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Massachusetts Statewide Quality Advisory Committee

Year 4 Final Report

January – November 2015



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BACKGROUND

The Massachusetts Statewide Quality Advisory Committee (SQAC) was established by Chapter 288 of the Acts of 2010, and reestablished by Chapter 224 of the Acts of 2012, *An Act Improving the Quality of Healthcare and Reducing Costs Through Increased Transparency, Efficiency, and Innovation*. Chapter 224 builds on Chapter 288 with an innovative set of market-based cost containment, health care delivery transformation, and health planning activities. Chapter 224 incorporated measures to ensure that cost containment efforts would not come at the expense of accessible, high quality health care. In a system where stakeholders are being increasingly asked to make value-based health care decisions, it was recognized that improved, standardized quality information was necessary to inform those decisions.

The SQAC is comprised of a diverse group of Massachusetts health care experts, industry stakeholders, and consumer advocates, and is chaired by the Executive Director of the Center for Health Information and Analysis (CHIA). The SQAC convened in 2012 with the goal of recommending the first-ever Massachusetts Standard Quality Measure Set (SQMS), a set of measures for each health care facility, provider type, and medical group in the Commonwealth. To do so, the SQAC engaged in a quality measurement priority setting process, solicited expert testimony on high-impact areas of quality measurement, and requested measure nominations. More than 300 nominated measures targeted to high-priority areas were reviewed and, ultimately, the SQAC recommended 130 measures for inclusion in the initial SQMS. Each year the SQAC reviews nominated measures, adds new measures, and removes retired measures to maintain an up-to-date and usable measure set.

The SQMS represents a wide range of clinical areas, including preventive health care, chronic disease management, pediatric, maternal and neonatal health, mental health, and substance abuse. It also includes indicators of efficiency, such as appropriate testing of upper respiratory infections and hospital readmissions, as well as measures of patient experience. The State Legislature mandated that the following nationally accepted measure sets also be represented in the SQMS: Centers for Medicaid and Medicare Services' Hospital Process Measures (for acute myocardial infarction, heart failure, pneumonia, and effective surgical care), Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

This report summarizes the work of the SQAC in 2015, including the fourth annual recommendation of measures for the SQMS.



FOURTH YEAR MEETING CYCLE

Year 4 Process and Priorities

In January 2015, the SQAC underwent an informal strategic planning process to determine its work for 2015. There were two primary motivations for this strategic planning process:

1. The SQAC determined that in addition to evaluating and recommending quality measures for the SQMS, it was interested in expanding its quality efforts beyond updating the SQMS.
2. SQAC members expressed interest in leveraging SQAC's potential as an advisory body to advise CHIA and other state agencies on quality related topics.

With this backdrop, the SQAC gathered stakeholder insights through roundtables and individual meetings. Through these meetings, stakeholders made a number of recommendations to the SQAC about their role and potential work. Those recommendations include the following:

- Standardize and align quality measures used in Massachusetts
- Set statewide health and quality improvement priorities
- Provide more outcomes measures and data
- Make current and relevant data available more frequently
- Use quality measures and data to support purchaser and consumer decision-making

Based on these discussions, the SQAC decided to focus its 2015 work on developing statewide quality improvement priorities.

Adopting a Process for Identifying Quality Priorities

In March of 2015, CHIA issued a request for quotes to find a qualified consultant to develop and implement a rigorous and thoughtful process for setting statewide quality priorities and goals. Bailit Health Purchasing, LLC. (Bailit) was selected as the consultant to facilitate the SQAC's work on quality improvement priorities.

As a first step, Bailit worked with the SQAC to develop parameters for the quality priority setting process and the criteria through which the SQAC would consider potential quality priorities. Bailit also conducted an environmental scan of the quality work underway in the state and conducted individual and group interviews with a number of stakeholders to solicit potential quality priorities. Following the discussion of many important quality topics, the SQAC selected five quality priority areas to focus on for the next 3-5 years. These areas include:

- Appropriateness of Hospital-Based Care
 - Reducing readmissions and preventable hospitalizations can improve care and lower health care costs. Doing so requires a coordinated and collaborative effort from actors in the health care system and in the community, and lowering readmissions remains a priority for stakeholders. Admissions and readmissions can be expensive, disruptive and disorientating, particularly for the frail elderly population and persons with disabilities.



