



150 YEARS
OF ADVANCING
PUBLIC
HEALTH

Massachusetts Department of Public Health

**EOHHS QUALITY MEASURE ALIGNMENT TASKFORCE
WORKING GROUP ON STRATIFYING MEASURES BY
SUBPOPULATIONS FINAL RECOMMENDATIONS**

BACKGROUND



EOHHS Quality Measure Alignment Taskforce seeks to incorporate a health equity perspective into the development and reporting of quality measures in the aligned measure set

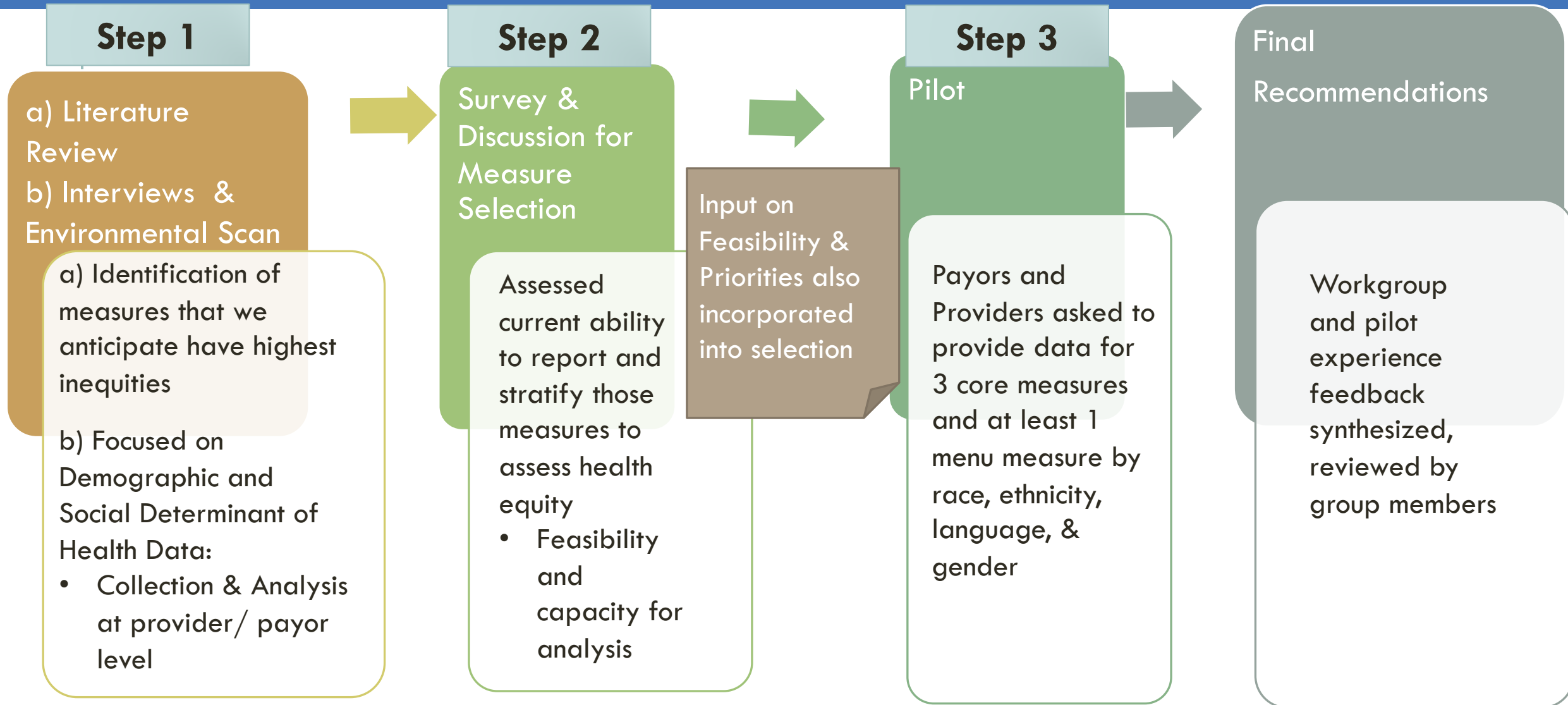


In response to QAT request, the Health Equity Workgroup designed and piloted a data collection form



Findings from the design and pilot of this form as well as group member discussions were used to draft recommendations on next steps and feasibility of stratifying the measures by key demographic and social determinant populations

PROCESS FOR WORKGROUP RECOMMENDATION DEVELOPMENT



KEY FINDINGS FROM PROCESS STEPS

1 A. LITERATURE REVIEW RESULTS

- Literature review was performed to aid in selection from aligned measure set
- From this review the quality measures with the clearest inequities in the literature were found to be:
 - **Chronic Diseases** such as heart disease and diabetes
 - Inequities were seen by race/ethnicity, housing status, income level, sexual orientation and gender identity
 - **Preventive Care**
 - Eye exams
 - Inequities were seen by race/ethnicity, housing status, income level, age
 - Immunizations
 - Inequities were seen by race/ethnicity, income level, religion

1 B. INTERVIEW/ENVIRONMENTAL SCAN RESULTS

Subcommittee members provided information on demographic and health-related social needs data collected as well as the response options/definitions.

