Virtual Meeting Track 2: Quality Measurement Part One

Maternity Multi-Stakeholder Action Collaborative

March 3, 2017

1:00-2:30pm ET

Highlights and Key Takeaways

MAC members participated in the first of the two-part series on quality measurement in maternity episode models. Below are highlights and key takeaways from the interactive meeting, which included a live interview with Lance Lang, MD, Chief Medical Officer from Covered California, and MAC co-chair Elliott Main, MD, Medical Director from the California Maternal Quality Care Collaborative. They discussed the multi-stakeholder process used by California to select meaningful quality measures to track maternity care. In addition to the expert interviews, participants were given a demonstration and overview of the Buying Value Measure Selection Tool, which is designed to help stakeholders with the measure selection process. A customized version of this tool in an excel format is available for download on the Maternity Online Resource Bank . These session highlights are intended to serve as a recap and reference for MAC participants and support shared learning with those not able to participate in this session.

Measure Selection Process Overview

During the MAC Kickoff Meeting on December 1, 2016, ten steps for measure selection were reviewed with MAC participants with the goal of helping the participants determine how to identify quality measures that will support the design and implementation of maternity episode payment. Five of these steps were reviewed in more detail during the part one *Quality Measurement* virtual meeting on March 3rd, with the goal of discussing additional steps during the part two Quality Measurement virtual meeting to be held March 20th. The five steps discussed during this meeting include:

- **Determine Who Should Be Participating in the Measure Selection Process**. Determining who will be included in the discussion about measure selection requires some consideration. It may be that only the parties entering a contract are involved (e.g., insurer and a medical group/hospital system), or there may be a more comprehensive multi-stakeholder process that includes consumers and/or purchasers. One example of this is the Washington State Bree Collaborative, a large multi-stakeholder group that successfully convened to develop measure sets.

- **Identify the Process by Which Measure Selection Decisions Will Be Made**. Measures can be selection via consensus decision-making, voting, or other means. The body that is brought together to develop the measure set must determine what this process will be, the extent to which discussion and negotiation will occur, etc. It is highly recommended that there be explicit selection criteria that informs which measures are included and which are excluded. If using explicit criteria, organizations can then determine if the measure selection process will use explicit scoring to ensure the final set of measures match up with the selection criteria or if they will employ implicit scoring, where there is an awareness of what the criteria for measure selection is, but there is not a formal assessment of how every measure lines up with each of the criteria.

- **Identify Criteria for Measure Selection.** The process can be well-supported if a set of criteria are developed, both for evaluating individual measures as well as for evaluating the totality of the measure set. Although many examples were provided on the slide during the virtual meeting for individual measures and the measure set as a whole, these are sample criteria and they are not prescribed, nor is it suggested that all of these criteria be adopted. Having too many criteria may be cumbersome for the measure selection process. It should be noted though, that the most commonly adopted criteria for individual measures include those that are evidence-based and scientifically acceptable, measures with relevant benchmarks, those which are feasible to collect, and those which align with other measure sets.

- **Identify Candidate Measures.** Often, a first step to identifying candidate measures is to look at what measures are currently being used within a geographic region or across a state; and/or the measures that are currently in place in contracts or in state-level measure sets. It can also be effective to consider measures currently used in national measure sets in an effort to create nation-level alignment. Through this process, organizations have the opportunity to compare their performance to various benchmarks to identify where there are the greatest opportunities or the greatest gaps within a region or state, and use this information to select measures with significant opportunity for improvement. If organizations find that their selected areas for improvement do not already have pre-existing measures available for use, it is possible to introduce "home grown" measures, however, this comes with many of its own challenges. Home grown measures may not have information to assess the criteria mentioned above related to evidence-base and scientific acceptability, feasibility to collect, and relevant benchmarks.

