Commonwealth of Massachusetts
Executive Office of Health and Human Services

EOHHS QUALITY MEASURE ALIGNMENT TASKFORCE

Meeting #26
March 20, 2019

Agenda

1. Welcome
2. Recap of 2-27-19 Meeting Decisions & Discussion of Follow-up Items
3. The Impact of Performance Measures on Clinician Burnout
4. Continued Discussion of Partners' eCare Measures
5. Quality Measure Catalogue Findings
6. Update on Clinical Data Repository Development Efforts
7. Impact of NCQA Proposed HEDIS Updates on the Aligned Measure Set
8. Next Steps

Note: Topics 5 through 7 were not discussed during this meeting due to lack of time.

2-27-19 Taskforce Meeting Decisions

- After considering feedback from a health plan regarding a provider's reluctance to adopt any non-Core measures into a contract, the Taskforce decided not recommend moving Childhood Immunization Status or Immunizations for Adolescents into the Core Set.
- The Taskforce agreed that Taskforce staff should track what happens during contracting for 2020 and then re-assess Aligned Measure Set composition.
- Following the meeting Lauren decided to request recommendations on insurer and ACO communication about the intended use of the Core and Menu sets.
  - *Please email any recommendations to Justine (jzayhowski@bailit-health.com).*

2-27-19 Taskforce Meeting Follow-up Items

- MassHealth will share results of the PBGH landscape review for Depression Remission or Response with the Taskforce once completed.
- Taskforce members were to consider Partners eCare measures in advance of the March Taskforce meeting using information disseminated during and following the meeting.
  - *We'll revisit this topic during today's meeting.*

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MMS-MHA Joint Task Force on Physician Burnout
Presentation to
Massachusetts Executive Office of Health And Human Services

Quality Alignment Taskforce

Wednesday, March 20, 2019, 2:30 pm
50 Milk Street

Alain A. Chaoui, MD, FAAFP MMS
Steve Defossez, MD EMHL MHA
Jatin Dave, MD NEQCA

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In order to improve Quality…

MMS – MHA Joint Task Force on Physician Burnout recommendations:

- **Decrease the number of Quality Measures**
- **Best way to achieve this is to ALIGN Quality Measures Across ALL PLANS and PAYMENT MODELS**

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Clinician Burnout

- **Emotional exhaustion**
  - Inefficient systems & useless tasks
  - (loss of enthusiasm)
- **Depersonalization**
  - Loss of empathy, inability to express grief
  - Interpersonal disengagement
  - Cynicism
- **Feelings of low achievement and decreased effectiveness**
  - As physicians begin to view their work as meaningless, the quality of their work suffers.

Common Drivers of Physician Burnout/Moral Injury

- Quality Measurement
- Prior Authorization
- E H R

Burnout effects…

- Physician
  - Satisfaction
  - SUD, alcoholism, divorce, depression, anxiety
  - Suicide
- Patient
  - Satisfaction
  - Engagement
  - Quality
  - Safety
- Practice
  - Income
  - Teamwork and team moral
  - Healthcare costs

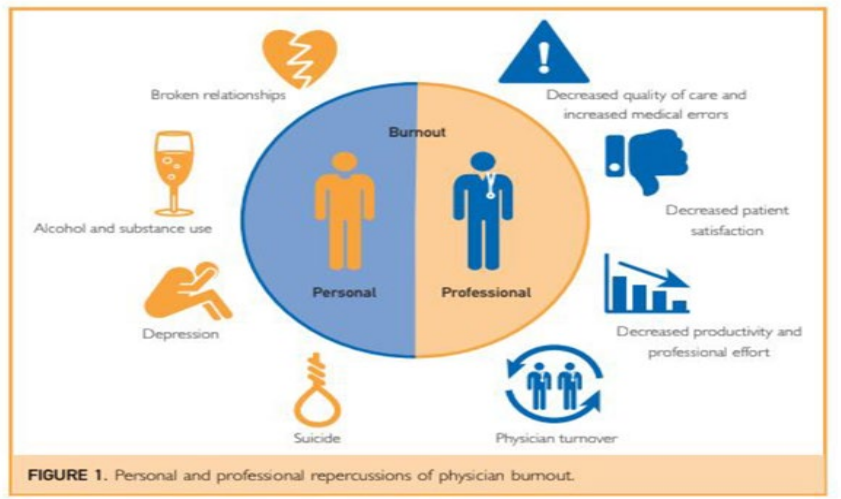

FIGURE 1. Personal and professional repercussions of physician burnout.

