NEW JERSEY HEALTH CARE QUALITY INSTITUTE

Quality powered.

QUALITY MEASURE ALIGNMENT

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I. Executive Summary

One key project component of the New Jersey State Innovation Model (SIM) design award is quality metric alignment. The SIM Quality Metrics Alignment Advisory Group was formed to examine how best to align quality metrics across payers and delivery systems to improve quality and reduce redundancy. As a member of this Advisory Group and a subgrantee on the SIM design award, the New Jersey Health Care Quality Institute (Quality Institute) partnered with Applied Medical Software (AMS) to develop a harmonized set of core quality metrics that would support alignment across several NJ and federal quality and efficiency improvement initiatives. Aligning measures across initiatives will, in turn, align incentives and increase the likelihood of contracting and collaboration between entities. After review from the SIM Quality Metrics Alignment Advisory Group, the harmonized set of quality metrics are to be recommended to the SIM Steering Committee for inclusion in their recommendations to CMS for future use.

The process for developing the harmonized set of core quality metrics included five steps:

1. Identify the various state and federal quality and efficiency improvement initiatives
2. Create an inventory of metrics by identifying all metrics used in each initiative found in Step 1
3. Refine the inventory by eliminating duplicates and determining the most commonly used metrics
4. Determine metric meaningfulness
5. Determine metric usability

Metrics from 18 state and federal quality and efficiency improvement initiatives were reviewed, yielding a list of 786 metrics. The initial list of initiatives to examine were selected by the SIM Quality Metrics Alignment Advisory Group and included initiatives such as DSRIP, the NJ Medicaid ACO Demonstration Project, NJ's Behavioral Health Home initiative and NJ's Medicaid MCO Contract, among others. From this initial set of initiatives, the project then looked broader to include other well-known and far-reaching programs that affect a large portion of providers and payers in the state. Examples include the CMS-AHIP ACO and PCMH measures that were recently released, HEDIS, PQRS, and the Adult and Child Core Measure Sets. (A full list of initiatives can be found in the complete report.) Of the 786 metrics identified from these 18 initiatives, 30 were being monitored in five or more initiatives.

These 30 metrics, as well as one additional metric that was added at the request of the SIM Quality Metrics Alignment Advisory Group, were screened for meaningfulness and usability. Meaningfulness was considered as whether the metrics being monitored accurately reflect the impact on care that an entity has achieved. Using the National Quality Strategy developed by the Agency for Healthcare Research and Quality (http://www.ahrq.gov/workingforquality/about.htm), six priorities were considered: making care safer by reducing harm caused in the delivery of care; ensuring that each person and family is engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and government. The 31 metrics were assigned to categories representing the 6 priorities from the National Quality Strategy to ensure the measures represented a wide range of priorities. The metrics were also categorized by target population (adult, adult/pediatrics, and pediatrics) to ensure all ages were included. In addition, research was conducted to determine whether the metrics have existing benchmarks that can be used to evaluate the metric outcome at individual entities. Lastly, metrics were categorized as either "Process" or "Outcome" using the definition from the Agency for Healthcare Research and Quality and the Patient Safety – Quality Improvement Program of the Duke

University School of Medicine/Department of Community and Family Medicine. After the measures were screened for meaningfulness, they were vetted for usability, or ensuring the metrics could be monitored in a repeatable and validated manner. This was done by examining the data source needed for each metric (e.g. billing, chart review, etc.).

The process yielded 31 metrics that were deemed meaningful and usable.