- **Identify Potential Data Sources and Operational Means for Obtaining Data, Including Timeliness.** Generally, there are three sources from which data can be obtained: clinical data from a chart or an EHR and/or HIE; claims data; and provider/patient experience survey data. It is important to consider data sources when identifying candidate measures because some measures may not have available data sources, there may not be operational means to obtaining data from those sources, or data may not be able to be obtained in a timely fashion.

Interactive Poll Results – Quality Measurement within Participant Organizations

Quality Measurement Poll Question	Participant Response	Total Percent*
Is your organization measuring maternity care quality?	Yes - For Payers	58%
	No - For Payers	8%
	Yes - For Providers	42%
	No - For Providers	15%
If yes, does your organization include other stakeholders - providers, patients, purchasers - in the selection process?	Providers	79%
	Patients	29%
	Purchasers	54%
	No	8%

What are your biggest challenges related to measuring maternity care quality?	Assess quality from claims data	57%
	Access clinical data for measures	52%
	Collect patient reported data	57%
	Other	13%
	"Other" responses typed in chat box: • Reliability of public data from state--it's outdated and potentially undercounted • Getting provider and plan engagement and buy-in	
What challenges do you foresee in linking financial accountability to quality, related to a maternity episode?	Obtaining baseline performance data	31%
	Setting target/benchmark thresholds	52%
	Sharing data with providers	31%
	Setting accountability for outcomes	72%
	Other	3%

* Participants were allowed to choose more than one option for each questions, therefore results do not equal 100%

Interview: Maternity Value Based Payment Measure Selection in California

- Lance Lang, MD, Chief Medical Officer for Covered California
- Elliott Main, MD, MAC co-chair, Medical Director of the California Maternal Quality Care Collaborative (CMQCC)

  - **Question 1 [to Dr. Main]:** The CMQCC worked with a range of stakeholders to develop a common maternity measure set. Related to some of the measure selection process steps just reviewed, can you discuss the types of organizations that participated in the measure selection process in California, describe the kind of selection criteria you developed, and the explain the process you followed for selecting measures?
    - The CMQCC started with the view of improving care for the entire population, not just for one health plan at a time. We wanted to develop a set of measures that would be used by all payers, including our Medicaid agency, our commercial plans, and our managed care organizations.
    - The multi-stakeholder group included professional organizations, nursing leadership, midwifery leadership, hospitals associations, health plans, public members, the Department of Public Health, the Department of Health Care Services, and the Medicaid agency.
    - It was important for us to include public health in this process because they can be the source of population based data, and provide us with data of every birth in the state through birth certificate data and discharge diagnosis data. We now receive that data fairly quickly, within 45 days.
    - The group met multiple times. The meetings focused on selecting measures that had national endorsement, were well recognized, had benchmarks, and will positively impact quality of care. We wanted to have some measures that focused on overuse/underuse of high value services within maternity care, and measures that could be used across different

care settings (i.e., the provider level, the hospital level, and potentially the health plan level as well). In an effort to create transparency, we wanted to include publicly-available measures, for which all specifications could be transparent.

- **Question 2 [to Dr. Main]:** Can you give us a sense of how the measure set has been used to date?
  - We work with a number of other state agencies to be able to release this data on public websites and use the measures for quality improvement projects and payment reform.
  - On an annual basis, the California Secretary of Health awards hospitals which meet the national benchmark for NTSV cesarean section rates.
  - The award money California received from the SIM grant (CAL-SIM) was used to align the payers and purchasers in the state. The CAL-SIM process has grown into Smart Care California, which is a program involving state organizations and health plans whose goal is to coordinate value-based purchasing activities for, among other areas, cesarean births.

- **Question 3 [to Dr. Main]:** Can you share how you considered the range of measures that were potentially available from different data sources and how you decided which data sources you wanted to utilize?
  - Claims data can be incomplete and there were attribution issues for some of the measures we were planning to include. Since California is decentralized, no one payer has more than 10-15% of the market, with the exception of Medicaid which has 50%, but that in turn is segmented into the managed care organizations. So we wanted to look at the totality of a provider's outcomes and use that as an all payer approach.
  - CMQCC was able to utilize state data sets and create, in real time, data that could be used for these measures and shared with the health plans and Medicaid organizations.

