Statewide Quality Advisory Committee (SQAC) Meeting
Monday, October 21, 2013
3:00pm-5:00pm
MEETING MINUTES

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

Chair: Áron Boros (CHIA)

Committee Attendees: Ann Lawthers, Dr. James Feldman, Dr. Michael Sherman, Iyah Romm (non-voting), Dolores Mitchell, Dr. Madeleine Biondolillo (non-voting), Deb Wachenheim (for Amy Whitcomb Slemmer), Dianne Anderson

Committee Members Participating by Phone: Dana Safran

Committee Members Not Present: Amy Whitcomb Slemmer, Jon Hurst, Dr. Richard Lopez, Kim Haddad (non-voting)

Other Attendees: Cristi Carman (CHIA), Lori Cavanaugh (CHIA), Kristina Philipson (CHIA)

1.) Chair Boros opened the meeting and asked the Committee members to introduce themselves.

2.) Chair Boros asked for a motion to pass the minutes from the September 30 meeting.

   a. The Committee approved the September 30 meeting minutes unanimously.

3.) Chair Boros introduced two guest presenters: Tim Prinz from The Lewin Group who would give a presentation about the measure assessments and the assessment tool, and Dr. John Wasson from Dartmouth Medical School who would give a presentation about the patient confidence measure that was proposed to be included in the Statewide Quality Measure Set (SQMS).

4.) Tim Prinz from The Lewin Group presented small changes to the measure assessments.

   a. Tim Prinz said that in September the Committee asked him to re-review measures on the "ease of measurement" criterion. He said that his group did further research on data collection for certain measures. They also re-examined how Massachusetts data resources could be used to calculate measures. The Lewin team concluded that the scores of six (6) measures changed from a 2 to a 3 on this criterion because the data for these measures was routinely collected and/or the measure could be calculated using a data resource available in Massachusetts.

b. The Committee also asked Lewin to re-assess Screening for Clinical Depression. Tim Prinz said that the measure still received a "moderate" rating in the re-assessment; he reminded the Committee that this measure also received a "moderate" rating in 2012.

    i. Dolores Mitchell said that despite the "moderate" rating of this measure using the assessment tool, it is an important measure to consider for many reasons, including that doctors have said that screening for clinical depression is very useful.

    ii. Chair Boros said that the preliminary assessment is intended to inform the Committee's recommendation. He reminded the Committee that it would make its recommendation of measures to be included in the SQMS today and that the Committee could vote to include this measure.

c. Dr. Madeleine Biondolillo asked Tim Prinz to explain the preliminary assessment of the Computerized Physician Order Entry (CPOE) measure, which was given a 2 on the ease of measurement criterion.

    i. Tim Prinz said his research indicated that calculating the measure required data that is not readily available.

    ii. Dolores Mitchell said that the CPOE measure is calculated routinely by Leapfrog and in Massachusetts most, if not all, hospitals report this data to Leapfrog.

    iii. Dr. Madeleine Biondolillo asked Tim Prinz if he would a change the score to reflect the data availability.

    iv. Iyah Romm said that hospitals report this data voluntarily to Leapfrog, which could explain the score. He also said that this measure is already included in the SQMS and might be recommended by the Committee for reasons other than data availability.

d. Chair Boros said that small changes can be made to the scores. He added that Lewin is developing a user's guide for the measure assessment tool, which could inform the interpretation of the assessments and scores.