II. Process

A. Identify the various state and federal quality and efficiency improvement initiatives

The first step taken was to identify state and federal quality and efficiency improvement initiatives that require entities such as plans, providers, and alternative delivery systems (e.g. PCMH, ACO, Health Homes), to monitor and/or report quality metrics. The initial list of initiatives to examine were selected by the SIM Quality Metrics Alignment Advisory Group and included initiatives such as DSRIP, the NJ Medicaid ACO Demonstration Project, NJ's Behavioral Health Home initiative and NJ's Medicaid MCO Contract, among others. From this initial set of initiatives, the project then looked broader to include other well-known and far-reaching programs that affect a large portion of providers and payers in the state. Examples include the CMS-AHIP ACO and PCMH measures that were recently released, HEDIS, PQRS, and the Adult and Child Core Measure Sets. Some programs were identified through on-line searches while others were provided by participating stakeholders. In all, 18 quality and efficiency improvement initiatives were identified, including:

- AHRQ Prevention Quality Indicators
- Behavioral Health Homes
- CMS- AHIP ACO Metrics
- CMS-AHIP Patient centered medical home Metrics
- Delivery System Reform Incentive Payment (DSRIP)
- Electronic Health Record Incentive Program
- Core Set of Health Care Quality Measures for Medicaid Health Home Programs
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Leapfrog Hospital Survey
- NJ Innovation Institute PTN Project
- NJ Medicaid MCO Contract
- 2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)
- 2015 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)
- NJ Medicaid ACO Demonstration Project
- Physician Consortium for Performance Improvement® (PCPI™)
- Physician Quality Reporting System (PQRS)
- CMS Performance Based Incentive Program (MIPS)
- CT Healthcare Innovation Plan (SIM) Core Measure Set

While additional programs and initiatives exist which focus on the inpatient experience (and other inpatient metrics are contained within the 18 identified programs), we focused primarily on measures for the outpatient population. The rationale behind this decision was that the metric set is largely intended for organizations and entities that deal with people outside acute care hospitals. According to the Merriam-Webster dictionary, an inpatient is defined as a patient who stays in a hospital while under treatment while an outpatient is defined as a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. This was the basis of

determining whether a measure was focused on the inpatient versus the outpatient population. For example, patient safety measures such as pressure ulcers, falls, and healthcare-associated infections, were classified as inpatient, while measures such as Medication Reconciliation Post-Discharge and Childhood Immunization Status were classified as outpatient because the patient would not be in the hospital for the measure to be assessed.

B. Create an inventory of metrics by identifying all metrics used in each initiative found in the first step

Once the programs were identified, an inventory was conducted of each program's quality metrics. The majority of the metrics were found on the program's websites, including but not limited to:

- http://www.samhsa.gov/data/national-behavioral-health-quality-framework
- http://www.qualityindicators.ahrq.gov/modules/PQI_TechSpec.aspx
- www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html
- www.dsrip.nj.gov/documents/NJ%20DSRIP%20PLANNING%20PROTOCOL_v1_08-09-2013.pdf
- www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/updated_files/HEDISTipSheetJan2016.pdf
- http://www.leapfroggroup.org/Hospitals
- https://www.cms.gov/Regulations-and-guidance/Legislation/EHRIncentivePrograms/CMS_EHR_Listserv.html
- https://www.medicaid.gov/medicaid-chip-program-information/medicaid-and-chip-program-information.html
- http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement/pcpi-measures.page
- http://njii.com/
- http://www.state.nj.us/humanservices/dmahs/info/resources/care/

Some programs had relatively few metrics (e.g. New Jersey Innovation Institute's Practice Transformation Network (PTN) Project – 10 metrics) while others had a much larger number of metrics (e.g. PQRS at 281; PCPI at 325 metrics). In total, 786 metrics from the 18 programs were identified.

C. Refine the inventory by eliminating duplicates and determining the most commonly used metrics

The next step was to review all of the metrics and eliminate duplicates. Where possible, eliminations were done on the basis of NQF reference numbers. In other cases, where no NQF reference was included in a program metric, the list was reviewed for similarity of measure descriptions. Where possible, like or closely similar measures were consolidated. For instance, 3 metrics that were consolidated because they collected the same information but used varying language in the metric name were, "Preventive Care and Screening for High Blood Pressure"; "Controlling High Blood Pressure"; and "Hypertension Blood Pressure Control". The review resulted in a final list of 737 metrics. A complete list of the 737 metrics is included in Attachment 1. We then examined alignment of measures across the various initiatives to see where there was overlap. This step is especially important to reporting entities, as focusing on metrics that overlap multiple initiatives can consolidate their monitoring efforts. A threshold of 5 or more initiatives was set as the appropriate cut-off for the number of initiatives in which a metric must be used to make it to the next round of vetting. This step resulted in a list of 30 metrics. One additional metric, 30 Day All Cause Readmission Rate, was also added to the set of

