

Adopting a Process for Identifying and Selecting Quality Priorities

A Report on the Process

Introduction

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. 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). It is the only statewide quality body existing in Massachusetts today.

In December 2014, the SQAC underwent an informal strategic planning process to determine its work for 2015 and ways to expand its quality efforts beyond updating the SQMS. The SQAC gathered stakeholder insights through roundtables and individual meetings. Based on these discussions, the SQAC decided to focus its 2015 work on developing statewide quality priorities. These quality priorities serve the purpose of:

- defining areas for the SQAC to focus its attention in the next 3-5 years; and
- giving the SQAC areas to emphasize as it seeks to promote statewide health and quality priorities among state agencies, public and private payers, health care providers, and the patient community.

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 work with the SQAC on quality priorities. This report documents the work that Bailit completed with the SQAC to select quality priorities.

Methodology

To develop its quality priorities, the SQAC followed a deliberate process to ensure appropriate consideration of different potential topic areas.

Quality Priority Criteria

As a first step, Bailit worked with the SQAC to develop initial parameters for the quality priority setting process and the criteria through which the SQAC would consider potential quality priorities in areas needing continued improvement. The criteria were meant to serve as a filter to help the SQAC categorize potential priority areas and not a definitive determination of whether a particular quality area was prioritized.

Environmental Scan

Bailit also conducted an environmental scan to review similar national or state-based initiatives and how those groups approached the task of defining quality priorities. Based on its research Bailit identified two national initiatives with frameworks that were useful in organizing thinking around quality priorities. The National Quality Strategy (NQS)¹ developed a framework with three overarching aims, six quality priority areas and nine strategy levers through a large stakeholder process. This framework was useful in differentiating between goals, priorities, and strategies and in the context of the SQAC providing a framework for differentiating between quality priorities, potential uses of priorities, and measures that would align with priorities.

As the SQAC began this work, the Institute of Medicine (IOM) released its *Vital Signs: Core Metrics for Health and Health Care Progress*² report in May 2015. To develop this framework, the IOM convened a Committee on Core Metrics for Better Health at Lower Cost to propose a basic, minimum slate of measures for assessing and monitoring progress in the state of the nation's health. This report proposed a basic minimum slate of measures for accessing and monitoring progress in the state of the nation's health, organized by key domains of influence. It also laid out a method to decide on quality priorities and an approach on how to organize them, and introduced cross domain priorities as a way of approaching concepts that are not limited to any one quality priority.

Interviews with Stakeholders

Bailit developed an interview tool, included as Appendix A, to guide a conversation with a number of stakeholders about their quality priority setting processes and potential quality priority areas. The SQAC reviewed the interview tool and Bailit incorporated its suggestions. The list of organizations represented by the interviewees is included as Appendix B. The results of these interviews informed both the SQAC's quality priority setting process and the quality priorities it considered. Depending on the organization, quality priorities were often dictated by a contracting or certifying entity rather than identified by the organization itself. However, many organizations also developed quality priorities based on a variety of individualized reports that identified areas where there are gaps in care or room for improvement. When given an option, most organizations felt it important to limit the number of quality priorities on which they focused to allow for optimal potential for improvement. However, many noted that they were not always able to control the number of quality priorities.

¹ This work is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services and mandated by the ACA. It was first published in 2011. For more information see: <http://www.ahrq.gov/workingforquality/about.htm>

² IOM (Institute of Medicine). 2015. *Vital signs: Core metrics for health and health care progress*. Washington, DC: The National Academies Press.

Most of these organizations reviewed their quality priorities on an annual basis. This can be as part of a formal annual quality improvement process. Others review current goals on an ongoing basis. It was also noted that some quality projects may have a longer or shorter timeframe. However, a strategic review of quality priorities tends to occur on a longer term basis, often every three years.

Interviewees used their own quality priorities to drive investment in the following ways:

- Focus their education and programming
- Guide their quality improvement projects
- Lobbying/advocacy

Interviewees noted that the SQAC's quality priorities could be a combination of cross cutting and clinical disease-specific measures. However, when asked what goals the Commonwealth should focus on they mostly selected cross cutting goals, such as care coordination.

