HEALTH CARE QUALITY MEASURE GLOSSARY

A Consumer Advocate's Guide to Quality Measurement, Including a Focus on Substance Use Disorders

COMMUNITY CATALYST

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Acknowledgements

About Community Catalyst

Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership required to transform the American health system so it serves everyone. We believe that this transformation will happen when consumers are fully engaged and have an organized voice in the local, state and national decisions that affect their health.

Introduction to the Glossary

Given the growing demand for substance use treatment and recovery services, there is a pressing need for consumer advocacy on measuring and improving the quality of services. But quality measurement is a jargon-heavy world. Without the knowledge of the terms and processes involved, it can be hard to engage in advocacy for the development of consumer-focused or consumer-driven measures.

This glossary explains key terms and processes in quality measurement to help you work on improving the quality of <u>all</u> health care. We included specific examples for substance use disorders quality measurement in the glossary because there are very few quality measures for substance use treatment, and data is very limited. Stronger advocacy will help catalyze the development, selection and use of quality measures, for substance use disorders and other health needs, that reflect outcomes important to people with lived experience. Longer-term, this will help expand access to quality care.

It is imperative that we advocate for investment in quality measurement in the pursuit of a health care system that eliminates [health inequities](). We know that our health care system is not equitable—income, race, gender, sexual orientation, and other social factors affect access to quality treatment and services—but we don't always know how and where to

make changes so the health care system is *more* equitable. Identifying the specific inequities and who experiences them is the first step; by tracking quality measures by race, gender, and other demographics, we can better pinpoint the inequities that exist, and target resources and improvements to lessen those inequities.

How to Use This Glossary

This glossary will help you understand quality measurement. All terms in **green** are alphabetized. Terms in **blue** are subcategories of the green term they are listed under and are indented to show this. A fully alphabetized index can be found at the end of the glossary.

Accreditation
The process of using quality measures and other factors to assess the overall performance of a health care provider to officially recognize that the provider is meeting standards.
- An example of an accreditation organization is CARF, a non-profit group that provides accreditation services worldwide in a range of areas, including mental health and substance use disorders.

Access
Ability to receive health services when needed.
- An example of an access measure is the wait time for scheduling a doctor's visit (how long until the doctor has appointment availability).

Agencies and Organizations

Agency for Healthcare Research and Quality (AHRQ)
A U.S. government agency that works to produce evidence to make health care safer, higher quality, more accessible, equitable and affordable. The agency works within the U.S. Department of Health and Human Services and with other partners to invest in research, create teaching and training materials, and generate measures and data for providers and policymakers.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
The Agency for Healthcare Research and Quality (AHRQ) uses the CAHPS program to advance the scientific understanding of patient experience with health care. CAHPS produces a number of different patient experience surveys that are widely used by state governments, health insurers and providers.

Massachusetts Health Quality Partners (MHQP)
An independent non-profit organization that creates and administers consumer surveys for MassHealth and other health insurers in Massachusetts.

National Committee for Quality Assurance (NCQA)
A non-profit organization that works on measurement, transparency and accountability to highlight top performers and drive improvement in health care quality. They do this through the administration of evidence-based standards, measures, programs and accreditation.

National Quality Forum (NQF)
A non-profit organization that reviews, endorses and recommends quality measures, as well as identifies areas for improvement.

National Quality Forum (NQF) Endorsed Measures
The NQF brings together public and private-sector organizations to determine how to measure quality in health care. When a measure is submitted for NQF endorsement, it goes through a process that includes a review by a group of experts, a public comment period, voting by NQF's membership, and approval by NQF's

Board of Directors. NQF endorsement is voluntary, but endorsed measures are typically favored for use. It is important to note that these criteria for endorsement were not developed with patient-centered outcomes in mind. Additionally, the endorsement process itself is slow and inflexible, and there are limited opportunities for public comment.

