

Statewide Quality Advisory Committee (SQAC) Meeting

Monday, June 16, 2014

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: Dianne Anderson, James Feldman, Jon Hurst, Ann Lawthers, Richard Lopez, Iyah Romm (non-voting), Amy Whitcomb Slemmer, Madeleine Biondolillo (non-voting), Dolores Mitchell, Dana Safran, Michael Sherman

Committee Members Not Present: Kim Haddad (non-voting)

Other Attendees: Elizabeth Chen (Ad Hoc End-of-Life Care Workgroup), James Conway (Ad Hoc End-of-Life Care Workgroup), Lachlan Forrow (Ad Hoc End-of-Life Care Workgroup), Suzana Makowski (Ad Hoc End-of-Life Care Workgroup), Kristina Philipson (CHIA)

1. Chair Boros opened the meeting and introduced committee members. Chair Boros reviewed the agenda, and said that the purpose of the meeting was to discuss moving forward the publicly nominated measures, and to hear from the Ad Hoc End-of-Life Care Workgroup about appropriate End-of-Life measures.
2. Chair Boros asked for a motion to approve the minutes from the April 14, 2014 meeting.
 - a. The Committee approved the April 14 meeting minutes unanimously.
 - b. Chair Boros noted that CHIA is still incorporating SQAC feedback on tiering from the April 14 meeting.
3. Madeleine Biondolillo introduced Elizabeth Chen, James Conway, Lachlan Forrow, and Suzana Makowski from the Ad Hoc End-of-Life Care Workgroup for a presentation of End-of-Life measures.
 - a. Lachlan Forrow said that while end-of-life measurement is a politically difficult subject, there is universal agreement among experts that patients with serious advancing illness must be reliably identified, informed of care options, and that their decisions should be documented and respected. He said that in nearly every measured example, patients' wishes are not matched to the care that they receive. He said that there are many pieces that contribute to a working system, but that one of the main factors, and the topic of today's presentation, is identifying quality indicators to track performance.
 - b. Madeleine Biondolillo said that Chapter 224 of the Acts of 2012 mentions serious advancing illness, and said that proposed regulations identify the need to inform patients of end-of-life options including hospice and palliative care.

- c. Elizabeth Chen discussed the progression of disease. She identified 4 phases: 1) Healthy or with reversible illness; 2) Early onset, chronic conditions; 3) Progressive, frequent complications; 4) Hospice eligible.
 - i. She said that end-of-life consists of phases 3 and 4, when palliative care and hospice are more important than chronic and curative care.
 - ii. She said that in this time, which can sometimes last several years, the patient needs to understand that death is approaching and understand the quality tradeoffs for the various care options. She said that care should then be matched with patient wishes.
 - 1. Dolores Mitchell asked about an appropriate way to interact with patients who are in denial or resist the idea that death is coming. Lachlan Forrow said that one patient preference to consider is how much information the patient wants to know. He said that if a patient does not want to know the details of their decline, the doctor needs to interact with a family member or someone who knows the patient well enough to ensure that the care provided is in keeping with the patient's wishes.
 - iii. Suzana Makowski said that one of the major barriers to care is that physicians want to heal, rather than take away hope. She said that for patients with serious advancing illnesses, a physician should try to redefine hope to be about the patient living with the time s/he has. Suzana Makowski also said that treatment often focuses on numbers from lab tests, and patients and families start to "speak the language" of healthcare, rather than looking at results in a more human context. She said that the need to focus on treating people first is especially important when moving from curative care to palliative care.
 - iv. Elizabeth Chen said that in the progression from phase 3 to phase 4, there are several important steps: 1) patient understands the prognosis; 2) evaluation of options; 3) disease/symptom treatment; 4) actively dying; 5) family experiences of the end-of-life process of their loved one. She said that a lot of focus is placed on disease and symptom treatment, but this is only one small part of the end-of-life experience. She said that we need ways to measure each of these steps.
- d. Suzana Makowski identified the "Measuring What Matters" set under development by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. She said that many of the measures in the set are similar to the NQF set, but that there are efforts to evaluate whether the measures can be enhanced to include additional populations. She said that Massachusetts is the first state to consider enhancing these measures.
- e. Amy Whitcomb Slemmer said that many of the measures documented the creation of a care plan, but asked how to measure whether the care plan was followed. Lachlan Forrow said that this information would need to come from a family survey, since the patient cannot provide the information directly.