When considering the breadth and number of priorities for the SQAC to focus on there was concern about missing either the forest or missing the trees. Interviewees felt the SQAC needed broad priorities, but a narrow implementation to focus on specific areas that need attention. Interviewees also thought that a handful of priorities (3-5) were the most that the SQAC could effectively focus on. Interviewees provided Bailit with potential quality priority areas to be considered by the SQAC.

When considering social determinants of health and disparities, there were diverging opinions about focusing on them. Those stakeholders who had a specific interest in these areas were interested in having targeted focused priorities. Others thought that priorities should be considered regardless of social determinants of health and disparities, but that specific initiatives could be targeted towards those areas and populations as appropriate. It was noted that social determinates of health and disparities are more than just race and ethnicity and also include geography and income. It was also noted that better data is needed on race/ethnicity to target initiatives to these areas, particularly in the commercial market.

Criteria for Evaluating Quality Priorities

Following a facilitated conversation, the SQAC choose to focus of the following criteria when considering quality priorities:

- Areas where quality of care and health outcomes could be measurably improved in the Commonwealth, considering the following:
 - Whether gaps in the quality of care are able to be identified (either relative to other states or absolutely)
 - Whether performance can be improved, because there is an evidence-base or known best practices as to how transform care

- Whether there is a performance goal that can be identified, and some evidence as to what correct level should be, or the direction the measurement should be moving toward
- Aligned, to the extent possible, with priorities of other stakeholders including:
 - State Purchasers (Medicaid and GIC)
 - Employer Purchasers
 - Other state agencies
 - Providers
 - Commercial insurers
 - National initiatives
- Areas where quality measurement is feasible by CHIA or by other entities
- Areas that either are broad enough that they impact all citizens, or a mix of narrowly focused priorities that together impact all citizens

In addition, the SQAC was interested in considering cost-containment potential and was focused on not introducing any new burden to providers based on the SQAC’s quality priorities.

Bailit developed a scoring mechanism to sort priorities by how well they met the criteria to assist the SQAC in selecting priorities. Using the scoring tool, Bailit scored each proposed quality priority across the following 10 criteria, using the definition included in the table, based on the degree to which it met the criteria. The scores were used only as a point to move forward the discussion and not as a final determination of whether a specific quality priority topic was potentially considered by the SQAC.

Criteria	Definitions
Can gaps in the quality of care be identified?	Can gaps in the quality of care be identified, either relative to other states or absolutely?
Can performance be improved and is there a performance goal that can be identified?	Is there an evidence-base or known best practice as to how to transform care and is there a performance goal that can be identified? Is there evidence as to what the correct level should be, or the direction the measurement should be moving toward?
Is it aligned with the priorities of other stakeholders?	Are there existing state or private efforts or planning initiatives focused on this proposed quality priority?
Is quality measurement feasible by provider/payer?	Do quality measures or initiatives to create measures exist that address this priority area?
Is quality measurement feasible by CHIA ³ ?	Are measures related to proposed quality priority included in the SQMS that CHIA are currently able to report, or could CHIA report measures that address this proposed quality priority?

³ CHIA scored this measure.

Criteria	Definitions
Does it impact a large group of citizens?	What is the relative size of the population impacted by the proposed quality priority?
Does it go beyond PCPs?	Does the proposed quality priority extend beyond the PCP to include others such as specialists, coordination among different providers or the health care system as a whole?
Can it lower costs?	Will implementing this proposed quality priority tend to lower costs across the health care system?
Will it not create new burden to providers?	Will the implementation of this proposed quality priority create a new practice or measure reporting burden on providers?
What is the ability of the health care system to drive change?	Can the health care system drive change in this proposed quality priority area, or is it outside the control of the health care system?

These scoring criteria were used to help reduce the number of quality priorities the SQAC had to consider. The SQAC then discussed each potential quality priority area and selected five areas needing continued improvement to focus on. As part of this discussion the SQAC realized that some potential quality priority areas could be used as ways to view other quality priority areas. These cross-cutting views were considered for each of the selected quality priority areas:

- disparities
- transparency
- care coordination
- patient experience and patient activation

Selected Quality Priorities

Based on the research and analysis discussed, and through thoughtful consideration, the SQAC identified the following five quality priority areas described below. To inform the discussion of these priorities Bailit drafted detailed priority briefs for each priority area.⁴ As noted above each quality priority area was considered across each of the cross-cutting dimensions: reducing disparities, increasing transparency and care coordination, and improving patient experience and patient activation.