Patient-Centered Outcomes Research Institute (PCORI)
An independent, non-profit research organization, funded by the U.S. government, to help patients and those who care for them make better informed health decisions.

Quality Improvement Organization (QIO)
A group of health quality experts, clinicians and consumers who work with the federal Centers for Medicare & Medicaid Services to improve the quality of care delivered to Medicare beneficiaries.
- The Quality Innovation Network QIO in Massachusetts is IPRO, a non-profit organization that works with government agencies, providers and patients to implement innovative programs.

External Quality Review Organization (EQRO)
An organization that analyzes and evaluates aggregated information on quality, timeliness and access to the health care services that a managed care plan, or its contractors, gives to Medicaid beneficiaries. States that deliver Medicaid and CHIP services through managed care must contract with at least one EQRO to provide an annual review and report.
- Health Services Advisory Group (HSAG) is the largest EQRO in the nation

Benchmarking
A way to evaluate or check something. In quality measures, this involves the process of comparing providers or facilities to peers or best practices.
- For example, asking, "How does Hospital A compare to the best hospital in the country?"

Components of a Quality Measure

> **Example Measure**: The percentage of emergency department visits for people 13 years and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow up visit for AOD, within 30 days or 7 days of the emergency visit.

Denominator
The group of people or items that a quality measure is using as its total population.
- Using the example from the box above, the denominator is the number of emergency department visits by people 13 or older with a primary diagnosis of substance use disorders during the year being measured.

Exclusion

A condition or circumstance that leaves out a group of people from the denominator.

- For the measure above, one exclusion is patients in hospice.

Measure ID

A standard method of naming. Measures receive a number from organizations such as the National Quality Forum or Centers for Medicare & Medicaid Services to denote the version of a measure and endorsement.

- Measure 3488 is the Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measure endorsed by the National Quality Forum (which we are using in these examples).

Measurement Period

The period of time that data for the measurement is being collected.

- For example, in the measure above, the measurement period is January 1 to December 1.

Numerator

A number of patients within the population of the denominator who received a service or achieved an outcome.

- In the measure above, the numerator includes either: The number of patients with a principal diagnosis of Alcohol and Other Drug Abuse or Dependence who had a follow-up visit with any practitioner, within 30 days after an emergency department (ED) visit, including visits that occur on the date of the ED visit; or the number of patients with this diagnosis who had a follow-up visit with any practitioner within 7 days after the ED visit.

Data Sources

Administrative Data

Data collected in the process of providing and paying for health care.

- Examples include the record of what procedures the doctor billed for, location of a service, or amount reimbursed.

Claims Data

Another term for administrative data; includes information about services provided including the diagnosis, treatment, visit cost, and amount paid. Claims data used in quality measurement is handled in a way that protects individuals' privacy.

Consumer / Patient Surveys

A method of collecting data from patients about experiences, preferences, goals and perceptions.

- Experience of Care and Health Outcomes Consumer Assessment of Healthcare Providers and Systems (ECHO CAHPS): An example of a survey created by the Agency for Healthcare Research and Quality (AHRQ). The

ECHO CAHPS measures patient experience with mental health care services received through managed care.

Patient Narrative
Stories from patients about their experiences.

Provider Surveys
A method of collecting data from health care providers and other clinical staff about experiences, preferences and perceptions.

Healthcare Effectiveness Data and Information Set (HEDIS)
A data set developed and maintained by the National Committee for Quality Assurance (NCQA) that gathers results on clinical performance and consumer experience. HEDIS allows consumers to compare health plan performance to other plans and to national or regional benchmarks. HEDIS measures are largely focused on clinical health care.

Standardized Clinical Data
Certain facilities, including nursing homes and home health agencies, are required to report a set of data about each patient at specific time intervals.
- The Minimum Data Set (MDS) is required of nursing homes and the Outcome and Assessment Information Set (OASIS) is required of Medicare certified home health agencies.

Disparities-Sensitive Measure
A type of performance measure that demonstrates inequities in care. For example, a way to look at how quality of care differs by race or by gender.

