Memo

Date: **May 1, 2015 (Updated May 21, 2015)**

Subject: **2016 Statewide Quality Reporting and Measurement System (SQRMS): MN Community Measurement (MNCM) and Stratis Health's Preliminary Recommendations for Physician Clinic and Hospital Quality Measures**

Minnesota Statutes 62U.02 requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. A subset of the standardized set of quality measures will be used for public reporting purposes. To implement the collection of quality measurement data, the Minnesota Department of Health (MDH) has developed the Minnesota Statewide Quality Reporting and Measurement System (SQRMS), created through Minnesota Rules, Chapter 4654. This rule compels physician clinics and hospitals to submit data on a set of quality measures to be publicly reported and also establishes a broader standardized set of quality measures for health care providers across the state. MDH collects data on those measures to be publicly reported, while health plans may only require providers to submit data on those measures that are part of the standardized set.

The Commissioner of Health is required to evaluate the measures included in the set of quality measures to be publicly reported on an annual basis. MDH contracted with MN Community Measurement (MNCM) and Stratis Health to make recommendations for SQRMS about new and/or modified quality measures, and measure removals. Accordingly, MNCM and Stratis Health submitted preliminary quality measure recommendations to MDH. The preliminary recommendations for physician clinic and hospital quality measures for the 2016 reporting year for SQRMS are attached. These recommendations were reviewed and approved by MNCM's Measurement and Reporting Committee (MARC) and the Hospital Quality Reporting Steering Committee convened by Stratis Health.

Key proposed changes include the following:

- Physician clinics
    - Addition of a new statin medication use component to the Optimal Diabetes and Optimal Vascular Care measures.
    - Technical change to the Depression Remission at Six Months specifications.

- Hospitals
    - Alignment of prospective payment system (PPS) hospital measures with CMS's Hospital Value-Based Purchasing, Readmissions Reduction Program, and Hospital-Acquired Condition Reduction Program.
    - Alignment of critical access hospital (CAH) measures with the Medicare Beneficiary Quality Improvement Project (MBQIP).
    - Addition of the Stage 2 Meaningful Use Advance Directive measure to support a focus on end of life care.
    - Removal of 23 hospital measures.

Complete descriptions of the proposed changes, as well as the recommendation process can be found in the attached preliminary recommendations.

The Minnesota Department of Health invites interested stakeholders to review and comment on the preliminary recommendations for physician clinic and hospital quality measures for the 2016

Statewide Quality Reporting and Measurement System (SQRMS). Please send your comments to health.reform@state.mn.us by June 5.

MNCM and Stratis Health will consider all public comments before submitting their final recommendations to MDH by June 15. The final recommendations will be presented at a public forum that MDH will hold on June 22, 2015. MDH will announce this public forum through its weekly Health Reform update which interested parties may subscribe to, and will post additional information for the forum to the SQRMS website.

April 15, 2015

TO: Denise McCabe
Quality Reform Implementation Supervisor, Health Economics Program
Minnesota Department of Health

FR: Dina Wellbrock
Project Manager
MN Community Measurement

RE: 2016 Preliminary Slate of Measures for Physician Clinics and Hospitals

Please find attached two separate groups of documents representing the Preliminary Slate of Measures for Physician Clinics and Hospitals recommended for the 2016 Statewide Quality Reporting and Measurement System (SQRMS). These preliminary recommendations are being delivered in accordance with the Minnesota Department of Health (MDH) – Health Care Quality Measurement Contract as noted in II.A.2.

Preliminary Slate of Measures for Physician Clinics

The preliminary slate of measures for physician clinics was approved by MN Community Measurement (MNCM)'s Measurement and Reporting Committee (MARC) on April 8, 2015. MARC's approval is informed by the work of MNCM's Measure Review Committee (MRC), a subcommittee of MARC, which met on March 25, 2015.

The measures reviewed by the MRC included Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Adults, Optimal Asthma Control – Children, Colorectal Cancer Screening, Maternity Care: C-Section Rate and the Depression measure set. The MRC is charged with making recommendations to the MARC and uses evaluation criteria based on the National Quality Forum criteria for endorsement (also referenced under II.A.4). Potential recommendations to MARC for ongoing use of each publicly reported measure might include:

1) Continue without change
2) Elevate to a higher level review
3) Transition to monitoring (collect without public reporting)
4) Retirement

The MRC's final recommendations were to continue, without change, all reviewed measures for public reporting purposes.

The 2016 preliminary slate of measures for physician clinics includes a redesign of the cholesterol management component for both the Optimal Diabetes Care (ODC) and Optimal Vascular Care (OVC) measures. This redesign was prompted by changing evidence and guidelines (American College of Cardiology/American Heart Association and Institute for Clinical Systems Improvement) that no longer supported treating patients to a LDL cholesterol target of less than 100. The redesigned cholesterol management component focuses on the appropriate use of statin medications. Including statin medications as a component completes the modification and redesign that was initiated in 2014 (initial justification with criteria for endorsement in MNCM's April 30, 2014 memo to MDH).

Key milestones of the redesign were:

- On September 2, 2014, MNCM convened the ODC/OVC cholesterol workgroup; they recommended statin use specifications based on the current evidence and guidelines.
- On October 1, 2014, MNCM convened the ODC/OVC cholesterol workgroup; they recommended contraindications/exception definitions for statin use.
- On October 8, 2014, MNCM convened the MARC. MARC approved the ODC/OVC cholesterol workgroup's recommendations for redesign of the cholesterol management component of the ODC/OVC measure.

Additionally, although the Depression Remission at Six Months measure construct has not changed, MNCM responded to feedback from medical groups and the MRC regarding the technically complicated nature of having two sets of criteria in the definition of an index event for the denominator. After consideration of the feedback and investigation in to the advantages and drawbacks of any proposed change, MNCM simplified the measure by aligning the definition of all index events to require an elevated PHQ-9 result and an accompanying diagnosis of major depression or dysthymia.

Key milestones in this effort included:

- In April 2014, the MRC was convened and tasked MNCM with exploring ways to simplify the depression measure set and optimize it from a technical perspective.
- From June through October 2014, MNCM staff held internal discussions to evaluate various approaches to simplification and, in parallel, investigated the technical impact/capabilities within the MNCM Data Portal. MNCM also had discussions with the previous measure development workgroup chairperson to understand the clinical appropriateness of the considered changes.
- In December 2014, feedback regarding the proposed change was solicited from the DDS Technical Advisory Group, which represents medical group data contributors. The TAG overwhelmingly supported the proposed change to the index definition.

Some of the recommended measures are part of a set (e.g. Total Knee Replacement) and the set may include process and/or outcome measures. The 2016 preliminary slate of measures recommended for physician clinics primarily includes outcome measures as this is MDH's stated preference for SQRMS (as noted in contract II.A.4). There are other measure sets with multiple outcome measures (e.g., Depression Remission at Six and 12 Months). The Depression Remission at Six Months measure is recommended because it is our community's preferred measurement period for internal quality improvement efforts.

Additionally, our recommendation is to not add any new measures to the 2016 Proposed Slate since four measures are being implemented for the first time in 2015 (two in specialty care and two in pediatrics).

<u>Preliminary Slate of Measures for Hospitals</u>

The preliminary slate of measures for hospitals was approved by Stratis Health's Hospital Quality Reporting Steering Committee (HQRSC) on March 26, 2015. The attached report entitled "Recommendations for 2016 SQRMS Hospital Measures Reporting" represents the recommendations (in Appendix D) and contains all supporting documentation.

All measures in both proposed slates are recommended for public reporting.

Enclosures for the Physician Clinic and Hospital Recommendations

The following items are attached as Appendices for the Physician Clinic Recommendations:

1. 2016 SQRMS Preliminary Slate of Measures for Physician Clinics
2. Measure Review Summary documents prior to March 25, 2015 meeting: Optimal Diabetes Care, Optimal Vascular Care and Depression Remission at Six Months
3. Measure Review Preliminary Rating Summary document for March 25, 2015 meeting
4. Approved MRC meeting minutes March 25, 2015 (to be provided when final)
5. Approved MARC meeting minutes April 8, 2015 (to be provided when final)
6. Diabetes Ad-Hoc Cholesterol Meeting #2 minutes, September 2, 2014
7. Diabetes Ad-Hoc Cholesterol Meeting #3 minutes, October 1, 2014
8. Approved MARC meeting minutes, October 8, 2014: http://mncm.org/wp-content/uploads/2014/11/2014.10.8-MARC-Minutes_Approved.pdf
9. Summary of DDS TAG feedback regarding Depression measure technical change, December 2014
10. Recommendations for 2016 SQRMS Hospital Measures Reporting, April 14, 2015

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Existing Measures

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Optimal Diabetes Care Composite: ***NQF# 0729*** ***Percent of patients with diabetes that are well-controlled*** • HbA1c (less than 8 percent) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use if patient has diagnosis of IVD (or valid contraindication to aspirin documented if patient has IVD) • Documented tobacco free • Statin use unless contraindicated	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Endocrinology	Collecting mid-January 2016 to mid-February 2016 on dates of service: January 1, 2015 through December 31, 2015. Data Source: MNCM	Numerator: number of patients in denominator who meet all components of HbA1c, blood pressure, daily aspirin use, statin use, and tobacco free during dates of service. Denominator: Adults age 18 to 75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with a diabetes ICD-9 code, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.
Optimal Vascular Care Composite: ***NQF# 0076*** ***Percent of patients with vascular disease that are well controlled*** • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use or valid contraindication to aspirin documented • Documented tobacco free • Statin use unless contraindicated	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Cardiology	Collecting mid-January 2016 to mid-February 2016 on dates of service: January 1, 2015 through December 31, 2015. Data Source: MNCM	Numerator: number of patients in denominator who meet all components of blood pressure, daily aspirin use, statin use, and tobacco free during dates of service. Denominator: Adults age 18 to 75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an IVD ICD-9 code, seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Depression Remission at 6 Months: ***NQF# 0711*** ***Percent of patients with depression that are in remission*** • Patients with major depression or dysthymia and an initial PHQ-9 score > nine whose PHQ-9 score at six months is less than 5.	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Psychiatry • Licensed Behavioral Health (if physician on site)	Collecting February 2016 on index dates: July 1, 2014 through June 30, 2015, allowing for 6 month (+/- 30 days) follow-up contact. Data Source: MNCM	Numerator: number of patients in denominator who have a PHQ-9 score less than 5 at 6 months (+/- 30 days). Denominator: Adults age 18 and older with patient visits or contacts during the measurement period with Diagnosis of Major Depression or Dysthymia, whose initial PHQ-9 score is > 9.
Optimal Asthma Control Composite ***Percent of patients with asthma that are well controlled*** • Asthma is well controlled as demonstrated by specified assessment tools • Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months) *Adult and pediatric measure reported separately*	• Family Medicine • General Practice • Internal Medicine • Pediatrics • Allergy/Immunology • Pulmonology	Collecting mid-July 2016 to mid-August 2016 on dates of service: July 1, 2015 through June 30, 2016. Data Source: MNCM	Numerator: number of patients with asthma well controlled and not at risk for future exacerbations. Denominator: Patient ages 5 to 17 or 18 to 50, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an asthma ICD-9 code, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Colorectal Cancer Screening ***Percent of patients current on colorectal cancer screening*** • Patients with colorectal cancer screening (allowable screens: colonoscopy within 10 years, sigmoidoscopy within 5 years, FOBT or FIT within the reporting period)	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Obstetrics /Gynecology	Collecting mid-July 2016 to mid-August 2016 on dates of service: July 1, 2015 through June 30, 2016. Data Source: MNCM	Numerator: number of patients in denominator with colorectal cancer screening. Denominator: Adults ages 50 to75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years for any reason, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.
Maternity Care- Primary C-Section Rate • Percentage of cesarean deliveries for first births *All clinics part of a medical group in which the medical group has providers who perform C-sections*	• Family Medicine • General Practice • Obstetrics/Gyn • Perinatology	Collecting mid-July 2016 to mid-August 2016 on dates of service: July 1, 2015 through June 30, 2016. Data Source: MNCM	Numerator: number of patients in denominator who had a cesarean delivery. Denominator: All live, singleton, vertex, term (≥ 37 weeks gestation) deliveries to nulliparous women performed by a medical clinic site during measurement period.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Total Knee Replacement: ***Average change of functional status and quality of life for total knee replacement patients*** • Average post-operative functional status at one year post-operatively measured by the Oxford Knee Score tool. • Average post-operative quality of life at one year post-operatively measured using the specified health related quality of life tool. *Primary and revision procedures reported separately*	• Orthopedic Surgery	Collecting mid-April 2016 to mid-May 2016 on dates of procedure: January 1, 2014 through December 31, 2014. Data Source: MNCM	Numerator: functional status (or quality of life) score at one year of patients in denominator. Denominator: pre-operative functional status (or quality of life) of adult patients age 18 and older with no upper age limit undergoing a primary total knee replacement or a revision total knee replacement during the required dates of procedure.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Spine Surgery: • Average change between pre-operative and post-operative functional status as measured with the Oswestry Disability Index, version 2.1a. • Average change between pre-operative and post-operative health related quality of life as measured with the health related quality of life tool. • Average change between pre-operative and post-operative back pain as measured with the visual analog scale (VAS) for pain. • Average change between pre-operative and post-operative leg pain as measured with the visual analog scale (VAS) for pain.	• Orthopedic Surgery • Neurosurgery	Collecting mid-April 2016 to mid-May 2016 on dates of procedure: January 1, 2014 through December 31, 2014. Data Source: MNCM	**Discectomy/Laminotomy:** Numerator: The average change in the pre- to post-operative functional status, pain, and quality of life for denominator patients at 3 months. Denominator: Adult patients age 18 and older with no upper age limit undergoing a lumbar discectomy/ laminotomy procedure for a diagnosis of disc herniation with the date of procedure occurring within a fixed measurement period. **Lumbar Spinal Fusion:** Numerator: The average change in the pre- to post-operative functional status, pain, and quality of life for denominator patients at one year. Denominator: Adult patients age 18 and older with no upper age limit undergoing any level of lumbar spinal fusion with a date of procedure occurring with a fixed measurement period.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening • Patient has a mental health and/or depression screening using specified assessment tools documented in medical record *Clinics that provide well-child visit services*	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting mid-April 2016 to mid-May 2016 on dates of service: January 1, 2015 through December 31, 2015. Data Source: MNCM	Numerator: number of patients in denominator with a mental health and/or depression screening documented. Denominator: Patients ages 12 to 17, seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.
Pediatric Preventive Care: Overweight Counseling • Patient with a BMI percentile ≥85% has documentation of both physical activity and nutrition discussion, counseling or referral documented in the medical record *Clinics that provide well-child visit services*	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting mid-April 2016 to mid-May 2016 on dates of service: January 1, 2015 through December 31, 2015. Data Source: MNCM	Numerator: number of patients in denominator with physical activity and nutrition counseling documented. Denominator: patients ages 3 to 17 with a BMI percentile ≥ 85%, seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.

Minnesota Statewide Quality Reporting and Measurement System
Preliminary Slate of Proposed Measures for **Physician Clinics**
2016 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator
Patient Experience of Care Survey topics cover: • Getting care when needed / access to care • Communication • Helpfulness of office staff • Providers with an exceptional rating Recommended CG-CAHPS Clinician and Group Survey **Measure is required every other year*	• All specialties except Psychiatry-only practices	Collecting October, 2016 to February 20, 2017. Dates of service for survey: September 1, 2016 through November 30, 2016. Sample should be sufficient to achieve a 0.70 reliability threshold; sample size calculation based on provider-scaling/clinic size according to CAHPS protocol. Data Source: MNCM	Question summary rollup into survey domains of access to care, provider communication, helpfulness of office staff, and provider rating. All patients ages 18 and older with a face-to-face visit at the clinic during the timeframe, are eligible for inclusion in the survey regardless of: • Physician specialty • Reason for visit • Duration of patient/physician relationship
Health Information Technology Survey • Survey topics cover adoption, use, and exchange of HIT information; and on-line services See attached MN Ambulatory Clinic HIT Survey for complete list of questions	All Specialties	Collecting February 15, 2016 to March 15, 2016 on current HIT status. Data Source: MNCM	Question summary rollup into survey domains of adoption, utilization, and exchange of EMR data.

Optimal Diabetes Care

Measure Review Summary

Measure description

The percentage of adult type 1 or type 2 diabetes patients who have optimally managed modifiable risk factors (A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. This is a patient level all-or-none composite measures in which all five components need to be met in order to be numerator compliant. The five components are:

1. HbA1c less than 8.0
2. Blood Pressure less than 140/90 (systolic value of less than 140 AND diastolic value of less than 90)
3. On a statin medication unless contraindication or valid exception
4. Non-tobacco user
5. If co-morbidity of ischemic vascular disease is on daily aspirin or anti-platelets unless contraindication or valid exception

(Note: This measure has changed significantly from the previous year with the redesign of the cholesterol component based on significant changes in evidence and guidelines. The information included in this report regarding historical measure performance is based on prior years' measure specifications in which the cholesterol component was LDL < 100.)

Criterion rating definition

H = High confidence that the criterion is met
M = Moderate confidence that the criterion is met
L = Low confidence that the criterion is met
I = Insufficient information to evaluate whether the criterion is met
NA = Not applicable

Criterion Rating Summary

	H	M	L	I	N/A
Evidence to support the measure focus	☐	☐	☐	☐	☐
High priority aspect of healthcare	☐	☐	☐	☐	☐
Performance gap	☐	☐	☐	☐	☐
Reliability and validity	☐	☐	☐	☐	☐
Feasibility and burden	☐	☐	☐	☐	☐
Use and usability	☐	☐	☐	☐	☐
Harmonization	☐	☐	☐	☐	☐

Review committee recommendation

☐ Continue without changes or with minor updates
☐ Higher level review warranted
☐ Transition to monitoring (collect without public reporting)
☐ Retire

Evidence

The measure focus is consistent with evidence-based standards of care and guidelines as appropriate for the measure type; i.e. health outcome, intermediate clinical outcome, process.

Findings: (Composite patient level all-or-none)

A multifactorial approach to diabetes care that includes emphasis on blood pressure, lipids, glucose, aspirin use and non-use of tobacco will maximize health outcomes far more than a strategy that is limited to just one or two of these clinical domains (American Diabetes Association, 2014; Duckworth, 2009; Gaede, 2008; Holman, 2008a).[i]

All components are supported by current Institute for Clinical Systems Improvement guidelines (July 2014). An ad-hoc measure development work group was requested by MARC in September 2013 to evaluate the cholesterol component of LDL < 100 and consider re-design to "LDL < 100 or on a statin". In November of 2013 with the publication of paradigm sifting guidelines by the American College of Cardiology and the American Heart Association, the scope of the redesign changed as it is no longer evidence based to treat to any LDL target. New cholesterol component for 2015 dates of service/ 2016 reporting focuses on appropriate statin use.

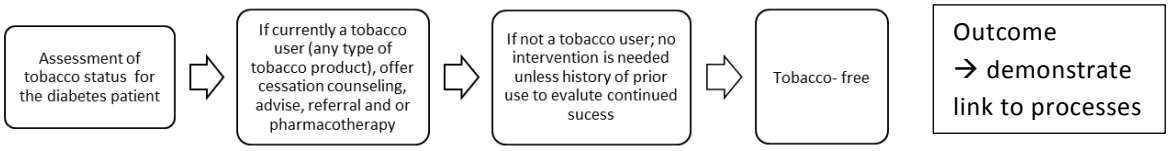
1. HbA1c less than 8.0; intermediate clinical outcome
   Recommendation: A clinician should personalize goals with patients diagnosed with T2DM to achieve glycemic control with a hemoglobin A1c < 7% to < 8% depending on individual patient factors.
   Benefits: Achieving near-normal glycemic control lowers risk of diabetes microvascular complications such as retinopathy, nephropathy and amputations. Achieving A1c of 6.9 to 7.9% may also significantly reduce macrovascular complications based on Steno-2 and UKPDS data.
   Quality of Evidence: High
   Strength of Recommendation: Strong

2. Blood Pressure less than 140/90; intermediate clinical outcome
   Recommendation: A clinician should initiate antihypertensive treatment for patients with T2DM with a blood pressure ≥ 140/90 mmHG and treat to a goal of < 140/90.
   Benefits: Uncontrolled hypertension is a major risk factor for ASVCD events. Multiple large studies (UKPDS, HOT, ADVANCE) have shown improved cardiovascular outcomes with treatment of blood pressure to this range in patients with diabetes.
   Quality of Evidence: High
   Strength of Recommendation: Strong

3. On a statin medication unless contraindication or valid exception; medication use/ process
   Recommendations: A clinician should recommend high-intensity statin therapy for patients diagnosed with T2DM, between the ages of 40-75 with established ASCVD (strong), and (B) may recommend high-intensity statin therapy for others at a 10-year ASCVD risk ≥ 7.5% (weak). A clinician should recommend moderate- or high-intensity statin therapy for all patients diagnosed with T2DM between the ages of 40-75 with a LDL ≥ 70 mg/dL.
   Benefits: A high-intensity statin reduces the relative risk of ASCVD events more than moderate-intensity statin in patients with and without diabetes, and in primary and secondary prevention in those with diabetes. The use of at least moderate-intensity statin therapy in persons of this age and an elevated LDL level with a diagnosis of diabetes has been shown to be effective. The only trial of high-intensity therapy in primary prevention was performed in a population without diabetes. High-intensity statin therapy reduces the relative risk of ASCVD events more than moderate-intensity statin therapy in patients with ASCVD. Because individuals with diabetes are at substantially increased lifetime risk for ASCVD events and death, similar to those who have had a previous ASCVD event, persons with diabetes with high estimated 10-year ASCVD risk are likely to benefit similarly from high-intensity therapy.
   Quality of Evidence: High

Strength of Recommendation: Strong with exception for high intensity dose statin based on CV risk calculator (weak)

4. Non-tobacco user; health outcome



According to the Centers for Disease Control, cigarette smoking is the most important preventable cause of premature death in the United States. Cigarette smoking is the leading cause of preventable death in the United States, accounting for more than 480,000 deaths, or one of five deaths, each year.

Tobacco smoking increases risk of macrovascular complications 4-400% in adults with T2DM and also increases risk of macrovascular complications. Tobacco cessation is very likely to be the single most beneficial intervention that is available, and it should be emphasized by clinicians.[ii]

5. If co-morbidity of ischemic vascular disease is on daily aspirin or anti-platelets unless contraindication or valid exception; medication use/ process
   Recommendation: A clinician should recommend aspirin therapy for patients diagnosed with T2DM with established ASCVD and consider aspirin therapy for others where the benefits outweigh the risk in primary prevention.
   Benefits: Patients with established ASCVD are at high risk for recurrent events, and aspirin therapy for secondary prevention has been shown to reduce the rate of future events to a clinically meaningful degree. As T2DM is an independent risk factor for ASCVD, patients with T2DM might be expected to benefit from aspirin therapy even before they manifest evidence of ASCVD.
   Quality of Evidence: High
   Strength of Recommendation: Strong

Rating

	H	M	L	I	N/A
Evidence to support the measure focus	☐	☒	☐	☐	☐

High priority aspect of healthcare

The measure addresses a demonstrated high-priority (high impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use; severity of illness; and severity of patient/societal consequences of poor quality.

Findings:

According to the MN Department of Health, diabetes is a high impact clinical condition in Minnesota. It is estimated that 7.3% of Minnesotans (~ 300,000) have diabetes and approximately 18,000 new cases are diagnosed each year. This estimate is even higher (~9%) including those with undiagnosed diabetes. It is estimated that 35% of adults in MN may have pre-diabetes.[iii]

According to the Centers for Disease Control, 29.1 million Americans have diabetes. It is estimated that 1 in 4 do not know they have diabetes and that an additional 86 million people have pre-diabetes. 15 to 30% of people with pre-diabetes will develop type 2 diabetes within 5 years. It is estimated that the annual medical costs and lost work and wages for people diagnosed with diabetes is 245 billion dollars and the risk of death for adults with diabetes is as much as 50% higher than those adults without diabetes.[iv]

A multifactorial approach to diabetes care that includes emphasis on blood pressure, lipids, glucose, aspirin use and non-use of tobacco will maximize health outcomes far more than a strategy that is limited to just one or two of these clinical domains (American Diabetes Association, 2014; Duckworth, 2009; Gaede, 2008; Holman, 2008a).[v]

Achieving the intermediate physiological outcome targets related to blood pressure and glycemic control in addition being tobacco free and use of daily aspirin and statins where appropriate are the diabetic patient's best mechanisms of avoiding or postponing long term complications associated with this chronic condition which affects millions of Americans. Measuring providers separately on individual targets is not as patient centric as a measure that seeks to reduce multiple risk factors for each patient. Diabetic patients are more likely to reduce their overall risk and maximize health outcomes by achieving several intermediate physiological targets.

Rating	H	M	L	I	N/A
High priority aspect of healthcare	☐	☐	☐	☐	☐

Performance gap

The data demonstrates that there exists considerable variation, or overall less-than-optimal performance, in the quality of care across providers and/or disparities in care across population groups.

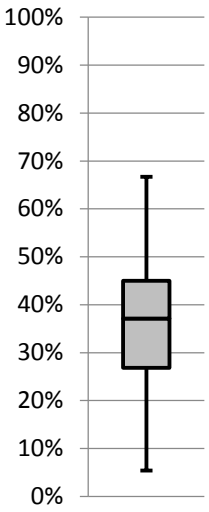
Findings:

Performance variation 2014: (580 reporting clinics)

Percentiles:
10th : 19.4%
25th : 26.8%
50th : 37.1%
75th : 45.0%
90th : 51.2%

Range: 5.4% - 66.7%

Mean: 36.0%



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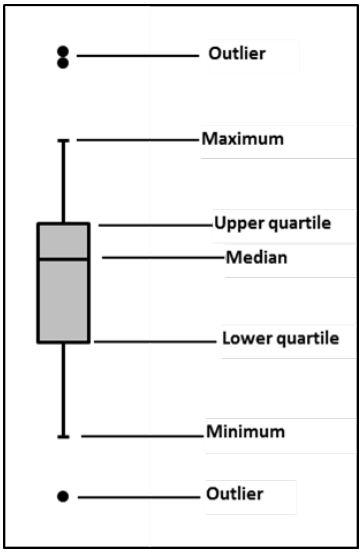


Disparities across population groups:

Different racial, ethnic, country of origin, and primary language population groups have significantly different Optimal Diabetes Care Rates.[vi]

FIGURE 1: STATEWIDE RATES FOR OPTIMAL DIABETES CARE BY **RACE**

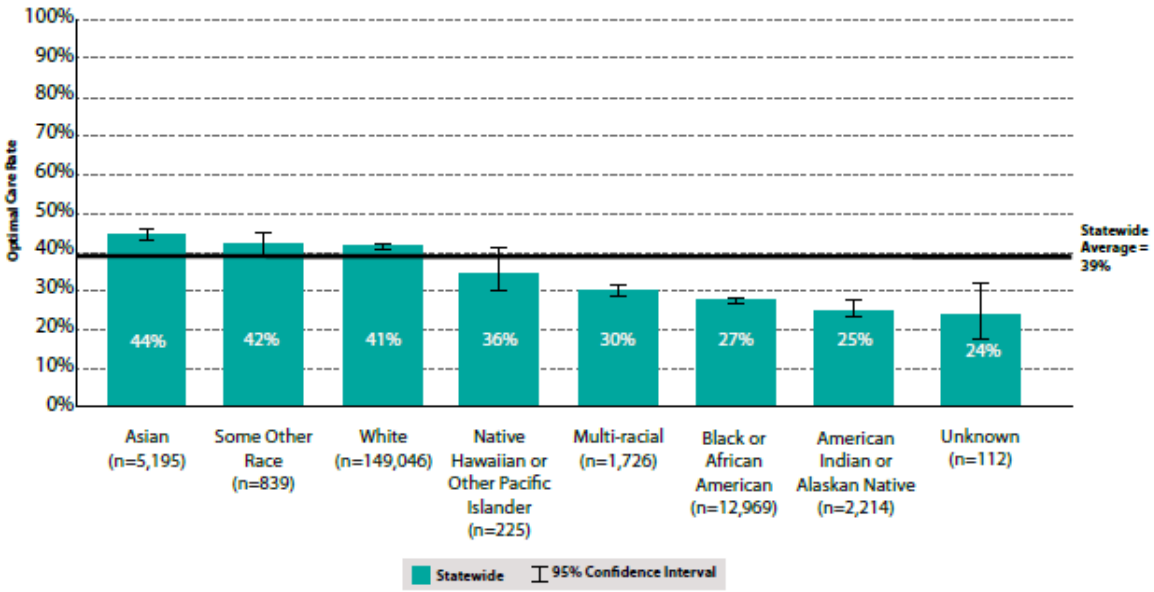


FIGURE 2: STATEWIDE RATES FOR OPTIMAL DIABETES CARE BY **HISPANIC ETHNICITY**

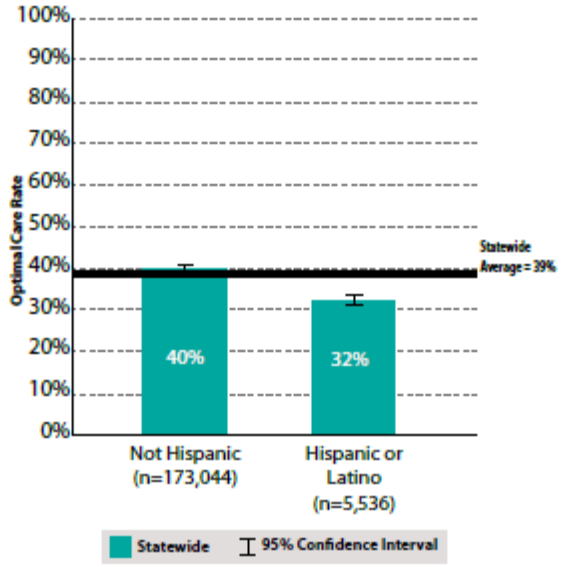
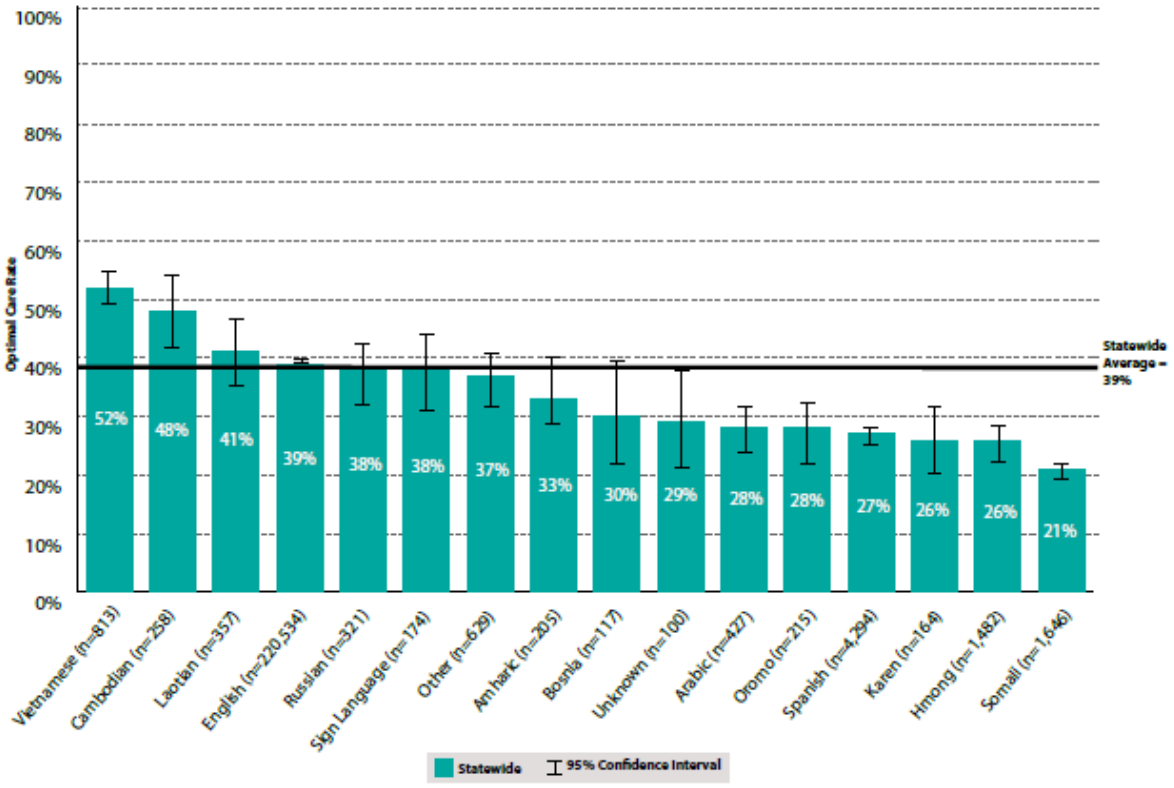
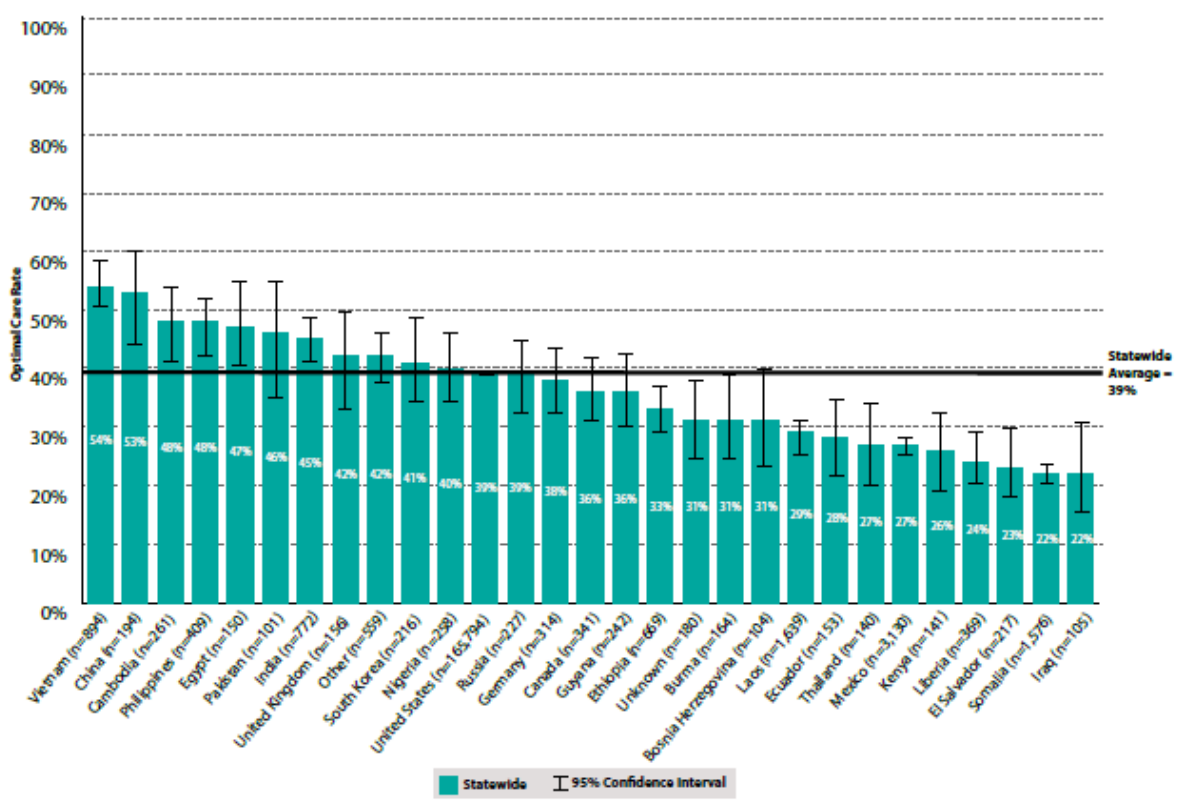
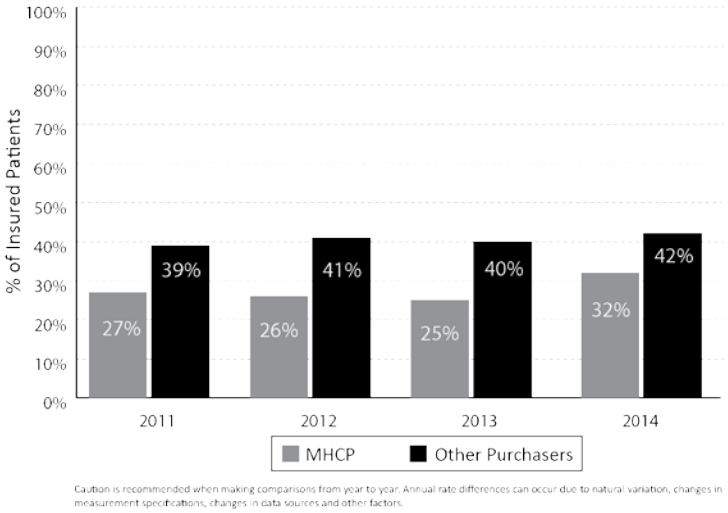


FIGURE 3: STATEWIDE RATES FOR OPTIMAL DIABETES CARE BY **PREFERRED LANGUAGE**





MHCP patients have a significantly lower rate of Optimal Diabetes Care than patients enrolled with Other Purchasers ($p<0.05$). The MHCP statewide rate for Optimal Diabetes Care is 32 percent; the rate for Other Purchasers is 42 percent.