Taken together these five quality priority areas span a wide age range, from birth to end of life and capture issues that go beyond primary care to address issues that involve specialists, community health workers, behavioral health providers, nursing homes, patients and members of the community. These quality priority areas also include areas where considerable work is already underway and areas that are new and innovative.

⁴ Each quality brief can be accessed at <http://www.chiamass.gov/sqac>.

Appropriateness of Hospital-Based Care

This priority area has three components that address improving quality in inpatient and institutional care use through reducing:

- unplanned readmissions to hospitals within 30 days of hospital discharge;
- preventable hospitalizations from the community,
- preventable admissions from Skilled Nursing Facilities.

When considering preventable hospitalizations there are two areas that stand out -- those admissions that that could potentially be avoided by better primary and preventive care in an ambulatory setting, and those admissions that could potentially be avoided through better care in a skilled nursing facility.

While many stakeholders in the Commonwealth have focused on reducing readmissions and preventable hospitalizations, there is still opportunity for improvement. Reducing readmissions and preventable hospitalizations can improve care and lower health care costs.⁵ Doing so requires a coordinated and collaborative effort from actors in the health care system and in the community, and that lowering readmissions remains a priority for stakeholders. Admissions and readmissions can be expensive and disruptive and disorientating, particularly for the frail elderly population and persons with disabilities. CMS recently published a report on an initiative to reduce such admissions among residents in nursing facilities and noted that 15% of residents experienced a preventable hospitalization.⁶

There are several paths for reducing readmissions and preventable hospitalizations which engage different members of the health care system and the community in different ways. In addition, there is ongoing focus on measurement both in the SQMS and elsewhere.

Integration of Behavioral Health and Primary Care

The integration of behavioral health and primary care allows for an individual to receive integrated care for all health conditions within one supportive setting. This care may address both physical and behavioral health including mental health and substance abuse issues, health behaviors and their relationship to chronic conditions, life stressors and ineffective care utilization.⁷

⁵ <http://healthaffairs.org/blog/2013/08/16/reducing-hospital-readmissions-its-about-improving-patient-care/>

⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html>

⁷ Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-

Integration of care is an important step in assuring access to behavioral health services and in providing whole person care which focuses on all physical and mental health care needs, leading to improved health outcomes. Behavioral health problems are reported to be 2 to 3 times higher in people with chronic conditions like diabetes, heart disease, back pain, headache and other conditions.⁸ While behavioral health integration is a best practice, there are a number of challenges to widespread implementation, including:

- reimbursement issues,
- outdated regulations that are based on separate systems for physical and behavioral health,
- difficulty accessing behavioral health treatment,
- the need for cross training of primary care and behavioral health providers,
- the lack of interoperability and connection to electronic health records for behavioral health providers, and
- real and perceived privacy issues.

Increased integration of behavioral health and primary care has the potential to improve quality in a number of ways, including improving access to behavioral health services leading to earlier detection and/or intervention of behavioral health issues. Treating behavioral health issues concurrently with medical issues, such as diabetes, may also lead to improvements in those conditions. Quality measurement in this area is emerging.

End of Life Care

End of life care is the support and medical care given to patients during the time surrounding death. This includes decisions about medical treatments, hospitalizations, admissions to skilled nursing facilities, palliative care and hospice as well as patient and family decision making.

There is significant variation in the amount of intervention and cost of care near the end of a patient's life.⁹ Often interventions are costly and do little to improve a patient's chance for sustained improvement in their condition in the mid to long term. Palliative and end of life care programs can help improve the quality of care that patients experience throughout the course of their illness.¹⁰ In addition to improving the patient's comfort, these programs can reduce spending on interventions and treatments that will not appreciably improve a patient's

IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at:

<http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

⁸ Katon, Wayne, Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness, *Society of Biological Psychiatry*, 2003;54:216-226; Katon, W. Lin, EH, and Kroenke, K. The association of depression and anxiety with medical symptom burden in patients with chronic medical illness. *Gen. Hosp. Psychiatry*. 2007; 29:147-155.