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Consequences of Burnout

- BMJ Review: Moderate evidence that burnout is associated with safety-related quality of care.

  Dewa CS, Loong D, Bonato S, et al. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. BMJ Open 2017

- NHS study: More engagement is associated with less MRSA in hospitals

  West, M. Dawson, J. The King's Fund. Employee engagement and NHS performance. 2012.

- Mayo: "Physician burnout is at least equally responsible for medical errors as unsafe medical workplace conditions."

  Shannafelt T, Tawfik D. Mayo Medical Procedings, July 8 2018.

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Too Many Quality Metrics: Tragedy of the Commons

Importance: *Measuring and reporting quality has become a barrier to improving it*

-63% of physicians reports that current measures do not capture the quality of the care that physicians provide

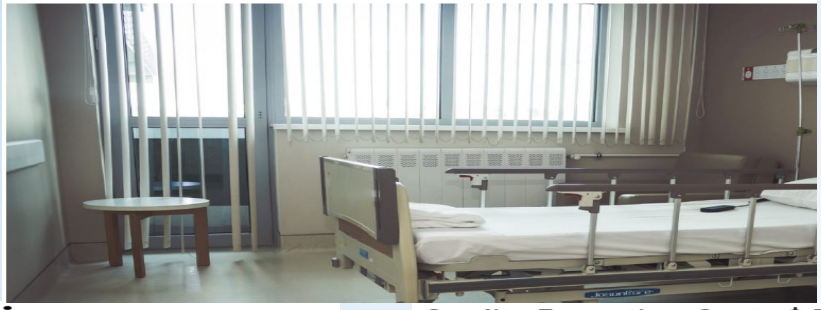
-Significant burden: Physicians are spending $15.4 billion each year-$40,000 per physician -close to 80 days of work time/year on reporting quality measures

STAT

A health care paradox: measuring and reporting quality has become a barrier to improving it

By Jerry Penso

December 13, 2017



Health Affairs

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US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures

Expand

Lawrence P. Casalino[1,*], David Gans[2], Rachel Weber[3], Meagan Cea[4], Amber Tuchovsky[5], Tara F. Bishop[6], Yesenia Miranda[7], Brittany A. Frankel[8], Kristina B. Ziehler[9], Meghan M. Wong[10] and Todd B. Evenson[11]

Author Affiliations

*Corresponding author

Abstract

Each year US physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion dealing with the reporting of quality measures. While much is to be gained from quality measurement, the current system is unnecessarily costly, and greater effort is needed to standardize measures and make them easier to report.