Endorsement
After a measure has been tested, the developers can seek endorsement from a measure-vetting organization such as the National Quality Forum (NQF). Endorsements help potential users of the measure have confidence in its accuracy.
- NQF has a multi-stakeholder review process for evaluating a measure that involves five steps. The first is evaluating whether a measure has the potential to drive improvements in care, is aligned with National Quality Strategy, and is based on strong clinical evidence. Next is scientific acceptability of the measure comments, or whether the measure will give valid conclusions. Then, NQF determines the feasibility of collecting measure information, as well as how useable the measure will be. Next, NQF determines whether the measure is collecting information already gathered by an existing measure. After this review process, NQF decides whether or not to endorse a measure.

Health Equity
When everyone has a fair opportunity to achieve their full health potential regardless of their race, color, religion, national or ethnic origin, immigration status, class, age, disability, veteran status, sexual orientation, gender, gender identity, or gender expression.

Health Information Technology (HIT)

Technology such as computer systems that receives, stores, analyzes and shares health care data

- Examples include systems that maintain electronic health records (EHRs) or personal health records (PHRs).

Measure Concept

An idea for a new measure that needs to be studied and refined before being adopted.

Measure Developer

Individuals or organizations that create measures.

Measure Evaluation Criteria

Standards used by agencies to determine whether to endorse a measure. For example, NQF's criteria include importance, acceptability, feasibility, usability and others.

Measure Harmonization

The process of aligning or consolidating similar measures. Providers and governments often want similar measures across Medicaid, Medicare, and private insurance so the same quality measures can be applied across the board.

Measure Specifications

Technical description of how to accurately calculate a measure; tells users how to implement the measure in their organizations so they are collecting and using the data in a standardized way.

Measure Steward

People or organizations that provide the information necessary to make the case for a quality measure to be endorsed by an organization. These groups are also responsible for making any updates needed. Every measure submitted for endorsement by the National Quality Forum (NQF) has a measure steward.

- National Committee for Quality Insurance and the Centers for Medicare & Medicaid Services are both examples of organizations that are measure stewards.

Medicaid Core Measures

A set of measures that Medicaid providers or managed care companies report on.

- For example, the Adult and Child Health Care Quality Measures, which contains specific sets such as the "2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)".

Morbidity

The ratio of people who have a disease to those who do not have the disease within a given community. Morbidity shows us how many people have symptoms or are unhealthy due to a disease or condition.

- For example, how many people in a given state are diagnosed with alcohol or other drug (AOD) abuse or dependence.

Mortality Rate

The number of deaths in relation to the number of people in the population at risk of dying; also known as the death rate. This indicates how deadly an illness is.
- For example, how many people died from a drug overdose.

National Outcomes Measures (NOM)

The Substance Abuse and Mental Health Services Administration (SAMHSA) identified categories of outcomes for people in recovery. These outcomes are primarily used to monitor the effectiveness of grants funding treatment and recovery services. Each outcome is defined by a series of questions about the effects of the services on individuals with substance use disorders. Some states also use NOMs to assess other services.
- Categories include: abstinence, employment and education status, crime and criminal justice involvement, stability in housing, social connectedness, social consequences.

National Quality Strategy (NQS)

A nationwide effort to improve the quality of health and health care in the United States. The strategy was designed by public and private stakeholders and guided by three aims: better care, healthy people and communities, and affordable care.

Patient-Centered Care

Care that is respectful and responsive to the needs, goals and preferences of an individual person.
- "Patient-centered care" for addiction ideally meets the person where they are in their recovery journey, and is geared toward that person's individual recovery goals.

Patient Reported Outcome (PRO)

An outcome or result of treatment that is reported by the patient.
- One example is the Patient Activation Measure (PAM) a 10- or 13- item questionnaire that assesses an individual's knowledge, skill, and confidence in managing their health and health care. The measure is not disease specific, but is used with a wide variety of chronic conditions. The outcome of interest is the patient's ability to self-manage. High quality care should increase the ability of people with chronic illnesses to manage their condition. The outcome measured is a change in confidence over time, indicating a change in the patient's knowledge and skills.