⁹ Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life - See more at: <http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx#sthash.0hjAKHdl.dpuf>

¹⁰ http://www.qualityforum.org/Topics/Palliative_Care_and_End-of-Life_Care.aspx

condition or quality of life and may also result in reduced emergency department visits and fewer preventable hospitalizations.

Quality can be improved in a number of different ways. Patients can make their wishes known to their families and loved ones through advanced directives. Providers can counsel patients and their families on the probable course of their illness and explain the choices for treatment, including being clear on when further treatment is likely to have little benefit and be traumatic for the patient. There are a number of existing quality measures that can be leveraged both in the SQMS and elsewhere.

Maternity

Maternity care includes pre-natal management visits with Obstetrics and Gynecology specialists, midwives and doulas before the delivery of a child, the delivery of a child either in a hospital setting or in another setting and then follow up with the mother within 6 weeks after delivery. It is a high cost service area that impacts a large group of citizens and directly impacts the next generation. Massachusetts' statewide C-section rate of 32%¹¹ is significantly higher than the World Health Organization's recommended rate of between 10-15%.¹²

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 to provide consumers with relevant and actionable information as they consider their obstetric care options.

While there is a clear, defined course of maternity services, gaps in care continue to persist.¹³ Recent reductions in early elective deliveries either by C-section or induction without medical indication in Massachusetts demonstrate that effective stakeholder engagement can lead to improved quality. Massachusetts Health Quality Partners (MHQP) Practice Pattern Variation Analysis (PPVA) found significant variation among providers in the number of prenatal ultrasounds performed for uncomplicated pregnancies.

There are several areas for improvement in the area of maternity care including:

- Reduction of C-section rates
- Increased rate of women having a vaginal birth after cesarean (VBAC)
- Reduced provider variation, through increased use of best practices.

¹¹ Massachusetts Department of Public Health, 2012 C-Section Rates. See

<http://www.cesareanrates.com/2015/02/Massachusettscesareanrates.html>

¹² World Health Organization Statement on C-Section Rates; Executive Summary. See

http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

¹³ CHIA previously conducted research on this quality priority and has published the results on their findings. <http://www.chiamass.gov/assets/docs/r/SQAC-Final-OB-Brief-6-26-15.pdf>

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. Many individuals who are addicted to opioids began using these drugs as part of a prescription for treatment of an injury. In identifying opioid use as a potential priority area, the SQAC reinforces the activities of the Baker Administration and two recent Task Forces focused on addressing the opioid crisis and supports the implementation of those activities through measurement of progress of the Commonwealth towards reducing the opioid epidemic.

There are several areas of focus in reducing opioid death and addiction, beginning with prevention and including intervention, treatment and recovery services.

Massachusetts provides a wide array of substance use treatment services.¹⁴ There has been significant work throughout the Commonwealth to identify ways to improve access to substance use treatment services, including provision of additional funding to support prevention, intervention, treatment and recovery.¹⁵ In particular, the Commonwealth is working to improve:

- access to and pricing of Naloxone, a prescription drug commonly known as Narcan, which can be an antidote to an opioid overdose.
- compliance with the Prescription Monitoring Program (PMP), where physicians and pharmacists can check to see whether an individual is receiving certain prescription drugs.
- understanding of access to the behavioral health system.
- access to treatment services through mandates on commercial insurers to cover services without prior authorization.
- access to medication assisted treatment (MAT).
- access to services covered through the Department of Public Health's Bureau of Substance Abuse Services (BSAS), including residential recovery homes and recovery support centers.

Because relapse is an expected and common part of the recovery process, it is difficult to measure the success and quality of substance use treatment services. There are limited standardized quality measures related to opioid use. To the extent measures do exist, they are

¹⁴Center for Health Information and Analysis, Substance Use Disorder Treatment in Massachusetts, April 2015; accessible at: <http://www.chiamass.gov/assets/Uploads/SUD-REPORT.pdf>

¹⁵ The findings from Governor Baker's Opioid Task Force, released in June 2015, are accessible at: <http://www.mass.gov/eohhs/feature-story/end-opioid-abuse-in-mass.html>; findings from Governor Patrick's Opioid Task Force, released in June 2014, are accessible at: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/opioid/report-of-the-opioid-task-force-6-10-14.pdf>.

focused on substance use generally, and not specifically on opioids. As an emerging area of quality measurement, the SQAC may seek to consult experts in developing measures for this area.