Rating

	H	M	L	I	N/A
Performance gap	☐	☐	☐	☐	☐

Reliability and validity

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

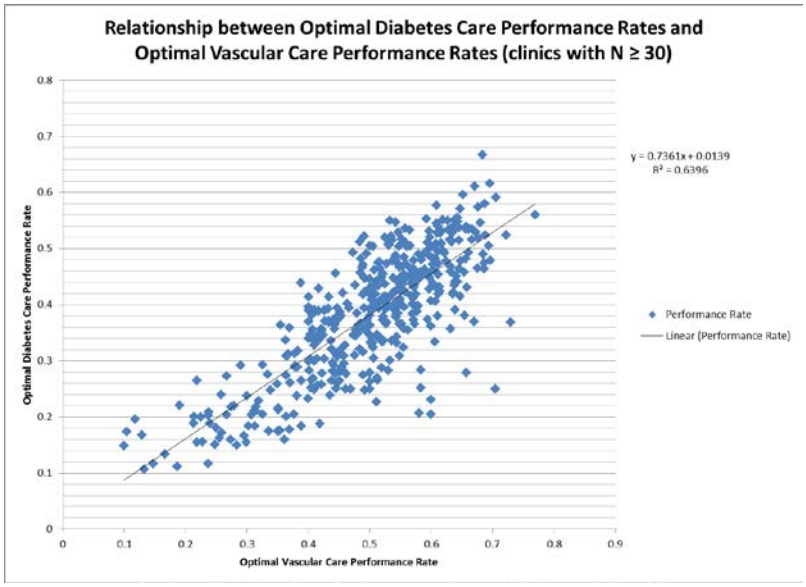
Validity *testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.*

Findings:

In 2014, for the diabetes measure, MNCM audited 128 medical groups; 76% of those submitting data. 85% passed the initial audit, 15% required a correction plan and all re-submitted their data and passed the audit with > 90% accuracy. The error rate with performance score impact was 0.3%; however, this did not result in any medical group level score errors.

Validity was tested for the computed composite score by testing the correlation of medical group performance with their performance on the Optimal Vascular Care measure (NQF#0076). Ischemic vascular disease and diabetes are chronic conditions that require ongoing management of multiple risk factors in order to reduce a patient's overall risk of developing long term complications. It is expected that the quality of care provided by a medical group to patient with diabetes would be of similar quality as the care provided to patients with ischemic vascular disease, and the respective performance measure scores should demonstrate such.

Based on linear regression analysis, a medical group's performance on the Optimal Diabetes Care measure is associated with its performance on the Optimal Vascular Care measure, as demonstrated by an r^2 value of 64%, representing a fairly strong correlation.



Rating

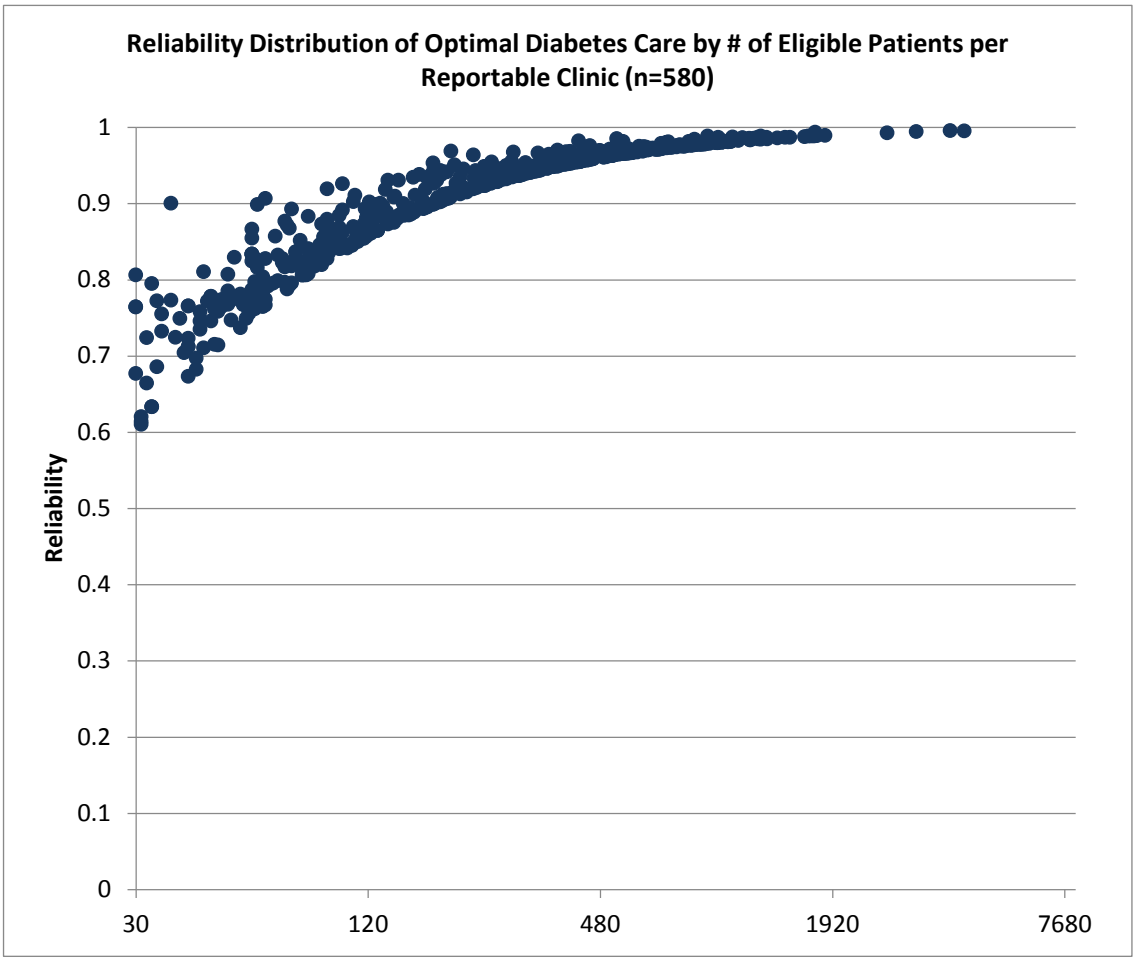
	H	M	L	I	N/A
Validity	☐	☒	☐	☐	☐

Reliability *testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or the measure score is precise*[vii].

Method and Findings:

Beta-binomial model: A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

Average clinic level reliability: 0.908 (n=580 clinics with 229,806 observations)



Rating

	H	M	L	I	N/A
Reliability	☒	☐	☐	☐	☐

Feasibility and burden

Extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

General Findings (applicable to all DDS measures):

The data used in the measure are generated by and used by healthcare personnel during the provision of care and/or coded by someone other than the person obtaining the original information (ICD-9, claims data, etc.). All data elements may be stored in structured fields in an EHR. The direct data submission is modeled to minimize inaccuracies, errors and unintended consequences. The detailed specifications include instructions on how to report most situations and guidance for EHR extraction. The data collection time frames and submission deadlines are staggered as to reduce burden on the medical groups in terms of abstraction/extraction at any one time.

MNCM conducts an annual medical group survey targeted to registered medical groups' administrators, quality improvement personnel, data analysts and medical directors. In 2014, when asked about submitting data, 56% rated the process as "very easy" or "easy" as compared to 47% the year prior.

This year's survey yielded a significant decrease in the number of comments regarding burden and feasibility. Those received were concerned with alignment of MNCM measurement activity with national reporting requirements.

Measure Specific Findings:

As part of data submission for this measure, clinics indicate the methodology for collecting data. 2014 results:

- 18 clinics had an EMR and looked up all data manually
- 322 clinics had an EMR and pulled all data via query
- 215 clinics had an EMR and used a combination of query and manual look up for data collection
- 17 clinics had a hybrid EMR and paper record system
- 8 clinics had paper records only

Rating

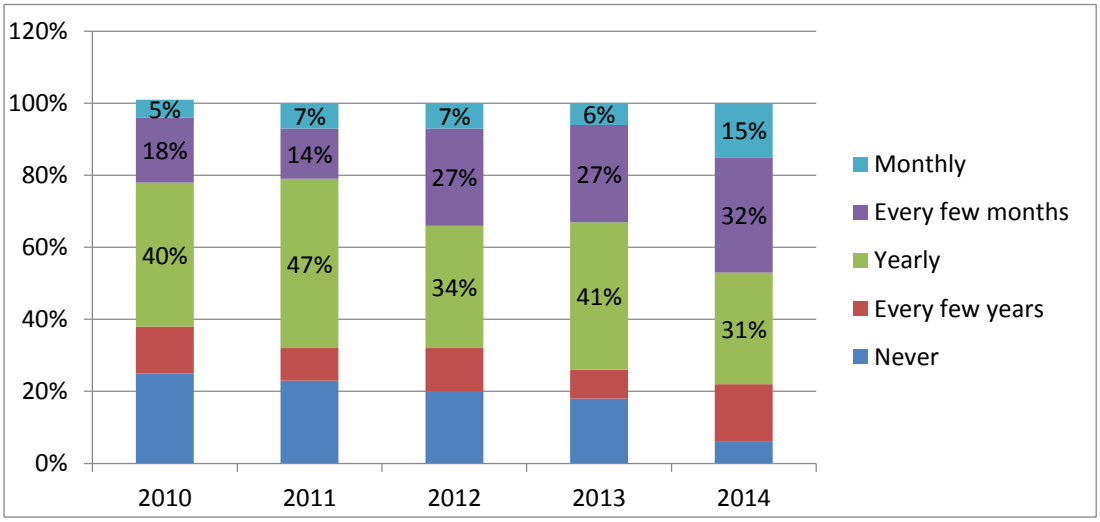
	H	M	L	I	N/A
Feasibility and burden	☒	☐	☐	☐	☐

Use and usability

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers, payers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

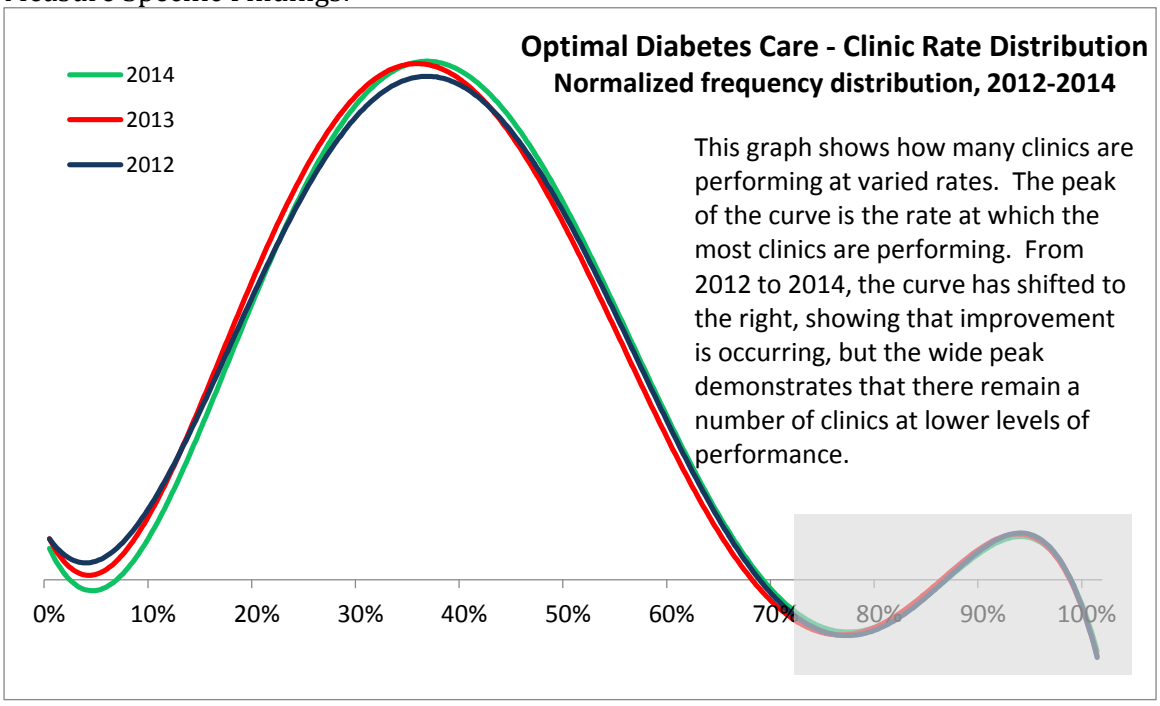
General Findings (applicable to all DDS measures):

Medical Group Survey findings regarding use of measure results for specific practice-based improvement.



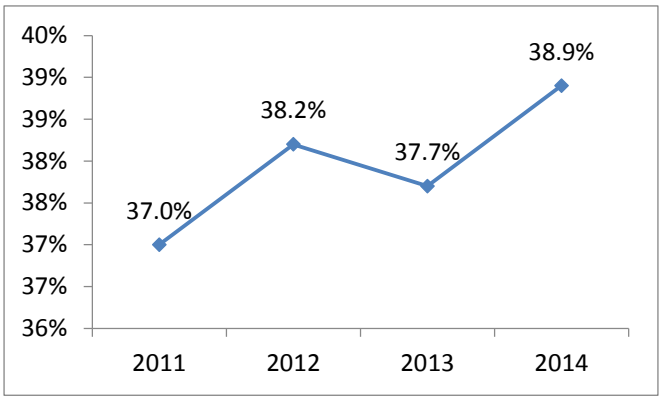
Ninety-nine percent (99%) of respondents to the annual medical group survey indicated using MNCM measures for QI initiatives; 43% for P4P programs; and 36% for contracting with health plans.

Measure Specific Findings:



Increased medical group participation and higher performance may indicate progress toward improving care.

Report Year	Statewide Average	Numerator	Denominator
2014	38.9%	90,499	230,818
2013	37.7%	80,190	208,809
2012	38.2%	73,037	184,234
2011	37.0%	61,930	158,770



This measure is currently included in MDH's Statewide Quality Reporting and Measurement System.
This measure is included in the MN Bridges to Excellence.
This measure is endorsed by NQF.
This measure is included in CMS' Medicare Shared Savings Program.

Rating

	H	M	L	I	N/A
Use and usability	☐	☒	☐	☐	☐

Harmonization

Extent to which the measure is aligned with other measures addressing the same or similar concepts or the same or similar target population and to which differences in specifications are justified.

Findings:

There are some related and potentially competing measures; however many related measures are currently in re-design mode based on ACC/AHA (cholesterol management) and JNC8 (blood pressure) guideline changes. Currently, there are three individual NCQA measures that make up their Comprehensive Diabetes Care composite: Blood Pressure Control (<140/90 mm Hg), LDL-C Control <100 mg/dL and Hemoglobin A1c (HbA1c) Control (<8.0%).

NCQA's composite is a different measure construct; it is calculated at the physician panel level (what percentage of my patients have an A1c < 8.0, what percentage had BP < 140/90) but is not a patient level composite. MNCM believes that its patient level all-or-none composite is superior, patient-centric (not provider centric) and individual patients achieving as many health targets as possible only increases their likelihood of reducing long term microvascular and macrovascular complication of diabetes.

These three measure's numerators are harmonized, at least currently, knowing that MNCM's cholesterol component has been redesigned to reflect updated evidence and guidelines that no longer treat to LDL target rather focus on appropriate statin use.

We have philosophical differences in the denominator definitions and this is due in part to the data source. NCQA uses claims data to identify diabetic patients, MNCM used EMR based data. NCQA's methodology looks for diabetes diagnosis codes but additionally will include patients on oral medications and insulin who do not have the diagnosis. Patients with polycystic ovary syndrome are sometimes treated with metformin, so NCQA excludes women with polycystic ovary syndrome; but there has been or more recent addition to try to pull PCOS patients with the diagnosis of diabetes back into the denominator. This is good because it is estimated that 40 to 50% of women with PCOS will develop diabetes. We also believe that is important to exclude diabetic women who are currently pregnant during the measurement year, related to cholesterol management. NCQA's denominator does not exclude these patients.

We have had discussions with NCQA about harmonization of denominator definitions and believe that definitions in ICD-10, based on the improvement in coding types of diabetes in ICD-10 will bring us closer to harmonized denominators.

Rating

	H	M	L	I	N/A
Harmonization	☐	☐	☐	☐	☐

[i] ICSI Diabetes Mellitus in Adults, Type 2; Diagnosis and Management of. July 2014, p. 20

[ii] Ibid ii, p. 32

[iii] MDH Diabetes in Minnesota Fact Sheet 2013 www.health.state.mn.us/diabetes/pdf/DiabetesinMinnesota-2013-final-0317.pdf

[iv] CDC US Diabetes Infographic http://www.health.state.mn.us/diabetes/pdf/CDC-2014-diabetes-infographic.pdf

[v] Ibid ii, p. 20

[vi] MN Community Measurement. 2014 Health Equity of Care Report. 2015. http://mncm.org/reports-and-websites/reports-and-data/

[vii] Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.
Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

Optimal Vascular Care

Measure Review Summary

Measure description

The percentage of adult patients with ischemic vascular disease who have optimally managed modifiable risk factors (blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use) with the intent of preventing or reducing future complications associated with poorly managed ischemic vascular disease. This is a patient level all-or-none composite measures in which all four components need to be met in order to be numerator compliant. The four components are:

1. Blood Pressure less than 140/90 (systolic value of less than 140 AND diastolic value of less than 90)
2. On a statin medication unless contraindication or valid exception
3. Non-tobacco user
4. On daily aspirin or anti-platelets unless contraindication or valid exception

(Note: This measure has changed significantly from the previous year with the redesign of the cholesterol component based on significant changes in evidence and guidelines. The information included in this report regarding historical measure performance is based on prior years' measure specifications in which the cholesterol component was LDL < 100.)

Criterion rating definition

H = High confidence that the criterion is met
M = Moderate confidence that the criterion is met
L = Low confidence that the criterion is met
I = Insufficient information to evaluate whether the criterion is met
NA = Not applicable

Criterion Rating Summary

	H	M	L	I	N/A
Evidence to support the measure focus	☐	☐	☐	☐	☐
High priority aspect of healthcare	☐	☐	☐	☐	☐
Performance gap	☐	☐	☐	☐	☐
Reliability and validity	☐	☐	☐	☐	☐
Feasibility and burden	☐	☐	☐	☐	☐
Use and usability	☐	☐	☐	☐	☐
Harmonization	☐	☐	☐	☐	☐

Review committee recommendation

☐ Continue without changes or with minor updates
☐ Higher level review warranted
☐ Transition to monitoring (collect without public reporting)
☐ Retire

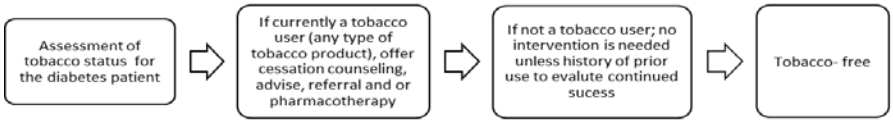
Evidence

The measure focus is consistent with evidence-based standards of care and guidelines as appropriate for the measure type; i.e. health outcome, intermediate clinical outcome, process.

Findings: (Composite patient level all-or-none)

All components are supported by various guidelines including the Institute for Clinical Systems Improvement guidelines (Coronary Artery Disease May 2013, Hypertension, and Lipid Management Nov 2013), and the most recent American College of Cardiology/ American Heart Association (ACC/AHA) Cholesterol Management guidelines released in Nov 2013. A diabetes ad-hoc measure development work group was requested by MARC in September 2013 to evaluate the cholesterol component of LDL < 100 and consider re-design to "LDL < 100 or on a statin" for patients with diabetes. In November of 2013 with the publication of paradigm sifting guidelines by the ACC/AHA, the scope of the redesign changed, 2 more cardiologists were added to the group and the cholesterol component of the vascular measure was included as it is no longer evidence based to treat to any LDL target. New cholesterol component for 2015 dates of service/ 2016 reporting focuses on appropriate statin use.

1. Blood Pressure less than 140/90; intermediate clinical outcome
   The recommended target blood pressure is 140/90 mmHg or less. Based on current evidence, pursuing blood pressure goals lower than < 140/90 should be considered on an individual patient basis based on clinical judgment and patient preference (ACCORD Study Group, 2010 [High Quality Evidence], Cooper-DeHoff, 2010 [Meta-analysis]). Refer to the ICSI Hypertension Diagnosis and Treatment guideline for recommendations regarding blood pressure management.[i]
   The ICSI Hypertension guideline work group endorsed the 2014 Evidence Based Guideline for the Management of High Blood Pressure in Adults Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8).[ii]
   Diabetes and atherosclerotic cardiovascular disease (ASCVD) patients no longer have a lower BP goal than the general population. The BP goal for these populations has been raised to < 140/90.[iii]
   MNCM staff note: JNC8, which is a guideline for the management of hypertension in <u>all</u> patients, does not specifically call out or designate a specific target for patients with atherosclerotic cardiovascular disease, a very high risk population in which blood pressure management significantly reduces risk of additional cardiovascular events. JNC8 <u>does</u> specify specific targets for other high risk conditions such as diabetes and chronic kidney disease with a blood pressure target of < 140/90 regardless of age. Reasonable, clinically and from a measurement perspective, to keep the component target at < 140/90.
2. On a statin medication unless contraindication or valid exception; medication use/ process
   Recommendation: High-intensity statin therapy should be initiated or continued as first-line therapy in women and men < 75 years of age who have clinical ASCVD, unless contraindicated.[iv]
   Quality of Evidence: GRADE A **Strength of Recommendation:** Strong
3. Non-tobacco user; health outcome



According to the Centers for Disease Control, cigarette smoking is the most important preventable cause of premature death in the United States. Cigarette smoking is the leading cause of preventable death in the United States, accounting for more than 480,000 deaths, or one of five deaths, each year.

4. On daily aspirin or anti-platelets unless contraindication or valid exception; medication use/ process
   The use of one aspirin tablet daily (81 mg) is strongly recommended unless there are medical contraindications. *(Kurth, 2003 [High Quality Evidence]; CAPRI, 1996 [High Quality Evidence]; Antiplatelet Trialists' Collaboration, 1994 [High Quality Evidence]; Fuster, 1993 [Low Quality Evidence]; Juul-Möller, 1992 [High Quality Evidence]; Ridker, 1991 [High Quality Evidence])*.[v]

Rating

	H	M	L	I	N/A
Evidence to support the measure focus	☒	☐	☐	☐	☐

High priority aspect of healthcare

The measure addresses a demonstrated high-priority (high impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use; severity of illness; and severity of patient/societal consequences of poor quality.

Findings:

According to the Minnesota Department of Health, vascular disease is a high impact clinical condition in Minnesota. More than 20% of all deaths in Minnesota are due to heart disease and more than 7% are due to stroke, making them the second and third leading causes of death, respectively, in the state behind cancer. Inpatient hospitalization charges alone in Minnesota were $1.7 billion for heart disease patients and $318 million for stroke patients in 2007. According to the American Heart Association, nearly 84 million Americans have cardiovascular disease. In every year since 1900 (except the 1918 influenza pandemic), cardiovascular disease accounted for more deaths than any other major cause of death in the United States. In 2006, cardiovascular disease claimed one of every 2.9 deaths in the United States.

Achieving the intermediate physiological outcome targets related to blood pressure and being tobacco free and use of daily aspirin and statins where appropriate are the ischemic vascular disease patient's best mechanisms of avoiding or postponing long term complications associated with this chronic condition which affects millions of Americans. Measuring providers separately on individual targets is not as patient centric as a measure that seeks to reduce multiple risk factors for each patient. Diabetic patients are more likely to reduce their overall risk and maximize health outcomes by achieving several intermediate physiological targets.

Rating	H	M	L	I	N/A
High priority aspect of healthcare	☒	☐	☐	☐	☐

Performance gap

The data demonstrates that there exists considerable variation, or overall less-than-optimal performance, in the quality of care across providers and/or disparities in care across population groups.

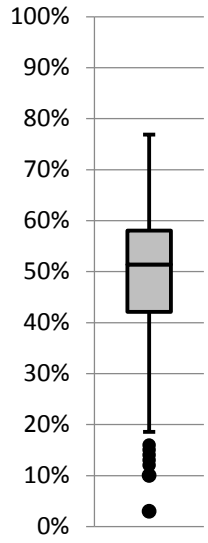
Findings:

Performance variation 2014: (480 reporting clinics)

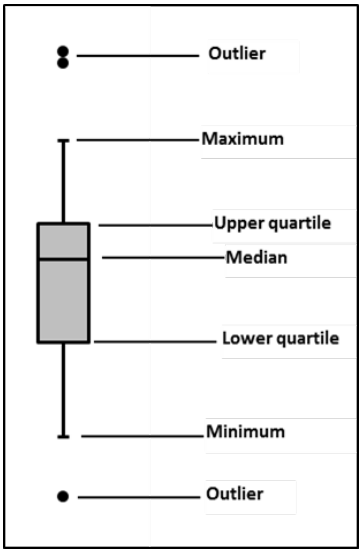
Percentiles:
10th : 31.3%
25th : 42.1%
50th : 51.4%
75th : 58.1%
90th : 63.9%

Range: 3.3% - 76.9%

Mean: 49.4%



BOX PLOT KEY:



Disparities across population groups:

Different racial, country of origin, and primary language population groups have significantly different Optimal Diabetes Care Rates.[vi]

FIGURE 5: STATEWIDE RATES FOR OPTIMAL VASCULAR CARE BY **RACE**

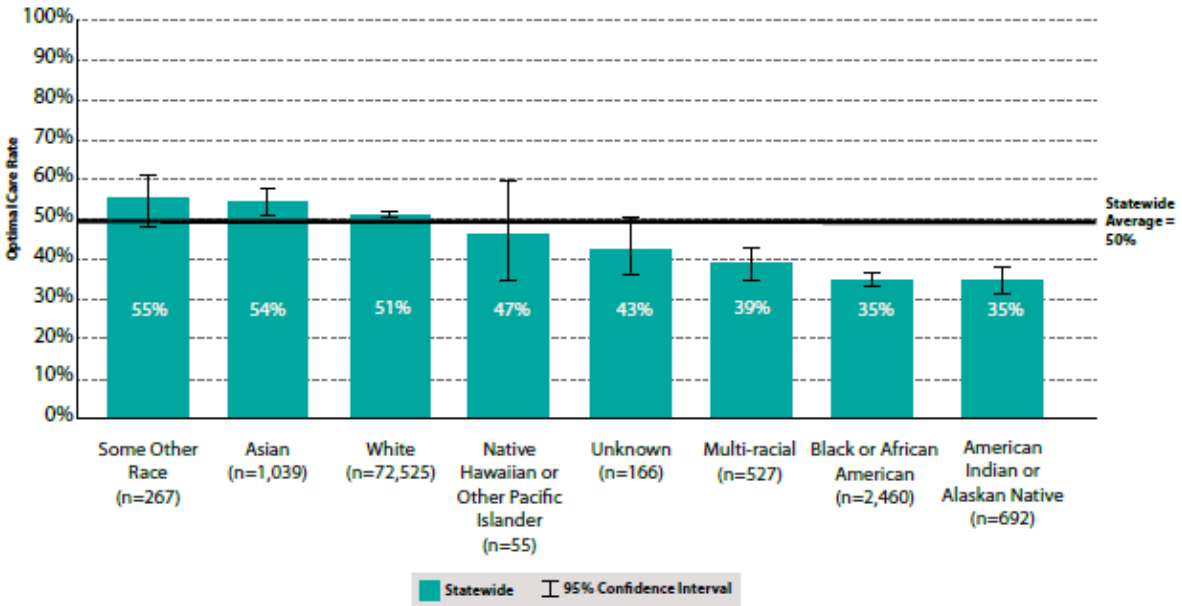


FIGURE 7: STATEWIDE RATES FOR OPTIMAL VASCULAR CARE BY **PREFERRED LANGUAGE**

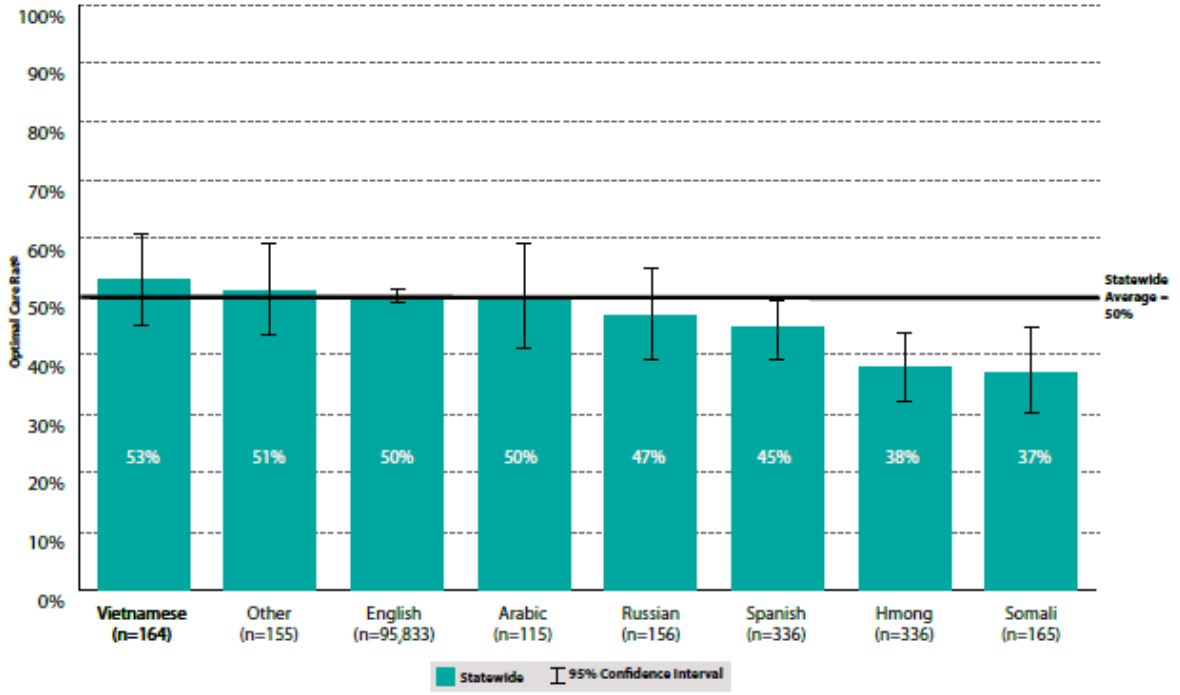
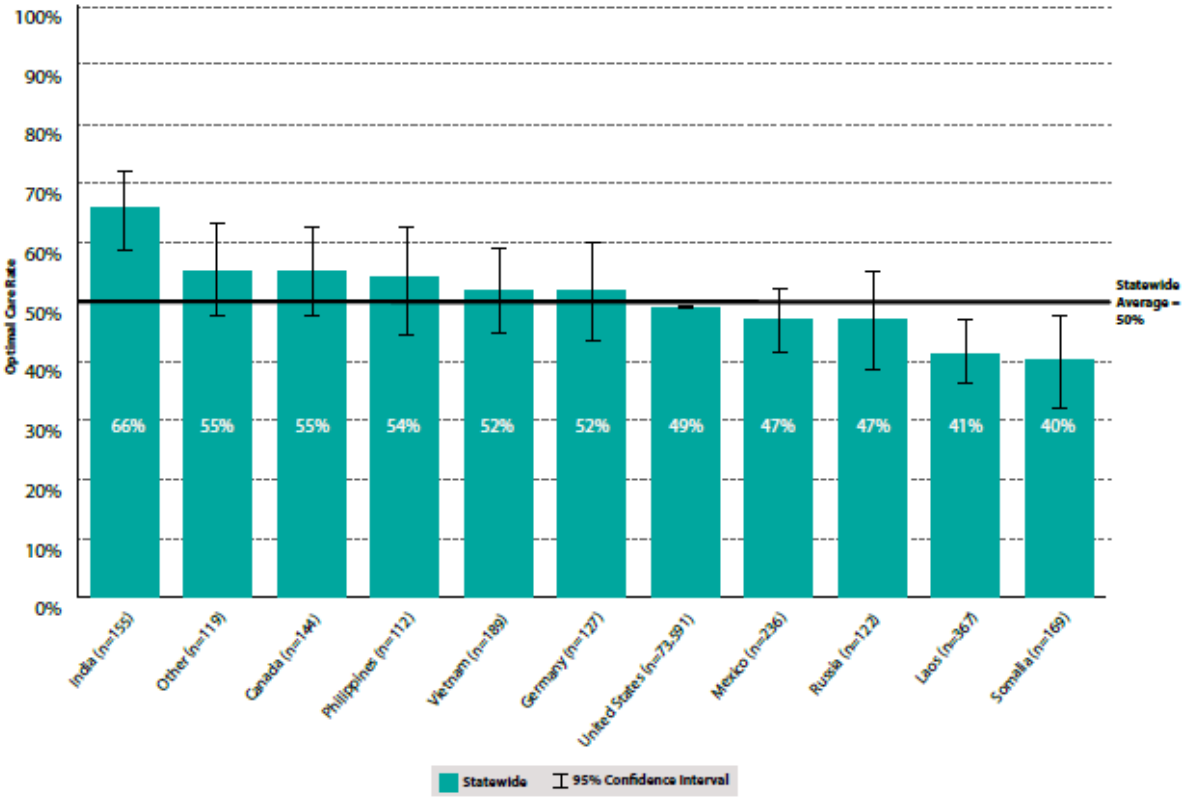