Quality Reporting Costs $40,000 per Physician per Year

Bridget M. Kuehn

March 07, 2016

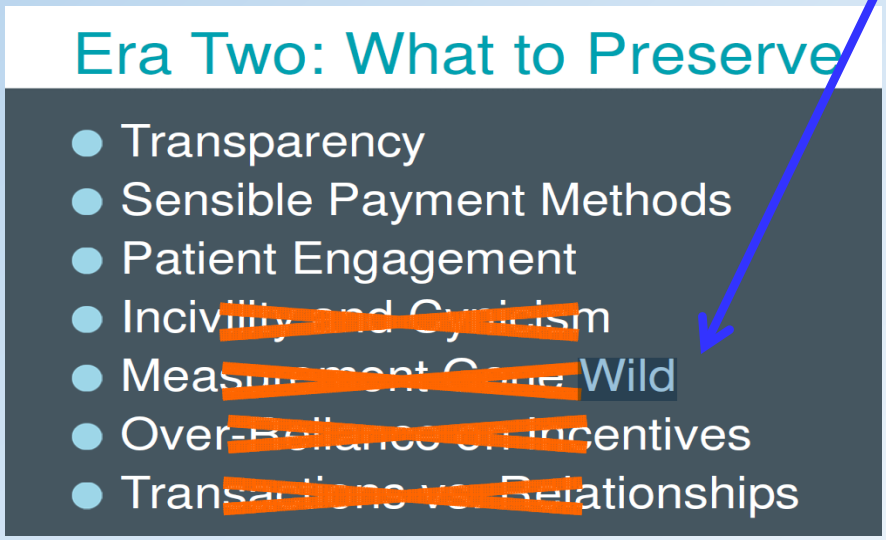
69

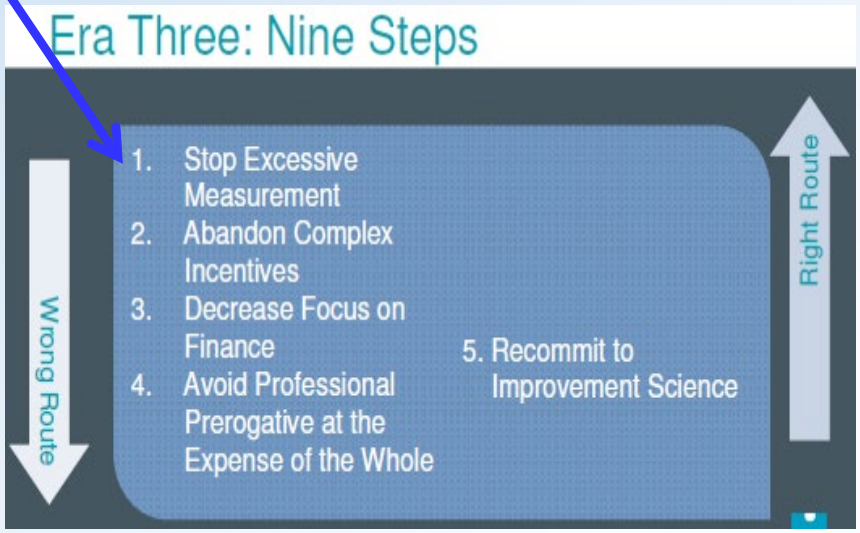
As the drive for value-based care advances, US medical practices in just four specialties spend an estimated $15.4 billion each year reporting whether they are meeting their quality targets, according to a survey.

The results of the survey, which were published in the March issue of *Health Affairs*, bolster anecdotal reports from physicians about the increasing cost and time burden associated with reporting quality measures to insurers, according to Lawrence P. Casalino, MD, PhD, MPH, from the Department of Health Care Policy at Weill Cornell Medical College in New York City, and colleagues.

Importance of reducing measurement burden

Even strongest advocates of Quality Measurement like Dr. Berwick and IHI are recognizing the needs to balance and reduce measurement burden





Source: Recent Presentation at IHI

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Etiology:
Due to Improvement and Innovation Lagging Significantly Behind Measurement/Control

CONTEMPORARY REVIEW

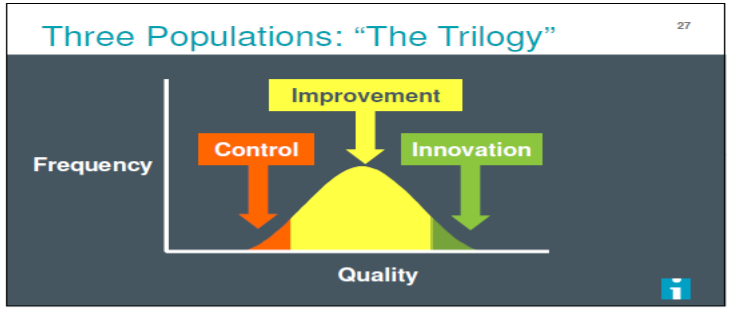
American Heart Association | American Stroke Association

Do Cardiology Quality Measures Actually Improve Patient Outcomes?

Paula Chatterjee, MPH; Karen E. Joynt, MD, MPH

Conclusion:

Quality metrics for cardiovascular disease are here to stay, though their utility in improving patient outcomes remains unclear. Measuring quality does seem to improve quality for processes of care, but unless these process measures are closely linked to patient-relevant outcomes, such as mortality,
hospital readmission, or patient experience, they may not have maximal impact.



