

## Statewide Quality Advisory Committee (SQAC) Meeting

Monday, May 18, 2015

3:00pm - 5:00pm

MEETING MINUTES

### **Location:**

Center for Health Information and Analysis (CHIA)  
501 Boylston Street, 5<sup>th</sup> Floor  
Boston, MA 02116

**Chair:** Áron Boros (CHIA)

**Committee Attendees:** James Feldman, Jon Hurst, Ann Lawthers, Iyah Romm, Amy Whitcomb Slemmer, Dolores Mitchell

**Committee Members Attending by Phone:** Richard Lopez, Dianne Anderson, Dana Safran (for the first 30 minutes)

**Other Attendees:** Kristina Philipson (CHIA), Beth Waldman and Michael Joseph (Bailit Health Purchasing, LLC.)

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1. Chair Áron Boros opened the meeting. He described how the SQAC would be moving forward with developing priorities, based on previous SQAC discussions. He introduced Bailit Health Purchasing and briefly discussed the role it would have in this process.
  2. Chair Boros asked for a motion to approve the minutes from the February 24, 2015 minutes. Minutes were unanimously approved.
  3. Kristina Philipson presented CHIA's findings related to its research of Obstetrics (OB) measures. She reminded the SQAC that the staff was asked to look into adding specialist measures. She reminded the SQAC they decided to focused on OB measures because providers have been able to make improvements in certain areas, such as reducing early elective deliveries (EED) variation from 38% to 5% over two years, because there was opportunities for consumer choice. It is an area of opportunity in Massachusetts as there are high C-section rates. Staff researched measures and found 63 potential measures, 12 of which are already in the SQMS. They also looked at neonatal measures as they are often paired with OB. Outreach was done to 20 organizations including providers, payers, patient advocates, quality improvement organizations, and professional associations. They interviewed representatives from 14 of those organizations (including Childbirth Connections, Neonatal Quality Collaborative, MassHealth), plus the Massachusetts affiliate of the American Congress of Obstetricians and Gynecologists (ACOG). MA-ACOG held a large meeting to address the staff's

questions with nurse midwives, OB/GYN physicians, labor nurses, MFM specialists, OB department chairs or designees, MMS OB/MFM administrative staff and pediatrics. Institutional representation included Baystate Medical Center, U.Mass Medical Center, Mass General, Brigham & Women's Hospital, St. Elizabeth's Hospital, Heywood Hospital, South Shore Hospital, and Cape Cod Healthcare. Staff asked about appropriate uses of measures including reporting, tiering, incentives, and quality improvement (QI). QI and public reporting were cited as appropriate uses of the measures more than incentives and tiering. The interviewees noted that the measures used by their organizations tend to be those that are required for federal and state programs. Overall interviewees noted that they had difficulty getting the necessary data. Most of the potential measures require medical record review; only a small number of potential measures required only claims data.

a. Dolores Mitchell asked what measures were missing data. She noted that claims data includes information regarding c-section vs vaginal delivery and whether it was induced or not.

i. Kristina Philipson replied that they interviewed three health plans and they did not have enough data to report on some outcomes for quality. She noted that we do not have measures for maternal outcomes like infection, incontinence, and other information that would be collected after delivery. The interviewees also noted the following measurement gaps:

- fertility treatment outcomes,
- the number of times someone tries to become pregnant using fertility treatments
- was the newborn healthy following fertility treatment
- Substance addicted newborns
- effective transitions
  - from obstetric care to primary care for mother
  - from hospital and obstetric to pediatric care for baby
- There was also a sense that measures were missing for the processes of care in labor and delivery including criteria for determining at what point during labor a patient should be admitted

Kristina Philipson presented the following measurement challenges they discovered:

- Data availability: stakeholders can have difficulty extracting data from electronic health records. Clinical data can provide more detail than claims data, which is better for quality improvement.
- Health plans may not have enough membership to draw meaningful conclusions from data.