FIGURE 8: STATEWIDE RATES FOR OPTIMAL VASCULAR CARE BY **COUNTRY OF ORIGIN**



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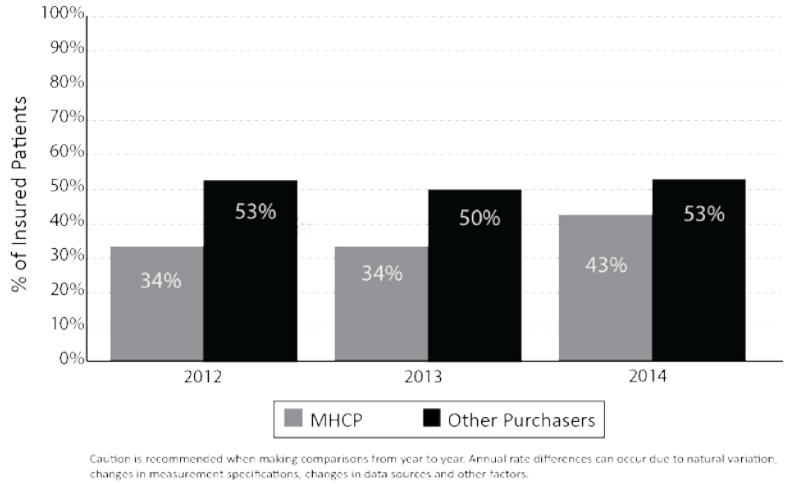


Rating

	H	M	L	I	N/A
Performance gap	☐	☐	☐	☐	☐

Reliability and validity

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

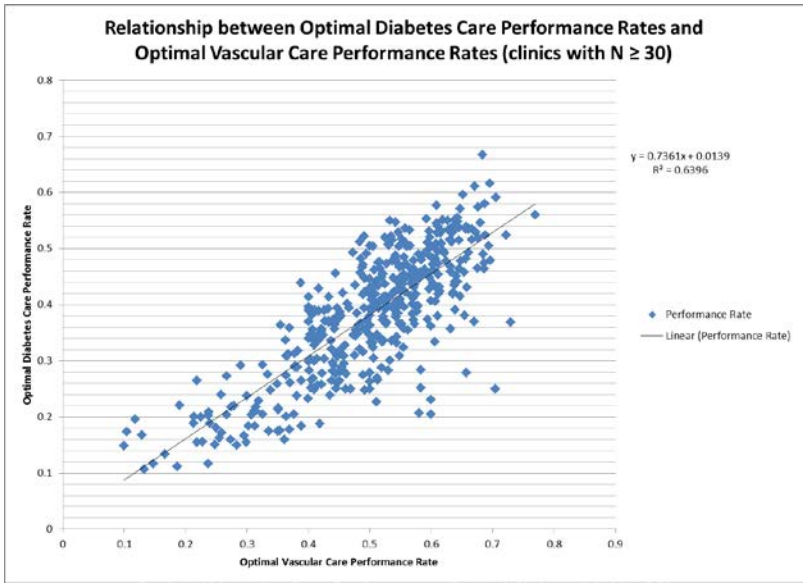
Validity *testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.*

Findings:

In 2014, for the vascular measure, MNCM audited 125 medical groups; 77% of those submitting data. 92% passed the initial audit, 8% required a correction plan and all re-submitted their data and passed the audit with > 90% accuracy.

Validity was tested for the computed composite score by testing the correlation of medical group performance with their performance on the Optimal Diabetes Care measure (NQF#0729). Ischemic vascular disease and diabetes are chronic conditions that require ongoing management of multiple risk factors in order to reduce a patient's overall risk of developing long term complications. It is expected that the quality of care provided by a medical group to patient with diabetes would be of similar quality as the care provided to patients with diabetes, and the respective performance measure scores should demonstrate such.

Based on linear regression analysis, a medical group's performance on the Optimal Diabetes Care measure is associated with its performance on the Optimal Vascular Care measure, as demonstrated by an r^2 value of 64%, representing a fairly strong correlation.



Rating

	H	M	L	I	N/A
Validity	☐	☐	☐	☐	☐

Reliability *testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or the measure score is precise*[vii].

Method and Findings:

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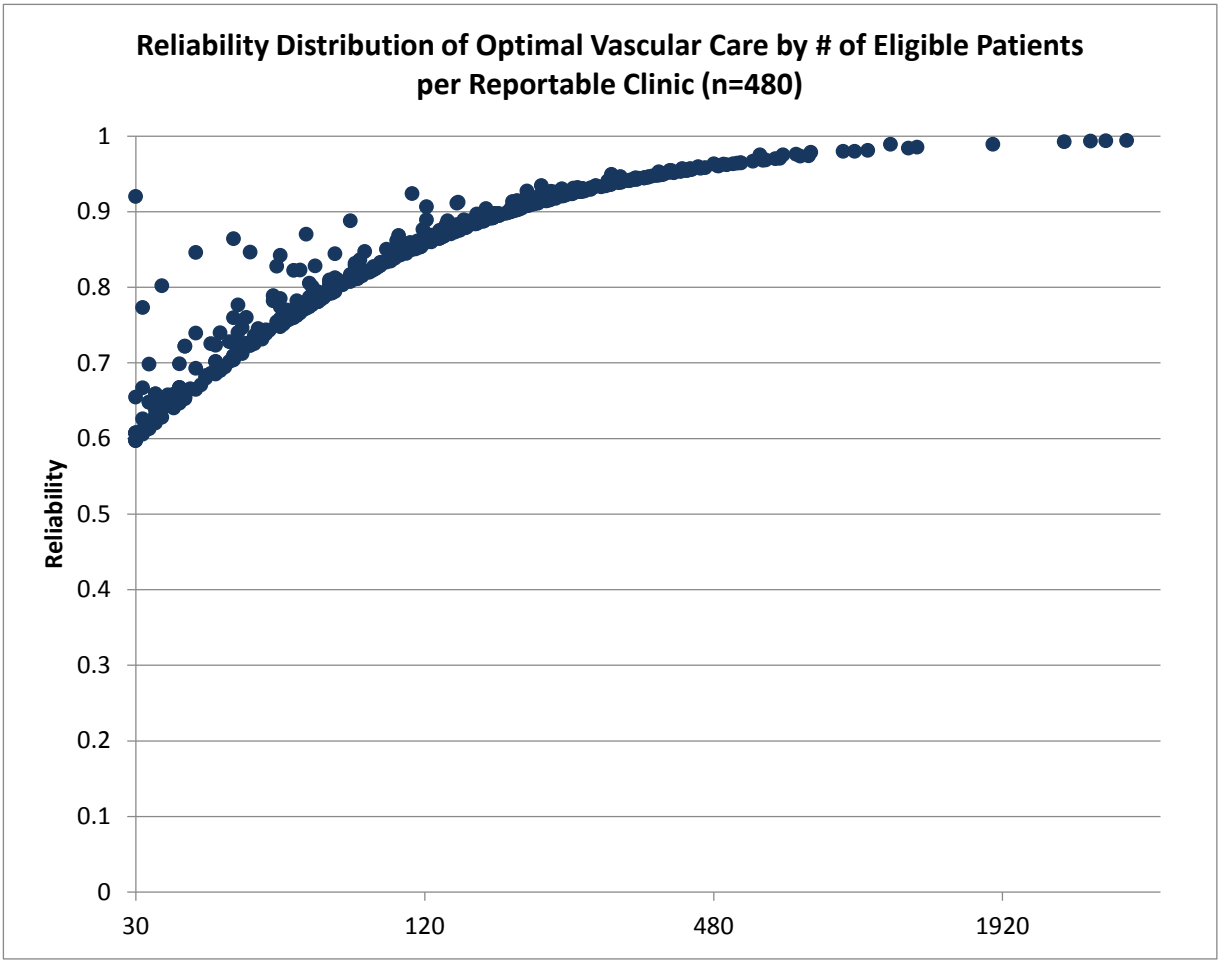
Average clinic level reliability: 0.840 (n=480 clinics with 96,734 observations)



Rating

	H	M	L	I	N/A
Reliability	☐	☐	☐	☐	☐

Feasibility and burden

Extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

General Findings (applicable to all DDS measures):

The data used in the measure are generated by and used by healthcare personnel during the provision of care and/or coded by someone other than the person obtaining the original information (ICD-9, claims data, etc.). All data elements may be stored in structured fields in an EHR. The direct data submission is modeled to minimize inaccuracies, errors and unintended consequences. The detailed specifications include instructions on how to report most situations and guidance for EHR extraction. The data collection time frames and submission deadlines are staggered as to reduce burden on the medical groups in terms of abstraction/extraction at any one time.

MNCM conducts an annual medical group survey targeted to registered medical groups' administrators, quality improvement personnel, data analysts and medical directors. In 2014, when asked about submitting data, 56% rated the process as "very easy" or "easy" as compared to 47% the year prior.

This year's survey yielded a significant decrease in the number of comments regarding burden and feasibility. Those received were concerned with alignment of MNCM measurement activity with national reporting requirements.

Measure Specific Findings:

As part of data submission for this measure, clinics indicate the methodology for collecting data. 2014 results:

- 13 clinics had an EMR and looked up all data manually
- 282 clinics had an EMR and pulled all data via query
- 168 clinics had an EMR and used a combination of query and manual look up for data collection
- 8 clinics had a hybrid EMR and paper record system
- 9 clinics had paper records only

Rating

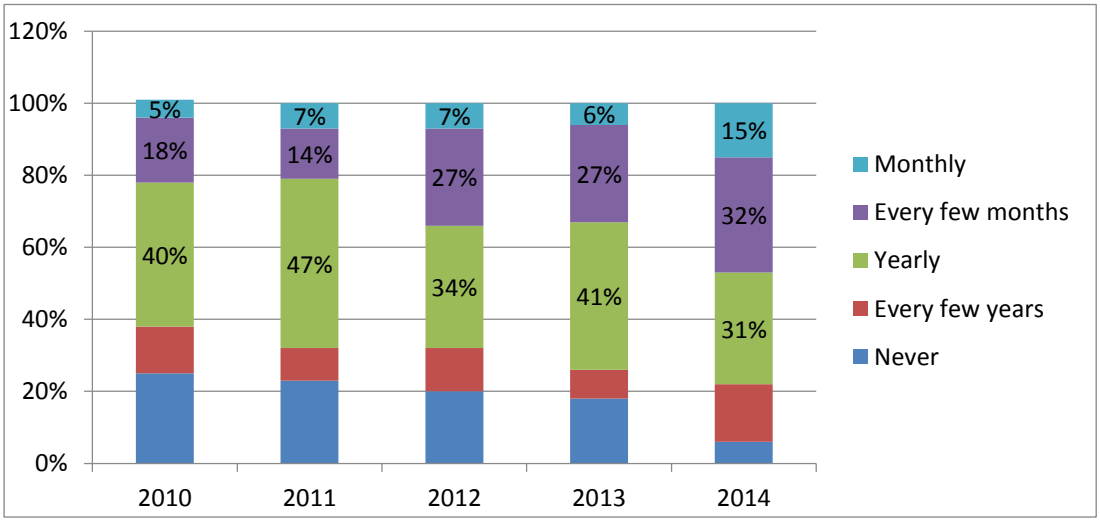
	H	M	L	I	N/A
Feasibility and burden	☐	☐	☐	☐	☐

Use and usability

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers, payers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

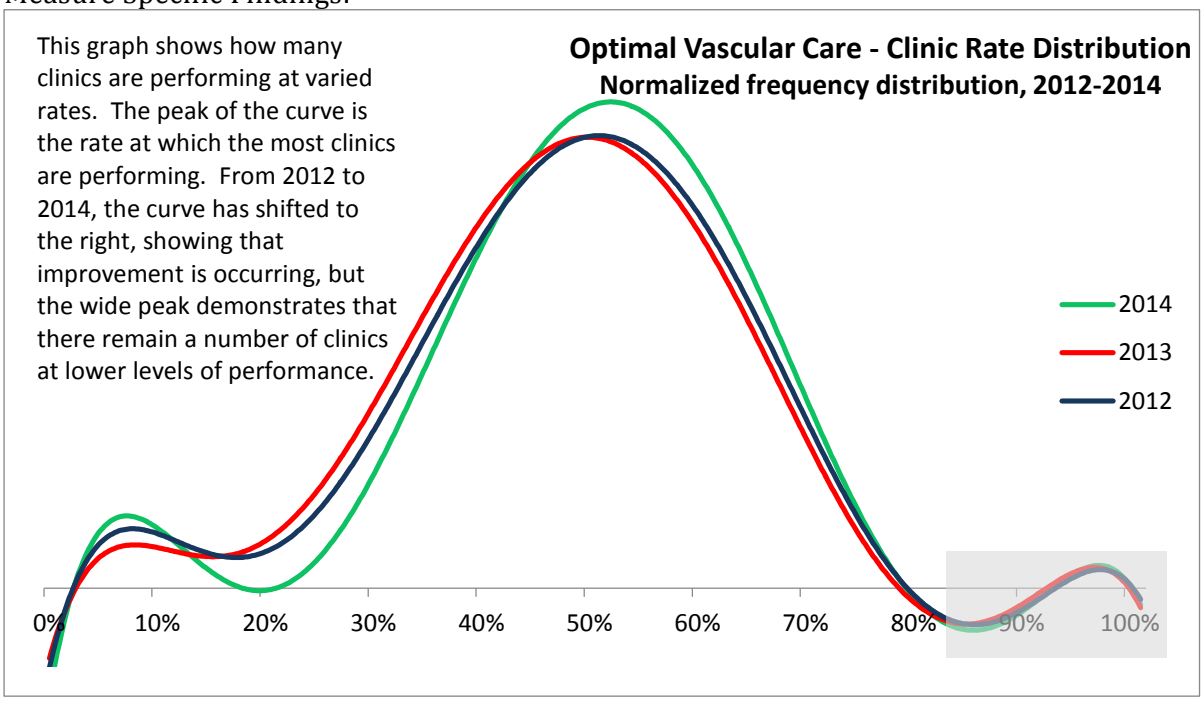
General Findings (applicable to all DDS measures):

Medical Group Survey findings regarding use of measure results for specific practice-based improvement.



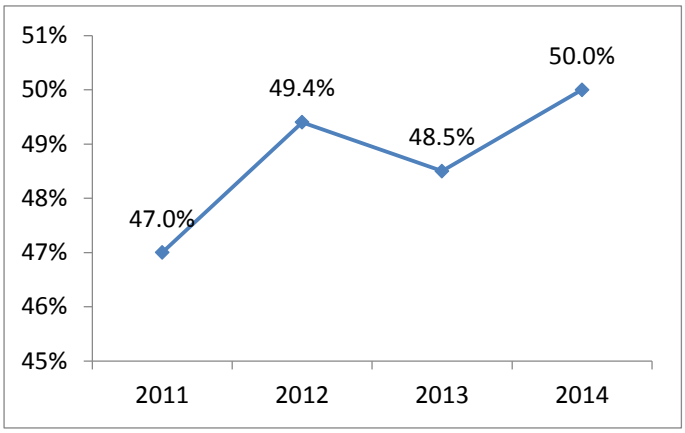
Ninety-nine percent (99%) of respondents to the annual medical group survey indicated using MNCM measures for QI initiatives; 43% for P4P programs; and 36% for contracting with health plans.

Measure Specific Findings:



Increased medical group participation and higher performance may indicate progress toward improving care.

Report Year	Statewide Average	Numerator	Denominator
2014	50.0%	49,408	98,803
2013	48.5%	42,689	87,345
2012	49.4%	39,242	78,886
2011	47.0%	27,083	66,910



This measure is currently included in MDH's Statewide Quality Reporting and Measurement System.
This measure is included in the MN Bridges to Excellence.
This measure is endorsed by NQF.
This measure is included in CMS' Physician Quality Reporting System.

Rating

	H	M	L	I	N/A
Use and usability	☐	☐	☐	☐	☐

Harmonization

Extent to which the measure is aligned with other measures addressing the same or similar concepts or the same or similar target population and to which differences in specifications are justified.

Findings:
Denominator was harmonized with NCQA's Cholesterol Management measure, however this measure is currently undergoing revision and not available for comparison this year. There is no competing composite measure for ischemic vascular disease patients.

Rating

	H	M	L	I	N/A
Harmonization	☐	☐	☐	☐	☐

[i] ICSI Stable Coronary Artery Disease guidelines fifteenth edition May 2013
[ii] ICSI Hypertension Endorsement of JNC8- Kenning I, Kerandi H, Luehr D, Margolis K, O'Connor P, Pereira C, Schlichte A, Woolley T. Institute for Clinical Systems Improvement. Hypertension Diagnosis and Treatment. Updated November 2014. www.icsi.org/_asset/24cmhc/HypertensionRecomTable.pdf
[iii] GroupHeath Hypertension and Treatment guideline www.ghc.org/all-sites/guidelines/hypertension.pdf
[iv] Ibid v, p. 22
[v] ICSI Stable Coronary Artery Disease guidelines fifteenth edition May 2013
[vi] MN Community Measurement. 2014 Health Equity of Care Report. 2015. http://mncm.org/reports-and-websites/reports-and-data/

[vii] Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.
Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

Depression Measurement Set

The following pages include sections of the measure review criteria that are applicable to all measures included in the Depression Measurement Set. The included criteria are:

- evidence base
- high-priority aspect of healthcare
- feasibility and burden
- harmonization

Performance gap, reliability and validity, and use and usability criteria are individulized per measure on addendum reports.

NOTE: In response to feedback received from the Measure Review Committee in 2014, technical improvements to this measure set were explored. As a result, effective with 2016 reporting, the criteria for index visits for all depression measures will be simplified to not include an indefinite look back period for the presence of a diagnosis of depression. Instead, all indexing (initial and subsequent) will have the same criteria for inclusion: an elevated PHQ-9 result with an accompanying diagnosis code for depression or dysthymia at the same contact.

Evidence

The measure focus is consistent with evidence-based standards of care and guidelines as appropriate for the measure type; i.e. health outcome, intermediate clinical outcome, process.[i]

Findings:

This is a patient reported health outcome measure that utilizes the validated and widely accepted Patient Health Questionnaire (PHQ-9).

The PHQ-9 demonstrates sound psychometric properties with a sensitivity of 0.88 and specificity of 0.88 for major depression with a score >9 with substantial heterogeneity I2 = 82%. It is validated for measuring depression severity,[ii] detecting and monitoring depression in the primary care setting,[iii] and found to be useful in psychiatric practices.[iv] Additionally, the PHQ-9 is in the public domain and available for clinical use, translated and validated into many languages, validated for telephonic administration, and easy for the patient to complete and the provider to score.

According to ICSI's Health Care Guideline, antidepressant medications and/or referral for psychotherapy are recommended as treatment for major depression. For medication treatment, patients may show improvement at two weeks but need a longer length of time to really see response (25-50% decrease in PHQ-9 score) and remission (PHQ-9 < 5). Most people treated for initial depression need to be on medication at least 6 – 12 months after adequate response to symptoms. For psychotherapy treatment, 8 – 10 weeks of regular and frequent therapy may be required to show improvement.[v]

Acute therapy is the treatment phase focused on treating the patient to remission. Acute therapy typically lasts 6 – 12 weeks but technically lasts until remission is reached. Full remission is defined as a two-month period devoid of major depressive signs and symptoms. Continuation therapy is the 4 – 9 month period beyond the acute treatment phase during which the patient is continuing therapy. Relapse is common within the first 6 months following remission from an acute depressive episode; as many as 20 – 85% of patients may relapse.[vi]

Rating

	H	M	L	I	N/A
Evidence to support the measure focus	☒	☐	☐	☐	☐

High priority aspect of healthcare

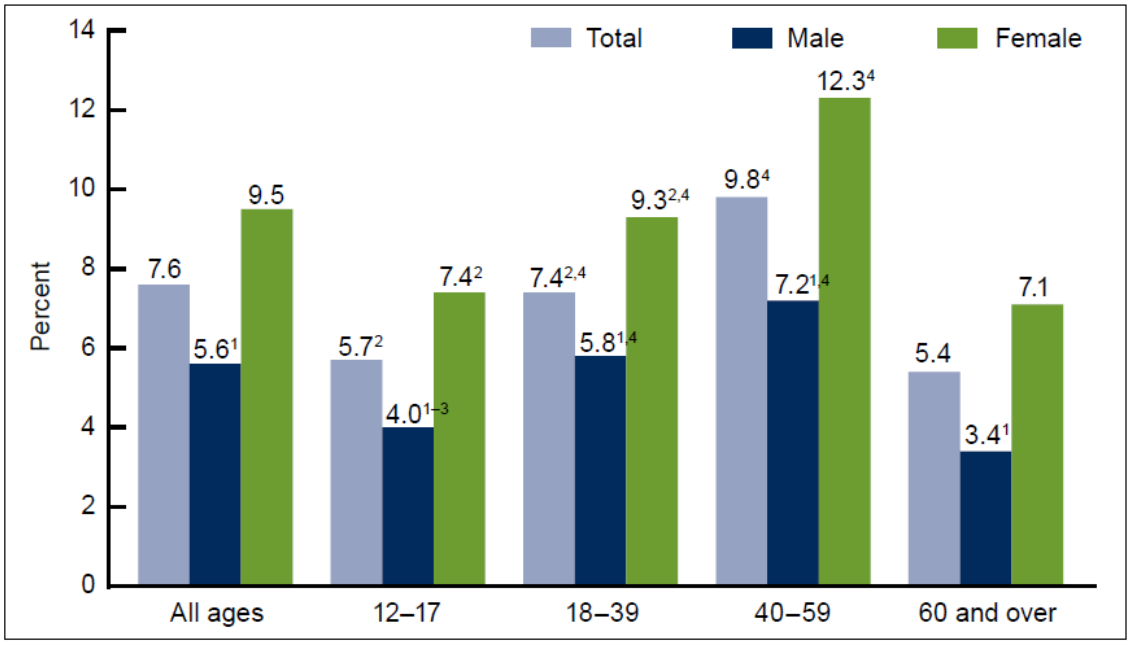
The measure addresses a demonstrated high-priority (high impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use; severity of illness; and severity of patient/societal consequences of poor quality.

Findings:

Depression is a common and treatable mental disorder. The Centers for Disease Control and Prevention states that during 2009-2012 an estimated 7.6% of the U.S. population aged 12 and over had depression, including 3% of Americans with sever depressive symptoms. Almost 43% of persons with severe depressive symptoms reported serious difficulties in work, home and social activities, yet only 35% reported having contact with a mental health professional in the past year.[vii]

In 2009–2012, 7.6% of Americans aged 12 and over had depression (moderate or severe depressive symptoms in the past 2 weeks).

Figure 1. Percentage of persons aged 12 and over with depression, by age and sex: United States, 2009–2012



[1]Males have significantly lower rates than females overall and in every age group.
[2]Significantly different from 40–59. [3]Significantly different from 18–39. [4]Significantly different from 60 and over.
NOTES: Depression is defined as having moderate to severe depressive symptoms. Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db172_table.pdf#1.
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2012.

Additionally, dysthymia accounts for an additional 3.3 million Americans. In 2006 and 2008, an estimated 9.1% of U.S. adults reported symptoms for current depression.[viii] Persons with a current diagnosis of depression and a lifetime diagnosis of depression or anxiety were significantly more likely than persons without these conditions to have cardiovascular disease, diabetes, asthma and obesity and to be a current smoker, to be physically inactive and to drink heavily.[ix]

Depression is associated with higher mortality rates in all age groups. People who are depressed are 30 times more likely to take their own lives than people who are not depressed and five times more likely to abuse drugs.[x] Depression is the leading cause of medical disability for people aged 14 – 44.[xi] Depressed people lose 5.6 hours of productive work every week when they are depressed, fifty percent of which is due to absenteeism and short-term disability.

People who suffer from depression have lower incomes, lower educational attainment and fewer days working days each year, leading to seven fewer weeks of work per year, a loss of 20% in potential income and a lifetime loss for each family who has a depressed family member of $300,000.[xii] The cost of depression (lost productivity and increased medical expense) in the United States is $83 billion each year.[xiii] The number of ambulatory care visits with major depressive disorder as the primary diagnosis was 8.0 million in 2010.

The 2006 and 2008 CDC study estimated that the prevalence of current depression among adults in Minnesota was 5.9%, and the percent of Minnesotans who have a lifetime diagnosis of depression is 13-15%. In 2011, the suicide rate for Minnesotans was 12.4 per 100,000 population, increased from 2010 and 2009 rates which were 11.2 and 10.8, respectively.[xiv]

Rating

	H	M	L	I	N/A
High priority aspect of healthcare	☒	☐	☐	☐	☐

Feasibility and burden

Extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

Findings:

The data used in the measure are generated by and used by healthcare personnel during the provision of care and/or coded by someone other than the person obtaining the original information (ICD-9, claims data, etc.). All data elements may be stored in structured fields in an EHR. The direct data submission is modeled to minimize inaccuracies, errors and unintended consequences. The detailed specifications include instructions on how to report most situations and guidance for EHR extraction. The data collection time frames and submission deadlines are staggered as to reduce burden on the medical groups in terms of abstraction/extraction at any one time.

MNCM conducts an annual medical group survey targeted to registered medical groups' administrators, quality improvement personnel, data analysts and medical directors. In 2014, when asked about submitting data, 56% rated the process as "very easy" or "easy" as compared to 47% the year prior.

This year's survey yielded a significant decrease in the number of comments regarding burden and feasibility. Those received were concerned with alignment of MNCM measurement activity with national reporting requirements.

Rating of the Depression Data Collection Guide as "very helpful" or "helpful" was 71%, in 2014, increased from 69% in 2013. Comments indicate a need for clarification in the guide regarding index visit date identification.

Rating

	H	M	L	I	N/A
Feasibility and burden	☒	☐	☐	☐	☐

Harmonization

Extent to which the measure is aligned with other measures addressing the same or similar concepts or the same or similar target population and to which differences in specifications are justified.

Findings:

This measure's specifications are completely harmonized with related measures, including:

- NQF# 0103: Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity
- NQF# 0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- MNCM's complementary depression set measures

There are no existing competing measures for the same measure focus and target population.

Rating

	H	M	L	I	N/A
Harmonization	☒	☐	☐	☐	☐

[ii] Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001;16:606-13.

[iii] Kroenke K, Spitzer RL, Williams JBW, Löwe B. The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *Gen Hosp Psychiatry* 2010;32:345-59. (Systematic Review)

[iv] Duffy FF, Chung H, Trivedi M, et al. Systematic use of patient-rated depression severity monitoring: is it helpful and feasible in clinical psychiatry? *Psychiatric Services* 2008;59:1148-54.

[v] Mitchell J, Trangle M, Degnan B, Gabert T, Haight B, Kessler D, Mack N, Mallen E, Novak H, Rossmiller D, Setterlund L, Somers K, Valentino N, Vincent S. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated September 2013.

[vi] American Psychiatric Association. *In* Practice Guideline for the Treatment of Patients with Panic Disorder. 2nd Edition, 2010.

[vii] Pratt LA, Brody DJ. Depression in the U.S. household population, 2009–2012. NCHS data brief, no 172. Hyattsville, MD: National Center for Health Statistics. 2014.

[viii] CDC. Current Depression Among Adults --- United States, 2006 and 2008. MMWR 2010;59(38);1229-1235.

[ix] Strine TW, Mokdad AH, Balluz LS, et al. Depression and anxiety in the United States: findings from the 2006 Behavioral Risk Factor Surveillance System. Psychiatr Serv 2008;59:1383--90.

[x] Joiner, Thomas Myths about suicide. Cambridge, MA, US: Harvard University Press. (2010). 288 pp.

[xi] Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. Journal of the American Medical Association, 289, 3135-3144.

[xii] Smith, J. P., & Smith, G. C. (2010). Long-term economic costs of psychological problems during childhood. Social Science & Medicine, 71, 110-115.

[xiii] Greenberg, P. E., Kessler, R. C., Birnbaum, H. G., Leong, S. A., Lowe, S. W., Berglund, P. A., et al. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? Journal of Clinical Psychiatry, 64, 1465-1475.

[xiv] Heinen M, Roesler J, Gaichas A, Kinde M. Suicide in Minnesota – 2011 Data Brief. Saint Paul, MN: Minnesota Department of Health, September 2013.

Depression Remission, 6m

Measure Review Summary

Measure description

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate remission six months after index with a PHQ-9 score less than 5.

Criterion rating definition

H = High confidence that the criterion is met
M = Moderate confidence that the criterion is met
L = Low confidence that the criterion is met
I = Insufficient information to evaluate whether the criterion is met
NA = Not applicable

Criterion Rating Summary

	H	M	L	I	N/A
Evidence to support the measure focus	☐	☐	☐	☐	☐
High priority aspect of healthcare	☐	☐	☐	☐	☐
Performance gap	☐	☐	☐	☐	☐
Reliability and validity	☐	☐	☐	☐	☐
Feasibility and burden	☐	☐	☐	☐	☐
Use and usability	☐	☐	☐	☐	☐
Harmonization	☐	☐	☐	☐	☐

Review committee recommendation

☐ Continue without changes or with minor updates
☐ Higher level review warranted
☐ Transition to monitoring (collect without public reporting)
☐ Retire

Review committee comments

Performance gap

The data demonstrates that there exists considerable variation, or overall less-than-optimal performance, in the quality of care across providers and/or disparities in care across population groups.

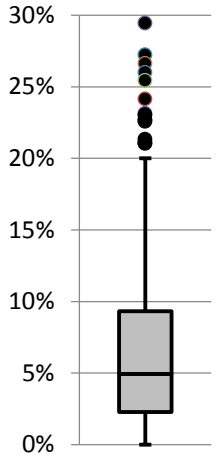
Findings:

Performance variation 2014: (441 reporting clinics)

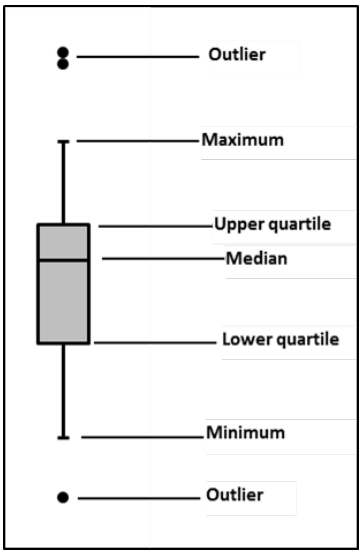
Percentiles:
10th : 0.0%
25th : 2.3%
50th : 4.9%
75th : 9.3%
90th : 15.5%

Range: 0.0% - 29.5%

Mean: 6.5%

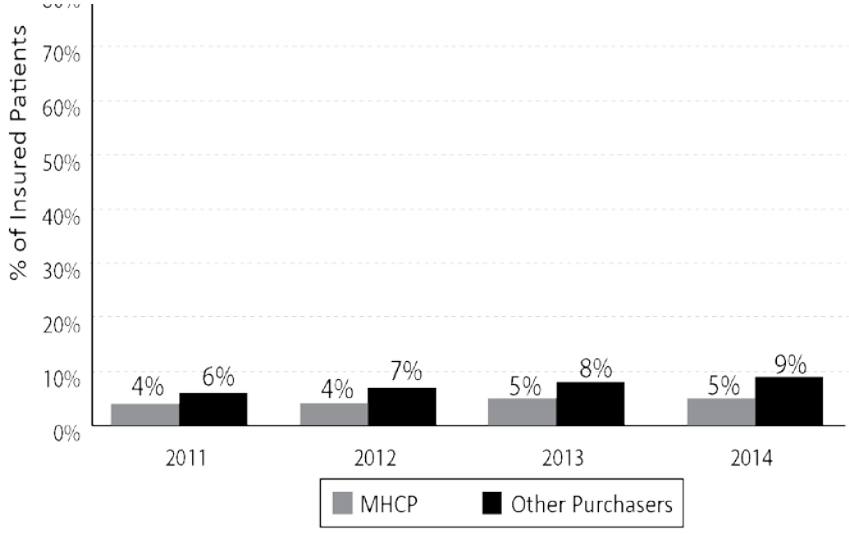


BOX PLOT KEY:



Disparities across population groups:

Data from 2011 – 2014 reporting demonstrates disparities in care between MHCP enrollees vs. those enrolled with other purchasers (p<0.05).