- End of Life Care
 - There is significant variation in the amount of intervention and cost of care near the end of a patient’s life. Often interventions are costly, do little to improve a patient’s chance for sustained improvement in their condition, and do not fully reflect the patient’s preferences. In addition to improving the patient’s experience, quality improvements at the end of life can reduce spending on interventions and treatments that will not appreciably improve a patient’s condition or quality of life and may also result in reduced emergency department visits and fewer preventable hospitalizations.
- Integration of Behavioral Health and Primary Care
 - Integration of care is an important step in assuring access to behavioral health services and in providing whole-person care that focuses on all physical and mental health care needs, leading to improved health outcomes.
- Maternity Care
 - Maternity care is a high cost service area that impacts a large group of citizens and directly impacts the next generation. Expectant parents have many choices from whom and where to receive their care and are particularly focused on receiving the highest quality care. Public reporting of quality data has the potential both to provide consumers with relevant and actionable information and to drive improvement.
- Opioid Use
 - There has been widespread attention to the opioid epidemic in Massachusetts over the past two years. Massachusetts has seen increasing deaths related to opioid use and increased addiction across all age ranges, race/ethnicity, and income levels. This priority will focus on quality of care both for pain management and substance use disorder treatment.

As part of each of these quality areas, the SQAC will consider cross-cutting system issues including availability of care coordination, racial disparities, and transparency. In 2016, the SQAC will begin to implement efforts to highlight these quality improvement priorities and to add related quality measures to the SQMS.

Use of the SQMS for Provider Tiering

M.G.L. Chapter 176J requires that when health plans use quality measures to tier providers for their individual and small group products,¹ the measures must be drawn from the SQMS. In September 2015, the Massachusetts Hospital Association (MHA) and the Massachusetts Association of Health Plans (MAHP) put forth a joint proposal for measures to use for tiering providers in the merged market

¹ This excludes self-funded health plans such as the Group Insurance Commission.



(individual and small group). The proposal included 41 quality measures, of which 21 were not currently in the SQMS. Given that, MHA and MAHP nominated the following measures for the SQMS:

Timely and Effective Care Measures

- STK-1 VTE Prophylaxis (NQF #434)
- STK-4 Thrombolytic Therapy (NQF #437)
- STK-6 Discharged on Statin (NQF #439)
- STK-8 Stroke Education
- VTE-1 VTE Prophylaxis (NQF #372)
- VTE-2 ICU VTE Prophylaxis (NQF #373)
- VTE-3 VTE Patients w/Anticoagulation
- VTE-5 VTE Warfarin Therapy Discharge Instructions
- VTE-6 Hospital Acquired Potentially-Preventable VTE
- SEP-1 Severe Sepsis & Septic Shock: Management Bundle (NQF #500)
- IMM 2 Influenza Immunization (NQF #1659)

Readmissions Measures

- CMS Hospital 30-day all-cause risk-standardized readmission rate following AMI hospitalization (NQF #505)
- CMS Hospital 30-day all-cause risk-standardized readmission rate following heart failure (HF) hospitalization (NQF: #330)
- CMS Hospital 30-day all-cause risk-standardized readmission rate following pneumonia hospitalization (NQF: #506)
- CMS Hospital 30-day all-cause risk-standardized readmission rate following acute ischemic stroke hospitalization
- CMS Hospital 30-day all-cause risk-standardized readmission rate following CABG surgery (NQF# #2515)
- CMS Hospital 30-Day all-cause risk-standardized readmission rate following COPD hospitalization (NQF #1891)
- Hospital-level 30-day all-cause risk-standardized readmission rate RSRR following elective primary THA and/or TKA (NQF# #1551)

Perinatal Care Measures

- PC-01 Elective Delivery (a Leapfrog equivalent is in the SQMS) (NQF #469)
- PC-04 Health Care-Associated Bloodstream Infections in Newborns (NQF #1731)
- PC-05 Exclusive Breast Milk Feeding (NQF #480)

The SQAC unanimously approved the addition of these measures to the SQMS.