- Attribution challenges at the provider level as the OB who delivers the baby may not be the patient's OB.
  - ACOG noted concern about PSI 18,19 regarding 3<sup>rd</sup> and 4<sup>th</sup> laceration trauma as to who coded it. They noted that no provider would intentionally cause this kind of trauma. AHRQ noted that they don't expect these rates to be zero as there will always be some cases where this is unavoidable.
- b. Dolores Mitchell noted that regarding attribution, it is known who the consulting OB and delivering physician is. She asked if we know how many are babies delivered by primary OB vs other OB. She also noted that sometimes physicians in group practice often code on only one MD and not another. Iyah Romm noted that this challenge is present for any provider-level reporting, not just the OB specialty.

Kristina Philipson presented her conclusions that

- Specialty measurement is feasible; but not at individual practitioner level at this time
  - Engagement of specialty society is ideal
  - Needs:
    - Provider ability to influence results
    - Data credibility
    - Defined level of reporting
  - The group discussed the conclusions:
- c. Dolores Mitchell noted that she is in favor of measuring individual specialists.
- d. James Feldman noted that the data could be used for quality improvement, but the nuanced issue is that we do not have the level of detail required for public reporting, but could work on getting it right at the group level.
- e. Áron Boros brought forth the following questions about what the data support: is the person whose name is on the claim the person who delivered the baby? Is the person who is professionally responsible for delivering the baby named on the claim? If we could solve the claims data issues and measure these things accurately, would the measures themselves be meaningful?
- i. Kristina Philipson responded that, yes, the OB is going to make a decision to conduct an early elective delivery or a c-section. However, much of OB care is team-focused. You might see a nurse practitioner. It's a team sport and stakeholders want measures that reflect that.
    - Áron Boros noted that we find team-based or group practice in other specialties.
- f. Iyah Romm noted that Cardiac Surgeon results are the only specialists that are currently subject to public reporting of performance. The practitioners do not

believe that they should be reported at the individual provider level due to similar attribution questions. Should the most senior person be responsible? In cardiac catheterization you will get the practitioner who is on call. He also noted that people may not take on the riskiest patients because it may impact their publicly reported performance results and that this is an important consideration.

- g. Dolores Mitchell noted that as this is a pilot we should collect data at the group level and the practitioner level and see what it looks like. She also noted that it typically is not random when you get an OB in the delivery room; the mother has usually met the OB before as part of the group she selected.
  - h. Áron Boros asked the SQAC what individual measures they might consider including in the SQMS and the level of service they should be reported on.
  - i. James Feldman noted that gaps of measurement would be important to cover, maternal experience for example.
  - j. Iyah Romm suggested that post-partum depression be included. He also noted that the Health Policy Commission is contemplating work on measures of consumer experience on “shoppable” conditions, maternity care being one.
  - k. Dolores Mitchell asked if we know if post-partum depression has a causal relationship with the care provided.
    - i. Kristina Philipson noted that there is an attribution question regarding which provider should do the post-partum screening.
4. Chair Boros introduced Beth Waldman and Michael Joseph from Bailit Health Purchasing. He described the decisions that led to the hiring of Bailit and the goals for the process. Beth Waldman then introduced the proposed process for setting statewide quality priorities and the project timeframe. To frame the discussion, Beth provided a brief overview of the recently released IOM Report *Vital Signs: Core Metrics for Health and Health Care Progress* as an example of a group that had identified priorities and then selected measures to illustrate their priorities. She also provided a brief overview of state-based quality priority work and the criteria used to select priorities in those states. These were meant only as examples, not to suggest the SQAC should adopt them. Beth then sought to confirm the focus of priority setting on the following:
- a. The SQAC is looking to set priorities for
    - i. Quality Improvements
    - ii. Within the Health Care delivery system
    - iii. Not bound by what is in current SQMS
  - b. Proposed Approach
    - i. Identify 8-10 narrow priorities (e.g., improved birth outcomes)
      - Prioritize 2-3 to be implemented annually over a 3 year period
    - ii. Alternatively can identify 2-4 broader priorities (e.g., diabetes; substance use)