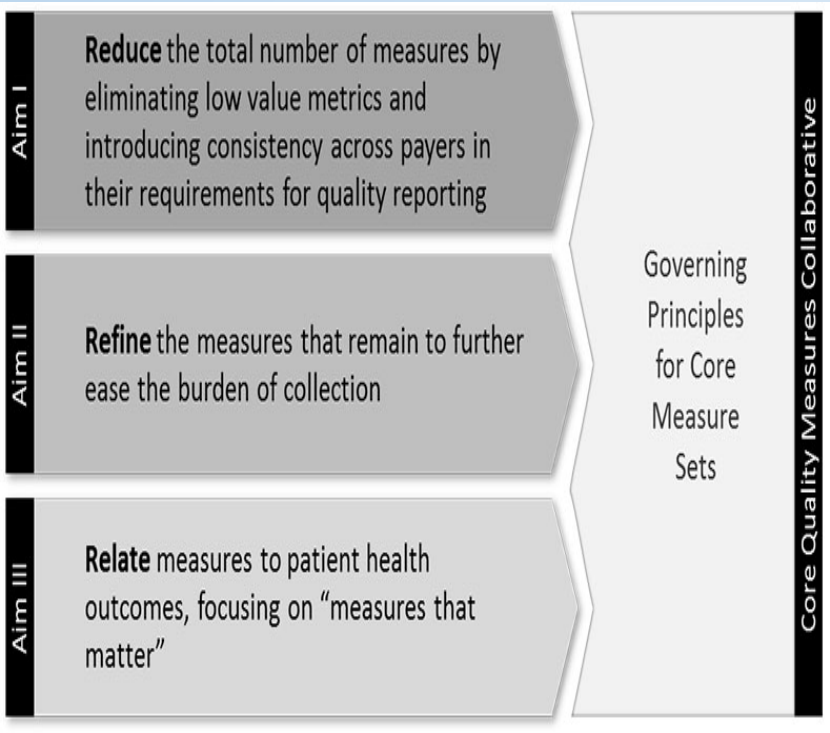
Source: Recent Presentation at IHI

Proposed Solutions: Recent efforts to improve the quality of quality measurement

	Launch year	Key Convener	Minimizing admin burden one of the core principles	Link	Burnout Taskforce Comments
Core Quality Measures Collaborative (CQMC)	2015	AHIP, NQF, CMS and total 55 stakeholder organizations	Yes	http://www.qualityforum.org/cqmc/	Agree and appreciate their aims and principles
CMS's Meaningful Measures Framework	2017	CMS	Yes	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html	Appreciate patients over paperwork initiative
Statewide Quality Advisory Committee (SQAC)	2010-reestablished in 2012	State-CHIA	?	http://www.chiamass.gov/sqac/	SQMS included 130 measures vs 800
The Massachusetts EOHHS Quality Alignment Taskforce	2018	State- EOHHS	?	https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce	Seeking uniformity across plans/payment models, under 15 total, (inc. monitor burnout)

Example of Aims/Principles for Balancing Quality Measurement

CQMC



EOHHS Quality Alignment Taskforce

1. Evidence-based, scientifically acceptable, nationally-endorsed and valid at the level at which it is being used (ACO-level in particular).
2. Required data should be either readily available, not overly burdensome to collect, or, if burdensome, of demonstrable value for improving patient care.
3. Represents an opportunity for improvement.
4. Is important to consumers and supports the triple aim of better care, better health and lower cost.