Specialty-Specific Measures



The current SQMS does not identify specialty-specific measures. Due to the importance and broad reach of primary care, acute hospital care, and post-acute care, specialist physician-level measures are less commonly used in national programs. However, the SQAC agreed that specialists make up an important component of care, and identified specialty-specific measures as a gap in the current SQMS. In 2014 the Committee voted to evaluate the feasibility of including specialist quality measures in the SQMS, beginning with an evaluation of obstetric and perinatal measures. The SQAC's evaluation included stakeholder outreach, key informant interviews with quality experts in maternity care in the Commonwealth and nationally, and a survey of available obstetric and maternity care quality measures. The results of this work were presented to the SQAC at its May 2015 meeting. The study found that specialty measurement is feasible, although there are a number of challenges. Measuring individual providers, however, could be challenging.

Changes to Mandated Measures

Chapter 224 requires four measure sets to be included in the SQMS: the CMS hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical care; HCAHPS; HEDIS and ACES. The latter was replaced in 2013 by the CAHPS survey tool. These sets are subject to ongoing updates from the measure stewards. Known updates to the mandated measure sets as of October 4, 2015 include:

1. The retirement of two measures from 2015 HEDIS:
 - a. Glaucoma screening for older adults
 - b. Cholesterol management for patients with cardiovascular conditions
2. The addition of four measures to the 2015 HEDIS:
 - a. Non-recommended PSA-based screening in older men
 - b. Use of multiple concurrent antipsychotics in children and adolescents
 - c. Metabolic monitoring for children and adolescents on antipsychotics
 - d. Use of first-line psychosocial care for children and adolescents on antipsychotics
3. The removal of nine measures from the CMS hospital process measures sets, as these measures are retired by CMS or provider data submission to CMS is now voluntary:
 - a. Prophylactic antibiotic received within 1-hour prior to surgical incision (SCIP-Inf-1a)
 - b. Prophylactic antibiotic selection for surgical patients (SCIP-Inf-2a)
 - c. Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero (SCIP-Inf-9)
 - d. Surgery Patients with Perioperative Temperature Management (SCIP-Inf-10)



- e. Surgery patients with recommended venous thromboembolism prophylaxis ordered (SCIP-VTE-1)
 - f. Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN 6)
 - g. Aspirin prescribed at discharge for AMI (AMI 2)
 - h. Primary percutaneous coronary intervention (PCI) received within 90 minutes of hospital arrival (AMI 8a)
 - i. Statin prescribed at discharge (AMI 10)
4. The addition of the 21 measures proposed by MAHP and MHA (see page 5)
 5. The removal of the HEDIS Health Plan All-Cause Readmission measure, as this measure does not apply to the current uses of the SQMS (provider quality reporting, provider tiering).

Future Work

The Committee will begin its next meeting cycle by engaging in work to move its quality improvement priorities forward. This may include reviewing the SQAC's role in reform-oriented initiatives in Massachusetts and engaging with stakeholders who are actively engaged in one of the quality improvement priority areas. The SQAC will also examine emerging measurement opportunities, particularly in the area of opioid use. In the coming year, the Committee may also identify, evaluate, and consider measures as part of their continued maintenance of the SQMS. Finally, the SQAC will continue to evaluate the extent to which measures for specialists are practical for public reporting and appropriate for the SQMS, given the challenges identified in their study.

Conclusion

Over the course of the 2015 meeting cycle, the SQAC underwent a strategic planning process to identify and adopt quality priorities. The SQAC also reviewed the potential of quality reporting for obstetric and perinatal care, and approved the addition of 21 measures proposed by MHA and MAHP to the SQMS. The SQAC looks forward to ongoing collaboration across the Commonwealth, including with CHIA, the Executive Office of Health and Human Services, the Group Insurance Commission, and the Health Policy Commission, as it seeks to collectively improve population health, improve care for each Massachusetts resident, and reduce costs for the health system.



APPENDICES

Appendix A: Standard Quality Measure Set

See attached

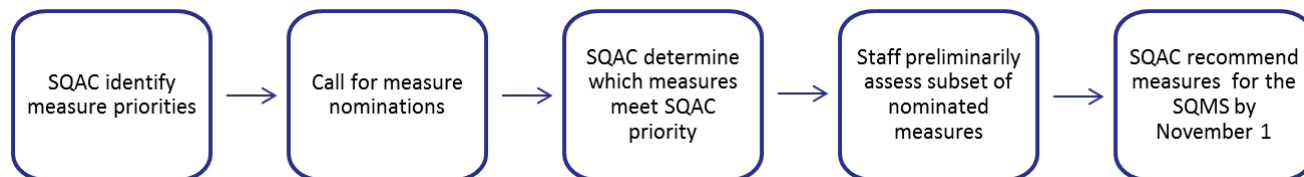


Appendix B: About the SQAC

SQAC Mission

The Statewide Quality Advisory Committee advises all branches of state government regarding the alignment of health care performance metrics and the efficient collection and uniform reporting of the Standard Quality Measure Set in order to support improvement in the health status of the residents of the Commonwealth.