- Focus on these within three years
- c. SQAC members had the following comments:
    - i. Iyah Romm asked if we were bound by something that is now measureable? He also asked if we are going to specify who is to act upon it, only through policy or by provider action or both? All actors?
    - ii. Ann Lawthers commented that we had to be sure to identify who is accountable
    - iii. Amy Whitcomb Slemmer noted that you want to be able to drive improvement, and ensure that people can act on your priorities.
  - d. In terms of the appropriate number of priorities, after discussion Chair Boros suggested that it may be helpful to identify 2 or 3 “Big Dot” priorities and then underneath them some “Little Dot” priorities that the group could tackle. After discussion the group agreed with this approach.
5. Beth introduced some proposed criteria for the SQAC to consider:
- Area where quality of care and health outcomes could be measurably improved in the Commonwealth
  - Aligned with priorities of other stakeholders including:
    - State Purchasers (Medicaid and GIC)
    - Other state agencies
    - Providers
    - Commercial insurers
    - 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
- a. The first criteria prompted much discussion: Ann Lawthers asked if it was about feasibility of measurement or gaps in care? Iyah Romm suggested that he read it as areas where we know how to improve. He also suggested that we should focus on areas where we know what the correct performance level is. Chair Boros proposed the following:
    - i. Areas where we can improve performance
    - ii. Areas where we know how to improve performance
    - iii. We know what the performance level should be.
  - b. Dolores Mitchell noted that the SQAC needs to advocate for someone to do the work, but that the SQAC won’t implement the quality improvement activities themselves. She also expressed concern about amending measures to add socio-economic or demographic data to them so to not punish a provider for their patient population or to set a lower standard of care.
    - i. Amy Whitcomb Slemmer noted that safety net hospitals often get credit for their populations and are risk-rated. She also noted that the reason for

not adjusting measure scores is to avoid excusing lower-quality care for high-risk populations.

- c. Ann Lawthers noted that much of what is focused on by MassHealth is Long Term Services and Supports, and that the SQAC may wish to not only focus on the health care delivery system.
  - d. Dolores Mitchell noted that hospitals should be wary of being told to focus on “hot spotting” and she cited the Camden experiment, as there is not clarity as to who’s budget that would come from.
  - e. Ann Lawthers noted that this type of work is part of delivery system reform.
  - f. Amy Whitcomb Slemmer said that some social services and supports have to be baked in to practice and having quality measures that accounted for that would help.
  - g. Iyah Romm noted that the delivery system is also providing many social services through community health centers
  - h. Chair Boros noted that, in regards to medical vs social determinants of health, if a quality area meets the criteria then we should consider it. Likewise accountability should be part of the priorities.
6. Beth then turned to the stakeholder interviews
- a. Jon Hurst suggested that Bailit interview purchasers, perhaps local chambers of commerce, perhaps a roundtable of employers some self-insured, some fully insured.
  - b. The national priorities partnership should also be considered for research purposes.
  - c. Iyah Romm noted that the Health Policy Commission is in the process of defining a health systems dashboard and that there may be some ability to link these activities. He also noted that we are going to have to rethink what quality is as most consumers think quality has something to do with cost.
    - i. Beth Waldman noted that we should ask the interviewees how they define quality.
7. Chair Boros closed the meeting by providing the SQAC with a brief update on the work that CHIA is doing, working on readmissions, organizing the routine updates to the measure set, developing a roadmap for sourcing data for the SQMS. Continuing to work on the research findings regarding OB, the HPC and CHIA are going to have conversations regarding new legislation around the SQAC. It was noted that some Committee members expressed interest in making revisions to the measure set and in June they will propose with a process as to how to do this.
8. The next meeting of the SQAC will be June 22, 2015. Jon Hurst asked to confirm the date of the September meeting. It is scheduled for September 21, 2015.