Rating

	H	M	L	I	N/A
Performance gap	☒	☐	☐	☐	☐

Reliability and validity

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Validity *testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.*

Findings:

MNCM conducts annual validation audits following NCQA's "8 and 30" process; samples of 30 charts for medical groups are randomly selected to undergo review for accuracy of data submission. Groups must pass at 90% for data to be included for reporting. Initial validation audit results in 2014 demonstrated a 77% pass rate for the depression measure set, after which corrections were made and a second round of validation was conducted with the medical groups that failed to confirm accurate data submission. All but one medical group required to resubmit did so and passed subsequent audit. The outstanding medical group did not resubmit data and its data was not used in measure calculations, reporting or analysis.

Construct validity of the PHQ-9 has been established with a score >9 having a sensitivity of 0.88 and a specificity of 0.88 for major depression. Additionally, a score <5 almost always signifies the absence of a depressive disorder, with a positive likelihood ration of 0.04. Also, ROC analysis showed that the area under the curve for the PHQ-9 in diagnosing major depression was 0.95, suggesting a test that discriminates well between persons with and without major depression.

Rating

	H	M	L	I	N/A
Validity	☒	☐	☐	☐	☐

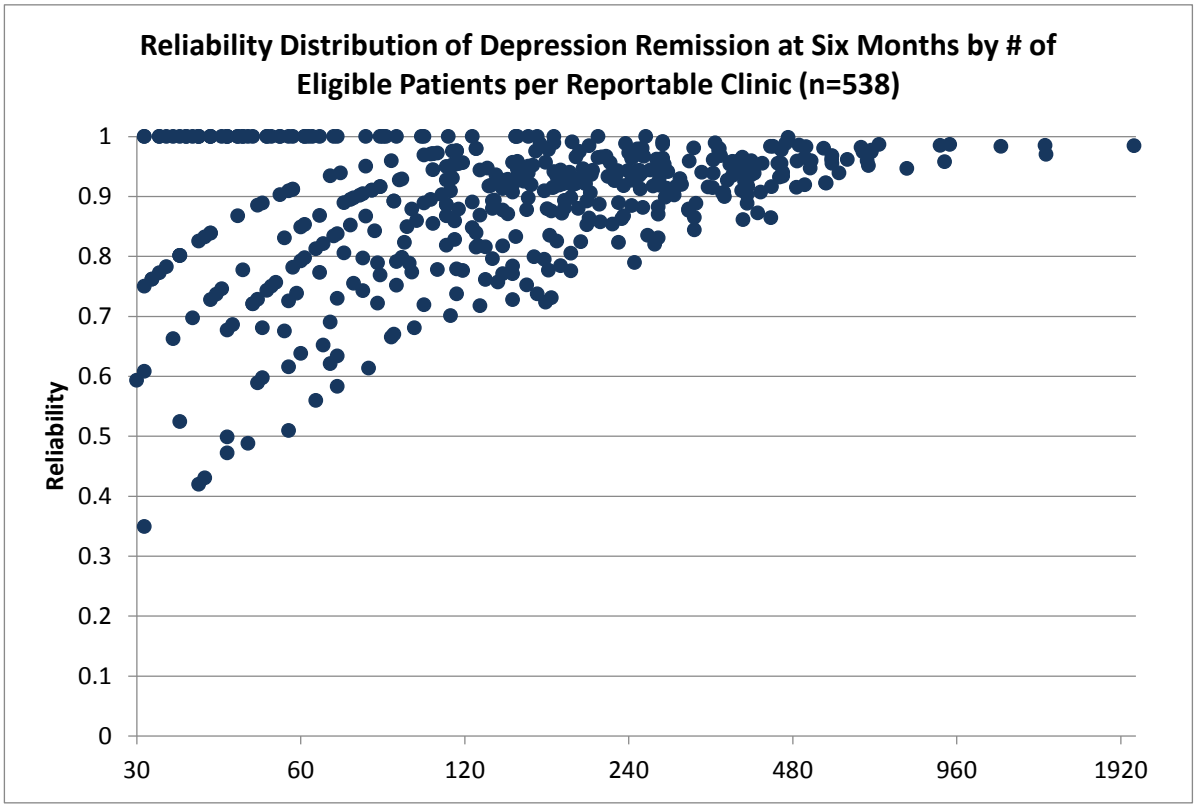
<u>Reliability</u> *testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or the measure score is precise*[i].

Method and Findings:

The internal reliability of the PHQ-9 is excellent, at 0.89 in the PHQ Primary Care Study and 0.86 in the PHQ Ob-Gyn Study.[ii]

Beta-binomial model: A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

Average clinic level reliability: 0.886 (n=441 clinics with 88,237 observations)



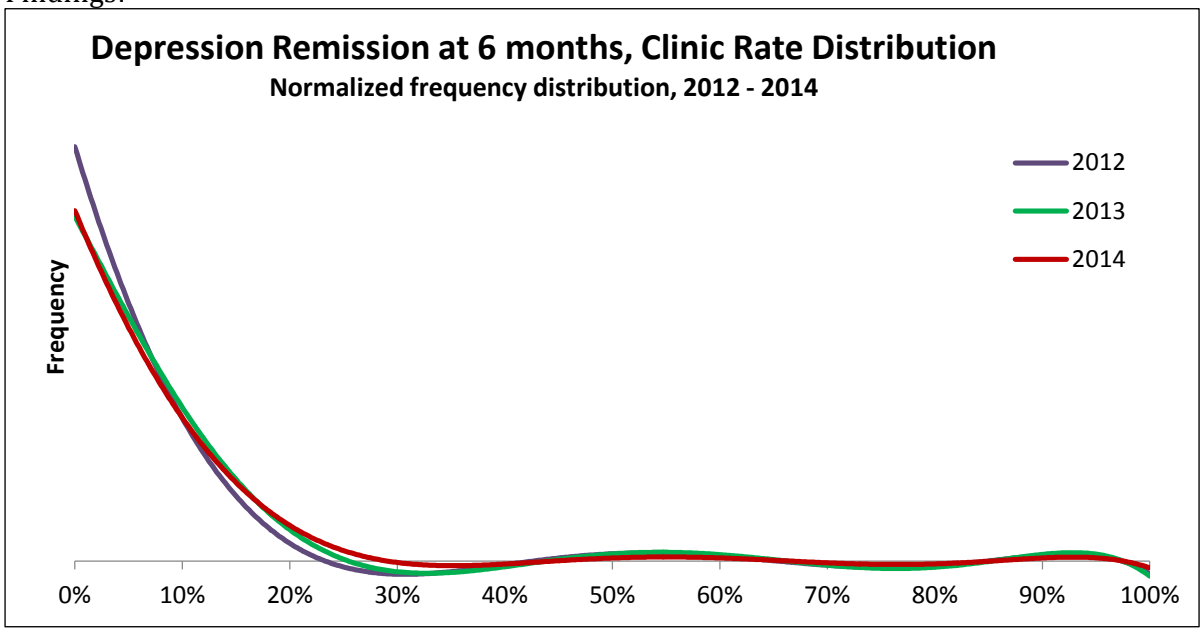
Rating

	H	M	L	I	N/A
Reliability	☒	☐	☐	☐	☐

Use and usability

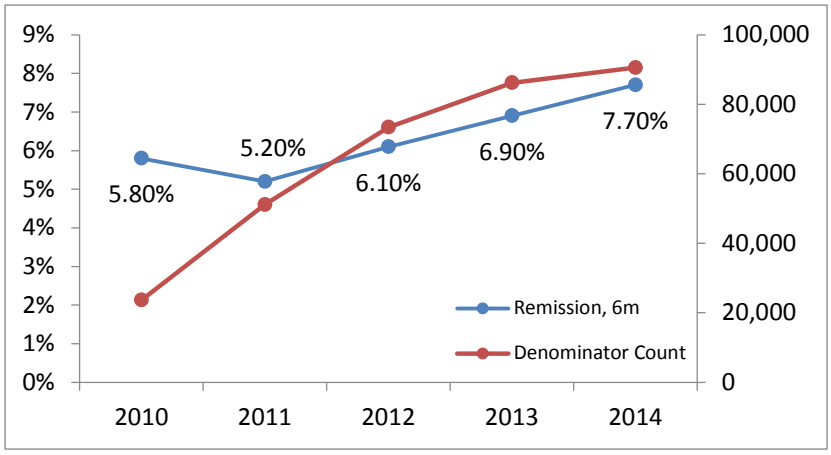
Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers, payers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

Findings:



This graph shows how many clinics are performing at varied rates. The peak of the curve is the rate at which the most clinics are performing (far left). Each year from 2012 to 2014, the curve has shifted to the right and flattened, showing that improvement is occurring.

Increased medical group participation and higher performance may indicate progress toward improving care.



This measure is currently included in MDH's Statewide Quality Reporting and Measurement System.

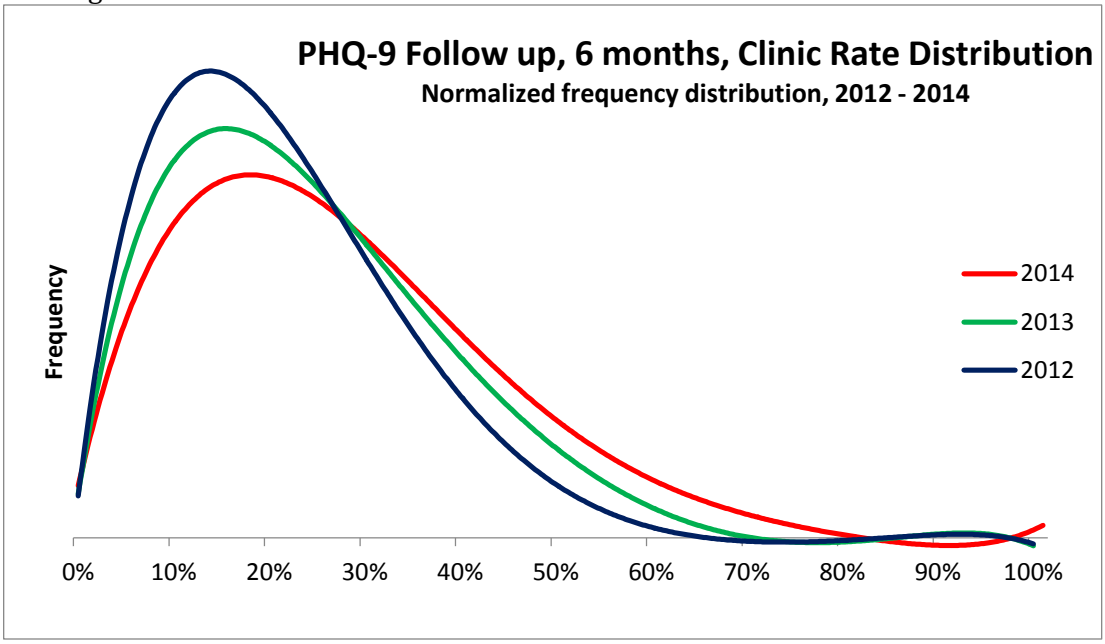
This measure is endorsed by the National Quality Forum.

This measure is included in MN QIPS and Bridges to Excellence programs.

Use and usability (paired process measure)

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers, payers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

Findings:



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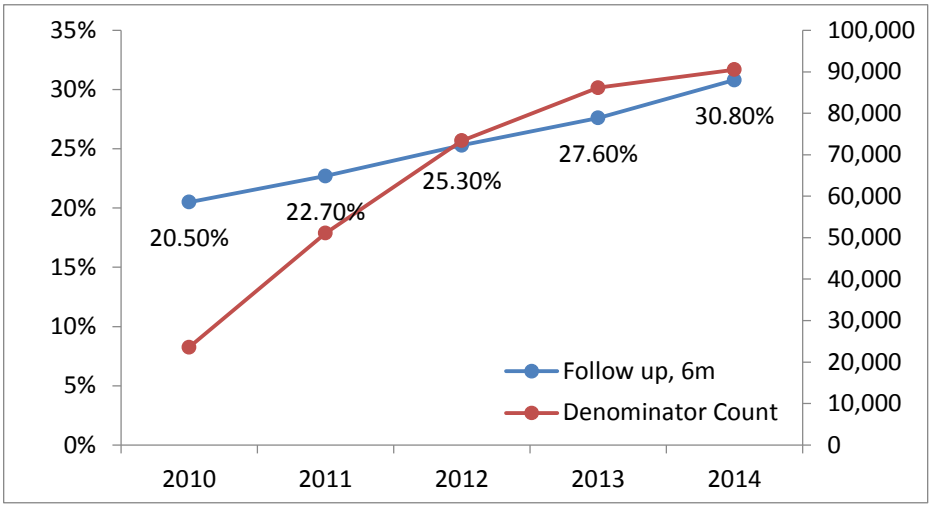
Increased medical group participation and higher performance may indicate progress toward improving care.



Rating

	H	M	L	I	N/A
Use and usability	☒	☐	☐	☐	☐

[i] Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan´s true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.
Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

[ii] Validity of a Brief Depression Severity Measure Kronke, Kurt, Spitzer, Robert et al. J Gen Internal Medicine 2001 September; 16(9): 606–613. www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/

Measure Review Preliminary Rating Summary

Measure description

The percentage of adult type 1 or type 2 diabetes patients who have optimally managed modifiable risk factors.

Recommendation summary			
Continue without changes	Refer for higher level review	Transition to monitoring	Retire
7	0	0	0

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	1	0	0	0
High priority aspect of healthcare:	6	0	0	0	0
Performance gap:	4	2	0	0	0
Reliability and validity:	5	1	0	0	0
Feasibility and burden:	5	1	0	0	0
Use and usability:	5	1	0	0	0
Harmonization:	3	1	0	2	0

Measure Review Preliminary Rating Summary

Measure description

The percentage of adult patients with ischemic vascular disease who have optimally managed modifiable risk factors.

Recommendation summary			
Continue without changes	Refer for higher level review	Transition to monitoring	Retire
7	0	0	0

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	1	0	0	0
High priority aspect of healthcare:	6	0	0	0	0
Performance gap:	4	2	0	0	0
Reliability and validity:	5	1	0	0	0
Feasibility and burden:	5	1	0	0	0
Use and usability:	6	0	0	0	0
Harmonization:	4	0	0	0	2

Measure Review Preliminary Rating Summary

Measure description

The percentage of patients who have asthma and meet specified targets to control their asthma [stratified by adults (ages 18-50y) and children (ages 5-17y)].

Recommendation summary			
Continue without changes	**Refer for higher level review**	**Transition to monitoring**	**Retire**
7	**0**	**0**	**0**

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	**4**	**2**	**0**	**0**	**0**
High priority aspect of healthcare:	**4**	**2**	**0**	**0**	**0**
Performance gap:	**4**	**2**	**0**	**0**	**0**
Reliability and validity:	**4**	**2**	**0**	**0**	**0**
Feasibility and burden:	**2**	**4**	**0**	**0**	**0**
Use and usability:	**4**	**2**	**0**	**0**	**0**
Harmonization:	**3**	**2**	**0**	**0**	**1**
Ongoing debate if should include Asthma Action Plan					

Measure Review Preliminary Rating Summary

Measure description

The percentage of patients who are up to date with appropriate colorectal cancer screening exams. This is a HEDIS measure adapted for Direct Data Submission. **MNCM is not the measure developer or measure steward.**
Patients aged 51 – 75 who have had a colonoscopy in the last 10 years OR sigmoidoscopy in the last 5 years OR stool blood test in the last year.

Recommendation summary			
Continue without changes	**Refer for higher level review**	**Transition to monitoring**	**Retire**
7	**0**	**0**	**0**

Comments:

- Would like for MNCM to include the community recommendations regarding colorectal cancer screening ages for African Americans and American Indians. Our clinical practice has a best practice alert that triggers the clinician to order this at age 45 and 50 for those races. **MNCM Comment:** MNCM is neither the measure developer nor the measure steward.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	**7**	**0**	**0**	**0**	**0**

High priority aspect of healthcare:	**6**	**1**	**0**	**0**	**0**

Performance gap:	**4**	**3**	**0**	**0**	**0**

Reliability and validity:	**6**	**1**	**0**	**0**	**0**
Relies on providers' ability to report. Have seen some providers doing inappropriate FIT on rectal exam smears.					

Feasibility and burden:	**4**	**3**	**0**	**0**	**0**
Can be burdensome to obtain reports from outside facilities. This should improve with continued implementation of EMR but most importantly the idea of medical neighborhoods and more national focus on CRC screening and involvement from the specialists.					

Use and usability:	**5**	**2**	**0**	**0**	**0**

Harmonization:	**5**	**2**	**0**	**0**	**0**

Measure Review Preliminary Rating Summary

Measure description

Primary Cesarean-section rate (percentage of nulliparous, term, singleton, vertex positioned cesarean deliveries). This measure is reported at the medical group level.

Recommendation summary			
Continue without changes	**Refer for higher level review**	**Transition to monitoring**	**Retire**
6	**0**	**1**	**0**

Comments:

- Seems like a tough measure for primary care clinics with many providers who do not have bearing on C-section rates, would be nice to see a measure focusing on earlier prenatal care for high risk populations... **MNCM Comment:** Only C-sections in which the prenatal care is managed by the delivering medical group are attributed to the medical group.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	**5**	**2**	**0**	**0**	**0**
High priority aspect of healthcare:	**5**	**2**	**0**	**0**	**0**
Performance gap:	**3**	**4**	**0**	**0**	**0**
Reliability and validity:	**1**	**4**	**2**	**0**	**0**
Consider adjusting n-size requirement to 200-240 to reflect relationship of .7 (or just below) for good reliability performance. This distribution of the medical groups in the chart appears to have several below the acceptable level for reliability (e.g. <.7 which meets the 240 n size level). **MNCM Comment:** Reporting of this measure is displayed with confidence intervals, meant to lessen the risk of misclassification. Confidence intervals (which are wider with lower n sizes) are also used in assigning a HealthScore (Top, Above Average, Average, Below Average) on MNCM's consumer facing website. This results in less ability to differentiate from the average.					
Feasibility and burden:	**2**	**3**	**2**	**0**	**0**
This is a difficult measure to programmatically extract, with more manual abstraction than any other of the MNCM measures which adds significant burden. What makes it so complicated is the parity (First born) and the gestational age. We have attempted building a workflow, but with the additional requirements of gestational age and estimated due date, we are in the midst of re-investigating additional/better ways to pull the data across our care system.					
Use and usability:	**1**	**6**	**0**	**0**	**0**
Harmonization:	**2**	**5**	**0**	**0**	**0**

Comments (apply generally to Depression Measure Set as whole):

- As important as depression is in our society as a source of morbidity, suffering and time lost from work and even though it contributes to making it harder to treat other chronic illnesses, I think we are overdoing it with the number of measures we have now. I would be in favor of consolidating several measures in order to get rid of one or two of them. I am less particular about whether we keep the 6 month in remission or the 12 month as I am thinking that one or the other would be adequate. **MNCM Comment:** Of note, in regards to the burden of data collection and submission, the entire Depression Measure Set is calculated with one data submission. Removal of any of the measures from the measure set would not change the data submission file.
- One other item that I think bears modification is the window which is acceptable to document that the patient is in remission. For example, if a patient is having true clinical depression, moderate or severe, few clinicians would want to wait 6 months before seeing a result of treatment. Let us say that a patient is seen and medication is started. Most clinicians would want to see results in 4-6 weeks; if the patient had definite improvement at 2 months and was doing particularly well, many of us would prescribe medication for up to a year and see the patient back at that time. However, that would not fit the 6 month remission measure (i.e. qualify for the numerator), which requires a visit between 4 and 8 months with a PHQ-9 documentation. I would expand the window to 1-8 months after the initial visit, and any PHQ-9 in that period showing remission would be acceptable. **MNCM Comment:** According to ICSI's Care Guideline, patients may show improvement at two weeks but most people treated for initial depression need to be on medication at least 6 – 12 months after adequate response to symptoms. During this time, symptoms should be regularly and routinely assessed as relapse is common with the first 6 months following remission from an acute depressive episode.
- I assume all the depression measure information was based on the newly revised initial contact, re-index contact and patient attribution logic that was recently modified. I support the new changes in these measures. **MNCM Comment:** The content in the report that contains measure specific data or analysis is NOT based on the newly revised index criteria. That data is not available and will not be available until 2016 reporting.
- I believe we need a way to track and improve performance in the area of depression. I am not sure if the current "set" is helpful the way it is and may present a high level of burden for clinics...???

Measure Review Preliminary Rating Summary

Measure description

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate remission six months after index with a PHQ-9 score less than 5.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
5	2	0	0

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	6	1	0	0	0
High priority aspect of healthcare:	7	0	0	0	0
Performance gap:	7	0	0	0	0
Reliability and validity:	4	3	0	0	0
Feasibility and burden:	1	5	1	0	0
Use and usability:	3	4	0	0	0
re-indexing continues to be an issue **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					
Harmonization:	5	2	0	0	0
re-indexing continues to be difficult to get provider buy-in **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					

Measure Review Preliminary Rating Summary

Measure description
Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate remission twelve months after index with a PHQ-9 score less than 5.

Recommendation summary			
Continue without changes	Refer for higher level review	Transition to monitoring	Retire
3	3	1	0

Comments:

- let's modify the set. If we have to assess for remission every 6 months why do we need a 12 month remission. We may as well just require those with a dx to get assessed every 6 months just like diabetics with A1C need every 3-6 months???
- 6 month remission is becoming national standard. Burden of reporting both 6 and 12 month measures may not be worth additional value. I recommend keeping 6 month remission measure and transitioning (or retiring) 12 month measure.
- **MNCM Comment:** Rationale of the measure development workgroup was that the 6 and 12 month measures, while aligned, have the potential to support different phases of depression treatment (acute and continuation therapy). The 6 month measures evaluate initial response and short term follow-up and monitoring of patients while the 12 month measure supports continued evaluation (with the goal of sustained absence of symptoms), particularly meaningful as relapse after remission commonly occurs after an acute depressive episode.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	6	1	0	0	0
High priority aspect of healthcare:	7	0	0	0	0
Performance gap:	6	1	0	0	0
Reliability and validity:	3	4	0	0	0
Feasibility and burden:	1	5	1	0	0
Use and usability:	3	3	1	0	0
re-indexing is a concern of providers **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					
Harmonization:	5	2	0	0	0
re-indexing continues to be difficult to get provider buy-in **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					

Depression, Response at 6 months

Measure Review Preliminary Rating Summary

Measure description

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate a response to treatment six months after index, as defined by a PHQ-9 score that is reduced by 50% or greater from the index value.

Recommendation summary			
Continue without changes	**Refer for higher level review**	**Transition to monitoring**	**Retire**
3	**3**	**1**	**0**

Comments:

- To simplify the measure let's consider going towards remission and eliminating the "response" measures for depression. or maybe there is a way to bring a dx of "partial remission" into the remission measure???
- 6 month remission is becoming national standard measure. Burden of response measure may not be worth any additional benefit. I recommend keeping 6 month remission measure and consider transitioning or retiring other depression measures.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	**6**	**1**	**0**	**0**	**0**
High priority aspect of healthcare:	**7**	**0**	**0**	**0**	**0**
Performance gap:	**5**	**1**	**0**	**0**	**0**
Reliability and validity:	**3**	**3**	**0**	**0**	**0**
Feasibility and burden:	**1**	**5**	**1**	**0**	**0**
Use and usability:	**4**	**2**	**0**	**0**	**0**
Harmonization:	**5**	**2**	**0**	**0**	**0**
re-indexing continues to be difficult to get provider buy-in **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					

Measure Review Preliminary Rating Summary

Measure description
Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate a response to treatment twelve months after index, as defined by a PHQ-9 score that is reduced by 50% or greater from the index value.

Recommendation summary			
Continue without changes	**Refer for higher level review**	**Transition to monitoring**	**Retire**
3	**2**	**1**	**0**

Comments:

- 6 month remission is becoming national standard measure. Burden of response measure may not be worth any additional benefit. I recommend keeping 6 month remission measure and consider transitioning or retiring other depression measures

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	**6**	**1**	**0**	**0**	**0**
High priority aspect of healthcare:	**7**	**0**	**0**	**0**	**0**
Performance gap:	**5**	**1**	**0**	**0**	**0**
Reliability and validity:	**3**	**3**	**0**	**0**	**0**
Feasibility and burden:	**1**	**5**	**1**	**0**	**0**
Use and usability:	**4**	**2**	**0**	**0**	**0**
Harmonization:	**5**	**2**	**0**	**0**	**0**
re-indexing continues to be difficult to get provider buy-in **MNCM Comment:** Re-indexing is being eliminated and all index events will have the same criteria, effective 2016 Report Year.					

Measure Review Preliminary Rating Summary

Measure description
Percentage of patients aged 18 years and older with major depression or dysthymia who had a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.

Recommendation summary			
Continue without changes	Refer for higher level review	Transition to monitoring	Retire
3	3	1	0

Comments:

- I do not think the PHQ-9 in and of itself is the sole determining factor for "performance gap"..?? **MNCM Comment:** This measure is solely focused on the regular and routine use of the PHQ-9 to assess an already diagnosed patient population.
- 6 month remission is becoming national standard measure. Burden of response measure may not be worth any additional benefit. I recommend keeping 6 month remission measure and consider transitioning or retiring other depression measures

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	6	1	0	0	0
High priority aspect of healthcare:	7	0	0	0	0
Performance gap:	5	1	0	0	0
Reliability and validity:	4	2	0	0	0
Feasibility and burden:	1	5	1	0	0
Use and usability:	5	1	0	0	0
Harmonization:	5	2	0	0	0

Measure Review Preliminary Rating Summary (weighted average scores, 4.0 point scale)

Measure	Evidence	High Priority	Performance Gap	Reliability & Validity	Feasibility & Burden	Use & Usability	Harmonization
Optimal Diabetes Care	3.83	4.00	3.67	3.83	3.83	3.83	2.83
Optimal Vascular Care	3.83	4.00	3.67	3.83	3.83	4.00	4.00
Optimal Asthma Control	3.67	3.67	3.67	3.67	3.33	3.67	3.60
Colorectal Cancer Screening	4.00	3.86	3.57	3.86	3.57	3.71	3.71
Maternity Care – Primary C-Section Rate	3.71	3.71	3.43	2.86	3.00	3.14	3.29
Depression, 6m Remission	3.86	4.00	4.00	3.57	3.00	3.43	3.71
Depression, 12m Remission	3.86	4.00	3.86	3.43	3.00	3.29	3.71
Depression, 6m Response	3.86	4.00	3.83	3.50	3.00	3.67	3.71
Depression, 12m Response	3.86	4.00	3.83	3.50	3.00	3.67	3.71
Depression, PHQ-9 Utilization	3.86	4.00	3.83	3.67	3.00	3.83	3.71

MNCM Measure Review Subcommittee

Spring 2015 Review

Wednesday, March 25, 2015

8:30 am to 10:30 am

Meeting Attendance:

Work Group		Staff		Observers	
X	Chris Norton, chair	X	Jasmine Larson, MNCM Facilitator	X	Dina Wellbrock, MNCM
X	Sue Knudson	X	Collette Pitzen, MNCM	X	Tony Weldon, MNCM
	Caryn McGeary	X	Anne Snowden, MNCM	X	Denise McCabe, MDH/ SQRMS
X	William Nersesian, MD	X	Rachel Mlodzik, MNCM	X	Sarah Evans, MDH/ SQRMS
	Rahshana Price-Isuk, MD			X	Bev Annis
	Allan Ross, MD			X	Ruth Danielzuk, MN Assoc of Comm Health Centers
X	Kris Soegaard			X	Tracy Krech, BCBS of MN
X	Dan Trajano, MD			X	Mark Skubic, Tapestry Hill Consulting

Minutes

Topic	Discussion	Action
Meeting Overview - Welcome, Agenda - Conflict of Interest (COI)	Meeting is conducted in person with a dial in option, recorded for minute taking purposes. Materials distributed prior to the meeting included: agenda, roster, and individual DDS measure reports with citations. Members present in person and on the phone introduced themselves. Goals for the meeting today include: ▪ Review of preliminary measure evaluations ▪ Responses/discussion regarding specific questions/requests for additional information ▪ Discussion of measure evaluation criteria, by measure ▪ Formulate recommendations for continuation, higher level review or retirement for each measure Measure recommendations will be included in the presentation of the 2016 Measurement Slate to MARC MNCM is committed to disclosing all potential conflicts and competing interests and taking action when	None

Topic	Discussion	Action
	necessary to assure that all measure related activities are free from any real or perceived control or influence of commercial, proprietary or political interests. We all have the responsibility to recognize and clearly state any potential conflicts of interest that may arise during the course of workgroup discussions. Jasmine Larson shared information relevant to the subcommittee's review of all measures. MNCM staff recommends that this committee follow a process that is aligned with the review conducted by the National Quality Forum steering committees when reviewing measures for endorsement. Primarily, the criteria of evidence, high priority aspect of healthcare and performance gap are all must pass elements for a measure to continue to be used for public reporting and the other criteria, while important, are not necessarily prerequisites for continuation. This is especially important as we consider the maturity of the measure, as these may criteria improve as a measure becomes established, adopted in to programs and systems are put in place to support it. With this in mind, it may make this group's work more manageable if we review the "must-meet" criteria and then determine whether there is a need to evaluate the other elements.	
Optimal Diabetes Care	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. The preliminary measure evaluations demonstrated consensus on a recommendation to continue the measure without changes. The specific measure evaluation criteria ratings were consistently scored as high or moderate by the committee with the exception of Harmonization. Two evaluators indicated that there was insufficient information provided to evaluate that criterion. Jasmine asked the committee what additional information could be provided to aid the committee's evaluation. **Discussion** Kris Soegaard stated that her rating of insufficient for the Harmonization criterion was more an indication of the current state of change that is occurring with the measure, specifically in regards to the revised cholesterol management component. Dan Trajano commented that all measures are in a state of flux as evidence changes and MNCM does a nice job of balancing the need to stay current without being so reactive as to inhibit measure stability. Bill Nersesian made a motion to recommend continuation without changes of the Optimal Diabetes Care measure. Dan Trajano seconded the motion. The motion passed unanimously.	**Recommendation:** This subcommittee recommends continuation without changes of the Optimal Diabetes Care measure on the 2016 MNCM Measurement Slate.
Optimal Vascular Care	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. The preliminary measure evaluations demonstrated consensus on a recommendation to continue the measure without changes. The specific measure evaluation criteria ratings were consistently scored as high or	**Recommendation:** This subcommittee

Topic	Discussion	Action
	moderate by the committee. **Discussion** No discussion. Bill Nersesian made a motion to recommend continuation without changes of the Optimal Vascular Care measure. Dan Trajano seconded the motion. The motion passed unanimously.	recommends continuation without changes of the Optimal Vascular Care measure on the 2016 MNCM Measurement Slate.
Optimal Asthma Control	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. The preliminary measure evaluations demonstrated consensus on a recommendation to continue the measure without changes. The specific measure evaluation criteria ratings were consistently scored as high or moderate by the committee. One comment was made in the Harmonization category regarding the ongoing debate around whether the written asthma management plan should be included in the measure. **Discussion** Dan Trajano commented that the harmonization comment was his and he did not have a recommendation or suggestion for change, just wanted to acknowledge the historical context. Sue Knudson made a motion to recommend continuation without changes of the Optimal Asthma Control measure. Dan Trajano seconded the motion. The motion passed unanimously.	**Recommendation:** This subcommittee recommends continuation without changes of the Optimal Asthma Control measure on the 2016 MNCM Measurement Slate.
Colorectal Cancer Screening	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. MNCM is not the steward or developer for this measure, but has adapted the NCQA HEDIS measure to allow for the DDS process. The preliminary measure evaluations demonstrated consensus on a recommendation to continue the measure without changes. The specific measure evaluation criteria ratings were consistently scored as high or moderate by the committee. Comments submitted included a community recommendation for colorectal cancer screening for African Americans and American Indians to occur beginning at age 45 years. Jasmine shared that MNCM's philosophy in regards to this measure has been to remain aligned with NCQA's HEDIS measure. Additionally, there was a comment that feasibility is at times limited by what is available in the medical record. This measure has up to a 10 year look back period which can be problematic when patients receive care outside of the reporting medical group. However, the continued adoption and evolution of EHR's is improving this situation.	**Recommendation:** This subcommittee recommends continuation without changes of the Colorectal Cancer Screening measure on the 2016 MNCM Measurement Slate.

Topic	Discussion	Action
	Discussion Bill Nersesian commented that racial disparities do exist with performance on this measure. Also, there is an "80 by 18" initiative rolling out that is targeting 80% CRC screening by 2018. With much of the increased awareness and focus on CRC screening, he stated that his understanding is that MN disparities aren't as great as elsewhere in the nation and efforts are ongoing in the community to address the disparities that do exist. Ultimately, he supports continuing the measure without changes. Sue Knudson shared that she submitted the comment regarding the community recommendation for communities of color. HealthPartners has had success in reducing disparities, in part by targeting African Americans and American Indians for CRC screening beginning at age 45. Sue does recommend continuing the measure without changes, however, would like to see a continued community dialogue on the topic. Dan Trajano reiterated that guidelines do recommend screening for these populations beginning at age 45 years. He agrees that the issue should continue to be highlighted. Also, the discussion regarding the potential applicability of the REL data collected by MNCM should continue. Anne Snowden stated that this measure is reported in the Health Equity of Care report that was published in January, and the reporting utilizes the REL data. Additionally, Anne recommended that MNCM staff provide comment and feedback to NCQA regarding the importance of screening in the aforementioned populations and encouragement to include screening at age 45 for them in the measure. Dan Trajano made a motion to recommend continuation without changes of the Colorectal Cancer Screening measure. Bill Nersesian seconded the motion. The motion passed unanimously.	
Maternity Care: Primary C-Section Rate	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. The preliminary measure evaluations demonstrated consensus on a recommendation to continue the measure without changes. The specific measure evaluation criteria ratings were consistently scored as high or moderate by the committee with the exception of 1.) Reliability and Validity and 2.) Feasibility and Burden. Regarding reliability and validity: Comment submitted stated that the reliability graph demonstrates that the reliability doesn't meet the 0.7 minimum threshold until the reported n size reaches approximately 200 deliveries. Consider adjusting the minimum n size requirement for reporting. Jasmine commented that MNCM's reporting of the results utilizes confidence intervals (which widen with lower n sizes) to diffuse the risk of misclassification. In order to be categorized as above or below average, the statewide average rate must be entirely outside of a medical group rate's range with the confidence interval applied. Comments specific to feasibility and burden stated that the measure is difficult to programmatically extract and requires a large amount of manual abstraction from patient records, particularly around parity and gestational age/estimated due date.	