SQAC Recommendation Process



Implementation of the SQMS

The Standard Quality Measure Set (SQMS) serves as a foundation for the uniform quality reporting CHIA is required to develop for each hospital, home health agency (HHA), skilled nursing facility (SNF) and registered provider organization (RPO) in the Commonwealth (957 CMR 4.00).

The Executive Director of CHIA determines the measures to include in the SQMS based on an annual recommendation from the SQAC. In developing the SQMS recommendation, the SQAC “shall select from existing quality measures and shall not select quality measures that are still in development” (MGL Ch. 12C, Section 14).

Mandated Uses of the SQMS

1. CHIA will publicly report hospital, HHA, SNF and RPO performance on the SQMS periodically (957 CMR 4.00).
2. Merged market carriers with >5000 enrollees must offer at least one selective or tiered plan; these plans include use of provider quality comparisons using measures in the SQMS. DOI will require uniform reporting of tiering information (M.G.L. c.176J s.11).
3. The Health Policy Commission (HPC) will develop quality standards for patient centered medical homes with reference to the SQMS (M.G.L. c.6D, s.14).
4. HPC is directed to improve the quality of health services provided through Accountable Care Organization certification, as measured by the SQMS (M.G.L. c.6D, s.15).



Appendix C: Section 14 of Chapter 224 of the Acts of 2012

The center shall develop the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the “standard quality measure set.

The center shall convene a statewide advisory committee which shall recommend to the center a standard quality measure set. The statewide advisory committee shall consist of the executive director of the center or designee, who shall serve as the chairperson; the executive director of the group insurance commission or designee, the Medicaid director or designee; and 7 representatives of organizations to be appointed by the governor, 1 of whom shall be a representative from an acute care hospital or hospital association, 1 of whom shall be a representative from a provider group or medical association or provider association, 1 of whom shall be a representative from a medical group, 2 of whom shall be representatives of private health plans, 1 of whom shall be a representative from an employer association and 1 of whom shall be a representative from a health care consumer group.

In developing its recommendation of the standard quality measure set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures.

The committee shall annually recommend to the center any updates to the standard quality measure set on or before November 1. The committee may solicit for consideration and recommend other nationally recognized quality measures, including, but not limited to, recommendations from medical or provider specialty groups as to appropriate quality measures for that group’s specialty.

At a minimum, the standard quality measure set shall consist of the following quality measures: (1) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (2) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (3) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (4) the Ambulatory Care Experiences Survey. The standard quality measure set shall include outcome measures. The committee shall review additional appropriate outcome measures as they are developed.



Appendix D: List of SQAC Members

Ex-Officio Members

- Áron Boros, Executive Director, Center for Health Information and Analysis (Chair)
- Dolores Mitchell, Executive Director, Group Insurance Commission
- Daniel Tsai, Director, Office of Medicaid (Designee: Ann Lawthers)

Gubernatorial Appointments

- Dianne Anderson, President and CEO, Lawrence General Hospital (Representative from an acute care hospital or hospital association)
- Dr. James Feldman, Chair of Committee on Quality Medical Practice, Massachusetts Medical Society (Representative from a provider group or medical association or provider association)
- Dana Gelb Safran, Blue Cross Blue Shield of Massachusetts (Representative from a private healthcare plan or health plan association)
- Jon Hurst, President, Retailers Association of Massachusetts (Representative from an employer association)
- Dr. Richard Lopez, Chief Medical Officer at Harvard Vanguard/Atrius Health (Representative from a medical group)
- Dr. Michael Sherman, Chief Medical Officer, Harvard Pilgrim Health Care (Health Plan Representative)
- Amy Whitcomb Slemmer, Executive Director, Health Care For All (Representative from a health care consumer group)

Non-Voting Members

- Iyah Romm (December to June); Katherine Shea Barrett (appointed in July), Health Policy Commission