- f. Amy Whitcomb Slemmer asked about the possibility of including shared decision-making measures. Lachlan Forrow said that there is a lack of coordination in transmitting care plans from one setting to another when transferring patients. He said that working on this would be necessary before we could develop useful measures for shared decision-making.
- g. Chair Boros asked about the quality of the measures, both individually and as a set. He asked whether these were a robust set, whether they were the best measures from a group of underdeveloped measures, and whether they could stand on their own or needed to be kept as a set. Richard Lopez also asked if there were a few measures that were more important than others. Suzana Makowski said that there are challenges to many of these measures and some are easier to measure than others. She said that each measure was there to address a specific aspect of end-of-life care, and further discussion with the Academy would be necessary to identify the most important measures. She also said that key domains relevant to end-of-life care might interact with other quality measures.
- h. Michael Sherman said that limited pay for performance initiatives do exist around advanced directives. He said that payers tread lightly in this area because of the perception that these are financially-driven “death panels”.
- i. Lachlan Forrow said that patients and providers are not forthcoming with “horror stories” about patient wishes not being respected, but that families will discuss these. He said that this type of measurement takes resources because it involves interviews with families and can’t be done using claims data.
- j. Dana Safran asked about the scalability of the Measuring What Matters set. She asked how much implementation work has already been done. Suzana Makowski said that some of the measures come directly from hospice quality metrics which have already been tested and implemented. Elizabeth Chen said that the All-Payer Claims Database is an asset because it is very robust. She mentioned the idea of adding validated questions to the Behavioral Risk Factor Surveillance System (BRFSS) survey. She said that it was worth considering measures that hadn’t already been extensively evaluated in existing literature.
- k. Madeleine Biondolillo said that there are various levels of feasibility, and that it may be possible to recommend a few of the measures for SQMS inclusion while continuing to test other measures.
- l. Dolores Mitchell asked who is held accountable by these measures. Lachlan Forrow said that an average person in end-of-life has 5 to 10 providers. He said that this fragmentation is a quality failure that makes measurement difficult.
- m. Iyah Romm asked if the Ad Hoc End-of-Life Care Workgroup was aware of any health plans that currently used the Measuring What Matters set. No members could identify a plan using this set.
- n. Iyah Romm asked if anybody was looking at utilization measures around end-of-life care. Madeleine Biondolillo said that the workgroup has looked at this, but the percent

admitted within 24 hours of death is extremely high. Since these people are not counted in these measures, this a difficult area to measure.

4. Chair Boros turned the discussion to the publicly nominated measures. He said that roughly 60 measures had been nominated by 11 parties, and that 45 of these measures would be discussed at the meeting. He reminded the Committee that the nominations that were moved forward would be sent to the Lewin Group to receive an objective score, and that the SQAC would take this objective score under advisement when determining which measures to add to the proposed Standard Quality Measure Set.
 - a. Dolores Mitchell noted that the Ad Hoc End-of-Life Care Workgroup did not put much weight on measures that had been proven in the literature. She asked if Lewin should be instructed to take this into account when considering an objective score. Chair Boros said that rather than changing Lewin's criteria, he would remind the SQAC in September that we had expected low objective scores on end-of-life because of the lack of existing literature, and that this did not necessarily preclude them from inclusion in the set.
 - i. Kristina Philipson asked if there were examples of credible measures without extensive support in the literature. Dolores Mitchell said that there were.
 - b. Kristina Philipson identified 25 publicly nominated measures that aligned with the focus areas identified with the SQAC: 1) end-of-life care (12 measures); 2) patient-centered care (2 measures); 3) pediatric care (5 measures); and 4) behavioral health (6 measures). Dolores Mitchell put forward a motion to move these measures forward for evaluation by the Lewin Group. The motion was unanimously approved.
 - c. Kristina Philipson identified 10 additional nominated measures that did not fall into SQAC approved categories. These consisted of 6 patient safety measures, the leapfrog measure set, and 3 CMS hospital measures. She said that CHIA recommended putting these 10 measures forward for evaluation by the Lewin Group.
 - i. Iyah Romm said that when looking at Surgical Site Infection (SSI) and Central-Line Associated Bloodstream Infection (CLABSI) measures, CHIA should also look at the NHSN standards.
 - ii. Iyah Romm said that serious reportable events were not on the list of measures, and that existing measures should be kept in mind when evaluating the PSI-90. He said that he was not recommending adding a category of SREs to the list of publicly nominated measures.
 - iii. The Committee unanimously agreed to move all 10 measures forward for evaluation by the Lewin Group.
 - d. Kristina Philipson identified 10 measures that required further discussion. These consisted of 5 CMS hospital measures and 5 primary care utilization measures.
 - i. Kristina Philipson said that the CMS hospital measures were considered for further discussion because they are outpatient measures, which is a current gap in the SQMS. However, she said that they are process measures with high compliance. She said that the only exception to this was the fibrinolytic therapy measure. James Feldman said that while the use of this measure varies across Massachusetts because of the transport time to hospitals, fibrinolytic therapy

was not common practice in the Boston area because PCI was more appropriate.