Topic	Discussion	Action
	Discussion Sue Knudson shared that the reliability comment was hers, and the additional information regarding confidence intervals addresses her concerns. She recommends inclusion of this additional information in future reports. Dan Trajano commented that he understands that there has been a historical concern regarding attribution of c-sections when a primary care provider refers high risk patients to providers outside of their medical group. Jasmine stated that when this measure was first published, it was reported at the clinic level, and the subsequent revision to report at the medical group was in part an attempt to address this concern. However, there is an acknowledgement that this only addresses referrals that occur within a medical group and not those that occur from one medical group to another. It is a known limitation of the measure. Bill Nersesian stated that the potential skewing because of referrals is a concern he has heard as well. Sue Knudson commented that the burden for this measure is significant and while some attribution issues have been addressed, some remain. Also, there exists some inconsistency in measure specifications between this measure and what is reported in the hospital domain, particularly around the definition of pre-term (37 weeks vs 39 weeks). Sue stated that she thinks the measure should move forward but that similar to the 2014 review of the depression measure, she recommends that MNCM staff review this measure to evaluate whether changes related to the comments submitted should be applied. Jasmine stated that when comparing this measure to other measures the problem lies in which hospital measure set to align with. While the AHRQ performance indicators use 39 weeks gestation to define term, the Joint Commission's measures use 37 weeks. Jasmine shared that MNCM had made a previous decision to align with the Joint Commission, but it may be worthwhile to confirm with stakeholders whether alignment with the Joint Commission or AHRQ is most appropriate. Sue agreed that this approach would be helpful and address the stated concerns. Dan Trajano made a motion to recommend continuation without changes of the Maternity Care measure with the qualification that the measure be critically evaluated for improved alignment. Sue Knudson seconded the motion. The motion passed unanimously.	**Recommendation:** This subcommittee recommends continuation without changes of the Maternity Care measure on the 2016 MNCM Measurement Slate. **Additionally:** This subcommittee directs MNCM to explore improved alignment of the measure and to engage stakeholders in the evaluation.
Depression Measure Set	Jasmine described the planned changes to the indexing methodology for the depression measure set, effective report year 2016. After a complete description, Jasmine asked the committee if there were questions. Sue Knudson commended MNCM staff for the work on this measure in the last year's time. She is very pleased with the outcome and HealthPartners is actually applying the changes now because they believe that it is a better way to manage patients even though they know they have to report it the "old way" for 2015.	

Topic	Discussion	Action
	Preliminary Measure Evaluations Jasmine presented the results of the preliminary evaluations. Comments received in regards to the measure set as a whole included 1.) concerns around the number of measures in the set and whether all of them are necessary or particularly useful in light of the burden of data collection, and 2.) the allowable window for PHQ-9 follow up at 6 and 12 months. Jasmine shared that the burden of data collection and submission would not change by eliminating any of the measures from this set. The data submission file is set up such that after index, all PHQ-9 administrations are submitted for a patient at the contact level. The task of multiple measure calculation occurs within the MNCM Data Portal. Jasmine also shared that according to ICSI's Care Guideline, patients may show improvement at two weeks but most people treated for initial depression need to be on medication at least 6 – 12 months after adequate response to symptoms. During this time, symptoms should be regularly and routinely assessed as relapse is common with the first 6 months following remission from an acute depressive episode. **Discussion** Bill Nersesian stated that with the increased pressure to keep costs down, there is a concern that the brief window for allowed follow-up to have a PHQ-9 count in the measure promotes office visits for PHQ-9 administration that may not be necessary. Jasmine commented that PHQ-9's administered outside of an office visit (telephone, patient portal, mail, etc.) are allowable. Dan Trajano stated that he had made comments regarding the usefulness of the entire set of measures. He appreciates that the removal of any measure from the set does not impact data reporting burden, however, he wonders how useful the entire set of information is to consumers. Furthermore, is the set as it is currently reported confusing? Anne Snowden shared that in the beginning of reporting of this measure set, MNCM did only report the 6 month remission measure and the response measure was added because performance on the remission measure was so low it could be demotivating. It was believed that the response measure would provide some encouragement that progress is occurring. Kris Soegaard stated that she thinks that the reporting of the entire set of measures is confusing to consumers. What does it mean if a provider performs well at 6 months but not at 12 months? Collette shared that the development of this measure set occurred in 2007 at the same time as the DIAMOND project and the timelines selected were in support of that care model. Dan Trajano stated that his understanding is that locally, programs and requirements are focused on the 6 month measures while nationally, programs include the 12 month measures. He shared that he is unsure on how best to reconcile those differences but suggests that for this year MNCM keep the entire set intact. Bill Nersesian commented that it is important to consider the provider's usability of the measures. He stated that he wants to see simplicity in the measures, not for a burden perspective but from an understandability	

Topic	Discussion	Action
	perspective and he stated that allowing a larger window for PHQ-9 collection would go a long way toward that effort. Kris Soegaard stated that for the purchasers these are incredibly important measures. She commented that given the fact that MNCM has done so much work on the technical aspect of the measures, she believes that we need to let the measures continue as they are for at least one or two years before considering making any changes. Sue Knudson agreed. Kris Soegaard asked MNCM staff if we are able to see how much traffic the individual measures get on MNHealthScores.org. Chris Norton asked if MNCM staff can determine the type of visitors to the website. Jasmine stated that MNCM can determine whether a visitor to the website comes from a search (ex. Google) or a direct url address entry and MNCM makes assumptions based on that information. Erin Ghere stated that MNCM can get to the detail regarding traffic on individual measure pages of MNHS. Depression is one of the most frequently visited pages. Dan Trajano stated that it may be helpful to understand the correlation that may or may not exist for a clinic's performance between the 6 and 12 month measures. Kris Soegaard made a motion to recommend continuation without changes of the Depression Remission at 6 and 12 months and Depression Response at 6 and 12 months measures. Dan Trajano seconded the motion. The motion passed with one committee member (Bill Nersesian) opposed.	**Recommendation:** This subcommittee recommends continuation without changes of the following Depression measures on the 2015 MNCM Measurement Slate: • Depression Remission, 6 months • Depression Remission, 12 months • Depression Response, 6 months • Depression Response, 12 months
Depression: PHQ-9 Utilization	**Preliminary Measure Evaluations** Jasmine presented the results of the preliminary evaluations. The specific measure evaluation criteria ratings were consistently scored as high or moderate by the committee. **Discussion** Bill Nersesian made a motion to recommend continuation without changes of the PHQ-9 Utilization measure. Kris Soegaard seconded the motion. The motion passed unanimously.	**Recommendation:** This subcommittee recommends continuation without changes of the PHQ-9 Utilization measure on the 2016 MNCM Measurement Slate.
Closing	Next Steps: Jasmine will send a survey for completion of Measure Review Rankings based on Impact and Work Effort.	

MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, April 8, 2015
Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Bruce Penner, Caryn McGeary, Chris Norton, Dan Walczak, Dan Trajano, David Homans, David Satin, Jordan Kautz, Kris Soegaard, Laura Saliterman, Mark Sonneborn, Robert Lloyd, Ruth Danielzuk (alternate for Rahshana Price-Isuk), Stefan Gildemeister, Sue Knudson
MNCM Staff: Anne Snowden, Collette Pitzen, Dina Wellbrock, Jasmine Larson, Rachel Mlodzik
Members Absent: Jeff Rank, Matt Flory, Rahshana Price-Isuk, Tamiko Morgan

Topic	Discussion
Welcome & Introductions; Review MARC Charter & COIs	Tim Hernandez welcomed committee members and observers. He reviewed the charter located at the bottom of the agenda. He also extended a special welcome and introduction of new committee members. First, Tim welcomed Jordan Kautz to the committee. Jordan is a physician from Mayo Clinic who will be serving on MARC as a large non-metro medical group representative. He is a faculty member of the Mayo Clinic Quality Academy and is well versed in many quality improvement (QI) methodologies. He will bring the perspective of a clinician as well as an educator in QI efforts in both outpatient and inpatient settings. Next, Tim welcomed Dan Trajano to the committee. Dan is a physician and vice president for population health at Medica. He oversees Medica's quality programs and alternative value-based payment strategies. Previously he worked at Park Nicollet serving as the senior medical director for quality and population health. Dan will serve as one of the committee's health plan representatives. Lastly, Tim welcomed Tamiko Morgan. Tamiko is a physician and chief medical director at Metropolitan Health Plan. She is a board-certified pediatrician and continues to practice one day a week. She is also a new member of the MN Community Measurement Board of Directors. Tamiko will serve as one of the committee's health plan representatives. Tim also welcomed back Kris Soegaard from the Minnesota Health Action Group, who represents purchasers/consumers, and Howard Epstein, MD from PreferredOne, who serves as a health plan representative. Both members had terms that ended last year, but applied for renewal and were found to be the best candidates. Tim reminded everyone that the committee strives to make their meetings and decisions as transparent as possible, but noted that only official MARC members can participate during the meeting discussion. If there are any questions or comments following the meeting, guests can email info@mncm.org. Finally, Tim reminded MARC members that MNCM has a Conflict of Interest (COI) policy for committees and workgroups. All MARC members have received a copy of the policy and have signed and returned the disclosure form. These forms were reviewed by a joint MNCM/Institute for Clinical Systems Improvement (ICSI) COI Review Committee. The committee's charge is to review all COI declarations and make recommendations about the management or mitigation of declared conflicts. The joint committee reviewed the COI forms from MARC members and all members were approved for full participation. Tim thanked everyone for fulfilling this requirement, noting that it is a very important process that supports and maintains our credibility. A handout of all MARC members' disclosures was provided to committee members for full transparency.
Approval of Minutes	The committee reviewed minutes from the November 2014 meeting. **Bill Nersesian made a motion to accept; Laura Saliterman seconded the motion. Motion passed.**
Action Item: Preliminary Charter of Cancer Care Workgroup	Collette Pitzen from MNCM presented the preliminary charter for the cancer care measure development workgroup. She reminded committee members that Jasmine Larson from MNCM had presented information on the impact of pursuing measure development activities for cancer patients undergoing chemotherapy and/or radiation therapy at the October 2014 meeting. At that time, MARC approved the convening of a measure development workgroup to explore this measure concept with a particular focus on management of symptoms and with a recommendation for using patient reported outcomes. Suggestions made at that meeting by MARC members were incorporated into the workgroup's preliminary charter. The measure development process includes several checkpoints for MARC review and approval; this review of the preliminary charter is one of those points. The measure development workgroup reviews and approves the final charter; if the workgroup recommends significant changes to the scope, those recommendations would come back to MARC for discussion and approval.

Highlights from the preliminary charter included:

- The measures are for oncology practices, a specialty focus;
- The concept for exploration is symptom management during treatment;
- Preference is for outcome measures utilizing patient-reported outcome tools;
- Cancer type/s that are relatively high in volume will be selected for these measures; and,
- Alignment and collaboration with the American Society of Clinical Oncology (ASCO).

It was additionally noted that these measure development activities are funded by MNCM and are not currently included in the Statewide Quality Reporting and Measurement System (SQRMS). However, there is the potential to receive funding for pilot testing of measure(s) developed through the Patient Centered Outcome Research Institute (PCORI) and the opportunity to partner and build on measure development work with the ASCO. These measure(s) will rely on voluntary participation from oncology practices. The cancer care measure development workgroup will be chaired by Nicole Hartung, from Minnesota Oncology and Hematology. The first meeting will be in two weeks.

Questions/Comments/Discussion:

Bill Nersesian asked Collette to provide an example of the type of measure the workgroup might consider. Collette indicated that some preliminary work to review several standardized tools used to capture and quantify symptoms during cancer treatment has been done. Ideally, one of these validated tools could be used to build a performance measure. However, the workgroup has not convened; these reflect decisions that are to be made during the measure development process.

Tim Hernandez asked if MNCM had performed any preliminary queries of oncology practices to determine whether they are interested in developing/participating in this measure, given that it will be voluntary collection. Collette indicated there was an overwhelming response from volunteers interested in participating on the workgroup, and that MNCM is hoping this translates to successful measure development and implementation.

Howard Epstein commented that as much as MARC needs to support patient-reported outcome measures, in general, he thinks there is an opportunity here to look at specific process measures as well - especially around resource utilization and evidence-based medicine. ASCO has strongly endorsed certain over-utilization measures through the *Choosing Wisely* campaign. He suggested adding overuse measures to the scope of the workgroup. Chris Norton asked if this addition would complicate or distract the workgroup's progress in the development of a new measure. Collette indicated that overutilization could be a topic for the workgroup to consider; however, the concept approved in October for this workgroup was very focused on outcomes for symptom management during chemotherapy and/or radiation therapy. Adding other measure concepts, types or data sources could slow the workgroup's process. This additional concept could be part of a second phase or alternate path of development.

Tim Hernandez asked who decides if there should be changes to a workgroup's scope. The preliminary charter is based on both the impact presented to MARC and the discussion of the measure concept that occurs at MARC, so the scope that is the starting point for measure development activities is in MARC's control. Jasmine Larson suggested that in parallel to this, foundational work could be done around the utilization topic to prepare for a potential future or alternate round of measure development. David Satin commented that he believes this suggestion is reasonable, since this would be our first measure development activity with this specialty.

David then asked if there is readily available data on outcomes for these symptoms and the tools utilized. Collette answered that while there is not much in terms of existing measures, there is supportive literature demonstrating the distribution of symptoms with given cancer populations. The workgroup has a large task ahead of them including validating between 10-15 tools to pick the best tool to measure the outcome. Tim Hernandez commented that oncologists will probably feel a bit of culture shock regarding this reporting, similar to how other providers have felt previously. He believes that a utilization measure is an important next step, and suggests informing the workgroup about MARC's thoughts and considerations for the future.

Howard Epstein shared that there could be some opportunity to focus specifically on over-utilization and appropriate testing/treatments with a separate workgroup, or building off of other workgroups' efforts, and that there may be future Robert Wood Johnson Foundation (RWJF) grants for regional improvement related to this topic. Dan Trajano added that there could be another venue to look at over-utilization, claims-based measures, such as the Total Cost of Care database specifically looking at cancer resource utilization.

Chris Norton made a motion to accept the preliminary charter of the Cancer Care workgroup; Dan Trajano seconded the motion. Motion passed.

Action Item: Preliminary Slate of Recommended Measures for Statewide Quality Reporting and Measurement System (SQRMS): Physician Clinics	Dina Wellbrock from MNCM presented the preliminary slate of recommended measures for physician clinics for the 2016 Statewide Quality Reporting and Measurement System (SQRMS). These recommendations inform the annual state administrative rule-making process by which measures are selected for required clinic reporting. The cover letter included a timeline of the rule-making process and scheduled milestones. The final slate of measure recommendations for SQRMS will be brought to the June MARC meeting. Dina reminded MARC members that this process is separate from the MNCM slate of measures for public reporting, which is brought to MARC for review and approval annually in September. Both slates are informed by the work of MNCM's Measure Review Committee (MRC), a subcommittee of the MARC. This committee was formed in 2013 to increase stakeholder involvement and transparency of the measure review and maintenance process. Chris Norton is the committee chair, and it is staffed by Jasmine Larson. Other MARC members who are on the MRC include Allan Ross, Caryn McGeary, Dan Trajano, Kris Soegaard, Rashana Price-Isuk, Sue Knudson and Bill Nersesian. The MRC has responsibilities for annual measure review and makes recommendations to MARC regarding next steps. Their recommendations can be one of the following: continue the measure without change; elevate to a higher review; transition to monitoring; or retire a measure. Dina noted that the MRC recommended continuation of all reviewed measures. There were no measures recommended for evaluation of a higher review, transition to monitoring or retirement at this time. She then reviewed the existing measures and highlighted changes. There are no new measures on the preliminary SQRMS slate for 2016. The first measure in the preliminary slate was the Optimal Diabetes Care composite measure. The use of a statin was added as a component of this measure, making it again a "D5." The other components remain unchanged. The Optimal Vascular Care composite measure is following suit with the Diabetes measure. The use of a statin was added as a component of this measure, making it again a "V4." The other components remain unchanged. The measure specifications for Depression Remission at Six Months remain unchanged from last year. However, a technical adjustment to the measure will be made in 2016. Going forward, any visit with an elevated PHQ-9 result following a patient's 13-month measurement period will also require a diagnosis of depression or dysthymia to be indexed. Last year, MARC elected to remove the written asthma management plan as a component of the asthma measure. As a result, there are now two components of the Optimal Asthma Control measure: 1) well-controlled asthma as measured by the appropriate control tool score and 2) patient being at low risk for exacerbations as measured by patient-reported hospitalization/ED visits during the measurement period. The Colorectal Cancer Screening measure has not changed since last year. The Maternity Care: Primary C-section measure has not changed since last year. The Total Knee Replacement measure has not changed since last year. However, it should be noted that the previously approved transition to the PROMIS Global 10 tool will be effective for the 2017 report year. The spine surgery measures have not changed since last year. However, it should be noted that the previously approved transition to the PROMIS Global 10 tool will be effective for the 2017 report year. The pediatric preventive care process measures have not changed since last year. The biannual Patient Experience of Care survey will include the measurement period of September 1, 2016, through November 30, 2016. The survey measures four domains using the recommended CG-CAHPS survey. Only psychiatry specialty practices are excluded. Eligibility for the survey has not changed from last year. The Health Information Technology survey assesses the phases of adoption, utilization and exchange of information through a clinic's Electronic Health Record (EHR). All clinics are required to complete this web survey annually. **Questions/Comments/Discussion:** Tim Hernandez commented that the MRC was chartered through the MNCM Board of Directors to discuss the issue of burden since there has been much talk from providers (particularly primary care providers) about working to alleviate some of the measurement burden. As we are adding measures, we need to thoughtfully consider retiring measures too. Tim said he appreciates the good work of the MRC.

Stefan Gildemeister asked how it is decided which measures on the MNCM slate will also be included on the SQRMS slate. He questioned whether or not there is more opportunity for alignment between the two slates. Jasmine Larson answered that the recommendations each year for the SQRMS slate take into account many factors such as historical decisions and investment of local stakeholders. The inclusion of each measure in various programs, locally and nationally, is part of the information reviewed by the MRC. In the most recent MRC meeting, the depression suite of measures was discussed as far as each individual measure's use in various programs. The recommendation for the SQRMS slate to continue with the Depression Remission at Six Months measure for 2016 reporting is based on local work that is ongoing in the community although national programs include the 12 month measure. However, this does not rule out the possibility of a transition in the future. Stefan further asked if there is a need for both the six and 12 month measures in the SQRMS slate. Jasmine answered that the recommendation for the SQRMS slate to continue only with the Depression Remission at Six Months measure is in part respecting the work of the community and also in consideration of the MRC's discussion regarding the measure set.

Sue Knudson, a member of the MRC, said this issue was discussed during the most recent MRC meeting. The six month depression measures are used consistently by local payers, the MN Department of Health (MDH), Minnesota Bridges to Excellence, etc., while the 12 month measures are adopted into some national programs. In addition, data for the MNCM depression measures are submitted in one file and the MNCM Data Portal calculates results for all measures (6 and 12 months); thus, there is no additional burden to data submission for the medical groups. In light of that, the MRC wanted to continue to see if they can get more harmony between national and regional programs. Kris Soegaard added that MRC also discussed that the further out a provider goes with depression treatment, the more likely they will lose patients to follow-up.

Tim Hernandez commented that one of the things to consider is the overall breadth of measures required of primary care physicians, which is another part of burden that is difficult to assess. Every measure seems to have value to somebody. When the measures are considered together, the front-line reality is that providers can only keep so much in their perspective when providing care to patients. Many of these measures require development of robust systems to keep them in the forefront. In other words, we need to consider the big picture and determine which measure(s) could be removed if this is found necessary.

Stefan Gildemeister asked whether the changes to the depression measures will allow tracking of performance over time. Jasmine noted that the technical change will not allow apples-to-apples comparisons to previous years; however, it was felt that this technical improvement is of such value to the measure that it is worth the loss of trending for one year.

Stefan then asked whether or not the collection of race, Hispanic ethnicity, preferred language and country of origin (REL) data should be included in the SQRMS slate. Anne Snowden noted that MNCM's contract with MDH no longer includes providing recommendations for risk adjustment variables. In addition, she said that recommendations and measure specifications include only the specific data elements required for calculating results for a measure.

Tim Hernandez asked Stefan if he could provide a summary on how MDH handled the asthma recommendations from MARC and the reconciliation process it went through when making its final decision. He noted that, this year, medical groups will still be required to submit data on the asthma action plan, but it will be considered a stand-alone measure. Stefan mentioned that a communication to medical groups went out the previous day regarding this decision. There are still strongly held opinions in the community about whether the asthma action plan is a valid and helpful tool in contributing to improvement. He said we had the unique experience where the asthma workgroup came forward with a recommendation to MARC to retain the asthma action plan, and MARC decided against it. The timeline provided in the MARC packet details the lengthy process of public comments where the Commissioner of Health hears different perspectives on the issue. In the end, the Commissioner's decision to move forward with the asthma action plan as a separate stand-alone measure was based on five factors: an analysis of empirical data indicating asthma control for patients that received an asthma action plan; parallel research by Health Care Homes that seemed to suggest causality in the relationship between the presence of an asthma action plan and asthma control; endorsements at the state and national level for the asthma action plan as part of a set of best practices/guidelines; the Commissioner's review of feedback; and the alignment of the asthma action plan with population health initiatives around reducing disparities. These reasons together resulted in the Commissioner's decision to retain the asthma action plan in the 2015 Administrative Rule.

Laura Saliterman asked if there was any consideration of segmenting the stand-alone asthma action plan measure by age category (adult vs. pediatric). Stefan said the data did not show significant differences between the effects of the asthma action plan on the two age categories. That being said, he believes that it would be beneficial to explore whether the asthma action plan is more effective for a specific population.

David Satin asked why OBGYN was listed under the required specialties for Colorectal Cancer Screening measure. Jasmine Larson answered that there are OBGYNs that are primary care providers for women. David then asked why OBGYNs are not required to report for the Depression Remission at Six Months measure. Collette answered that OBGYNs have the option to report for this measure, but it is not required. David Homans commented there has been ample work on postpartum

	depression and suggested that at some point MARC discuss whether it is appropriate to include this type of depression in this measure. He added that screening is done on pregnant women, and providers try to predict whether some medications will have negative effects on postpartum mothers. Tim Hernandez commented that from an ICD-9 standpoint, postpartum depression has a different code than general depression. Anne Snowden commented that this type of depression is not part of the current specifications. Howard Epstein commented that there is an issue of general screening of the OBGYN population. Postpartum depression is unique and no less important, but it has a different clinical course that may not be appropriate for inclusion in a major depressive disorder measure. Tim followed by saying that this depression measure is an improvement measure. If an OBGYN did not manage a patient's depression, then he believes it is not appropriate to measure them. Dan Trajano agreed with the point, and said he believes some OBGYNs are treating general depression which could be teased out from postpartum depression. If OBGYNs are responsible for reporting under the Colorectal Cancer Screening measure, he questions why they would not be responsible for reporting under the depression measure too. Ann Robinow agreed and commented that if research was done on the percentage of patients prescribe SSRIs by provider type, OBGYNs would have a high percentage compared to other provider types. Howard asked Jasmine if this discussion would be brought back to the depression workgroup. Jasmine answered that we could certainly engage in a discussion with the workgroup chair since there is not a full workgroup active right now. Jasmine indicated that we would look at the history of decisions around the depression measure and discuss the issue with the workgroup chair between now and the final SQRMS slate. Sue Knudson commented that during the last MRC meeting, the different age category requirements for this colorectal cancer screening were discussed. According to guidelines, colorectal cancer screening for African Americans and American Indians should start at age 45. She noted that many organizations are already running their internal measures this way. MRC did not address the issue during this round of review, but it will be discussed in future meetings. Howard commented that, in parallel to this conversation, he believes NCQA has taken this same approach with HEDIS measures. In other words, NCQA is continuing to evaluate this issue for their Colorectal Cancer Screening measure, and the measure will remain at age 50 for all populations. David Satin commented that in the future, the colorectal cancer screening measure could be segmented into more than one measure based on screening requirements; that we would not need to risk adjust by REL but instead use stratification. Anne Snowden commented that our Colorectal Cancer Screening measure is a direct adaptation of the HEDIS colorectal cancer screening measure. NCQA has not made a move towards this change. It would be more difficult for them to do so since their data is claims-based, and to date the health plans are not collecting REL data in a standard way. That said, Anne said MNCM will contact NCQA about the possibility of revising their Colorectal Cancer Screening HEDIS measure to include stratification by age and race. At some point MNCM could steer in a different direction, but we are currently aligned with NCQA's measure. Laura Saliterman commented that MNCM's Risk Adjustment Committee is making huge strides and will have recommendations for MARC that may impact some of this discussion. She believes at this point, MARC should wait and see what the Risk Adjustment Committee brings forward. Anne Snowden added that MNCM is in the process of studying the impact of REL data elements on risk adjustment. Whether results will be risk adjusted using REL data is still to be determined. David Homans commented that Park Nicollet defined what primary care meant in their organization, and the OBGYN specialty elected not to be primary care by their definition. Bill Nersesian commented that his organization talked to many OBGYNs about this issue as they were deciding whether to become an Accountable Care Organization because primary care doctors have patients attributed to them and can only be listed under one network, whereas other specialists do not have patients attributed to them and can be listed in multiple networks. The OBGYNs seemed to like it both ways. His organization reimburses primary care providers higher in ACO because they do more work. It also seems that there is a slight difference between rural and metro area OBGYNs. There is more competition in the metro area and the majority of the OBGYNs seem to practice some primary care. In rural areas where an OBGYN can be the only one within 20-30 miles, they mostly practice just their specialty. He suggested keeping things simple. Dan Trajano commented that the discussion should be framed around whether or not OBGYNs provide the primary treatment for depression and not around if they should be considered primary care providers. He believes OBGYNs do provide this care in many cases. He would strongly advocate that MARC considers adding them to this measure. Jasmine Larson said this discussion will be taken back to the workgroup chair. **Dan Walczak made a motion to accept the preliminary slate of recommended measures for SQRMS; Sue Knudson seconded the motion. Motion passed.**
Meeting Adjournment	Howard Epstein thanked everyone for attending the meeting and informed them that the next meeting will occur on Wednesday, May 13. Meeting adjourned.

Next Meeting: Wednesday, May 13, 2015

MNCM Diabetes Ad-hoc Cholesterol Work Group
Minutes Meeting # 2

Tuesday, September 2, 2014

3:00 pm to 5:00 pm

Meeting Attendance:

Work Group Member		Work Group Member		Work Group Member	
X	Beth Averbeck, MD, Chair		Jonathon Ward Godsall, MD	X	Terry Murray, RN
X	Mark Nyman, MD (phone)	X	Christopher Restad, DO	X	Jeanine Rosner, RN
	Victor Montori, MD	X	Rebecca Moxness, MD		Monica Simmer
X	JoAnn Sperl-Hillen, MD	X	Thomas Knickelbine, MD (phone)	X	Pam York
X	Courtney Baechler, MD (phone)	X	Woubeshet Ayenew, MD	X	Kris Soegaard
Guests		**Observers**			
X	Senka Hadzic, ICSI	X	Denise McCabe (phone)		
MNCM Staff					
X	Collette Pitzen, facilitator	X	Alison Helm	X	Dina Wellbrock
X	Jasmine Larson	X	Anne Snowden		

Minutes

Topic	Discussion	Action
Meeting Overview - Welcome - Conflict of Interest (COI)	Meeting is conducted in person and by phone; recorded for minute taking purposes. Materials distributed prior to the meeting included: agenda, roster, meeting slides, relevant sections from the new ICSI diabetes guideline with links to full guideline, minutes from the previous meeting, suggested measure algorithms for the cholesterol component of the optimal vascular and diabetes care measures and an article on the safe use of statins. Members in present and on the phone introduced themselves. We welcomed new work group members, cardiologists Woubeshet Ayenew (Hennepin County Medical Center) and Tom Knickelbine (Minneapolis Heart Institute). MNCM is committed to disclosing all potential conflicts and competing interests and taking action when necessary to assure that all measure related activities are free from any real or perceived control or influence of commercial, proprietary or political interests. We all have the responsibility to recognize and clearly state any potential conflicts of interest that may arise during the course of work group discussion.	None

Topic	Discussion	Action
Goals for Meeting Scope of Redesign Re-cap of March Meeting	All work group members completed a conflict of interest (COI) declaration. All declared COIs were reviewed by the ICSI/MNCM Conflict of Interest Committee. Current work group members' declarations were reviewed and approved for participation in measure development activities. • Victor Montori- non financial association with board member for BMJ British Medical Journal • JoAnn Sperl-HIllen- work with international diabetes center and an educational grant teaching QI in China • Ward Godsall- BCBSM case review for endocrine questions related to hormone use • Chris Restad- serves on HealthEast's community practice advisory council • Woubeshet Ayenew- Pfizer stock ownership maintained in a managed retirement fund Beth reviewed the goals for the meeting today 1) brief re-cap of the March meeting, 2) MARC approved plan to increase scope to include the vascular measure and add cardiologists, 3) review new and evolving measures at the national level, 4) review updated ICSI guidelines and recommendations for measures and 5) determine measure redesign details, and make decisions about contraindications. Originally, we were directed to explore the redesign of the cholesterol component for the diabetes measure and consider the metric LDL < 100 or on a statin. As we were planning our first meeting, the new ACC/AHA guidelines were released and treating to an LDL target for any at-risk population was deemed not evidenced based and the focus of the new guidelines was the use of statins for four at risk populations, two of which were patients with diabetes and patients with cardiovascular disease. Now the cholesterol component of the vascular measure, LDL < 100, was no longer supported by guidelines and needed redesign as well. In March the measurement and reporting committee (MARC) approved our plan to 1) suppress the cholesterol component for 2014 dates of service, 2) delay measure development/ redesign activities until after the updated ICSI diabetes guidelines were completed (July 31) and 3) to increase the scope and work group membership to allow for redesign of the cholesterol component as well. Beth also reviewed the guiding principles for measurement, strive for measures that are meaningful, evidence based, have opportunity for improvement, actionable, creditable and feasible. Now that our scope has increased to the vascular measure, and because treating to an LDL target is no longer appropriate for clinical practice or measurement, it is desired that the cholesterol components are aligned across the two measures. We would not want a patient with diabetes and vascular disease to be treated differently measurement-wise depending on which measure they were being expressed in. Summary of decisions we made at the last meeting: ▪ Because the guidelines came out so late in the year, there was no need to make changes to the measures for patients seen in 2013 (reported in 2014); continue to report the cholesterol component as LDL < 100 ▪ Cholesterol management is too important to the overall risk reduction for patients with diabetes or cardiovascular disease to drop completely from a measure that seeks to reduce modifiable risks. We need to keep some form of cholesterol management as part of the patient level all-or-none composite measures. ▪ No need to differentiate between moderate or high level of statin. At the last meeting, in discussion the diabetes population we were considering a measure of statin use that indicated that the patient was at least on a moderate level statin. Do not include the use of the CV risk calculator to determine who should be on a higher or moderate	No additional agenda or discussion items added. For information and to get all work group members up to date.