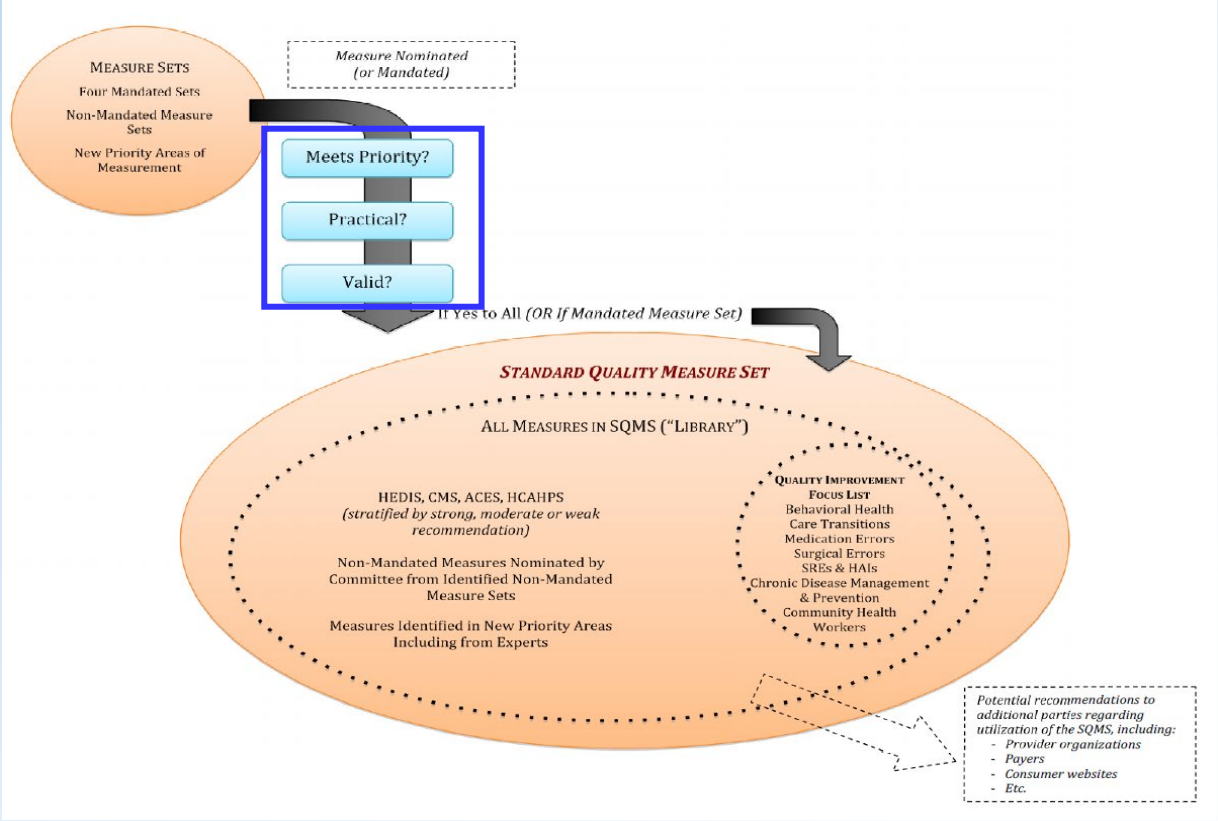
1. Prioritize health outcomes, including measures sourced from clinical and patient-reported data.
2. Provide a largely complete and holistic view of the entity being evaluated (e.g., ACO, primary care practice, hospital).
3. The measure set should strive for parsimony.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Promotes value for consumers, purchasers, and providers.

Criteria for measure selection

1	Measure sets must be aimed at achieving the three part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care.
2	NQF-endorsed measures are preferred.* In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process where applicable.
3	Data collection and reporting burden must be minimal.
4	Overuse and underuse measures should both be included.
5	Measure sets for clinicians should be limited to fewer than 15 measures when possible.
6	Measures that are currently in use by physicians, measure patient outcomes, and have the ability to drive improvement are preferred.
7	Measures that are cross-cutting across multiple conditions to reflect a domain of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation) are preferred.
8	Measures should be meaningful to and usable by consumers, and also applicable to different patient populations.
9	Patient outcome measures should allow careful and prudent physicians to attain success.
10	As with all measures, those which reform payment or delivery systems should measure clinical quality, patient experience, and costs.

