal.
        iv. Dr. Feldman clarified that Miriam is recommending the Committee adopt the construct as opposed to the acronym. He wanted to know if they could change the SQAC enabling statute to reflect this.
            1. Chair Boros responded that CHIA has the discretion to interpret the law in any way that makes sense and that the SQAC can also recommend changes to the law. He also said that the SQAC could discuss this in the context of process in the next meeting.

2. Miriam Drapkin noted that a technical amendment for the SQAC statute has been submitted to the Legislature for consideration.

12. Chair Boros opened up the discussion about how or if the work of the SQAC could align with other quality measure sets and/or measurement efforts and reminded the Committee that with the exception of a handful of measures, there is strong alignment of the SQMS with one or more provider accountability initiatives in Massachusetts. Chair Boros raised the questions of whether the SQAC would like to seek alignment with other measures sets.
    a. Dr. Sherman asked if staff have evaluated what is being used in other programs that is not in the SQMS. Chair Boros responded that more staff work would be needed to provide that analysis.
    b. Dianne Anderson said that many of the SQAC members also sit on the Health Policy Council's Advisory Committee. She suggested that the SQAC align their efforts with the HPC. Chair Boros said that he hopes to invite the HPC to participate in the SQAC.
    c. Ann Lawthers asked Chair Boros what he meant by "alignment." Does he mean using all the same measures? Or, using the same or similar measures that others use where feasible? Dianne Anderson said she agrees with Ann and raised concerns about the burden on providers and the logic behind adding new measures.
    d. Amy Whitcomb Slemmer said that she appreciates the sensitivities but feels that the SQAC is not bound by what others are doing or by other jurisdictions. She said that she sees an opportunity for the SQAC to identify measures to lead the way, particularly with regards to patient-centered decision making efforts.
    e. Dr. Lopez said that the question comes down to what you value the most, whether it is alignment or if it is furthering the vision of where health care should be. He recommended that the Committee should select measures that they see as having a better value. Dr. Lopez also suggested that the SQAC may want to limit the number of measures they add.
    f. Dana Gelb Safran said she agrees with Dr. Lopez's point and mentioned that a responsible way for the SQAC to lead the way would be to identify gaps in measurement and pointed out that the task of identifying gaps is more daunting than alignment.
    g. Dolores Mitchell pointed out that the Committee may want to study why the handful of measures in the SQMS doesn't align with other efforts. She suggested that different populations may require different measures.
    h. Dr. Feldman raised the point that cost, burden and usefulness should all be taken into consideration when thinking about alignment. He added that the provider community would like to see the same measures used across patients with that condition, while others feel that is restrictive. He feels that it doesn't make sense for providers to be scored differently for the same conditions (as in the case of GIC measures and MassHealth measures).
        i. Ann Lawthers responded and said that MassHealth isn't really different but MassHealth is focusing on measures that relate to maternal health and behavioral health. MassHealth can't align with other quality measurement efforts if the efforts don't apply to the MassHealth population.
    i. Amy Whitcomb Slemmer noted the value of SQAC is to evaluate measures to see if they are useful and use the nomination process to add to or take away from the Standard Quality Measure Set.

j. Jon Hurst said the Committee should also keep the consumers in mind and the SQAC can help consumers make decisions about their health care.
    i. Amy Whitcomb Slemmer said that making this data useable to consumers is an exciting area of opportunity, especially with regards to cost and quality.
    ii. Dana Gelb Safran said that the literature shows that the information patients value is the experience of other patients. She believes that patients would be more engaged with outcomes-based measures and positively-oriented measures, versus clinical process and complications-oriented measures.
k. Chair Boros said that CHIA is also tasked with developing a consumer website and that the SQAC staff could provide additional information about how the SQAC might work on consumer engagement. He also referenced the federal HHS Measurement Policy Council and the work it does to reduce the volume of measures of certain conditions. He raised the question about if the SQAC would like to engage in a similar process. Dianne Anderson said she wanted to emphasize Dr. Lopez's comments about limiting the number of measures. She asked the SQAC to do their due diligence to make sure these measures are useful and suggested that the Committee use a scorecard that balances cost and quality measures.

13. Chair Boros began the discussion about gap filling and noted that the SQMS is organized by priority area and provider type. He asked the Committee if they are interested in evaluating completeness and if there are other areas that are worthy of discussion.
    a. Ann Lawthers said behavioral health is an area for more discussion.
    b. Dr. Lopez said that the SQAC could frame its recommendations using the "Triple Aim," which would support a balanced scorecard.
    c. Dr. Feldman said that patient-centered outcomes would be another area where more work needs to be done.
    d. Dr. Sherman said that the SQAC should focus on providing information that is useful and meaningful to consumers, like functional status. He added that care coordination is also important. Dr. Lopez agreed with Dr. Sherman.
    e. Dolores Mitchell raised the question of who was measuring what for whom. She said that consumers are worried about which provider will bring the best outcome but that consumers are also concerned about out-of-pocket costs.
    f. Chair Boros summarized the Committee members' suggestions into the following areas: patient centeredness, patient outcomes measures, behavior health measures, domains of care (including care coordination) and cost.
14. Chair Boros provided an update about the two quality measurement programs that CHIA is currently involved with: Quality Alignment Initiative (QAI) and the Health Information Technology (HIT) Trailblazers project. He noted that these two programs may also provide an opportunity for discussion at future meetings.

The meeting adjourned at 4:50pm.