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td></td><td colspan="2">dose of statin.
▪ Plan to suppress the cholesterol component for patients seen (dates of service- DOS) in calendar year 2014. Plan for a statin based measure for DOS in 2015
▪ Re-convene following the completion of ICSI guidelines July 31
▪ Need to further discuss and define appropriate contraindications to statin for measurement</td><td></td></tr>
<tr><td>Evolution of Cholesterol Measures- National</td><td colspan="2">There has also been some work by other measure developers since we last met and their thoughts and potential direction of draft measures related to cholesterol management can inform our decisions as well. Historically, NQCA has had a measure for ischemic vascular disease that is related to a target LDL of < 100. This measure is now retired and they may or may not have a replacement measure in the future. Additionally, MNCM has tried to remain aligned with NCQA's definition of ischemic vascular disease (IVD) for our Optimal Vascular Care measure. Others have stepped forward in this arena. CMS had a newer population based measure for cholesterol management developed about 18 months ago that had LDL targets based on risk, but in light of new guidelines they needed to do some redesign as well. The American College of Cardiology (ACC) has also developed a new post-guideline measure that recently went out for public comment. Both of these measures are in draft and MNCM is participating in the groups "alignment party". Some of the measure details are included below:</td><td rowspan="2"></td></tr>
<tr><td colspan="2"><table>
<tr><td>CMS
Population-based Cholesterol Management Measure
▪ Only addressing 3 of the 4 statin groups; age ≥ 21 with ASCVD, Age ≥ 21 with LDL ≥ 190, and diabetes age 40 to 75
▪ Not tackling the risk calculator
▪ Measure is treated with statin and not specifying a dose
▪ Exclusions = pregnancy/ breastfeeding, palliative care, active liver disease and LDL < 70 for diabetes
▪ Numerator exceptions = adverse effect, allergy or intolerance to statins</td><td>American College of Cardiology
ASCVD (IVD) Cholesterol Management Measure [#5]
▪ Age 21 to 75 with ASCVD
▪ Measure is statin is prescribed or offered*
▪ Are looking for an associated dose of statin requiring a high dose statin or a moderate dose statin with exception documented
▪ Numerator exceptions are for medical reasons only
* Could be a high performing check-the-box measure
ASCVD defined as: acute coronary syndrome, history of acute myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke or TIA, or peripheral artery disease of atherosclerotic origin.</td></tr>
</table></td></tr>
<tr><td>Discussion
Shared Decision Making
Exclusion/ Exception Philosophy</td><td colspan="2">Work group member adds that for statin prescribed or offered, the ACC has some language in their proposed measure draft about shared decision making and moving in that direction, but not there yet in terms of defining or documenting shared decision making and for this reason, for this iteration of the measure are defining exceptions only for medical reasons. The ASCVD definition is the same as our vascular measure, does the ACC further go on to look at blood pressure, tobacco status, aspirin use? No, is simply a stand-alone cholesterol measure. Measures can sometimes serve difference purposes and be used in different programs; the MNCM optimal diabetes and vascular measures are NQF endorsed and used in several federal programs. The best place that measure developers can align is in their definitions of the population and exclusions; it also makes no sense to have little one-offs in the numerator. Another member shares that there is concern as providers are advocating for the guidelines going forward, working with their patients through a shared decision making process that for whatever reason, the patient is not going to take a statin. Doesn't think that providers should be held accountable for this decision. Chair</td><td></td></tr>
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Topic	Discussion	Action
	comments that there may be opportunity to work through the exclusions to account for some of the reasons patients will not be taking a statin. Our other measures do not take into account patient refusal (e.g. mammography, colorectal cancer screening, immunization), and we need to be consistent, but perhaps some of the clinical exclusions will get at some of the patient reasons. Questions about check-the-box measures; member related to a hospital measure for being on aspirin at discharge, which is what you are measured on, not if you are on aspirin 31 days later. Many of the hospital based measures are related to processes of care, but the ambulatory measures have been moving towards outcomes and understanding that with outcome measures you are never going to hit 100%. We are fairly far along in measure development, but not yet far enough along to consider incorporating shared decision making, is a larger discussion and perhaps the next evolution of measurement. Prior to the meeting, Collette did a scan of NQF endorsed measures and currently there are none that focus on or define shared decision making. Member references NQF endorsed measure #0074 Chronic Stable Coronary Artery Disease Lipid Control where they have listed in their exclusions: documentation of medical reason(s) for not prescribing a statin (e.g., allergy, intolerance to statin medication(s), and other medical reasons). Documentation of patient reason(s) for not prescribing a statin (e.g., patient declined, other patient reasons). **Post meeting** note: True, this is an older ACC measure that will be replaced and the ACC is only using medical reasons, not patient or societal in the new cholesterol management measure. Another member shares that within the ACO measures, that there is latitude to start documenting the patient reasons portion of these types of measures and a platform in Epic to do so. In order to avoid a complete check-the-box measure; as long as these exceptions to the numerator (patient still remains in the denominator) remain under 5% there is no penalty. The measures that this is being used in are medication related and some prevention measures. Collette shares that this is not a new concept and many measures included in the PQRS program developed by the AMA/ PCPI have this allowance for any provider documented reason being allowed as an exception … it doesn't make it right or the best way to construct a measure, in fact can significant impact the validity and reliability of a measure. Member also shares that in previous iterations of these types of measures, documenting all the patient related reasons may not have been feasible.	
Updated ICSI Guidelines Discussion about level of statin intensity inclusion in a measure	Recommended Outcome Measure- Cholesterol Component Percentage of patients ages 40-75 years with T2DM with untreated LDL > 70 mg/dL who are prescribed statin therapy. Note that this measure recommendation does not include dose of statin as part of the measure. Clinical Recommendations ▪ Statin Therapy High Risk- A clinician should recommend high-intensity statin therapy for patients diagnosed with T2DM, between the ages of 40-75 with established ASCVD (strong), and (B) may recommend high-intensity statin therapy for others at a 10-year ASCVD risk ≥ 7.5% (weak) ▪ Statin Therapy Moderate Risk- A clinician should recommend moderate- or high-intensity statin therapy for all patients diagnosed with T2DM between the ages of 40-75 with a LDL ≥ 70 mg/dL Lengthy discussion about interpretations of the ACC/ AHA guidelines for level of statin dose; achieving a percent reduction of the LDL versus expectation to be on a certain dose of medicine (table 5 ACC AHA definition by drug and dose of high, moderate and low intensity of statin versus other benefits of statins beyond LDL lowering capability.	Agreed to move forward with a measure design that is not dependent on statin dose, simply that the patient is on a statin.

Topic	Discussion	Action
	Chair shares that this great discussion illustrates how difficult it is to implement a guideline and individualize to different patients and perhaps this is a reason why the dosage of statin is not being included in some of the recent measure recommendations like ICSI and CMS. Group did decide to revisit earlier decision (March) to set the expectation that DM patients be placed at least on a moderate level statin, based on new ICSI guidelines and new development activity by CMS and the ACC. Current recommendation is that the measure be constructed as simply "on a statin" without incorporating what level of intensity of the dose the patient is receiving.	
Suggested measure algorithms	Please refer to the measure algorithm handouts labeled "Visio Vasc Chol Statin and no dose 8-27-2014.pdf and "Visio DM Chol Statin w IVD and no dose 8-27-2014" Colette reminded groups that for the data submission and calculation of these measures that we are collection "raw" patient level data and then are writing rules within the data portal to program and calculate the measure. It is desirable to have all the patients flow through the logic, even if at some steps there are only a few patients, like age 18 to 20 with cardiovascular disease (yes, we have a few patients). It is also desirable for a patient that falls into both measures (by virtue of having cardiovascular disease and diabetes, about 30%) that they are treated (or calculated) the same way in each measure. So while the algorithms may not flow how one would think clinically, they are structured to address some of the larger things first, for example if you are on a statin versus looking for a contraindication first. Clarifications: ▪ "On a Statin" means that the patient was prescribed a stain/ had a statin ordered ▪ Does not need to be prescribed the whole measurement period, just on a statin sometime during the measurement year and this is the same for the aspirin/ anti-platelet component of the measures. So even if you started a statin and then stopped it, credit for the current measurement period. ▪ We will be asking for a date (the most recent) to anchor the activity to the measurement year ▪ If the patient is not on a statin but has valid contraindications, is a numerator pass ▪ Will be having the groups the contraindication reason as well as the date ▪ If a patient has a contraindication for the cholesterol component, they are treated specially for this component (numerator exception) but not removed completely from the composite measure. ▪ Intolerance is usually tied to a reason or diagnosis like GI bleeding in the aspirin measure Member clarifies that for the actual measurement of the fasting cholesterol every four to six years for the assessment of risk. ACC/AHA guideline recommendations for monitoring every 3 to 12 months to assess response to therapy and adherence of statin medication. Question the recommendation for every four to six years for the general population, or is it for diabetics. Historically, but under old guidelines, recommendation for testing the diabetes population was annual, but no guidance specifically to assessment of those patients with diabetes not on a statin. Members were comfortable with have the date parameter for assessing LDL to within a five year time frame. Discussion revisited for the patients with diabetes who fall in the age category of 21 to 39, what if their LDL is $\geq$ 190, they really should be on a statin and not given a numerator exception (free pass). This was included on prior iterations of the measure algorithm, but dropped off when the focus shifted to diabetics age 40 to 75. There is some concern about this particular age group and the use of statins in women of potential child bearing years, balanced	Modifications for measure algorithms include: DM ages 21-39 add step to incorporate if LDL $\geq$ 190 to flow into receiving a statin. LDL values used in measure calculations need to be obtained within the last five years. This would be during the measurement period and four years prior and this is to be applied consistently where LDL is part of the algorithm. Vascular patients are to have a safety component/ step added where there is not an expectation of statin use when the LDL is less than 40.

Topic	Discussion	Action
	with the desire to reduce the long term risk for those women in this age group with elevated cholesterol levels and LDL ≥ 190. One member suggested removing all women of child bearing years from the from diabetes measure, either as an exception from this component or from the measure all together; another member commented that child bearing years has now increased by a decade and that this would be a large number of patients with diabetes. Initially, work group supports its original decision to not include LDL ≥ 190 for Diabetes (DM) age 21 to 39 based on the concern of use in statins with child bearing years. Continued discussion about remaining aligned with guidelines and cardiologist feedback that there are many with familial hyperlipidemia (FH) with elevated LDL levels that will have disease manifested before they hit 40 and they can benefit from statins. The clinical coronary heart disease rates for untreated FH are 30% by the age of 30 and 50% by the age of 50. Several of the cardiologists concur that if we were to leave these higher risk patients out of the DM algorithm by giving them a free pass, we would be doing a disservice to reducing cardiovascular risk for patients with diabetes. Group thoroughly discussed and decided that DM age 21 to 39 should have LDL ≥ incorporated into the algorithm. Guidelines talk about a level of LDL ≥ 190 anytime during one's life time, and again we run into the assumption that it is an untreated LDL, and although EMR's may be able to search back through many years, for purposes of measurement and consistency will look for an LDL ≥ 190 within the last five years. For cardiovascular patients, another concern was raised regarding situations where the patient's LDL is between 40 and 50; do the patients actually get started on a statin? Cardiologists say no, in all practicality they do not because even with a lower dose statin they would soon be lowered to a place where they would have to be taken off. medications. Guidelines state that when a patient is treated and the LDL falls below 40 that one needs to start backing down on the dosing. Cardiologists share that once your LDL is below 70 it is just not quite clear how much benefit there will be, it is unchartered territory. Suggestion to set a lower parameter of LDL of 50, but question whether this would be evidence based and would it be better to use less than 40 as indicated in the guidelines? Another suggestion was to build this into the contraindications/ exceptions for a patient/ provider based reason, feeling that a LDL based parameter is a blunt tool. Another member shared that in trying to implement the guidelines for patients with cardiovascular disease that they have gotten push back from providers "Do you really want me to start a statin on a patient with an LDL of 44?" We do actually have the value coming through in the data system, so we could build this into the measure. Although this represents a small amount of patients, members feel that there is a safety component and it would be most in line with ACC/AHA guidelines to use less than 40. Group was comfortable with setting this lower target, understanding that if the evidence changes in the future (i.e. you shouldn't go below 30), then we will get together again.	
	Changes to Vascular Measure Algorithm ▪ Add to algorithm at age 21 to 75 additional flow to account for LDL < 40 = numerator pass. LDL value reflects the most recent within the last 5 years.	
	Changes to Diabetes Measure Algorithm ▪ For LDL < 70 change from during the measurement year to LDL (most recent) within the last 5 years ▪ Add to algorithm at age 21 – 39 additional flow to account for LDL ≥ 190 (most recent) within the last 5 years should be on a statin unless contraindicated	

Topic	Discussion	Action
Contraindications/ Exceptions to the Numerator- being on a statin	Contraindications for the cholesterol component of this measure are treated as exceptions to the numerator, that is patients are still included in the denominator for the patient level all-or-none composite measure, but are treated differently for this component based on contraindications for taking statins. To start the discussion about contraindications, Collette created a list of the contraindications that are currently listed in the draft CMS cholesterol management measure: Pregnancy, breastfeeding, liver disease, allergy, drug interaction and intolerance (listed as myopathy, myositis, rhabdmylosis and myalgia) Pregnancy- for the diabetes measure, pregnancy, or diabetics that are pregnant are an up-front exclusion to the measure so are of less an issue, but there is not a similar exclusion for the vascular measure, so this will been to be built into the contraindications. This is a condition that is codable using ICD-9/ ICD-10 diagnosis codes and we already have a definition that we use across several measures, so this is doable, feasible and as it is an absolute contraindication to taking statins, we should include this. Breastfeeding- this is also an absolute contraindication that we need to take into account, but it is harder to get at through documentation in that it is not able to be expressed via diagnosis codes. This would have to be built within group's EMR systems. Question was raised in that if we are going to the length of having something built in the EMR, so we consider something for women who are actively trying to get pregnant? One member feels strongly that all women of child-bearing years should be an exception to this statin based component. Concern if a women is of child bearing age and not actively using birth control, but today the upper end of the age range could be 35 to 50. Idea suggested again about having any provider documented reason count as a contraindication and that some type of mechanism could be set up to make sure that providers don't use that field too much. Collette shares her viewpoint that she would rather have well defined contraindications rather than carte blanche use of a contraindication or exception. It decreased the reliability and validity of a measure and is really difficult to validate on audit. The chair shares that this might be a larger issue across measures, perhaps addressed at some point in the future by MARC, but outside of the scope of these two measures. One of the cardiologists shares his perspective on statin use and pregnancy, the reason that you don't want to give statins to a pregnant women relates to nourishment, and cholesterol is needed. Concerned that it we get too broad in exempting a whole age group that we will be missing the opportunity to treat women who are truly at risk of developing cardiovascular disease before they hit age 40. Another cardiologist concurs that if the measure sends a signal to not treat someone who is at high risk due to FH just because they might get pregnant in the future is a concern. Another viewpoint expressed that we most likely are talking about a relatively few number of patients at	

Topic	Discussion	Action
	risk and that we should lean towards the side of safety. Staff suggestion: Currently for the aspirin/ antiplatelet component of both of these measures we have as one of the acceptable contraindications as "Other reason if documented by the physician" … but we list what those reasons are. For the construction of this measure, we are planning on groups telling us which contraindication does apply to the patient and we could structure it something like this: **[Collette's post meeting thinking]** This is not a complete list by any means, just a way to get us thinking: The first part of the list are things that can be identified by code; the second part of the list that starts with those things that are not captured by diagnosis codes and would need to be documented by a provider. 1 = pregnancy during the measurement period 2 = liver disease (we still need to discuss this) 3 = myositis or rhabdomylosis (we still need to discuss this) 4 = other provider documented reason: women of childbearing age not actively taking birth control 5 = other provider documented reason: breastfeeding during the measurement period 6 = other provider documented reason: allergy 7 = other provider documented reason: drug interaction (cyclsporins and protease inhibitors?) need more discussion) Earlier comments in the meeting about myopathy, to be continued at the next meeting. Concern about the terminology for intolerance- myopathy can mean many things, any disease of the muscle, and sort of a bucket category. Would recommend the more discrete conditions of myositis, rhabdomyolysis and myalgia … not myopathy.	
Next Steps	Group requested another in-person meeting to finish discussions and decisions for numerator exceptions related to contraindications. Will try to schedule as soon as possible and as schedules allow.	

MNCM Diabetes Ad-hoc Cholesterol Work Group
Minutes Meeting # 3

Wednesday, October 1, 2014

9:00 am to11:00 am

Meeting Attendance:

Work Group Member		Work Group Member		Work Group Member	
X	Beth Averbeck, MD, Chair		Jonathon Ward Godsall, MD	X	Terry Murray, RN
	Mark Nyman, MD (phone)	X	Christopher Restad, DO	X	Jeanine Rosner, RN
	Victor Montori, MD		Rebecca Moxness, MD		Monica Simmer
X	JoAnn Sperl-Hillen, MD	X	Thomas Knickelbine, MD (phone)	X	Pam York
	Courtney Baechler, MD (phone)	X	Woubeshet Ayenew, MD	X	Kris Soegaard
Guests		**Observers**		**MNCM Staff**	
X	Senka Hadzic, ICSI	X	Denise McCabe (phone)	X	Collette Pitzen, facilitator
		X	Sarah Evans	X	Jasmine Larson

Minutes

Topic	Discussion	Action
Meeting Overview - Welcome - Conflict of Interest (COI) - Goals for Meeting	Meeting is conducted in person and by phone; recorded for minute taking purposes. Materials distributed prior to the meeting included: agenda, minutes from the previous meeting, vascular measure algorithm, diabetes measure algorithm, summary of exceptions to statin use, safety recommendations from the ACC/AHA guidelines, codes for liver disease, and codes for other diseases suggested as exceptions to statin use. Members in present and on the phone introduced themselves. MNCM is committed to disclosing all potential conflicts and competing interests and taking action when necessary to assure that all measure related activities are free from any real or perceived control or influence of commercial, proprietary or political interests. We all have the responsibility to recognize and clearly state any potential conflicts of interest that may arise during the course of work group discussion.	None

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td>Goals for Meeting & Agenda</td><td colspan="2">Beth reviewed the goals for the meeting today. At the last meeting, the group felt there was insufficient time to discuss and make decisions for the contraindications/ exceptions for statin use. Our goal is to complete our recommendations today and present them to the Measurement and Reporting Committee (MARC) Wednesday of next week. Additionally, we are the measure stewards for the Optimal Diabetes and Optimal Vascular Care measures and the diabetes maintenance application (with guidelines related changes) is due in December.
▪ Review ACC/AHA Table 5 Safety Recommendations
▪ Review, Discuss and Decide Contraindications and Exceptions to Statin Use. List for group to discuss includes the following; ✓ indicates already discussed and deemed important to have these exceptions</td><td rowspan="2">No additional agenda or discussion items added.
For information.</td></tr>
<tr><td>Absolute Contraindications
[Identifiable by code]
▪ Pregnancy (641.01 – 679.02 and V22.0 to V23.89) ✓
▪ Liver failure (see ICD-9/ ICD-10 code list)
▪ Rhabdomyolosis (728.88)
[Not identified by code; need provider documentation]
▪ Breastfeeding during the measurement period ✓
▪ Women of childbearing age not actively taking birth control ✓
▪ Allergy ✓</td><td>Other Exceptions (potential)
▪ Active Liver disease (see ICD-9/ ICD-10 code list or lab value > 3 times UNL)
▪ Heart Failure (428.xx, 425.xx)
▪ ESRD/ Dialysis (V56.x. V45.11 and 585.6)
Other provider documented reasons
▪ Drug interaction- suggest listing long term/ contraindicated to some
▪ Intolerance (need to define)</td></tr>
<tr><td>Review of Measure Calculation Algorithms</td><td colspan="2">Collette walked through each measure algorithm to assure that all changes that the work group had asked for during the last meeting are taken into account. This a technical view of the component, not necessarily a clinical one that asks first if the patient is on a statin, then if not proceeds through all of the possibilities of age parameters, low LDL evaluation and then contraindications or exceptions.
For the vascular measure and the exception for LDL < 40, most recent in the last 5 years. There was some discussion around having any LDL in the last five years, not just the most recent. Collette shares that it has typically been our measurement standard for physiological based measures (A1c, blood pressure) to evaluate the most recent value in a measurement period. Concern expressed that some patients might be off and then on then off statins based on trying to meet the measure, but also in the context that we could be talking about a very small number of patients. From a technical standpoint, it could add complexity in terms of programming and validation to look for any value in a five year time frame. Suggestion was made to just make it a choice in the exception field, adding a category to indicate that LDL has been less than 40 in the last five years. Countered with the LDL value and date of the LDL test is already a part of the data submitted and would be more accurate to continue to accept the value and date. Data analyst shares that if they were to provide a LDL value with a date, adding the caveat of any value in the last 5 years would add complexity. After further discussion in the context of all contraindications and exceptions, the work group reached consensus that all LDL low values (< 40 for vascular and < 70 for diabetes) should be specified as the most recent LDL in the last five years.
No changes to the cholesterol component calculation algorithm for the vascular measure.
For the diabetes population: This measure algorithm initially looks just like the vascular measure to account for patients with both diabetes and ischemic vascular disease. We want this type of patient to be calculated the same way regardless of which measure. Collette walked through the additional algorithm steps for patients with diabetes.</td><td>Measure calculation algorithms approved.</td></tr>
</table>

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td>Review ACC/AHA Table 5 Safety Recommendations</td><td>Please refer to handout “Summary Exceptions Statin Use 9-29-2014”. During our last meeting we did discuss and agreed about the absolute contraindications for pregnancy and breast feeding. Quotation from guideline safety recommendation # 1:
To maximize the safety of statins, selection of the appropriate statin and dose in men and nonpregnant/ nonnursing women should be based on patient characteristics, level of ASCVD* risk, and potential for adverse effects. Moderate-intensity statin therapy should be used in individuals in whom high intensity statin therapy would otherwise be recommended when characteristics predisposing them to statin associated adverse effects are present:
・ Multiple or serious co-morbidities, including impaired renal or hepatic function
・ History of previous statin intolerance
・ Unexplained ALT elevations > 3 times the upper normal limit
・ Patient characteristics or concomitant use of drugs affecting statin metabolism
・ Age > 75 years
Additional characteristics that may modify the decision to use higher statin intensities may include, but are not limited to:
・ History of hemorrhagic stroke
・ Asian ancestry
Beth reminds us that while considering the selection of exceptions to statin use that we need to have a strong evidence base for doing so, but also keeping in mind that these are brand new guidelines that may be refined in the future and changes may necessitate the work group re-visiting the measure design.

No comments or questions.</td><td></td></tr>
<tr><td>Discussion of Contraindications and Exceptions to Statin Use</td><td>Table 1 = Definable by diagnosis codes/ more reliable/ less burden
<table><tr><th>Exception</th><th>Thoughts</th><th>Status</th></tr><tr><td>Pregnancy</td><td>Strong evidence; supported by guideline</td><td>✓ agreed</td></tr><tr><td>Rhabdomyolysis</td><td>Strong evidence; supported by guideline</td><td>✓ agreed</td></tr><tr><td>Liver failure</td><td>Evidence implied; statins metabolized by liver</td><td>Discuss/ Define</td></tr><tr><td>Active liver disease</td><td>Inconsistent w guideline for alternative dose statin</td><td>Discuss/ Define</td></tr><tr><td>Kidney failure (ESRD)/ hemodialysis</td><td>Not enough evidence for benefit</td><td>Discuss</td></tr><tr><td>Heart Failure</td><td>Not enough evidence for benefit</td><td>Discuss</td></tr></table>
(please refer to handouts containing suggested lists of codes)

Liver Failure and Active Liver Disease-
VSAC- on a call with other developers of cholesterol measures was asked to check the VSAC (Value Set Authority Center) for existing codes sets for liver disease. Collette did search the VSAC and there are no current definitions for liver failure or liver disease. Key codes for liver failure include codes with the following: necrosis, cirrhosis, alcoholic liver damage, hepatic encephalopathy, hepatorenal syndrome, and hepatic coma.
Work group member asked if the patient would need to have one of these codes present or could the provider “check a box” to</td><td>Exceptions to Stain use include:
▪ Pregnancy
▪ Active liver disease (liver failure, cirrhosis, hepatitis)
▪ Rhabdomyolysis
▪ Ends stage renal disease on dialysis
▪ Heart failure
▪ Breastfeeding
▪ Woman of child bearing years not actively taking birth control
▪ Allergy to statin
▪ Drug-drug interaction with specified list of drugs for all statins</td></tr>
</table>

Topic	Discussion	Action
	indicate that liver failure or liver disease is present. Collette clarified that yes, this is desirable. When we do have disease codes that represent the desired condition, a programmer can look for those codes in either the encounter diagnoses or the patient's problem list to populate the exception, rather than an EMR build of a new field to capture the information. Work group member shares that they currently have a BPA (best practice alert) for cardiovascular disease and not on a statin. Collette shared that other mechanisms besides ICD-9 codes can be used to population the exception field if a contraindication exists but that not all groups have those mechanisms and where it is possible to define by diagnosis code we should, but it is not the only mechanism. Need to remember that we need to build something that will work for several different EHR's. Collette refers to the summary document field AF (pg. 4) that outlines the suggested choices for the exceptions; however the group based on their EHR gets to that determination is up to them/ their system, but it needs to be auditable. Member proposed that we accept all liver failure and active liver disease diagnosis codes as an exception because they represent a risk to the patient who has those conditions and is considering statins. Takes into account patients with liver disease preference because they can take statins if willing to accept the risk and they fall into the numerator at the first decision point (on a statin?) but if they decide not to take the statin, would be counted as an exception. Example is given that patient who have chronic compensated stable cirrhosis would still be a candidate for statin therapy; is not absolutely contraindicated. Hepatitis and Hepatitis C also discussed as patients who could receive statin therapy. Member counters with it's not so much an issue of taking a statin or not, rather it is can the condition influence the risk-benefit ratio that leads to a rationale decision by the patient to not take a statin. In our current measure construct, the patient with liver disease would get credit for being on a statin or conversely not get penalized for not being on a stain because it is considered a reasonable exception. Looking at the ICD-10 code list NASH (non-alcoholic steatohepatitis should be removed from the list of liver disease codes; these patients can and should be on a stain. Discussion ensued regarding population health versus individual patients, having a measure that is meaningful and in the population's best interest, knowing that not every patient / provider will hit 100%. In terms of liver disease itself 1) patients with this condition tend to be excluded from clinical trials for statins and 2) we are really talking about a small percentage of the patient population. One of the aims of a good measure is to do no harm and in light of lack clinical trial experience with patients with liver disease, work group feels comfortable in the decision to include all proposed active liver ICD-9 disease codes (see handout). **Dialysis/ End Stage Renal Disease (ESRD)**- Evidence for patient deriving benefit from initiating statins once they are on dialysis is not great; guidelines have no recommendations (don't say treat or don't treat with statins). Provider's experience is that these patients often have significant ischemic cardiovascular disease and many patients may be on a statin prior to ESRD and continue their statin use. There may not be a mortality benefit, but there is a morbidity benefit (less hospital readmission, AMI) for these patients. Although it may be a good idea to continue to treat these patients with statins, it is outside the scope of the current guideline recommendations and we should consider including as an exception. Common themes around group's discussion and decision making around which exceptions should be allowed include 1) exclusion of a particular condition from clinical trials and 2) not being penalized if statin is utilized per individual determination of benefit, but providing reasonable exceptions for patients who are not on a statin. Work group member clarifies that there are clinical trials that included ESRD and there was no benefit; these patients have a high number of co-morbids and they tend to die of conditions other than cardiovascular disease. Work group member expresses concerns in regards to the significant impact of cardiovascular disease on the patients with heart failure and end stage liver disease, particularly for the large proportion of the dialysis patients are minority and African Americans. In the next iteration of this measure we need to more closely examine the current decisions around these two	▪ Intolerance (with supporting documentation of trying a statin at least once within the last 5 years)

<table>
<tr><th>Topic</th><th>Discussion</th><th>Action</th></tr>
<tr><td></td><td>
exceptions. Work group members shares that a nephrologist's personal experience with this has been if the patient who is starting dialysis has been on a statin, they leave the patient on a statin. If the patient starting dialysis has not been on a statin prior to dialysis, they don't initiate it. Work group members who have talked with ACC guideline work group members share that the ACC/ AHA group really struggled with this topic. National Kidney Foundation guidelines concur with the ACC/AHA; no benefit for patients on dialysis. Measure development workgroup members feel that this is a really gray area and after discussion agree that end stage renal disease on dialysis should be an exception.

Heart Failure-
Most common reason for heart failure is ischemic heart disease, either a history of coronary artery bypass graft or significant cardiovascular disease. Trying to identify the heart failure patients referenced in the guidelines, based on severity class II – IV heart failure, is not feasible utilizing current ICD-9 codes, or feasible to try to tease apart that patient population, One could simply use the existing heart failure codes (without indication of severity) as an exception. Recommendation to include all the heart failure codes listed as they related to ischemic disease, but don't include the proposed cardiomyopathy codes.

Table 2 = Not definable by diagnosis codes/ Need EMR fields builds/ less reliable/ more burden
<table>
<tr><th>Exception- Other Provider Documented Reasons</th><th>Thoughts</th><th>Status</th></tr>
<tr><td>Women of childbearing age not actively taking birth control</td><td>Strong evidence</td><td>✓ agreed</td></tr>
<tr><td>Breastfeeding during the measurement period</td><td>Strong evidence</td><td>✓ agreed</td></tr>
<tr><td>Allergy</td><td>Strong evidence</td><td>✓ agreed</td></tr>
<tr><td>Drug interaction (list common)</td><td>Some inconsistency with guideline for alternate dose statin</td><td>Discuss and Define</td></tr>
<tr><td colspan="3">If pursue drug interaction would recommend sticking to longer term meds that have absolute contraindications with <u>some</u> of the statins: HIV protease inhibitors, nefazone, cyclosporine, gemfibrozil, and danazol. See supporting FDA tables below.</td></tr>
<tr><td>Intolerance to statins</td><td>Potential for being inconsistent with guideline recommendations for alternate dose statin</td><td>Discuss and Define</td></tr>
</table>

Women of childbearing age not actively taking birth control-
Breastfeeding during the measurement period-
We had an extensive discussion of this at our last meeting; there is guideline support for these two exceptions. They are not definable by ICD-9 diagnosis codes, so will need to be included in other provider documented reasons. Despite the potential burden, need to be included as allowable exceptions because of the absolute category X contraindication to the use of statins during pregnancy and breastfeeding.

Drug Interaction-
In reviewing FDA information on statins; there is a fairly short list of long term drugs that are considered a contraindication to some stains: HIV protease inhibitors, nefazone, cyclosporine, gemfibrozil, and danazol. Not planning to include the shorter term drugs (anti-biotics) in the list of acceptable drug-drug interactions because a different anti-biotic could be selected or the statin
</td><td></td></tr>
</table>

Topic	Discussion	Action
	discontinuation would only reflect a small portion of time during the measurement year. Questions raised in terms of not all the drug-drug interactions are related to all statins; one could find another statin to place the patient on. Should we even have this as an exception? Work group member shares that from a technical standpoint, all of type of drug-drug interactions are already built into the EMR systems; a meaningful use requirement and all groups are downloading and using the same application. After lengthy discussion which included feasibility of a granular by drug methodology and the appearance of black box warnings on simvastatin and lovastatin applying to other statins as well, the group was in favor of including drug-drug interaction as an exception with the short list of drugs for all statins. **Intolerance**- From a technical standpoint, using the very limited ICD-9 codes for myositis and toxic myopathy might be cleaner because typically all intolerance is "buried" in an EMR field that combines allergy and intolerance into one field … currently not able to tease apart although some groups are working on doing this. Collette shares that current state of this field would force a medical group to default to one or the other of the current categories (8 = allergy or 10 = intolerance) could provide challenges in the validation audit process and there will need to be allowances made (accept either category and then look for verification in the record). Collette also shared that because this measure component redesign is going to MARC next week, we had a prep call with the co-chairs Howard Epstein and Tim Hernandez. Tim felt that there would be significant concern around intolerance, which is a significant issue for patients. The ACC/AHA guidelines (pg. 35 Table 5 recommendation # 8) are fairly black and white around methods to evaluate myalgia or musculoskeletal symptoms, trails of rest and then different doses to get patients back on statins. Perhaps this is one area that we could accommodate patient preference and include an exception around any documented intolerance with supporting documentation of trying a statin at least once in the last 5 years. Suggestion was made that there are at least two different statins tried; which is a good idea clinically, but could be very burdensome for groups to collect and submit data. The intolerance code for exceptions will be listed as: 10 = other provider documented reason: intolerance (with supporting documentation of trying a statin at least once within the last 5 years) Will also provide guidance that the ICD-9 codes myopathy and myositis may be used (but not required) for the documentation of intolerance. 359.4 Toxic myopathy (myopathy due to drugs) 728.0 Infective myositis (purulent or suppurative myositis) 728.81 Interstitial myositis	
Next Steps	Will be presenting the work group recommendations to the Measurement and Reporting Committee (MARC) next week, Wednesday October 8th at 7:30 am. Materials for MARC are due for distribution in two days; Collette will distribute the MARC packet with completed materials to the work group on Friday, October 3rd. All work group members are invited to attend the meeting as guests. Component changes will be in effect for dates of service 1/1/2015 to 12/31/2015 reported in 2016. Question related to pilot testing of the measure. We will be performing our normal validation processes for this existing measure with a new component keeping a keen eye to any threats to validity. If there are threats to the validity, as determined	

Topic	Discussion	Action
	by the measure review committee, issues will be considered and reviewed by MARC and/ or the measure development work group prior to any decision for public reporting.	

Depression Measures: Proposed Re-Index Methodology Change
Feedback from DDS Technical Workgroup

Communication to Workgroup (sent 12/09/2014)

To: MNCM DDS Technical Advisory Group
Re: Proposed technical improvements to Depression Measure Set

Background/ History

When the depression measure set was first developed in 2008, the diagnosis field was required on every record. Immediate feedback from medical groups was that not every contact had an associated diagnosis; in fact, some contacts (for example: telephone, case manager, nurse or survey returned by mail) had no diagnosis code associated with the encounter at all. The intent of the measure is to allow every PHQ-9 that is administered to the patient, so the programming was changed to:

- Use the diagnosis field to index the patient (diagnosis + elevated PHQ-9)
- After index, accept all subsequent PHQ-9 scores for the indexed patient and do not require a diagnosis for any subsequent PHQ-9 scores
- After a previously indexed patient's 13 month measurement period has ended, a subsequent PHQ-9 score greater than 9 initiates a new measurement period (re-index), with or without an accompanying diagnosis code.

As time has passed, and as these measures have grown to include a larger patient population with each measurement year, MNCM has received feedback from medical groups regarding the technical challenges with the large data files as well as the re-indexing methodology, making it difficult to identify patients in a given assessment period. As a result, MNCM has explored possible technical changes to the measure set that are aimed at addressing these concerns. Prior to implementing any changes, MNCM would value your feedback and comments regarding the proposed changes.

Current Re-index Methodology

The depression measure is longitudinal and measures a patient's progress towards remission after an index visit or contact.

Indexing occurs when:

- Patient has aPHQ-9 score greater than nine AND a diagnosis of Major Depression or Dysthymia at the index visit.

  OR

- A previously indexed patient, whose associated 13 month measurement period has passed, has a subsequent PHQ-9 score greater than nine.

As stated above, a previously indexed patient does not require an accompanying diagnosis with an elevated PHQ-9 result in order to be indexed again. Early decisions about the technical functioning were based on 1) the episodic nature of depression and the likelihood that an elevated PHQ-9 for a patient with a history of major depression was entering a new episode of depression, and 2) the technical decision to not require a diagnosis for every PHQ-9 record submitted. As the measure has matured and the database of indexed patients has grown, there is a need to technically simplify the re-index event and confirm the new episode of major depression or dysthymia.

In January of 2014, MNCM explored the feasibility of relying on patient problem lists with active diagnoses for major depression or dysthymia. This work group (DDS Technical Advisory Group) determined that, based on their experiences, the problem lists were not reliably updated by providers, particularly for removing diagnoses that were no longer active.