30 metrics. This addition was to account for the large number of disease-specific readmission rate metrics (e.g. readmission rate for heart failure, AMI or, pneumonia) that appeared in the inventory but did not meet the 5 initiative threshold independently, but would have done so as a set of readmission rate metrics. This addition was also recommended by the NJ SIM Quality Metrics Alignment Advisory Group. The 31 metrics are:

Harmonized Metrics

Measure	Total Programs	NQF Focus	Target Population	Source of Data	Process vs Outcome
Ambulatory Care – Emergency Department (ED) Visits (AMB) / rate and/or preventable	5	Affordable	A/P	O	O
CAHPS (Appointments, How Well Providers Communicate with Patients; and Access to Specialists)	5	Coordination	A/P	O	O
Medication Reconciliation Post-Discharge (see NQF 554)	5	Coordination	A/P	B	P
30 Day All Cause Readmission Rate	4	Coordination	A/P	B	O
Follow-up After Hospitalization for Mental Illness (FUH)	9	Partners	A	B	P
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	8	Pop Health	P	C	P
Childhood Immunization Status	7	Pop Health	P	B	P
Prenatal & Postpartum Care: Postpartum Care Rate (PPC)	7	Pop Health	A	B	O
Depression Remission at Twelve Months	6	Pop Health	A/P	C	O
Immunizations for Adolescents	6	Pop Health	P	B	P
PC-01 Elective Delivery : (Patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed)	6	Pop Health	A	C	O
Well-Child Visits in the First 15 Months of Life	6	Pop Health	P	B	O
Adolescent Well-Care Visit (AWC)	5	Pop Health	P	B	O
Controlling High Blood Pressure	12	Rx	A	B	P
Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing	8	Rx	A/P	B	P
Diabetes: Hemoglobin A1c Poor Control	7	Rx	A/P	C	O
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	7	Rx	A	C	P
Medication Management for People with Asthma	7	Rx	A/P	C	P
AD/HD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (AD/HD) Medication	6	Rx	P	B	O
Anti-Depressant Medication Management	6	Rx	A/P	B	P
Diabetes: Eye Exam	6	Rx	A/P	B	P
Diabetes: Medical Attention for Nephropathy	6	Rx	A/P	B	P
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	5	Rx	A	O	P
Use of Imaging Studies for Low Back Pain	5	Safety	A	B	P
Cervical Cancer Screening	10	Screen	A	B	O
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	10	Screen	A	C	O
Chlamydia Screening for Women	8	Screen	A	B	O
Breast Cancer Screening (See NQF 31)	7	Screen	A	B	O
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	7	Screen	A/P	C	P
Colorectal Cancer Screening	6	Screen	A	B	O
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	5	Screen	A/P	O	P
			A = Adult A/P = Adult/Peds P = Peds	B = Billing C = Chart O = Other	P = Process O = Outcome

NQF Focus

Affordable - making quality care more affordable
Coordination - Promoting effective communication and coordination
Partners - Ensuring people/families engaged in care
Pop Health - Promotinh wide spread use of best practices to promote healthy living
Rx - Effective prevention and treatment practices
Safety - Reducing harm
Effective Screening

D. Determine meaningfulness

In considering the 31 metrics, the ability of the measures to reflect the impact of the care being provided must be taken into account. In healthcare, such a consideration is vital to accurately reflect how well an entity is reaching its goals in the provision of health care.