Demographic Variables	Percent Collecting
Race	100%
Ethnicity	100%
Language	100%
Gender Identity	44%
Sexual Orientation	33%
Veteran's Status	33%
Social Determinants of Health Variables	
Financial Wellbeing/Employment	89%
Food Insecurity	89%
Living Situation/Housing Stability	89%
Transportation	89%
Utilities	78%
Education Status	67%
Other	67%
Social and Community Supports	56%
Immigration Status	11%

2. SURVEY & DISCUSSION

- Members gave feedback on their priorities, as well as feasibility and capacity to stratify health measures by demographics to assess health equity. Health-related social needs had a number of challenges to inclusion, including being paper format or scanned into the system and not being available in existing data formats that could be utilized for the quality measures pilot.
- Based on this, the following criteria were selected for the pilot:

Stratify by:
Race,
Ethnicity,
Language,
Gender, Age

Core Measures (all)

- Controlling High Blood Pressure
- Comprehensive Diabetes Care: HbA1c Poor Control
- Depression Screening and Follow-Up: Adolescents and Adults

Menu Measures (1 minimum)

- Adolescent Well-Care Visit
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life

3. PILOT RESULTS

Responses

- Sent to Payors (3) and Providers (5)
 - 2 completed tables received: both were providers
- Reasons for limited participation included:
 - Capacity/resources (i.e. time, staff)
 - Concerns about data validity in HER
 - COVID-19 pandemic and competing priorities

3. PILOT LESSONS LEARNED: TIME & RESOURCE CHALLENGES

- **Assessing inequities is time-consuming**
 - Accessing data in EHR may be a lengthy process to develop
 - Requires analytic capacity and staff time to populate tables/reports and to interpret results and clean data
 - Validity of data and addressing missing data needs to be resolved
- **Structural barriers exist**
 - Health-related social needs screeners are often scanned forms and would require manual data entry to get them in a format to use for quality measure stratification
 - To complete request, some members had to convert HEDIS measures for provider-level reporting
 - Modifications to EHRs to be able to pull and analyze the data (different elements exist in different systems) require both technological resources and workforce re-training
- **Massachusetts Aligned Measure Set is currently voluntary for ACO contracts**

3. PILOT LESSONS LEARNED: DATA STANDARD CHALLENGES

- There is a lack of data standards and definitions
 - Interpretations may differ between systems and within system facilities
- Aligned Measure Set differs from the MassHealth ACO measure set
 - Members expressed concerns about inefficiencies that can result from applying guidelines to a subset of contracts and/or measures
- Need greater guidance on inclusion criteria for denominator
 - Developing measures internally without further guidance to fulfill request can cause large variations in reported data
 - For example, one participant had to generate denominators based on an internal decision tree because they did not have a HEDIS-derived denominator list from their ACO partner

3. PILOT LESSONS LEARNED: MEASURE APPLICABILITY

- Aligned measures can be a challenge to apply to system's patient population
 - Measures that have follow-up components, including referral and receipt of services from external providers, may not be captured across EHRs
 - As a result HEDIS measures may not fully reflect disparities in patient population
 - Measures may not be reportable for all organizations depending on their patient panel
 - May have either small numbers or no patients that make up an eligible population
 - E.g. pediatric patient panel would not qualify for 2 of the core measures selected for this pilot

FINAL RECOMMENDATIONS

SUMMARY

- Overall there was enthusiasm for the development of a systematic approach to assess health disparities and inequities
- Workgroup members expressed concerns and have made the recommendations in 4 categories to overcome the challenges encountered during this process:
 1. Allow for the Time & Resources Needed to Report Data
 2. Establish and Improve Data Standards and Definitions
 3. Encourage Health Equity Collaborations and Learning Opportunities
 4. Review Measure Alignment Applicability and/or Allow for Flexibility in Reporting

RECOMMENDATIONS FROM MEMBERS

Allow for the Time & Resources Needed to Report Data

- Ensure that providers/payors have adequate time to complete requests
- Mandatory reporting will improve prioritization given conflicts with other reporting requirements and need to build capacity for these measures
- Data collection and analysis require EHR modification and staff training

Establish and Improve Data Standards

- Consider guidelines and caveats for those that use hybrid data
 - e.g. Create or suggest HEDIS-calculated quality measures for providers that can easily incorporate EHR demographic data
- Discuss areas of overlap and supplementing information with MassHealth data
- Ensure communication with providers/payors once decision on which measures to adopt is made and clear guidance on participant expectations
- Develop standard definitions
- Reporting guidelines should acknowledge variation in the starting point of systems and develop both short and long-term expectations to meet participants where they are in ability to report and stratify data

RECOMMENDATIONS FROM MEMBERS

Review Measure Alignment Applicability and/or Allow for Flexibility in Reporting

- Consider having selection from core measures as was done for menu measures
- Establish clear inclusion/exclusion criteria for denominators especially those using hybrid measures (e.g. if providers are using measures developed for payors)
- Create separate data dictionaries and definitions/guidelines for payors and providers

Encourage Health Equity Collaborations and Learning Opportunities

- Leverage existing literature and stakeholder/member expertise on data collection and analysis
 - E.g. Establish spaces for members to share data dictionaries, definitions, and standards
- Create opportunities for engagement with others to allow for continued collaboration within this group and aligned work happening elsewhere
 - E.g. Collaboration with MassHealth DSRIC Health Equity Subcommittee as a space for members to learn and share their experiences