March 30, 2012 SQAC Internal Framework for Standard Quality Measure Set

Striving for **Practical, Valid** measures aligned to overarching priorities of improving patient care



Proposed Solution

Help reduce administrative burden and improve patient care by having

- Aligned (across all plan and payment models) measures
  - ✓Alignment among local and national payers and government agencies is critical

- Limited Numbers of Meaningful Measures (Under 15)
  - ✓Those that matter to Patients and Physicians and can be measured without inordinate administrative work

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How do you Improve Care?

Stanford: “Professional fulfillment of clinicians is inextricably linked to **quality, safety and patient-centeredness**.”

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Primary ask:

- Help Reduce Administrative Burden and Improve Patient Care by…

- ***Aligned, Uniform Quality Measures across Plans and Payment Models***
- ***Thus Improve Quality of Care for Patients***

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Thank You!

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Partners' eCare Measures

- On 2/27, Christian Dankers, Amy Feeney, and Nicole Larue shared information about the Partners eCare measures with the Taskforce.
- After the meeting, Taskforce staff sent out a document on 3/8 framing the discussion about potential inclusion of eCare measures in the Innovation measures category. Taskforce staff requested feedback by 3/14.
- Five Taskforce members responded to the request. The following slides present their input.

Criteria for Assessing Innovation Measures

- Taskforce staff recommended the Taskforce consider the following when assessing the eCare measures:

1. Do the eCare measures address clinical topics or clinical outcomes in the Core or Menu Sets utilizing a novel approach?
2. Do the eCare measures pass a face validity test based on the information shared with you during the 2-26-19 Steering Committee meeting and specifications found on the Partners website: https://qualityandsafety.partners.org/Prevention-And-Chronic-Care/Default.aspx?
3. Are eCare measures replicable (i.e., could other ACOs and payers adopt the measures for their own use such that the eCare measures could potentially become part of the Aligned Measure Set in the future)?

Feedback from Taskforce Members

- One respondent supported categorizing the eCare measures as Innovative, providing the following rationale:
  - "It will enable the collaboration between plans and provider groups to further explore the opportunities in EHR data exchange and quality measurement. As we all agree, there are many challenges in EHR data sharing and integration, but incorporating EHR data into measurement is the direction for the future. With NCQA aggressively shifting to e-measure specification, it is becoming more urgent to have such innovation in the field, even if just for the future viability of the existing core measures sourced from HEDIS. Any lesson learned from the innovation will help inform state, plans and providers on the path forward."

Feedback from Taskforce Members

- Three respondents did not support categorizing the eCare measures as Innovative.
  - "They are too similar to publicly endorsed measures in the measure set we have - the engagement of these provider group measures should lead to higher rates in the already used publicly endorsed measures set."
  - "These [are] HEDIS measures with the denominator changed to accommodate 100%. HEDIS is not about meeting 100% for the denominator."
  - The measures do not meet the criteria we have set and their adoption could put us on a slippery slope. (paraphrased)
- One respondent asked how Partners had validated its measures, and also recommended the application of clear criteria to the decision process.

State's Feedback

Assessment of Innovation Measures

Do the measures address:

a) clinical topics or clinical outcomes in the Core or Menu Sets utilizing a novel approach?
- NO (HEDIS adapted measures with exclusions to standard specifications, some differences in collection approach)

b) clinical topics that are not addressed in the Core or Menu Sets?
- NO (clinical topics are already addressed)

c) Intent to advance measure development, not previously considered and rejected?
- Yes (but advancements or changes in existing standard specifications should be addressed with the measure steward to advance their measure)

Consideration:

Innovative measures specifically adapted from standard measures should be used (if used at all) **in addition to,** not in lieu of using the standard measure in the Aligned Measure Set.

- Enables appropriate comparability and reporting of standard aligned measures
- Adaptations (i.e., exclusions, clinical changes etc…) to specifications of standard measures should be addressed through the measure stewards
- Innovative measures could be candidates in the future, for Aligned Measure Set adoption

Questions:

- Will measure stewards consider adaptations to their measures innovative or appropriate?
- Innovation measures: Fit for purpose? QI? Reporting? Performance? Comparability?

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Upcoming Meetings

- April 29, 2:30-4:30pm
- May 29, 2:30-4:30pm
- June 24, 2:30-4:30pm