5.) Chair Boros said that Health Care for All asked Dr. John Wasson to present to the Committee more information on the proposed patient confidence measure. Dr. Wasson provided additional materials that were not made available for review and consideration previously. Chair Boros reminded the Committee that Lewin's assessment of the measures are intended to inform the Committee's recommendation of a measure for the SQMS.

    a. Deb Wachenheim introduced Dr. John Wasson from Dartmouth Medical School.

b. Dr. John Wasson briefly introduced himself and said that the patient confidence tool is well-established, has evolved to meet different patient needs, and is easy to use. He said that the tool is used to answer the question: "How confident are you that you can manage your health?"

c. Dr. Wasson said a patient's response provides a "confidence score." He said this tool is important because it engages a patient in his/her care and measures the productivity of interactions between patient and provider. Dr. Wasson noted that this tool has been examined by the Commonwealth Fund, crosswalks well with other measures, and has no ceiling for change over time. He added that, with regards to field implementation, the tool is used in 11 countries and by employers. He noted that this tool should not be used for payment and that Health Care for All intends to use this measure for educational purposes.

    i. Dr. Michael Sherman asked if confidence as measured by this tool correlates with other outcomes, like medication adherence.

        1. Dr. Wasson said that when this tool was used in South Carolina, chronic conditions improved when confidence increased.

    ii. Dolores Mitchell asked Dr. Wasson to explain how to increase a patient's confidence using this tool. She also asked if he had any demographic cross-tab data to support the use of the tool. She noted that it was not clear who is measured using this tool and for what actions they are being measured using this tool; typically the Committee considers measures that capture a distinct process or outcome.

        1. Dr. Wasson said that certain populations are generally less confident in managing their health but education can help. He said that in a hospital setting, doctors have used this tool to ask patients to identify, on a thermometer, their level of confidence. He also noted that, from a doctor's perspective, the goal is for the patient to become more confident, so the tool could be both a process and an outcome measure.

    iii. Dianne Anderson said that the concept makes sense but it is concerning that she is not aware of hospitals or providers who use this tool now.

        1. Dr. Wasson said that a recent issue of *Health Affairs* included articles related to the concept of patient confidence. He also said that the thermometer method is not widely used in current medical practice to measure patient confidence.

iv. Chair Boros asked Dr. Wasson if a paper survey could be used to measure patient confidence.

    1. Ann Lawthers asked if providers could attach a single question to the end of an existing patient satisfaction survey to see if patients would answer it.

    2. Dana Safran said that the clinical depression measure indicates how a patient feels mentally and physically and the patient confidence measure is about how a patient feels about his care. She said that this tool is not intended to measure health status and this is an important distinction. Dana Safran also said it did not seem that this tool is a really a test of patient experience.

        a. Dr. Wasson confirmed that the patient confidence measure is not a patient experience measure. He said that questions about how a patient feels mentally and physically are different than questions about health confidence.

v. Dr. Michael Sherman said that if a patient feels more pain, then the patient may feel less confident. He noted that while he does not disagree with Dr. Wasson's description of the tool and the use of the tool, he was not clear how it would be used in practice.

vi. Dr. Wasson said that all of the issues raised are important. He said that the clinical basis for the tool is a patient-oriented view of the health care they receive.

    1. Dr. James Feldman said that patient confidence is important but that implementation of this tool could be challenging. He added that it appears that the Committee agrees that the idea of patient confidence is important but this particular measure is not within the scope of the SQMS at this time.

vii. Chair Boros asked Dr. Wasson to explain the role the state may have with regards to this measure.

    1. Dr. Wasson expressed concern that the Committee was not taking advantage of an opportunity to put patient confidence on the table. He said that provider burden should not be a reason to exclude this measure from the SQMS and he asked the Committee to endorse this measure on an ad-hoc basis for quality improvement despite potential regulatory constraints.

2. Iyah Romm responded to Chair Boros' question about the state's role in the measure; he said that the Health Policy Commission could potentially use a tool like this as one of several methods of gauging patient confidence. However, he added that it is not the SQAC's role to tell hospitals to implement particular programs. He added that the Committee may decide to continue the dialogue on patient confidence in general, as it is acknowledged as an important area of quality measurement.

3. Dr. Madeleine Biondolillo said she is enthusiastic about the idea of a program to measure patient confidence and the collection of this information across settings may be useful. She said she would like the Committee to continue to discuss patient confidence.

viii. Chair Boros said that the SQAC final report would be amended to reflect this discussion.