- **Question 4 [to Dr. Main]:** What were your considerations of the potential use of patient experience or patient reported outcome measures?
  - California is interested in using patient reported outcome measures, but because they haven't been formally validated or endorsed, they have not been incorporated as a part of the pay for performance process.
  - We may decide to develop pilot projects on reviewing and analyzing these measures, and I think it is very important for providers and hospitals to receive feedback on their patients' experiences.

- **Question 5 [to Dr. Lang]**: Why did Smart Care California decide to coordinate efforts on improving maternity care, and how did you decide to use one of the measures recommended by the CMQCC?
  - First, let me give the audience some context: Smart Care California is a group of state purchasers that includes Covered California, Medicaid, and the entity that purchases for public employees, who are all working together to convene a multi-stakeholder group. Covered California is the health benefits exchange in California which has adopted an active purchaser model, so health plans apply and go through a rigorous, competitive selection

process to participate in the exchange business in California. Almost 1.5 million patients are on the exchange with another 800,000 in mirrored products that are identical to the exchange products and considered as a part of the same risk pool. In total, we represent about 2.3 million patients in California.

- About a year ago, Smart Care California embarked on an active, multi-stakeholder process, coordinated by the purchasers, where health plans, providers, consumer advocates, and national measurement experts like CMQCC were working together toward delivery system reform and quality improvement. The group decided to use standard quality metrics where there were available quality improvement resources to help achieve delivery system reform results.
- We were cognizant of the fact that by focusing on the high leverage, single metric of NTSV cesarean rates, we could lower cesarean rates for future deliveries, reduce morbidity and mortality, and hold health plans accountable for network design and variation across networks. Instead of contracting with most of the more than 250 maternity hospitals in California with varying NTSV cesarean rates from 12% to 70%, we communicated to health plans that those hospitals which were significantly above the Health People 2020 target of 23.9% were of concern to us. The Pacific Business Group on Health was able to demonstrate in a pilot that purchaser concern, combined with support from CMQCC, could lower cesarean rates by 20% within one year, proving this to be a provider driven issue.
- Smart Care California has further determined that in order to move the market on target measures, there are six important elements to include: 1) transparent data – a mix of claims and clinical data – that are credible to providers; 2) Quality improvement resources which are easily available, 3) Payment that is aligned with quality goals, 4) Public policy is used, selecting a measure like the Healthy People 2020 target is very powerful, 5) Address patient engagement, and 6) Develop purchaser requirements.
- This coalition is also looking for the gaps in care and determining how we can coordinate around them. We have selected topics to focus on including recognition for quality improvement, patient education, and payment reform.

– **Question 6 [From participant to Dr. Lang and Dr. Elliott]:** You suggested that one of the selection criteria for measures should be the availability of resources to assist providers in improving their performance. Can you elaborate on what types of resources are available in California to assist providers relative to target measures?
  - There are many freestanding materials available online, such as the CMQCC's nationally awarded toolkits which include information on topics such as responding to obstetric hemorrhage and pre-eclampsia, and reducing primary cesarean births.
  - There are also various maternity care collaboratives across the 50 states which may provide additional resource support through the coordination of provider organizations, professional organizations, State Departments of Health, and hospital associations.

– **Question 7 [Participant to Dr. Lang and Dr. Main]:** Have any freestanding birth centers participated in the collaborative?

- Freestanding birth centers historically have very low rates of primary cesarean births, so they are only peripherally involved as that is not where the issue lies with high rates of cesarean births. Midwives, who cross over quite extensively between freestanding birth centers and traditional maternity delivery sites, do participate in the collaborative.