1. Kristina Philipson said that most of these measures are not part of the CMS Value-Based Purchasing program, but that one plan is using these measures for tiering.
 2. Iyah Romm said that he was not in favor of adding measures with high compliance.
 3. Chair Boros said that the committee's consensus seemed to be that there was a gap in the SQMS for outpatient measures, but that these measures were not appropriate to fill that gap. The committee unanimously agreed.
- ii. Kristina Philipson said that the primary care utilization measures were nominated by the Boston Public Health Commission. She said that they are currently only used in Boston, and that they measure important aspects of care, but that they were different than many existing quality measures.
1. Ann Lawthers said that with good race and ethnicity data, these measures would be good to measure disparities, but that high quality race and ethnicity data is not available.
 2. Richard Lopez said that these measures make sense in an urban health center but may be harder to evaluate across the state.
 3. Dolores Mitchell said that adding socioeconomic factors to quality measures can excuse poor quality care for disadvantaged people.
 4. Chair Boros said that outside of the SQMS, CHIA is very interested in these metrics. He said that CHIA is interested in collaborating with the Boston Public Health Commission to explore these areas.
 5. Dianne Anderson said that more creative care management approaches that don't technically require primary care visits are not considered by these measures.
 6. Michael Sherman said that we don't know what an ideal number is for some of these measures.
 7. Dianne Anderson asked how CHIA plans to use the SQMS moving forward. Chair Boros said that the focus for now is on tiering, and on taking any measure data available and making this information transparent to researchers. He also said that CHIA is looking at developing a state scorecard for existing measures.
 - a. Chair Boros said that in the future, CHIA will focus on population-specific and specialty-specific measures.
 8. The Committee voted unanimously to not put these primary care utilization measures forward for evaluation by the Lewin Group. However, Chair Boros noted that CHIA will try to explore these areas further with the Boston Public Health Commission

5. Chair Boros said that CHIA is planning to research specialist measures. He said that CHIA's recommended approach is to choose one specialty and research it thoroughly, including interviews with payers and providers. He said these discussions would include not only existing measures, but meaningful ways to measure care in the specialty. He said this process could take 6 months or longer. After an email poll of SQAC members prior to the meeting, Chair Boros had identified 3 potential specialties: 1) orthopedics; 2) cardiology; 3) obstetrics.
 - a. Madeleine Biondolillo said that the Department of Public Health has lots of data on cardiac surgery that CHIA could leverage if this specialty was chosen, but that CHIA may want to consider another specialty because much work had already been done in cardiology.
 - b. Dana Safran supported choosing obstetrics because there is so little existing measurement.
 - c. Iyah Romm also supported obstetrics. He said that work on early elective deliveries has shown that obstetric measures are interpreted and acted upon by an engaged provider community.
 - d. Michael Sherman said that the strength of all of the proposed specialties is that attribution, which is often an obstacle in quality measure development, is not in question. He said that the strength of orthopedics was that there is a high volume of non-evidence-based practice, but he also said that obstetrics was a good specialty for beginning discussions.
 - e. Amy Whitcomb Slemmer said that obstetrics was an area of interest for consumers.
 - f. Ann Lawthers said that obstetrics is an important area of interest for MassHealth.
 - g. Jon Hurst said that orthopedics is a strong potential area to educate consumers about making the right decisions.
 - h. Richard Lopez said that orthopedics gets caught in procedure metrics (whether the procedure was successful), rather than whether the patient actually needed the procedure. He said that obstetric measures address both of these questions.
 - i. The Committee unanimously passed a motion for OB to be the first specialty considered by CHIA. Chair Boros asked for ideas from the committee on who to talk to and topic areas to discuss.
 - i. Suggested people:
 1. Suggestion from Iyah Romm: Neil Shah from Beth Israel Deaconess Medical Center
 2. Suggestion from Amy Whitcomb Slemmer: A public forum
 3. Suggestion from Madeleine Biondolillo: Department of Public Health Perinatal Quality of Care Committee
 4. Suggestion from Richard Lopez: Luke Sato from CRICO
 5. Suggestion from Dolores Mitchell: Nurses
 6. Suggestion from Dolores Mitchell: Leapfrog and Choosing Wisely groups
 - ii. Suggested topics:
 1. Suggestion from Iyah Romm: Looking at OB in concert with neonatal metrics

2. Suggestion from Dianne Anderson: Differences between family practice obstetricians and regular obstetricians
3. Suggestion from Dianne Anderson: Use of laborists (obstetricians or midwives who are present for the entire time a woman is in labor)