Depression Measures: Proposed Re-Index Methodology Change
Feedback from DDS Technical Workgroup

In April of 2014, during the annual measure review process conducted by the Measure Review sub-committee of the Measurement and Reporting Committee (MARC), it was recommended that MNCM staff explore ways to technically simplify the measure, particularly in regards to the re-indexing events.

Proposed Re-Index Methodology (2016 Report Year)

For dates of service beginning 2/1/2015 (the next full submission cycle):

- Require an accompanying diagnosis of major depression or dysthymia and an elevated PHQ-9 > 9 for the ALL index visits or contacts
- When diagnosis codes are available on a contact record; groups are to submit the code for the patient's major depression or dysthymia and not suppress codes following any index contact(s).
- It is recommended that groups continue to utilize their EMR's for submitting PHQ-9 results. The MNCM data portal will identify index visits or contacts based on the index contact definition.

Impact for Medical Groups:

1. Data files no longer need to include PHQ-9 scores for all patients who have EVER indexed. Look back date ranges will be included in the Data Collection Guide.
2. If programming is suppressing diagnosis codes for Field = Diagnosis (column T); must modify to include the depression or dysthymia diagnosis codes. If groups are not suppressing any depression or dysthymia diagnosis codes; no additional action is required.
3. Query program primary care: if encounter diagnosis 296.2x, 296.3x or 300.4 is in any position (primary or secondary diagnosis) populate Field = Diagnosis (column T) with the diagnosis code
4. Query program behavioral health: if encounter diagnosis 296.2x, 296.3x or 300.4 is in the primary position (only) populate Field = Diagnosis (column T) with the diagnosis code.

Feedback

Please comment on the technical feasibility of including the depression diagnosis codes (when present) for every visit or contact record included in the data submission file.
Please provide your thoughts/opinions on whether this change will impact your group's ability to identify index events for internal QI use and/or tracking of patients.
Additional thoughts, comments or feedback?

Feedback

Caryn McGeary, Affiliated Community Medical Center	I work with our IS staff to create the query and understand this information very well. I do not believe the new logic at least for Allscripts EMR users is technically feasible as not all PHQ-9 entries will be linked to a diagnosis code. For example a patient may have a PHQ-9 done however no visit so to require confirmation of the presence of major depression this would require a significant workflow change for staff as well as the issue of how ensure it is a "reoccurrence" not the same episode. **Feedback** Please comment on the technical feasibility of including the depression diagnosis codes (when present) for every visit or contact record included in the data submission file. (with today's process at ACMC capturing the diagnosis code at each contact would be extremely difficult. Potentially nurses could be contacting patients

	to rescore PHQ-9's (as a data entry) however they aren't providers and therefore cannot enter diagnosis codes creating the patient to be re-indexed. This proposed process doesn't appear to allow for utilizing staff to the highest level of their licensure. Please provide your thoughts/opinions on whether this change will impact your group's ability to identify index events for internal QI use and/or tracking of patients.- no this will not make tracking for internal QI use easier as it actual appears to complicate the measure even more as we would have to try to find a way to track diagnosis codes for each patient contact in the record (if even possible), reeducate all staff, and then rebuild all the reports! Additional thoughts, comments or feedback? I believe the larger issue that isn't really addressed in this is why patients who are getting "re-indexed" are considered in the same measurement as those who are newly indexed for the first time. It would be difficult to determine in EMR's via tracking what is an actual brand new episode versus an ongoing episode that might be tracked via PHQ-9 utilization monthly, quarterly, yearly for patients. I don't know what the solution to the "re-indexing is" but I do not think this change is the solution as it appears to add more complexity and difficulty retrieving data than the current process. I would recommend not changing to this process without a pilot group testing submission of the new and old methodology. Please call me if you have questions. *Topic was further discussed by Caryn McGeary & Measure Development Team on 01/07/2015*
Terry Murray, Allina Health Clinics	1. We do not anticipate a problem with technical feasibility on our end but unless it substantially reduces the size of the sample file, problems with upload may persist. 2. The draft specifications of re-indexing mirror our current internal re-indexing methodology and would not represent a change in population identification. 3. We are somewhat disappointed that the draft changes do not improve alignment with the CMS eMeasure specification which Allina will begin reporting for 2015 DOS as part of our ACO commitment. Since MNCM is the measure steward for the CMS version, you must be well aware of the differences in outcomes between the 2 sets of specifications. Although problem list maintenance is certainly an issue, so is the random chance of a previously indexed patient having both a coded visit and a PHQ9 score >9. A recent comparison of the 2 populations suggests that we may be missing 50% of patients currently being treated for depression using the MNCM registry indexing. We believe that the problem list identification would significantly and accurately identify a larger population that needs the same level of care as that of our currently indexed registry patients. *Topic was further discussed by Terry Murray & Measure Development Team on 01/07/2015*
Lisa Aker, HealthPartners	The below feedback is for Park Nicollet, HP Medical Group, HP Central MN Clinic and Stillwater Medical Group. Feedback is positive regarding the proposed changes. However, we do have a few

	comments from the technical perspective as it pertains to the specifications.
	
	• How will the numerator/denominator data be calculated while transitioning from old to new definition of reactivation?
	  o Will each patient currently being followed according to the old definition continue to be actively followed for 13 months based on the PHQ9 alone, and then transition to the new definition of reactivation requirement of PHQ9 and ICD9 Dx code following that 13 month window?
	  OR
	  o Will patients that are currently indexed be re-activated under the new definition only, once implemented?
	
	• Is it expected that it will take two data submission cycles before all patients will have transitioned to the 'new' definition?
	
	• Is it anticipated that these changes will go into effect for 2016 submission (2015 collection)? If so, when is it anticipated that updated specifications will be provided?

Angela Nathan, CentraCare	CentraCare has reviewed this recommendation and agrees that it would not only be easier from a reporting standpoint, but would better represent the care that is being provided. Thank you for reviewing this measure and exploring an improved way to report depression data.
Deb Erickson, Olmsted Medical Center	We at OMC have discussed these changes and think they are a great idea. We always submit a diagnosis code with the phq9 if there is one available. Therefore these changes will not affect how we collect and submit our data to MNCM. Additionally, these changes will make it easier for us to determine internally when a patient was indexed and for how long. I also believe the data, and therefore the metrics, will be more accurate. If a patient was previously indexed, a phq9 taken anywhere in our system would re-index the patient according to the current criteria. In some cases, this patient should not have been re-indexed as the elevated phq9 might be from a higher level of anxiety on that particular day and is not indicative of the overall mental state of the patient. The diagnosis of depression and subsequent re-indexing is something that must be determined by a clinician's diagnosis, not by a single test. Thank you for giving us the opportunity to provide feedback on this measure. It is one we have struggled with internally because it is extremely difficult to determine when a patient is re-indexed unless we keep track of every index and re-index. Our clinicians want to focus on patient care and not on when a PHQ9 needs to be administered in order to have it count for a metric. This is a great step in the right direction toward that goal.

Depression Measures: Proposed Re-Index Methodology Change
Feedback from DDS Technical Workgroup

Drs. Jeffrey Gursky & Randy Hemann, Olmsted Medical Center	To Whom It May Concern: We at Olmsted Medical Center are in favor of your proposal to modify the criteria used to re-index patients for the Minnesota Statewide Quality Reporting and Measurement System of Depression. From a technical standpoint, the proposed criteria would improve our efficiency for re-indexing in comparison to current practice. Currently, we are required to use different criteria for the initial index visits and the re-indexing visits. This has a higher likelihood of creating confusion for clinical staff and requires the use of additional databases to monitor for re-indexing visits. Using the same criteria for both indexing and re-indexing would help simplify our internal criteria and improve our ability to educate staff, as well as internally track our quality measures As for quality, the proposed changes would better represent the true response to treatment of depressive disorders within Minnesota. The current guidelines allow patients to be re-indexed that may have an elevation in a PHQ-9 that is unrelated to a recurrent episode of a depressive disorder. The proposed guidelines would help assure that the patients being followed by re-indexing for quality measures do indeed have a recurrent depressive episode, and improve the utility of the data produced to measure and improve quality, while more properly representing the quality of care delivered by providers within Minnesota. Sincerely, Jeffrey T. Gursky, MD Department Chair Department of Psychiatry and Psychology Randy P. Hemann, MD VP Medical Services

Recommendations for 2016 SQRMS Hospital Measures Reporting

April 14, 2015

Contact: Vicki Olson, Program Manager, Stratis Health
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This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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I. 2016 Hospital Measures Recommendation Process

Based on the changes approved during the 2015 hospital measures recommendation process, the Hospital Quality Reporting Steering Committee (HQRSC) met throughout the year for this recommendation cycle instead of the previous 2-3 month recommendations process. The committee charter and membership from 2014 stayed the same which allowed for continuity from year-to-year (Appendix A)

There were four steering committee meetings from October 2014 through March 2015 (Appendix B) supported by the following subgroup meetings:

- Input on priorities from the MHA patient safety registry advisory group
- Development of a guidance document through four Safer Care Subgroup meetings
- Input from PPS and CAH representative members on three subgroup calls regarding alignment with federal measures
- Exploratory call with a national expert regarding diagnostic error
- Exploratory outreach to the HIT survey developer to test out possibility of using HIT survey to submit advance directive measure
- Discussion regarding spending measures at a meeting with representatives from Stratis Health and the Minnesota Hospital Association
- Updates from the RARE Readmissions analysis through the all payer claims database
- Exploratory call with MDH, MNCM, Stratis Health to discuss measure development needs in key areas and subsequent development of a brief

The October HQRSC set the stage in identifying the measurement priorities of:

1. Care Transitions and readmissions
2. Safer Care and Avoiding Harm
3. Cost/Spending
4. End of Life
5. Behavioral Health
6. End of Life care

<u>Care Transitions and Readmissions</u>

Currently, there is a RARE readmissions measurement group looking at how the all payer claims database can support learning about patterns of readmissions and providing improvement guidance. Currently MHA is providing avoidable readmissions data to hospitals for all payers but it does not include readmissions to other hospitals. The CMS readmissions measures includes readmissions to other hospitals but only for Medicare patients. The group continues their work but there is not a plan to create a SQRMS measure using the APCD. As part of the work to align the PPS measures to the CMS incentive programs, all the CMS readmission measures that are included in the Readmission Reduction program will be added to SQRMS for PPS hospitals. Three of the CMS readmissions measures related to chronic conditions: heart failure, pneumonia and

chronic obstructive pulmonary disease are recommended to be added to the SQRMS measures for CAH.

Safer Care and Avoiding Harm

The MHA patient safety registry advisory committee was asked for their prioritization of patient safety topics. The NQF patient safety family of measures was used to identify the topic areas. These results were brought to the October HQRSC and the group reviewed. A Safer Care Subgroup was convened and over the course of four meetings developed a document to give direction to future development of a patient safety composite measure (Appendix C) Diagnostic error was identified as a an emerging patient safety issue and currently there is an IOM group that is meeting with an anticipated report date of September 2015. An initial call was held with Mark Graber, MD who is a national leader in this area and some exploratory discussion about measures.

Cost/Spending

A subgroup of MHA and Stratis Health representatives did some initial brainstorming about spending measures. The Medicare spending per beneficiary is an outcome measure for PPS hospitals. For CAH, MHA is involved in developing some financial models which may be helpful for future measurement discussion.

End of Life

There was consensus that end of life is an important and cross-cutting topic. The first step is to have conversations about end of life wishes and so a starting measure is determining if advance directives are available in the hospital electronic chart. The stage 3 meaningful use advance directive measure was approved and there was outreach to the coordinators of the annual HIT survey to test the feasibility of incorporating this question on the 2016 survey.

Behavioral Health

Access was previously identified as the major challenge facing healthcare facilities. The steering committee did not identify an expert group to provide input into this topic. There continues to be high interest and are current and future initiatives focusing on depression and other mental health topics. This priority will be further explored in the next measurement cycle.

Alignment of SQRMS measures with federal requirements

Usually the group reviews changes in the inpatient and outpatient quality reporting programs and recommends measures to be added or deleted into SQRMS. There were two prep meetings with committee members representing CAH and PPS hospitals and those recommendation were brought to a HQRSC call in February. A follow-up call was held with CAH subgroup to discuss the recently released MBQIP measures. Recognizing the complexity and wondering if this time intensive activity was adding value to SQRMS, Stratis Health initiated a discussion with MNCM and MDH to test out a potential idea of simplifying this alignment while meeting other goals to support consumer use of public reporting by

focusing on composite measures. Based on a positive response, a plan was proposed and approved at the March HQRSC to align SQRMS with the measures contained in the value-based purchasing program, readmission reduction program, hospital acquired condition program for PPS hospitals with a composite measure for each program. For CAH, the measures would align with the required measures for the Medicare beneficiary quality improvement program (MBQIP)

II. 2015 Hospital Measures Recommendations for 2016 Reporting

PPS Hospitals

The steering committee voted to align the SQRMS hospital measures with the measures included in the value-based purchasing program, readmission reduction program, hospital acquired condition program along with a composite measure for each program. Measures not meeting this criteria were recommended for removal with the exception of the "all hospital" measures listed below.

CAH Hospitals

The steering Committee voted to align the required measures with the Medicare beneficiary quality improvement program (MBQIP) and to develop a roll-up measure in next year's recommendation process. Measures not meeting this criteria were recommended for removal with the exception of the "all hospital" measures listed below.

All Hospitals

The steering committee voted to add the stage 2 meaningful use advance directive measure to support a focus on end of life care. Data submission would occur through the annual HIT survey which would continue as a SQRMS measure.

Measure summaries

To support communication and understanding of the measure changes outlined above, the following views of the changes were developed:

2016 Hospital Measure Recommendations (Appendix D)

- The changes are summarized in the format used for the MN rule appendices.

2016 CMS and State Measures proposed (Appendix F)

- The changes from 2015 are in red – either a "r" will be added or deleted "~~r~~" in the PPS, CAH or Children's columns

2016 SQRMS PPS measures proposed (Appendix G)

- A summary of proposed state measures for PPS hospitals with all payer/Medicare information

2016 SQRMS CAH measures proposed (Appendix G)

- A summary of proposed state measures for CAH with all payer/Medicare information

2016 Hospital Measure Recommendations (Appendix E)

- An excel file with two tabs – one for PPS, one for CAH – that shows what measures are added, continue, or are removed

Future direction

Several recommendations will drive the work for the 2017 measurement cycle:

- Develop a composite measure for all the MBQIP measures included in SQRMS for critical access hospitals.
- Develop a display for the PPS composite measures for VBP, RRP and HAC programs
- Develop and test a patient safety composite measure
- Look at measures that cross settings that would drive improvement (Appendix H)
- Continue to focus on the five priorities and look at opportunities with behavioral health, cost/spending and readmissions/care transitions.
- Continue to monitor diagnostic errors as an emerging patient safety issue/national priority.

Appendix A
2014/15 Hospital Quality Reporting Steering Committee Charter/Members

Hospital Quality Reporting Steering Committee

Committee Charge

2014/2015

The Minnesota State Legislature passed significant Health Care Reform legislation into law in 2007 and 2008. As part of this legislation, the MN Statewide Quality Reporting and Measurement System was established. The measures are reviewed annually and additions or deletions are made. The goal is to create a uniform approach to quality measurement in Minnesota to enhance market transparency and improve health care quality.

Minnesota Community Measurement is leading a consortium of organizations to make recommendations to the state regarding the design and implementation of the public reporting and incentive payment system. As part of this consortium, Stratis Health, in collaboration with the Minnesota Hospital Association, will convene and facilitate the Hospital Quality Reporting Steering Committee to make recommendations to MN Community Measurement regarding measures to be used for hospitals as part of the MN Statewide Quality Reporting and Measurement System.

The focus for additional measures in 2010 was on pediatric measures. In 2011, The Minnesota Department of Health was focused in looking at rural sensitive measures and clinically enhanced AHRQ indicators. The focus in 2012 was evaluating existing measures and processes, but not adding any new measures. Last year, a perinatal and stroke measure were added and several measures were removed.

Committee Charge

The committee is charged to recommend any modifications to and/or removal of the existing slate of required measures for 2015 Hospital Measures for the MN Statewide Quality Reporting and Measurement System. The hospitals affected include PPS, CAH and Children's hospitals. Recommendations regarding deletions or updated specifications to the current measures are within the scope. Clinic measures and Ambulatory Surgery measures are out of scope. The steering committee will recommend changes in the measures in an advisory capacity to MN Community Measurement; final decision-making rests with the MN Department of Health. The committee will:

A. Review existing measures to make recommendations for alignment with other required measures. Recommended changes to the existing measure set should consider two criteria:
    a. Alignment should drive change to patient-centered outcomes and improvement.
    b. Alignment should streamline reporting to reduce burden.

B. Review existing measures to make recommendations for rural relevance. Recommended changes to the existing measure set should consider two criteria:
   a. Likelihood of CAHs to produce adequate volume to support measure reporting.
   b. Relevance of the measure to services provided at CAHs.
C. Recommend a slate of 2015 hospital measures for the MN Statewide Quality Reporting and Measurement System to MN Community Measurement by May 2014, and recommend a slate of 2016 hospital measures for MN State Quality Reporting and Measurement System to MNCM by April 2015. Topic specific workgroups may convene as necessary to develop recommendations for the Committee's consideration. Measure additions, removals, or modifications should relate to one or more of standard criteria for all SQRMS recommendations.
   •

The group will convene a face-to-face (with conference call option) for one meeting to accomplish the tasks for 2014, and submit a summary report and recommendations by May 31, 2014. The process for 2015 will start in October 2014 with meetings in October 2014 and January 2015 to consider measures and make final decisions in February and March to put forth a slate of measures by April 1, 2015. A follow-up meeting will convene in May 2015 to consider the comments made during the informal comment period and to launch the 2016 process which will start with an October 2015 meeting.

MDH has defined the recommendation criteria and process described below.

Recommendations for publicly reported quality measures in SQRMS must be developed in consideration of what information will aid consumers, employers, and other health care purchasers in their comparison of physician clinics and hospitals, and decision making. At a minimum, quality measure recommendations for public reporting and quality improvement will adhere to, and include discussion of conclusions related to, each of the criteria outlined below. It is understood that different measures may relate more to some criteria than others, and that the Hospital Quality Reporting Steering Committee may choose to consider additional criteria. In recommending measures, the Contractor must consider MDH's strong preference for outcome, patient-reported outcome (or functional status), and electronic measures. In recommending measure modifications and removals, the Hospital Quality Reporting Steering Committee should consider clinical research findings and evidence, and the results of previously collected quality measure data.

Recommendation criteria:

- Degree of impact. The magnitude of the individual and societal burden imposed by a clinical condition being measured by the quality measure, including disability, mortality, and economic costs.
- Degree of improvability. The extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in the clinical processes.

- Degree of inclusiveness. The relevance of a measure to a broad range of individuals with regard to: age, gender, socioeconomic status, and race/ethnicity; the generalizability of quality improvement strategies across the spectrum of health care conditions; and the capacity for change across a range of health care settings and providers.
- National consensus. The measure has either been developed or accepted/approved through a national consensus effort (e.g., the National Quality Forum).
- Degree of performance variation. The measure performance rates show a wide degree of variation across the health care system.
- Degree of validity and reliability. The extent to which the measure is valid and reliable.
- Degree of alignment. The measure is aligned with other state and national quality measurement, improvement, and reporting initiatives, and does not duplicate existing efforts.
- Degree of reporting burden. The reporting burden is reasonable in balance with the previous criteria.

Written preliminary and final quality measure recommendations for SQRMS must, at a minimum:

- Clearly convey in writing (1) the extent to which each measure meets the applicable aforementioned recommendation criteria, (2) how the concordance with measurement criteria addition, modification, or removal of each quality measure, and (3) what process was used to determine concordance with each criterion.
- Include quality measures that were considered but ultimately not recommended for addition, modification, or removal, and the supporting justifications.
- As part of articulating the process used, explain the stakeholder input employed and include a summary of any concerns or objections that stakeholders raised during the recommendation process.
- Include a description of each quality measure: name, data elements (i.e., denominator, numerator), specification information, measurement time period, data submission dates, the entity to which the data is reported (e.g., Contractor, Minnesota Hospital Association, Centers for Medicare & Medicaid Services, etc.), National Quality Forum (NQF) number (if applicable), and technical description.

Members

Name	*Organization*	*Representation*
Shaina Witt, MA	American Heart Association (AHA)	Disease advocacy/ consumer organization
Peter Benner	Former AFSCME Council 6 Executive Director	Consumer/Labor
Carolyn Pare	Minnesota Health Action Group	Purchaser leadership
Terry Crowson, MD	HealthPartners	Health plan leadership

Larry Lee, MD	Blue Cross Blue Shield	Healthplan leadership
Laurie Drill-Mellum, MD, MPH	MMIC	Physician risk insurer
Marie Dotseth, MHA	Minnesota Alliance for Patient Safety (MAPS)	Patient safety leadership
Hugh Renier, MD	Essentia Health System	PPS/CAH health system medical leadership
John Kvasnicka, MD	HealthEast Health System	PPS health system medical leadership
Steve Meisel, PharmD	Fairview Health System	Health system, patient safety leadership and pharmacy
Demeka Campbell, MD	Regions	Hospitalist
Allie Coronis	Allina Health	PPS hospital regulatory
Kathy Geier, RN, BS, CPHIMS	HealthEast Health System	PPS hospital regulatory
Judy Bernhardt, RN, MSN	St. Luke's Hospital Duluth	PPS hospital quality
Darrell Carter, MD	Community Medical Centers PA, Granite Falls	CAH medical leadership, CALS
Mary Mayer, RN	Perham Memorial Hospital and Home	CAH hospital operations
Cheryl Hurbig, RN	St Francis Healthcare Campus	CAH quality leadership
Tammy Suchy, RN	TriCounty Hospital	CAH quality leadership

Appendix B
2014/15 Hospital Quality Reporting Steering Committee Minutes

health reform MINNESOTA
A Better State of Health

Statewide Quality Reporting and Measurement system
Hospital Quality Reporting Steering Committee
Date: October 27, 2014

Members present:
Peter Benner
Judy Bernhardt
Demeka Campbell
Allie Coronis
Terry Crowson
Marie Dotseth
Kathy Geier
Cheryl Hubrig
Jennifer Lundblad (facilitator)
Laurie Drill-Mellum
Vicki Tang Olson (facilitator)
Tammy Suchy
Carolyn Pare
Hugh Renier
Shaina Witt

Ex-officio members present:
Mark Sonneborn
Stefan Gildemeister

Hospital Quality Reporting Steering Committee
Summary of Recommendations for 2016 Hospital Measures

Denise McCabe
David Hesse
Dina Wellbrock
Anne McGeary Snowden

Not present:
Darrell Carter
Larry Lee
John Kvasnicka
Mary Mayer
Steve Meisel

Topic	Discussion/Decision	Follow-up: Who/What/When
Welcome and introductions Supporting materials: • Mini-bios		Corrections: Remove RN after Tammy's name
Setting the context for hospital quality measures Supporting materials: • Quality Reporting and Value-Based Purchasing: National and Minnesota	Jennifer gave context of national priorities and structure	

• National Quality Strategy http://www.ahrq.gov/workingforquality/		
Reminding ourselves of the SQRMS criteria and process Supporting materials: • 2014 Hospital Quality Reporting Steering Committee Charge • Approaches to measures – previously endorsed vs developmental • Measure purpose: Improvement, public reporting, payment	Jennifer reviewed charter and background on measurement purpose •	Correct "Recommenda" in project charter
Review meeting goals and desired outcome	Jennifer reviewed meeting goals: • Frame the Committee's 2014-2015 work • Review expert input received to date and determine measurement area priorities • Summarize work to date and plan for alignment of SQRMS and current CMS measures and programs • Identify next priority area(s) for expert input	

Identify hospital measurement priorities	A prioritization vote was taken among the committee members at the meeting, focused at a high level on topic areas, to get a preliminary "pulse" among the group. Each committee member could select three priority measurement areas. Results in priority order: 1. *Care Transitions and readmissions – 10 votes* 2. *Safer care and avoiding harm – 7 votes* 3. *Cost/Spending – 5 votes* 4. *Behavioral health – 4 votes* 5. *End of Life Care – 4 votes* 6. Emergency and time critical care – 3 votes 7. Mortality – 2 votes 8. Patient and Family Centered care – 2 votes 9. Rural relevant/small volume – 2 votes As a result of the vote, the committee agreed that the efforts will initially be on the italicized topics above.	
Gather input from expert groups and discuss priorities Supporting materials: • NQF Patient Safety Family of Measures • MHA Patient Safety Registry expert feedback • 2015 Draft Hospital Measure Summary • Stratis Health feedback during SQRMS comment period	Two overall discussion themes emerged from the committee discussion: Always ask ourselves, "What is the point of this measure – is it going to make a difference?" Be clear about the purpose of the measure – for consumers, for accountability, for incentives, for improvement **<u>Safety</u>**	

	3 themes emerged in the "safer care and avoiding harm" arena after hearing the input from the MHA Safety Registry Committee (from a September 2014 meeting):
	
	1. Measuring safety as a system attribute
	  • Culture, learning, reporting, patient engagement, and feedback loops
	2. Measuring safety in ways meaningful for consumers
	  • Infections are example of something meaningful and understandable to consumer
	3. Measuring safety by measuring delayed and missed diagnosis/misdiagnosis
	  • There is an IOM report in the works now on this, slated for release in Fall 2015. MMIC reports this is a high malpractice payment occurrence
	  • Examples might be missed AMI, sepsis and failure to rescue, access to specialists via telemedicine
	Additional information needed for continuing safety measurement discussions:
	
	• MN performance on existing measures that fall into safety family of measures
	  ○ MN compared to national
	  ○ Variation within MN hospitals
	• Understanding national efforts
	  ○ IOM report draft
	Diagnostic Error in Health Care
		Safety
		
		Convene Safety subgroup – Marie Dotseth , Steve Meisel, Mark Sonneborn, Carolyn Pare, Allie Coronis

	http://www8.nationalacademies.org/cp/projectview.aspx?key=49616 Who are committee members and might we "interview" one or more of them? Improvediagnosis.org – Mark Graber leader Sepsis • Discussion about proposal to have structural measure that hospitals would report yes/no related to bundle use (not on each patient, but overall process implementation) • Committee members thought it would be helpful to require of all hospitals, not just CAHs • Look at NY state **Care Transitions** Background given by MDH and MHA on RARE subcommittee looking at a study to understand readmission patterns throughout state using Minnesota's all payor claims database (APCD) Request data summary of current readmission rates: MN rates compared to national	

	Variations within MN hospitals Invite a presentation from this APCD data workgroup at future Committee meeting *After the meeting, individual committee members raised the following issues for consideration:* • Race, ethnicity, language data will be part of future state reporting mandate – how to consider in this Committee's work? • What more do we need to consider from a cost and capacity perspective for implementing sepsis bundles in CAHs?	Care Transitions Committee members are invited to share ideas on what questions would be helpful to ask of the APCD that would inform actions to improve readmission rates Have update at January meeting from the RARE subgroup

Establishing the plan leading up to recommendations in April 2015	Schedule meetings/calls for January, Feb, and March 2015. Before January meeting • Convene safety subgroup • Prepare and share data at next meeting • Follow-up with information requests • Develop proposed next steps on the other prioritized areas (cost/spending, behavioral health, end of life)	

Statewide Quality Reporting and Measurement system
Hospital Quality Reporting Steering Committee
Date: January 9, 2015

Members present:
Peter Benner
Judy Bernhardt
Terry Crowson
Marie Dotseth
Kathy Geier
Cheryl Hubrig
Jennifer Lundblad (facilitator)
Mary Mayer
Steve Meisel
Laurie Drill-Mellum
Vicki Tang Olson (facilitator)
Tammy Suchy
Carolyn Pare
Hugh Renier
Shaina Witt

Ex-officio members present:
Mark Sonneborn
Denise McCabe
David Hesse
Anne McGeary Snowden

Not present:
Allie Coronis
Demeka Campbell
Darrell Carter
Larry Lee
John Kvasnicka

Hospital Quality Reporting Steering Committee
Summary of Recommendations for 2016 Hospital Measures

Stefan Gildemeister
Dina Wellbrock

Topic	Discussion/Decision	Follow-up: Who/What/When
Welcome and introductions	**Meeting Goals:** • Follow-up on priorities identified in October meeting: safer care and avoiding harm, care transitions, end of life, cost and spending, and behavioral health • Review alignment of current SQRMS measures to measures included in federal programs • Identify timeline and remaining work to achieve hospital measure recommendations for SQRMS	
Recap of committee work to date •	• Society of Thoracic Surgeons reporting via Consumer Reports, are there other data/measure repositories useful to be aware of for hospital SQRMS? • Prompted the idea of SQRMS not only reporting on a set of hospital measures, but referring and/ or endorsing measures or measure sets published by others • Need to be attentive to consumer access, which can be a challenge with proprietary databases and repositories	Stratis Health, MNCM and MDH will meet to discuss: • *Longer planning cycles:* As the measurement of hospital quality evolves and reflects new research in what contributes to quality and safety, it is becoming more sophisticated, thus, it calls for longer multi-year planning cycles. The discussion today on development of a hospital safety

		composite or index, and on preparing for measuring and reporting diagnostic error, are examples of this. • *'Endorsement' as well as reporting role:* As more organizations measure and report hospital quality and safety, the question was raised at today's meeting about whether SQRMS could not only report measures, but also endorse and refer to other measures. • *Coordinated hospital and clinic measurement:* Today's discussions on measuring and reporting care transitions and on end-of-life care/advance care planning are appropriate and needed in both acute and ambulatory settings of care. Might there be possibility in the future of some joint SQRMS work?

Safer Care: sub-group update and recommended next steps	• Reviewed MN Safety Performance Snapshot:
	  ○ MMIC failure to rescue measure
	  ○ Research is emerging on the relationship between clinician/staff burnout and safety culture and outcomes (Bryan Sexton/Johns Hopkins)
	  ○ Are there questions to be excerpted from HCAHPS related to safety? (e.g., pain management)
	• Discussed sub-group recommendation to develop safety composite or index over the long term, in a phased or staged approach
	  ○ Group consensus was that this is a worthwhile direction, but challenging, and needs MDH support
	  ○ An index needs to have appropriate explanation and description to help patients use and interpret the data (e.g., JD Powers rating) – why important?
	  ○ MHA measures Potentially Preventable Complications – could this be used as part of a composite/index?
	  ○ Preliminary discussion of criteria for an index: reflective of data which are easily retrievable, risk adjusted appropriately, reflect community consensus, adequate volume to be meaningful
	• Potential resource: "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care", Marty Makary
	• Pending MDH follow-up discussion, committee agreed that sub-group should continue working in this direction toward a composite or index
	•
		•

Diagnostic Error in Healthcare: update and recommended next steps	• Stratis Health and Laurie Drill-Mellum are having a call with IOM committee member Dr. Mark Graber for insight on measuring mis/missed diagnosis and delays • Very complex to distinguish errors from good care that has poor results – assessment, inappropriate testing, lack of follow-up • Consumer desire for specificity to know "what is the probability of error for my condition?" So measure for high likelihood/high risk conditions? • Committee agreed that this topic is for learning, and keeping our eye on for future potential hospital SQRMS measures, perhaps revisiting post-IOM report in late 2015 o Consider community forum (outside of SQRMS work, but potentially informing future measurement) – co-sponsored by multiple orgs (e.g., MHA, MMIC, MAPS, Stratis Health, MNCM, ICSI)	Call scheduled for February 11

Alignment with federal programs: CMS/MBQIP and recommended next steps	• Reviewed NQF MAP recommendations and 2015 federal/state measure summary
	  o MAP themes: safety culture, falls with injury, nursing measures, complications, and revised definitions
	• Convene critical access hospital advisory group, overlapping with HQRSC
	  o Tammy, Cheryl, Mary
	•
		For February Committee call, Stratis Health will convene CAH and PPS group to provide specific recommendations to bring SQRMS hospital measures into alignment with federal measures

Plan for remaining priority measurement areas	Care transitions and readmissions	Action will be to get a report back from the RARE APCD workgroup at the March meeting

	• MDH All Payer Claims Database (APCD), could provide data for study of readmissions patterns, RARE workgroup is currently prioritizing areas for study • Readmissions to different facility is important but currently unknown – 22% of Medicare readmissions are to a different facility, but huge variation across the state • Caution raised about appropriate readmissions – current pressures in the marketplace not to re-admit, even if necessary • Big opportunity in end of life care, and readmissions with different diagnosis • Need to re-define "readmissions" – can the Committee play a role in this? 1. What is preventable or avoidable? 2. Consider process/structural measures (rather than rates) End of life • Reviewed current inpatient and outpatient measurement of advanced care planning • Discussion hospice family surveys, oncology measures, goals of care discussion • MN Epic Users Group has previously identified access to advanced care planning as a priority, nearly all MN hospitals now have and an EHR, and Meaningful Use Stage 2 includes advanced directives as an optional measure. • As a result, committee supported moving toward the Stage 2 Meaningful Use measure, potentially collecting it through the annual Minnesota HIT hospital survey supplement.	Will add meaningful use measure to recommendations list to be reviewed at March meeting

	Cost and spending (Did not get to this during the meeting) Behavioral health (Did not get to this during the meeting)	Vicki will meet with Mark Sonneborn and Joe Shindler to do some brainstorming on cost measures Will add to future agenda
Workplan, Timeline, Upcoming Meetings	• February 10 Committee call will be focused on national measure alignment • March 26 meeting needs to result in final set of recommendations for 2016 reporting, and for any longer terms plans or goals •	

Hospital Quality Reporting Steering Committee
Summary of Recommendations for 2016 Hospital Measures

Statewide Quality Reporting and Measurement system

Hospital Quality Reporting Steering Committee
Date: Febuary 10, 2015 9-10

Members present:
Peter Benner; Judy Bernhardt; Demeka Campbell; Allie Coronis; Terry Crowson; Marie Dotseth; Kathy Geier; Jennifer Lundblad(facilitator); Vicki Tang Olson (facilitator); Tammy Suchy; Carolyn Pare; Hugh Renier
Ex-officio members present:
David Hesse; Denise McCabe; Mark Sonneborn; Dina Wellbrock
Not present:
Demeka Campbell; Darrell Carter; Laurie Drill-Mellum; Larry Lee; Shaina Witt; Stefan Gildemeister; Cheryl Hubrig; John Kvasnicka; Mary Mayer; Steve Meisel; Anne McGeary Snowden;

Topic	Discussion/Decision	Follow-up: Who/What/When
Welcome and introductions	**Meeting Goals:** Review feedback from subgroups on aligning SQRMS hospitals measures with federal programs • Review alignment of current SQRMS measures to measures included in federal programs • Identify next steps with new measure areas of cost spending and behavioral health	
Alignment with federal programs: PPS alignment with CMS	Two subgroups met to give feedback on the what inpatient and outpatient measures the committee should consider for adding, keeping or removing from the hospital slate of SQRMS measures.	1.