The first step taken to ensure meaningfulness of the metric set was evaluating whether the set of 31 measures covered a broad range of health priorities. Using the National Quality Strategy developed by the Agency for Healthcare Research and Quality http://www.ahrq.gov/workingforquality/about.htm), six priorities were considered: making care safer by reducing harm caused in the delivery of care; ensuring that each person and family is engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and government. Each of the 31 metrics was assigned to a category representing one of these 6 priorities. This, again, was to ensure that the 31 measures covered a broad scope in terms of health care priorities and quality.

The metrics were also grouped by target population: adult; adult/pediatrics; or pediatrics. This step was to guarantee that the care being monitored covered a spectrum of ages. This analysis revealed that 39% of the measures covered adults; 42% represented a combination adult and pediatrics; and 19% involved pediatrics.

The next consideration was whether benchmarks existed that reporting entities could use to assess their performance on specific standards. While comparison on an entity's own performance from one period to the next can provide analysis of the progress being made, entities must be able to judge their performance against an external source. Benchmarks were found for each of the 31 metrics. These sources included:

- Healthy People 2020
- National Committee for Quality Assurance
- Healthy NJ 2020
- Agency for Healthcare Research
- Child and Adolescent Health Measurement Initiative
- American Psychiatric Association – Physician Consortium for Performance Improvement
- Institute for Clinical Systems Improvement
- National Center for Health Statistics

An example of the benchmarking that might be incorporated relates to the metric "Diabetes: Eye Exam". The Healthy NJ 2020 target is 72.2% of diabetics should receive an eye examination. An organization can judge itself against this goal initially and track its progress towards this goal period to period. This will assist in judging the care delivered from an internal perspective as well as an external perspective.

Finally, at the request of the SIM Quality Metrics Alignment Advisory Group, each of the harmonized metrics was categorized by the type of measure: process versus outcome. Using the definition from Agency for Healthcare Research and Quality (AHRQ) and the Patient Safety – Quality Improvement Program of the Duke University School of Medicine/ Department of

Community and Family Medicine[1], each metric was assigned as a process measure or outcome measure. Sixteen of the metrics were assigned to the Process category while fifteen were allocated to the Outcome category.

After applying these analyses to the 31 identified metrics, all were deemed meaningful in evaluating the quality of care being delivered to the recipient population.

E. Determine usability

The second phase in evaluating the 31 metrics was to determine the usability of the measures. This was defined as the ability to collect the data in an organized and replicable manner, using a process that was least disruptive to the organization. Three data collection approaches were identified: billing data; chart audits; and other means. A review of the metrics revealed that 63% of the measures could be monitored with billing data; 27% through chart audit; and 13% from other sources (e.g. patient-reported data).

III. Stakeholder Feedback

A. Presentation to relevant stakeholders

The final list of 31 metrics was presented to the members of the NJ SIM Quality Metrics Alignment Advisory Group for review and discussion. The focus was on both the process used to identify the measures and the appropriateness of the 31 identified metrics. The Advisory Group appreciated the analysis and found the project's process to be suitable, with a few suggestions and edits. For example, it was suggested that an 18th initiative – Physician Consortium for Performance Improvement, or PCPI – be added to the list of quality and efficiency improvement initiatives that was used in conducting our metric inventory. The measures from this initiative were added to the inventory but did not change the final 31 recommended metrics. The Advisory Group also recommended that the project categorize the core set of 31 metrics as either Process or Outcome metrics to determine the balance. The metrics were examined and it was found that there was a healthy balance of process versus outcome measures (16 process measures and 15 outcome measures). In reviewing the core set of 31 quality metrics, there was agreement that the set was robust and covered a wide range of priorities and ages. One suggestion regarding the measure set that was incorporated into the project and this final report was the addition of the metric, 30 Day All Cause Readmission Rate, making the count of metrics in the harmonized set 31. This metric did not make it past the 5-initiative threshold, however, there were many disease-specific readmission rate metrics (e.g. AMI, pneumonia, heart failure) across the 18 initiatives that if combined as a single 30 Day All Cause Readmission Rate metric, would have met the 5-initiative minimum threshold. Besides that one addition, stakeholders approved of the harmonized measure set.