Conclusion

The SQAC's quality priority work provided the SQAC with a process to evaluate quality priorities now and going forward. The five quality priorities detailed above – appropriateness of hospital-based care, integration of physical and behavioral health, maternity care, end of life care, and opioid use – are all areas where ongoing improvement is essential and which continue to receive deserved attention through the Commonwealth. As the State and others consider how to spend limited resources for both quality measurement and program innovations, these areas should receive prioritized attention. Efforts focused on these areas may help the Commonwealth in improving the quality of health and health care for all citizens.

Appendix A: Interview Tool

1. What does quality mean to you and your organization?
2. Do you have a system for choosing which quality areas to focus on? In other words, how do you prioritize quality areas today? Who sets those priorities?
 - [For associations and/or consumer groups] How do you find out what your stakeholders are most concerned about?
3. How many priority areas does your organization focus on at any one time and for what purpose?
4. How frequently are priority areas reviewed and changed? By whom?
5. [If still need to tease out] What are the three biggest priority areas for health care quality improvement in your organization and why?
 - [For associations/consumer groups] What are the biggest priority areas for health care quality improvement for your stakeholders and why?
6. If you have identified quality priorities at your organization, how do they drive your operations/projects/investments or other activities?
7. What do you believe the Commonwealth's top three health care quality priorities should be that will influence quality activities across the state (both governmental and private) to ultimately improve health care outcomes.
 - Why did you select these priorities?
 - Are you doing anything to address these priorities today?
8. Do you think priorities should be cross-cutting (e.g., wasteful care, consumer engagement) vs. clinical/specific (diabetes, maternal health) and why?
9. How broad or narrow should the priority areas be and why? Please give examples.
10. How many areas of focus should the SQAC recommend the Commonwealth focus on to drive improvement and why?
11. Do you think about or analyze disparities or social determinants of health in choosing priorities? If yes, how does that impact your areas of focus?
12. What do you think it would take to move the "quality dial" in MA for the priorities you've stated?
13. Is there anything else that you would like to share about quality priorities?

14. The SQAC has developed the following proposed criteria for use in selecting quality priorities to promote quality alignment throughout the Commonwealth. How does this compare to the criteria you use in selecting priority areas for health care improvement?
- Area where quality of care and health outcomes could be measurably improved in the Commonwealth, considering the following:
 - a. Whether gaps in the quality of care are able to be identified (either relative to other states or absolutely)
 - b. Whether performance can be improved, because there is an evidence-base or known best practices as to how transform care
 - c. Whether there is a performance goal that can be identified, and some evidence as to what correct level should be, or the direction the measurement should be moving toward

 - Aligned, to the extent possible, with priorities of other stakeholders including:
 - a. State Purchasers (Medicaid and GIC)
 - b. Employer Purchasers
 - c. Other state agencies
 - d. Providers
 - e. Commercial insurers
 - f. National initiatives

 - Area where quality measurement is feasible by CHIA or by other entities

 - Areas that either are broad enough that they impact all citizens, or a mix of narrowly focused priorities that together impact all citizens

Appendix B: Organizations Interviewed

Betsy Lehman Center for Patient Safety and Medical Error Reduction

BMC Health Net

Boston's Children's Hospital

Executive Office of Health and Human Services

Greater Boston Interfaith Organization

Harvard School of Public Health

Health Care for All and its Patient and Family Advisory Council

High Point

Massachusetts Association of Health Plans (MAHP), Medical Directors

Massachusetts Council of Community Hospitals

Massachusetts Health Quality Partners

Massachusetts Hospital Association

Massachusetts League of Community Health Centers

Massachusetts Medical Society

Partners Health Care

Towers Watson

University of Massachusetts, Department of Geriatrics

Appendix C: Other Quality Priorities

The SQAC initially considered a long list of potential priority areas. The SQAC limited its initial quality priorities to five areas so that it can focus its attention and resources. The other areas that were considered but not chosen are also important and deserve focus in the future, including:

- Access to care
- Childhood obesity
- Children's access for MH and SA treatment services
- Integration of community and social supports with medical care
- Obesity
- Patient safety