Pay for Performance

A process used by insurers or government agencies to provide financial rewards or enforce financial penalties based on quality measures.

- For example, the Centers for Medicare & Medicaid Services use the Value Modifier (VM) or Value-Based Modifier Program for Medicare Part B, which covers mostly outpatient services. The VM program rates providers "high, average, or low" based on quality and cost measurements as compared to their peers, and adjust payments accordingly by 2 to 4 percent. The penalties on low-performing providers are designed to subsidize the rewards for high-performing providers.

Quality
The degree to which health services increase the likelihood of desired outcomes.
- For example, good "quality" substance use disorders services are those that help people meet their treatment or recovery goals.

Quality Measure
A specific way of analyzing the quality of a health care service, provide, system or insurance plan.
- A National Quality Forum endorsed measure is the percentage of emergency department visits for people 13 years and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow up visit for AOD, within 30 day or 7 days of the emergency department visit.

Quality Measure Types
Composite Measures
A combination of multiple measures that produce a single measure in a certain illness or area of services. The combined elements can present a more comprehensive picture.
- For example, the National Quality Forum endorsed measure, Mortality for Selected Conditions, is a combination of measures that determine the rate of in-hospital deaths for selected conditions.

Experience Measures
A measure of a patient's experience.
- For example, the percentage of patients who reported they received treatment that was respectful and non-stigmatizing.

Outcome Measures
Measures that look at what happens to a patient as a result of treatment or services.
- For example, the percentage of patients who decreased their substance use after individual counseling.

Measure of Affordability
A measurement of the cost, resource use, efficiency and value of health care.
Cost
A dollar amount related to health care. Costs can be direct or indirect.
- An example of direct cost is the cost of medication.

- An example of indirect cost is the lost productivity in the workplace due to poor health.

Resource Use
The materials or services required to provide care.
- For example, the staff and items required to administer naloxone.

Efficiency
A combination of cost and quality that demonstrates how well something is being done.
- High efficiency care provides high quality health care at a low cost; low efficiency care provides low quality care at a high cost.

Value
A measure that accounts for the cost of care, health outcomes achieved, and patient satisfaction.

Process Measure
Measures related to what the health care provider does, usually based on current treatment guidelines.
- For example, the percentage of patients who received counseling along with medicine for opioid use disorder.

Structural Measures
Measures related to characteristics of a facility or providers.
- For example, the ratio of patients to providers in an addiction clinic.

Quality Improvement (QI)
A process of continually assessing and addressing issues that affect quality. In Medicaid, a PIP (Performance Improvement Plan) is a common part of QI.
- "Quality improvement" efforts can include tracking people's experiences with addiction treatment providers, identifying where the problems are, and ensuring the providers fix the problems.

Quality Rating System
Rating health insurers based on quality and price. These can be used to help consumers select a health plan or to help officials monitor the performance of a health plan.

Quality Scorecard
A way to present quality measure data that may include star ratings, numbers or letter grades.

Reliability
The reliability of a measure generally addresses whether repeated measurement will capture the same result. In quality measures, this refers to the degree to which the

variation in performance between different providers (or processes or systems) are true differences rather than due to chance.

Stratified Data
Data that is split into different groups; these splits can be based on criteria such as race, gender, zip code and many others
- For example, the Agency for Healthcare Research and Quality (AHRQ) survey on Experience of Care & Health Outcomes (ECHO) can be stratified to show the results based on gender, level of education, race and other patient characteristics.

Validation
The process of showing that the data collected will address what the measure is trying to study.

Validity
A way to see whether a measure assesses what it intends to.

Index

A

B

C

D

E

H

M

N

O

P

Q

R

S

V