B. Presentation to the SIM Steering Committee

The final list of 31 metrics and the process used to determine the core set of metrics were presented to the SIM Steering Committee. The SIM Steering Committee is comprised of representatives of the Office of the Governor, and NJ Departments of Health (DOH), Human Services (DHS) and Banking & Insurance (DOBI). There were two key suggestions provided by the committee. The first was to share the project and its results with stakeholders representing

[1] *Process measures assess activities carried out by health providers to deliver services. Outcome measures assess the final product or results. http://patientsafetyed.duhs.duke.edu/module_a/measurement/measurement.html accessed 4/20/2016. https://www.qualitymeasures.ahrq.gov/tutorial/ProcessMeasure.aspx accessed 4/20/2016.*

the developmentally disabled (DD) population and the Managed Long Term Services and Supports (MLTSS) population. The second was to consult the New Jersey Division of Medical Assistance and Health Services (DMAHS) Quality Strategy from June 2014 (http://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf) to ensure the project and its outcome – a proposed set of harmonized quality measures – was in line with this strategy.

In response to the first suggestion, we contacted The Boggs Center on Developmental Disabilities and solicited feedback from Dr. Deborah Spitalnik and Dr. Michael Knox, Executive Director and Deputy Director, respectively. They provided some useful input that we took into consideration for our final set of metrics, as well as other suggestions that were more specific to details concerning the MLTSS and DD populations. Ultimately the core set of metrics that was previously presented to the SIM Steering Committee did not change, as the measure set is intended to capture clinical processes and outcomes that indicate quality of care provided to a general population.

In addition, the DMAHS Quality Strategy was consulted and it was concluded that this project – its process and the resulting measure set – is in line with this overarching strategy. Although the core metric set does not include metrics specific to the MLTSS or DD populations, the project does incorporate metrics taken from the Medicaid MCO contract and many of the Quality Strategy Objectives taken from Healthy NJ 2020 Topics, listed in Table 1 – Dashboard Quality Strategy Objectives. Additionally, many of the initiatives listed in the Achievements and Opportunities section, such as the NJ Accountable Care Organization Demonstration Project, the Medical Home model, the Value-Based Purchasing program and the Delivery System Reform Incentive Payment (DSRIP) Program, were included in the project's survey of initiatives from which metrics were inventoried.

C. Final list

The final list of core metrics is included in Attachment 2.

IV. Recommendations

Three key recommendations came out of this project and the feedback provided by the SIM Quality Metrics Alignment Advisory Group. They are as follows:

1. The Quality Institute, with input from the SIM Quality Metrics Alignment Advisory Group and other relevant stakeholders, recommends that the core set of 31 metrics identified via this project be adopted by the State as the core set of harmonized metrics to be used when considering future Medicaid projects, incentive programs, and contracts.
2. The Quality Institute, with input from the SIM Quality Metrics Alignment Advisory Group and other relevant stakeholders, recommends that an independent entity either within or outside of government be commissioned to house the harmonized metric set.
3. The Quality Institute, with input from the SIM Quality Metrics Alignment Advisory Group and other relevant stakeholders, recommends continuous examination of the harmonized metric set by the identified independent entity commissioned to house the measure set. The entity will be responsible for updating the measures and gathering continuous stakeholder feedback as metrics and priorities evolve. Per the SIM Quality Metrics Alignment Advisory Group feedback, specific areas to examine in the future include:
    a. Measure ranking, or weighting the measures by importance;
    b. Metric meaningfulness, specifically from the provider's perspective;
    c. Availability of metric benchmarks specific to New Jersey;

d. Consideration of risk adjustments versus risk stratification for reporting purposes;
e. Other opportunities to use the harmonized set of metrics, including innovation projects released from state and federal agencies (e.g. CMMI).