- **Question 8 [Participant to Dr. Lang and Dr. Main]:** How were you able to get NTSV rates for each hospital and what do you suggest to organizations from other states as a source for obtaining that information?
  - State Health Departments would be the first place to check if they are collecting and publishing the data using vital records.
  - Every hospital in the country is now obligated to report this information to the Joint Commission if they are a Joint Commission member, so another option is to request that these hospitals share the data they are already reporting with other entities.

- **Question 9 [To Dr. Lang]:** The MAC includes a number of state purchasers, some insurers, and a handful of providers. Our focus is on payment, but based on the experience you've had thus far as a purchaser, what recommendations would you make to other purchasers embarking on the development of a maternity value-based payment program?
  - Too often we have been working in quality improvement without tying it to payment. As the purchaser, you influence your health plan network design, how payers will in turn pay their providers, the quality goals and criteria you are looking for, and the benefit structure. All four of these areas need to be aligned.

- **Question 10 [Participant to Dr. Lang and Dr. Main]:** Can state vital record calculations for NTSV cesarean rates be stratified based on the payer or other characteristics?
  - Vital records data is fairly accurate with providing the ability to stratify by commercial plans vs Medicaid. Where it gets more difficult is when you are trying to look at data for specific payers. Linking to hospital data is actually a more accurate way to receive this data.
  - The birth certificate is the gold standard for analyzing health equity issues for race, ethnicity and even cesarean rates.

- **Question 11 [To Dr. Main]:** Despite the fact that there has not been a specific link to provider payment, this initiative has had an impact on the cesarean rates in California. Can you share what the results have been thus far and what you attribute it to?
  - Getting provider attention is the key piece to creating change. Most of the time, you won't get providers' attention until you start talking about payment, but sometimes you can get attention on payment models without actually implementing the payment models. For example, major employers in a geographic area may meet with hospitals to express concerns about cesarean rates and suggest narrowing the networks in the future if these rates don't improve.
  - By ensuring hospitals and providers all have potential income at stake, they have incentive to work together and improve quality of care.

The Buying Value Measure Selection Tool

- The Buying Value Measure Selection Tool is an online resource created with the Robert Wood Johnson Foundation's support in 2014. It is a suite of tools to help any entity wanting to create a performance measure set with a specific eye on aligning the measure set. Users can look at how measures exist in other measure sets, as well as search for over 600 measures. It is not specific to maternity measures, but it is a flexible tool that allows users to input additional measures and measure sets into it for analysis and consideration. The website also includes an overview of the steps to develop a measure set, and tools for doing so. For example, Step 2 is about selecting criteria and the website provides you with examples of criteria for selecting measures. It includes additional helpful resources such as 15 Federal and national measure sets, and 6 state measure sets.
- On the LAN Maternity Online Resource Bank Quality Measures link, you can download an excel document that is a simplified, streamlined, customizable version of the Buying Value Measure Selection Tool. We pre-loaded maternity quality measures into the spreadsheet that are currently in a number of both state and national measure sets. **Please note, these are not necessarily recommended measures, but they give you a sense of what is currently in use.**

Interactive Poll Results – Feedback on the Value of this Meeting

Question	Answer	Total Percent
Please let us know how you would rate the value of this meeting?	Very Valuable	47%
	Valuable	53%
	Somewhat Valuable	0%
	Not Valuable	0%
How can the next meeting be more valuable?*	Allow for more Q&A time	42%
	Restructure guest presentation	8%
	More aligned reporting focus	0%
	Provide meeting agenda sooner	25%
	Other	33%

* Participants were allowed to choose more than one option for this question, therefore results do not equal 100%

Wrap Up: Meeting Follow-Up Activities & Feedback

- Available on the MAC Events page for this meeting:
  - The PowerPoint slides used during the virtual meeting
  - A MAC participant list
  - A complete summary of Carol Sakala's discussion on women-reported measures for maternity care APMs