6.) Tim Prinz gave a summary of minor changes made to the measure assessment tool. The changes were made to provide clarity and make definitions more precise.

a. Measures that score below a 1.49 are now given a "weak" rating rather than "Not recommended at this time."

b. The Ease of Measurement criterion includes language referring to the ease of measurement *current*ly.

c. For the first definition under Field Implementation, the phrase "evaluation results were inconsistent" was replaced with "evaluation results were inconclusive."

d. The order of the criteria was changed to reflect Dolores Mitchell's suggestions that "amenability to targeted improvement" appear after "reliability and validity."

i. Iyah Romm asked Tim Prinz if different members of the Lewin team used the tool and if their uses yielded the same outcomes.

1. Tim Prinz answered yes, multiple members of his team used the tool to assess the proposed measures. He said assessments of reliability and validity were consistent across reviewers. He said that the "amenable to targeted improvement" criterion was more difficult to evaluate when a measure also did not have widespread implementation, particularly newer measures. He added that the clinical depression measure is an example of a measure that fell short on "amenable to targeted improvement" due to a lack of evidence that the measure is actionable.

He said that the criteria and definitions are well-defined and the results of the assessment tool were consistent across reviewers.

e. Chair Boros said that additional information will be provided for measures that scored below a 3 on the preliminary assessment, in order to provide the Committee with considerations about a measure's use and limitations.

7.) Chair Boros summarized changes to the mandated measure sets and the outcome of the preliminary assessment of proposed measures.

a. In April, the SQAC staff presented on five new measures that were added to the HEDIS measure set. They also informed the Committee of three measures that are no longer collected by CMS or reported on Hospital Compare.

b. In addition, the SQAC staff recommended to the Committee that the CAHPS Clinical and Group Survey would be the best tool to measure patient experience of care in ambulatory settings.

c. The measure of obstetric trauma (PSI 18) was strongly rated and two patient-centered care measures received weak ratings in the preliminary assessments.

d. The Committee agreed that patient confidence is an important concept but the tool proposed by Health Care for All is not appropriate for the SQMS at this time.

e. Dolores Mitchell said that the Committee had three priority areas for 2013 (patient-centered care, behavioral health and care coordination) and although the measures proposed this year do not necessarily reflect the priority areas, she asked that the final report include more language about the priorities for the year. She also said that NQF is developing "families of measures" by domain and asked if the Committee could consider these measure sets as well.

i. Dr. Madeleine Biondolillo said that "families of measures" on priority areas would be very helpful.

ii. Chair Boros said that staff would research the NQF measure sets and that the Committee can discuss and revisit its 2013 priorities at the December meeting.

f. Iyah Romm said that he would like the final report to reflect areas where the Committee has expressed an interest in doing further work but face some limitations, like Serious Reportable Events.

i. Chair Boros said that he will ask the SQAC staff to add these discussion points to the final report.

1. Ann Lawthers said that patient confidence measure should be noted in the final report as not considered because it's not appropriate for the SQMS, but that the Committee agrees it is an important area of measurement and a potentially useful tool.

2. Iyah Romm said that the final report can reflect two distinct categories of measures: measures that have been recommended for inclusion in the SQMS and measures for continued discussion.

3. Dr. James Feldman said that he wanted to echo Dolores Mitchell's comments about the 2013 priorities and hoped that the areas that are not covered in the SQMS currently, like efficiency measures, will be added to the for Future Work section.

ii. Chair Boros read revised language to the final report and noted that the final report must be published by November 1, per the statute.

iii. Chair Boros asked for a vote to approve the final report.

1. All of the voting members who were present or participating by phone voted in favor of the final report.

g. The meeting was adjourned.

Next Meeting:

December 16, 2013
3:00-5:00 p.m.
2 Boylston Street, 5th Floor
Boston, MA 02116