•	The committee walked through a summary of these recommendations, 2016 SQRMS Hospital Measure Alignment with Federal Programs Recommendations. Some of the considerations were the changes in the inpatient program to have both electronic and chart abstraction as data submission options for some measures. It was recommended to • Not add the VTE and Stroke eCQM measures set for either CAH or PPS hospitals. Stroke – 1 is not an eCQM would be appropriate for PPS hospitals and was recommended. • Keep PC-01 for CAH and PPS hospitals • Keep ED-1 and ED-2 for PPS hospitals. • Add Safe surgery checklist for CAH and evaluate again after one year. • Add the other 30 day mortality measures for PPS hospitals: Stroke, COPD and CABG. • Add total knee/total hip complication for PPS hospitals • Add all of the inpatient cost measures for PPS hospitals: Medicare spending per beneficiary, AMI payment, Heart Failure payment, Pneumonia payment • Not add OP-1 to either PPS hospitals or CAH	

	• Not add any of the outpatient imaging measures since they need further analysis • Add OP-18, 20, 22, and 23 the outpatient throughput measures to both CAH and PPS hospital measures. Check on the volume for OP-21. • Defer decision to future for readmission measures and outpatient endoscopy measures • Add CLABSI as well as the MBQIP required measure of HCP/OP 27 to CAH slate of measures • Remove AMI mortality from the CAH measures since these patients are transferred and not admitted unless they are end of life/making a choice for nonaggressive treatment.	
Cost/spending measures	Vicki Olson, Mark Sonneborn and Joe Schindler met at MHA to brainstorm cost/spending measures. Currently, there is a medicare spending per beneficiary measure in the inpatient program and the value-based purchasing program. There are no spending measures in MBQIP for CAH but MHA is planning to do some financial modeling to identify ways to align incentives to the financial model.	It was suggested that we do a pilot with the MSPB measure in several hospitals to better understand the relationship between the claims types and time periods.
Discussion of plan for remaining priority measurement areas of behavioral health	This will be deferred for future meeting discussion.	
Timeline, steps for preliminary slate of measures due April 1st	Our final meeting to recommend preliminary measures is on March 26, 2015. It will be a face-to-face meeting.	

Hospital Quality Reporting Steering Committee
Summary of Recommendations for 2016 Hospital Measures

Statewide Quality Reporting and Measurement system
Hospital Quality Reporting Steering Committee
Date: March 26, 2015 9-11

Members present:
Peter Benner; Judy Bernhardt; Allie Coronis; Terry Crowson; Marie Dotseth; Kathy Geier; Cheryl Hubrig; John Kvasnicka; Jennifer Lundblad(facilitator); Mary Mayer; Steve Meisel; Vicki Tang Olson (facilitator); Tammy Suchy; Carolyn Pare; Hugh Renier
Ex-officio members present:
Stefan Gildemeister; David Hesse; Denise McCabe; Mark Sonneborn; Anne McGeary Snowden; Dina Wellbrock
Not present:
Demeka Campbell; Darrell Carter; Laurie Drill-Mellum; Larry Lee; Shaina Witt

Topic	Discussion/Decision	Follow-up: Who/What/When

Welcome and introductions	**Meeting Goals:**
	• Agree on how the Hospital Quality Reporting Steering Committee can best contribute to and recommend SQRMS hospital measures going forward:
	  o In PPS hospital reporting
	  o In critical access hospital reporting
	  o For all hospitals
	• Recommend a hospital slate of measures for 2016 SQRMS reporting	

Alignment with federal programs: PPS alignment with CMS •	The Committee voted by consensus to preliminarily recommend that SQRMS align quality reporting for PPS hospitals in 2016 with the CMS incentive programs, i.e., to report the PPS hospital Total Performance Score (both the composite measure and the component measures), along with the Readmissions and HAC CMS incentive program measures.	2. The Committee would like to see the complete list of measures which would be reported under this approach, and the complete list of measures currently reported which would no longer be reported.

	Once the Committee has been presented with this information, the recommendation can move from preliminary to full recommendation. The Committee affirms that alignment with the incentive programs, and the use of the Total Performance Score composite measure, is a good platform for future reporting, with a future goal of a better approach to reporting in ways meaningful and useful to consumers.	3. The Committee wants the reporting to clearly indicate which of the CMS incentive program measures are Medicare only, and which are all payer measures.
Alignment with federal programs: CAH alignment with MBQIP	The Committee voted by consensus to recommend that SQRMS align quality reporting for critical access hospitals in 2016 with the HRSA MBQIP (Medicare Beneficiary Quality Improvement Program) measures, i.e., to report on a suite of 16 measures; and to add for 2017 a MBQIP composite measure to also be publicly reported. o The MBQIP alignment approach was endorsed by a CAH sub-group of the Committee. o The Committee voiced strong support for escalating a falls measure in terms of priority and importance for public reporting. Recognizing that this is not a required measure for PPS hospitals at this time either, the committee was willing to defer adding this until it can be considered for both PPS and CAH, perhaps as part of the patient safety composite measure	The Committee would like to see the complete list of measures which would be reported under this approach, and the complete list of measures currently reported by CAHs which would no longer be reported.
Advance Directives	The Committee voted by consensus to recommend that SQRMS add an advance directive measure for 2016 reporting for all hospitals, specifically, to include a	

	question on the annual HIT hospital survey taken verbatim from the CMS EHR Meaningful Use Stage 2 measures. *More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.* The Committee noted that advance care planning and advance directives is a measurement area which lends itself to cross-setting measurement, and work is simultaneously underway to report an advance directive measure in Health Care Homes and more generally for clinics. The Committee voiced support for continuing to work toward more meaningful structure and process measures around end-of-life care.	
Safer Care: sub-group update and recommended next steps	In addition to the recommended changes above for 2016 reporting, the Committee endorsed the proposed plan to develop a patient safety composite or index measure, recognizing the challenges in doing this well, but willing to take it on given the importance of measuring hospital safety.	

Appendix C
Safer Care Subgroup

Hospital Quality Reporting Steering Committee
"Safer care and avoiding harm" Sub-Group Charter

Sub-Group Overview
Patient safety emerged as one of the high priority areas for measuring hospital care for the SQRMS Hospital Quality Reporting Steering Committee at its October 2014 meeting. Members of the Committee volunteered to be part of a short-term sub-group to focus on "safer care and avoiding harm" and bring options and/or recommendations to the full Committee for consideration, building from the October 2014 discussion.

Summary scope statement
Three themes emerged from the Committee in the "safer care and avoiding harm" arena:
1. Measuring safety as a system attribute
2. Measuring safety in ways meaningful for consumers
3. Measuring safety by measuring delayed and missed diagnosis/misdiagnosis

The sub-group will:

- Review the current performance of Minnesota hospitals in safety to understand strengths and opportunities for improvement *(Stratis Health and MHA to provide a data snapshot)*
- Review existing measures or measurement approaches, including data collection systems and data repositories, which support the three themes identified (whether Minnesota or elsewhere) *(Stratis Health to develop a high level inventory of available measures)*
- If there are not adequate measures or measurement approaches currently available to meet the goals and needs, identify and debate options for developing new measures aligned with one or more of the three themes, including pros and cons
- Recommend to the HQRSC an approach for moving forward with measuring "safer care and avoiding harm" in Minnesota hospitals

Goal/Aim of the sub-group
To recommend to the HQRSC an approach for moving forward with measuring "safer care and avoiding harm" in Minnesota hospitals, in enough detail and with enough time to include a safety measure recommendation in the Committee's April 2015 report to MDH.

In recommending a measurement approach, clarify the purpose of publicly reporting of safer care measures – whether for hospitals to improve, and/or for consumer understand and use, or for both.

Milestones

- *Scheduled sub-group conference calls:*
  December 19, 2014
  January 7, 2015

- *Next HQRSC meeting:* January 9, 2015

- *Report and Recommendations Due to MDH:* April 1, 2015

Document date: December 10, 2014

Recommendation for SQRMS Hospital Quality Reporting Steering Committee from HQRSC Safer Care Sub-Group

To be included in the Committee's recommendations and reports for 2016 SQRMS Hospital Measures

(to set the direction for future measures work, not specific to any new 2016 reporting)

March 26, 2015

Patient Safety Composite or Index

Why Measure?

Patient safety consistently emerges as a high priority for both health care delivery organizations and for patients and families. There are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system, nor do today's clinical only safety measures reflect the growing body of research related to organizational properties and systems which are essential for safety. Today's measures tend to be condition-specific or harm-specific (e.g., surgical site infection, falls, sepsis), and do not include how reliable a hospital's care is, or whether the culture is set up for reliability and learning.

To make patient safety hospital measurement meaningful and comprehensive, and more understandable to consumers, SQRMS could build upon the reporting individual hospital safety measures with reporting of a multi-faceted patient safety index or composite measure. The index or composite would include a balanced set of process, outcome, and structural measures, and can at least somewhat be derived from existing measures and indices put together in a combination to meet community needs. The composite or index approach is consistent with both national measurement strategies from CMS (e.g., the Hospital Total Performance Score) and with composite measurement that MN Community Measurement has developed in the ambulatory setting (e.g., the D5 for diabetes).

A composite approach meets needs identified by the Hospital Quality Reporting Steering Committee for measuring the safety of hospital care in Minnesota. The intent is that a composite measure bring value – that it is more than an additive list of measures, rather, that the whole is greater than the sum of its parts as the composite represents essential components of safer care. First, it is a single score, easy to understand by patients and consumers. Second, it brings a sharp focus to what is otherwise a long list of measures to help ensure that safety remains a priority for hospital leaders, clinicians, and staff. Lastly, the underlying data elements which comprise the composite score are available to hospitals, making it actionable for improvement.

Vision

Minnesota assesses and publicly reports the safety of its hospital care through a balanced set of measures that meaningfully reflects safety in a single composite score easily understood by consumers and actionable by hospitals.

Principles/Assumptions:

- Methodology and calculation of the composite are transparent
- Underlying elements of the composite will be available to the hospitals so that they can identify their performance by indicator to be able to improve

- Draw on existing measures for which data are available and are widely collected to the extent possible
    - Expect the composite to evolve over time as measures, evidence, and infrastructure evolves
- Measure not only harm to patients but organizational and system characteristics of hospitals
    - Such as reliability, culture, transparency and learning systems
- Reflect evidence-based practices to the extent feasible
- Be attentive to rural and small volume hospitals, such that they are neither advantaged or disadvantaged
- Consider unintended consequences
- Develop for an audience that is consumers and hospitals
    - Addresses patient safety in PPS and CAH (need to clarify if Children's hospitals would be included)
- Consider risk adjustment when appropriate
- Hospitals should be able to verify their results

Proposed Process/Timeline

- MNCM/Stratis Health would co-facilitate
- 18-24 month process
- Includes measure testing and pilot
- Opportunity for community and stakeholder involvement and endorsement
    - Build in opportunity for consumer and hospital input and feedback
- Incorporate discussion and possibly measurement to ensure there are not harmful unintended consequence
- Explore NQF endorsement

Appendix D
2016 Hospital Quality Reporting Recommendations (MNCM format)

Existing Measures

CMS Measures	Dates of Service	Data Elements
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates* • Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) *PPS hospitals only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures Calculated rate

CMS Measures	Dates of Service	Data Elements
All prevention global immunization process of care measures for applicable hospital discharge dates • Influenza immunization-overall rate (Prev-Imm-2)	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the inpatient prevention global immunization quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measure

CMS Measures	Dates of Service	Data Elements
Early elective deliveries - Early elective delivery prior to 39 completed weeks of gestation (PC-1) process of care measure for applicable hospital discharge dates	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the early elective delivery process of care quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the measure • Numerator: Number of patients with elective deliveries • Calculated rate
Outpatient acute myocardial infarction (AMI) and chest pain Measures. The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) • Median time to transfer to another facility for acute coronary intervention (OP-3) • Aspirin at arrival (OP-4) • Median time to ECG (OP-5) *CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

All mortality outcome of care measures for applicable hospital discharge dates • Acute myocardial infarction (AMI) 30-day mortality rate (MORT- 30-AMI) • Heart failure (HF) 30-day mortality rate (MORT-30-HF) • Mortality pneumonia (PN) 30-day mortality rate(MORT-30-PN)	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Patient experience – This measure is used to assess patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). (This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)	2015	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey

AHRQ Measures	Dates of Service	Data Elements
Patient safety for selected indicators composite measure. (PSI-90) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Pressure ulcer (PSI 3) • Iatrogenic pneumothorax (PSI 6) • Selected infections due to medical care (PSI 7) • Postoperative hip fracture (PSI 8) • Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) • Postoperative sepsis (PSI 13) • Postoperative wound dehiscence (PSI 14) • Accidental puncture or laceration (PSI 15)	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

Other Measures	Dates of Service	Data Elements
Health Information Technology (HIT) This survey is used to assess a hospital's adoption and use of Health Information Technology (HIT) in its clinical practice. Specification Information: 2013 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C. with MN-Specific Additional Questions.	**2015**	**Survey**

All ED throughput process of care measures for applicable hospital discharge dates ED Measure: Transfer Communication • Administrative communication (NQF 0291) • Vital signs (NQF 0292) • Medication information(NQF 0293) • Patient information(NQF 0294) • Physician information(NQF 0295) • Nursing information(NQF 0296) • Procedures and tests(NQF 0297) • All or none composite *Specification Information:* Transfer Communication Measure Specifications, University of Minnesota Rural Health Research Center. *CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the transfer communication quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

Measures to be added

CMS Measures	Dates of Service	Data Elements
VTE-1 Venous Thromboembolism prophylaxis *Added to CAH*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for inpatient measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate.
Median time from ED arrival to ED departure for admitted ED patients (ED-1a) Median time from admit decision time to ED departure time for admitted patients (ED-2a) *Changed from voluntary to required for CAH*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information: • Number of minutes for defined steps in patient flow

Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line- associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention *Added to PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals with intensive care unit must submit data for the central line-associated bloodstream infection (CLABSI) event This data includes the following information for each intensive care unit: • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.
Catheter associated Urinary Tract Infection (CAUTI) event This measure is used to assess the infection rate of patients with a Catheter associated Urinary Tract Infection (CAUTI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention *Added to PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30))	Hospitals with l intensive care unit (must submit data for the Catheter associated Urinary Tract Infection (CAUTI) event by intensive care unit. This data includes the following information for each intensive care unit: • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.

Catheter associated Urinary Tract Infection (CAUTI) event This measure is used to assess the infection rate of patients with a Catheter associated Urinary Tract Infection (CAUTI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention *Added to CAH*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for Catheter associated Urinary Tract Infection (CAUTI) event. This data includes the following information for each unit: • Denominator: Number of patient days. • Numerator: Number of events definition for a CAUTI • Calculated rate.
Surgical Site infections (SSI) event following colon surgery This measure is used to assess the infection rate of patients with a Surgical Site infections (SSI) event following colon surgery *Specification Information:* Surgical Site infections (SSI) event following colon surgery Specifications: Center for Disease Control and Prevention *Added for PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals performing colon surgery must submit data Surgical Site infections (SSI) event. This data includes the following information : • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.

Surgical Site infections (SSI) event following abdominal hysterectomy surgery This measure is used to assess the infection rate of patients with a Surgical Site infections (SSI) event following abdominal hysterectomy surgery *Specification Information:* Surgical Site infections (SSI) event following abdominal hysterectomy surgery Specifications: Center for Disease Control and Prevention *Added for PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospitals performing abdominal hysterectomies must submit data Surgical Site infections (SSI) event. This data includes the following information : • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.
Clostridium Difficile (CDI) event This measure is used to assess the infection rate of patients with a Clostridium Difficile (CDI) event *Specification Information:* Clostridium Difficile (CDI) event Specifications: Center for Disease Control and Prevention *Added for PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospital wide lab event • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.

Methicillin resistant Staphylococcus aureus (MRSA) bacteremia event This measure is used to assess the infection rate of patients with a Methicillin resistant Staphylococcus aureus (MRSA) bacteremia event *Specification Information:* Methicillin resistant Staphylococcus aureus (MRSA) bacteremia event Specifications: Center for Disease Control and Prevention *Added for PPS hospitals*	Discharge dates First Quarter 2015 (January – March 31) through Second Quarter 2015 (April – June 30)	Hospital wide lab event • Denominator: Number of expected events • Numerator: Number of observed events • Calculated rate.
Healthcare personnel influenza immunization This measure is used to assess the infection rate of patients with a central line- associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification Information:* Healthcare Personnel Specifications: Center for Disease Control and Prevention *Added for CAH*	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals with neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate.

Outpatient acute myocardial infarction (AMI) and chest pain Measures. The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Median time to fibrinolysis (OP-1) • • •	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate
OP-18 Median time from ED arrival to ED departure for discharged ED patients *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for ED throughput quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate
OP-20 Door to diagnostic evaluation by a qualified medical professional *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the ED throughput measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate

OP-21 ED-median time to pain management for long bone fracture *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the ED throughput measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures Calculated rate
OP-22 ED-patient left without being seen (numerator/denominator one time per year for the previous year) *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the ED throughput measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate
OP-23 ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival. *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the ED throughput measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate

OP-25 Safe surgery checklist *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for the safe surgery checklist structural measures. This data includes the following information: • Attestation that CAH are using safe surgery checklist for all procedures.
OP-27 Influenza Vaccination Coverage among Healthcare Personal (combined with HCP) *Added to CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for the combined HCP/OP-27 measures. This data includes the following information: • Denominator: Number of healthcare personnel meeting the criteria for inclusion in the quality measures • Numerator: Number of healthcare personnel meeting the targets in the quality measures • Calculated rate

Medicare Spending per Beneficiary outcome measure for applicable hospital discharge dates *Added to PPS hospitals only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30 Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the Medicare spending per beneficiary measure. This data includes the following information: • Calculated ratio
30 Day Readmissions • READM-30 Acute Myocardial Infarction (AMI) *PPS hospitals only* • READM-30 Heart Failure (HF) *PPS hospitals and CAH* • READM-30 Pneumonia (PN) *PPS hospitals and CAH* • READM-30 Total Hip (THA) /Total Knee Arthoplasty (TKA) *PPS hospitals only* • READM-30 Chronic Obstructive Pulmonary Disease (COPD) *PPS hospitals and CAH* • READM-30 Coronary Bypass Graph Surgery (CABG) *PPS hospitals only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30	Hospitals must submit data for each of the readmissions: • Risk standardized readmission rate (RSRR)
Stage 3 meaningful use Advance Directives measure *More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.*	2015 dates of service	Hospitals must attest to meeting or not meeting measure on annual HIT survey
Value- based purchasing Total Performance Score *PPS hospitals only*	FY2016 results	Hospitals must submit data for the fiscal year: • Total performance score

Readmissions Reduction Program Composite Score Number of 30 readmission measures with excess readmissions *PPS hospitals only*	FY2016 results	Hospitals must submit data for the fiscal year: • Excess readmissions for AMI • Excess readmissions for Pneumonia • Excess readmission for total knee/total hip arthroplasty • Excess readmission for Chronic Obstructive Pulmonary Disease • Excess readmission for Coronary Bypass Graph Surgery
Hospital Acquired Conditions Program Score *PPS hospitals only*	FY2016 results	Hospitals must submit data for the fiscal year: • Total HAC score

Measures to be Removed

CMS Measures	Dates of Service	Data Elements
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates* • Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) *Discontinued voluntary reporting for CAH hospitals*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Median time from ED arrival to ED departure for admitted ED patients (ED-1a) Median time from admit decision time to ED departure time for admitted patients (ED-2a) *Discontinue reporting for PPS Hospitals*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016(April – June 30)	Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information: • Number of minutes for defined steps in patient flow

Outpatient acute myocardial infarction (AMI) and chest pain Measures. The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) • Median time to transfer to another facility for acute coronary intervention (OP-3) • Aspirin at arrival (OP-4) • Median time to ECG (OP-5) • *Discontinued reporting for PPS hospitals*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

All mortality outcome of care measures for applicable hospital discharge dates • Acute myocardial infarction (AMI) 30-day mortality rate (MORT- 30-AMI) • Heart failure (HF) 30-day mortality rate (MORT-30-HF) • Mortality pneumonia (PN) 30-day mortality rate(MORT-30-PN) *Discontinue reporting for CAH only*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

AHRQ measures		
Mortality for selected conditions composite measure. (IQI-91) This composite measure includes the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions: • Acute myocardial infarction (AMI) mortality rate (IQI 15) • Congestive heart failure (CHF) mortality rate (IQI 16) • Acute stroke mortality rate (IQI 17) • GI Hemorrhage mortality rate (IQI 18) • Hip fracture mortality rate (IQI 19) • Pneumonia mortality rate (IQI 20) *Discontinue reporting for PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the mortality for selected conditions composite measure and for each of the mortality for selected conditions composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization. *Discontinue reporting for PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in each of the quality measure • Calculated rate

AHRQ Measures	Dates of Service	Data Elements
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries. *Discontinue reporting for PPS hospitals and CAH*	Discharge Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance. *Discontinue reporting for PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure

Patient safety for selected indicators composite measure. (PSI-90) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Pressure ulcer (PSI 3) • Iatrogenic pneumothorax (PSI 6) • Selected infections due to medical care (PSI 7) • Postoperative hip fracture (PSI 8) • Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) • Postoperative sepsis (PSI 13) • Postoperative wound dehiscence (PSI 14) • Accidental puncture or laceration (PSI 15)	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Pediatric Heart Surgery Mortality Rate measure (PDI 6) This measures the number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease *Discontinue reporting for Children's, PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric patients undergoing surgery for congenital heart disease • Numerator: Number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease
Pediatric Heart Surgery Volume measure (PDI 7) This measures the number of in-hospital congenital heart surgeries for pediatric patients. *Discontinue reporting for Children's, PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the pediatric patient for selected indicators: Volume: Pediatric patients undergoing surgery for congenital heart disease

AHRQ Measures	Dates of Service	Data Elements
Pediatric patient safety for selected indicators composite measure. (PDI-19) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Accidental puncture or laceration (PDI 1) • Pressure ulcer (PDI 2) • Iatrogenic pneumothorax (PDI 5) • Postoperative hemorrhage or hematoma (PDI 8) • Postoperative respiratory failure (PDI 9) • Postoperative sepsis (PDI 10) • Postoperative wound dehiscence (PDI 11) • Selected infections due to medical care (PDI 12) •	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for the pediatric patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Other measures		
Late Sepsis or Meningitis in Neonates (Vermont Oxford Network) Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements. *Specification Information:* Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network. *Discontinue reporting for Children's, PPS hospitals*	2015 dates of service	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: inborn and outborn infants meeting criteria (see full specifications) • Numerator: Infection criteria (see full specifications) • Calculated rate.

Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line- associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention *Discontinued for Children's and PPS hospitals*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016(April – June 30)	Hospitals with neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate.
All ED/ inpatient stroke registry process of care measures for applicable hospital discharge dates • Door-to-imaging performed time • Door-to-needle time to intravenous thrombolytic therapy Specification Information: Emergency Department Stroke Registry Process of Care Indicator Specifications. Minnesota Stroke Registry. *Discontinue reporting for PPS hospitals and CAH*	Discharge dates Third Quarter 2015 (July – September 30) through Second Quarter 2016 (April – June 30)	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill-defined stroke (MN Stroke Registry specifications). This data includes the following information: • Number of minutes for defined steps in patient flow.

Submission Deadlines for Hospitals

Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Measures

Inpatient Quality Measures

Discharge Dates; Data Submission Deadline
Third Quarter, 2015: July 1 – September 30; February 15, 2016
Fourth Quarter, 2015: October 1 – December 31; May 15, 2016
First Quarter, 2016: January 1 – March 31; August 15, 2016
Second Quarter, 2016: April 1 – June 30; November 15, 2016

Outpatient Quality Measures
Discharge Dates Data Submission Deadline
Third Quarter, 2015: July 1 – September 30; February 1, 2016
Fourth Quarter, 2015: October 1 – December 31; May 1, 2016
First Quarter, 2016: January 1 – March 31; August 1, 2016
Second Quarter, 2016: April 1 – June 30; November 1, 2016

Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures
Event Dates; Data Submission Deadline
Third Quarter, 2015: July 1 – September 30; February 15, 2016
Fourth Quarter, 2015: October 1 – December 31; May 15, 2016
First Quarter, 2016: January 1 – March 31; August 15, 2016
Second Quarter, 2016: April 1 – June 30; November 15, 2016

Appendix E
2016 Hospital Quality Reporting Recommended Changes – PPS and CAH Hospitals

2016 Hospital Measure Recommendations

PPS measures that would be added

Topic	Measure	Collection method	Submission method	VBP	RRP	HAC
Inpatient Healthcare Associated Infections (HAI)	Central Line Associated Bloodstream Infection (CLABSI)	Chart Abstracted	NHSN	x		x
Inpatient Healthcare Associated Infections (HAI)	Surgical Site Infections (SSI) following colon surgery	Chart Abstracted	NHSN	x		x
Inpatient Healthcare Associated Infections (HAI)	Surgical Site Infections (SSI) following abdominal hysterectomy	Chart Abstracted	NHSN	x		x
Inpatient Healthcare Associated Infections (HAI)	Catheter-Associated Urinary Tract Infection (CAUTI)	Chart Abstracted	NHSN	x		x
Inpatient Healthcare Associated Infections (HAI)	MRSA Bacteremia	Chart Abstracted	NHSN	x		x
Inpatient Healthcare Associated Infections (HAI)	Clostridium Difficile (C.difficile or CDI)	Chart Abstracted	NHSN	x		x
30-Day Risk-Standardized Readmission Rates	READM-30-AMI Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	Claims	Billing		x	
30-Day Risk-Standardized Readmission Rates	READM-30-HF Heart Failure (HF) 30-Day Readmission Rate	Claims	Billing		x	
30-Day Risk-Standardized Readmission Rates	READM-30-PN Pneumonia (PN) 30-Day Readmission Rate	Claims	Billing		x	
30-Day Risk-Standardized Readmission Rates	READM-30-TH/TKA: 30 day all-cause risk-standardized readmission rate(RSRR) for elective primary Total Hip(THA) /Total Knee Arthoplasty(TKA)	Claims	Billing		x	
30-Day Risk-Standardized Readmission Rates	READM-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission rate	Claims	Billing		x	
30-Day Risk-Standardized Readmission Rates	READM-30-CABG Coronary Bypass Graph Surgery (CABG) 30-Day Readmission rate	Claims	Billing		x	
Cost Efficiency	Medicare Spending per Beneficiary	Claims	Billing	x		
End of Life	Meaningful Use Stage 2 Advance Directives	HER	HIT survey			
Value-based Purchasing	Total Performance Score (TPS)	Composite	none			
Readmission Reduction	Readmission Reduction Program (number of measures w/excess readmissions) (RRP) Score	Composite	none			
Hospital Acquired Conditions	Total Hospital Acquired Conditions (HAC) Score	Composite	none			

PPS measures that would continue

Topic	Measure	Collection method	Submission method	VBP	RRP	HAC

Inpatient Acute Myocardial Infarction (AMI)	AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	eCQM/chart abstracted	QualityNet	x		
Inpatient Prevention: Global Immunization Measures	IMM-2 Influenza immunization	Chart Abstracted	QualityNet	x		
Inpatient Perinatal Care	PC-01 Elective delivery prior to 39 completed weeks gestation	eCQM/chart abstracted	QualityNet	x		
30-Day Risk-Standardized Mortality Rates	MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Claims	Billing	x		
30-Day Risk-Standardized Mortality Rates	MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	Claims	Billing	x		
30-Day Risk-Standardized Mortality Rates	MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	Claims	Billing	x		
Inpatient Patient Experience of Care	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)	Survey	QualityNet	x		
Agency for Healthcare Research and Quality (AHRQ)	PSI 90 Complication/Patient Safety for Selected Indicators (composite) (3, 6-8, 12-15)	Claims	Billing	x		
Health Information Technology (HIT)	Health information technology survey	Survey	Online link			

PPS measures that would be removed

Topic	Measure	Collection method	Submission method	VBP	RRP	HAC
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-2 Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival	Chart Abstracted	QualityNet			
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-3 Median time to transfer to another facility for acute coronary intervention	Chart Abstracted	QualityNet			
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-4 Aspirin at arrival	Chart Abstracted	QualityNet			
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-5 Median time to ECG	Chart Abstracted	QualityNet			
Inpatient Emergency Department Throughput	ED-1 Median time from ED arrival to ED departure for ED admitted patients	eCQM/chart abstracted	QualityNet			
Inpatient Emergency Department Throughput	ED-2 Median time from admit decision to departure for ED admitted patients	eCQM/chart abstracted	QualityNet			

PPS/CAH measures that would be removed because not part of VBP, RRP or MBQIP

Topic	Measure	Collection method	Submission method	VBP	RRP	HAC
Stroke	Door-to-imaging initiated time	Chart Abstracted	MN Stroke Registry			

Stroke	Door-to- needle time – time to intravenous thrombolytic therapy	Chart Abstracted	MN Stroke Registry			
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 04 Death Among Surgical Patients with Serious, Treatable Complications (Harmonized with NSC measure for FY2011)	Claims	Billing			
Agency for Healthcare Research and Quality (AHRQ) Measures	IQI 91 Mortality for Selected Medical Conditions (composite) (15,16,17,18,19,20)	Claims	Billing			
Nursing Sensitive Care Measure	Death Among Surgical Patients with Serious Treatable Complications (Harmonized with PSI 4 measure, Failure to Rescue)	Claims	Billing			
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 18 Obstetric trauma – vaginal delivery with instrument	Claims	Billing			
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 19 Obstetric trauma – vaginal delivery without instrument	Claims	Billing			
Inpatient Healthcare Associated Infections (HAI)	Central Line Associated Bloodstream Infection (CLABSI) (NICU/PICU)	Chart Abstracted	NHSN			
Vermont Oxford Network	Late sepsis or meningitis in very low birth weight neonates (Level III NICU)	Chart Abstracted	MHA			
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 6 Pediatric heart surgery mortality rate	Claims	Billing			
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 7 Pediatric heart surgery volume	Claims	Billing			
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 19 Pediatric patient safety for selected indicators composite (1,2,5,8,9,10,11,12)	Claims	Billing			

2016 Hospital Measure Recommendations

CAH measures that would be added

Topic	Measure	Collection method	Submission method	MBQIP required	MBQIP optional
Inpatient Venous Thromboembolism (VTE)	VTE-1 Venous thromboembolism prophylaxis	eCQM/chart abstracted	QualityNet		x
Inpatient Emergency Department Throughput	ED-1 Median time from ED arrival to ED departure for ED admitted patients	eCQM/chart abstracted	QualityNet		x
Inpatient Emergency Department Throughput	ED-2 Median time from admit decision to departure for ED admitted patients	eCQM/chart abstracted	QualityNet		x
Inpatient Healthcare Associated Infections (HAI)	Catheter-Associated Urinary Tract Infection (CAUTI) (hospital wide)	Chart Abstracted	NHSN		x
Inpatient Healthcare Associated Infections (HAI)	Healthcare Personnel Influenza Vaccination (combined with OP-27)	Chart Abstracted	NHSN	x	
Outpatient Healthcare Associated Infections	OP-27 Influenza Vaccination Coverage among Healthcare Personnel (combined with HCP)	Chart Abstracted	NHSN	x	
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-1 Median time to fibrinolysis	Chart Abstracted	QualityNet	x	
Outpatient ED Throughput	OP-18 Median time from ED arrival to ED departure for discharged ED patients	Chart Abstracted	QualityNet	x	
Outpatient ED Throughput	OP-20 Door to diagnostic evaluation by a qualified medical professional	Chart Abstracted	QualityNet		x
Outpatient Pain	OP-21 ED-median time to pain management for long bone fracture	Chart Abstracted	QualityNet		x
Outpatient ED Throughput	OP-22 ED-patient left without being seen (numerator/denominator one time per year for the previous year)	Chart Abstracted	QualityNet		x
Outpatient Stroke	OP-23 ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival)	Chart Abstracted	QualityNet		x
Outpatient Structural Measure	OP-25 Safe surgery checklist	Web entry	QualityNet		x
30-Day Risk-Standardized Readmission Rates	READM-30-HF Heart Failure (HF) 30-Day Readmission Rate	Claims	Billing		x
30-Day Risk-Standardized Readmission Rates	READM-30-PN Pneumonia (PN) 30-Day Readmission Rate	Claims	Billing		x
30-Day Risk-Standardized Readmission Rates	READM-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission rate	Claims	Billing		x
End of Life	Meaningful Use Stage 2 Advance Directives	HER	Online link		

CAH measures that would continue

Topic	Measure	Collection method	Submission method	MBQIP required	MBQIP optional
Inpatient Prevention: Global Immunization Measures	IMM-2 Influenza immunization	Chart Abstracted	QualityNet	x	
Emergency Department Transfer Communication	EDTC-1 Administrative communication	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-2 Vital signs	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-3 Medication information	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-4 Patient information	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-5 Physician information	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-6 Nursing information	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC-7 Procedures and tests	Chart Abstracted	MHA	x	
Emergency Department Transfer Communication	EDTC- All or None composite	Chart Abstracted	MHA	x	
Inpatient Perinatal Care	PC-01 Elective delivery prior to 39 completed weeks gestation	eCQM/chart abstracted	QualityNet		x
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-2 Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival	Chart Abstracted	QualityNet	x	
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-3 Median time to transfer to another facility for acute coronary intervention	Chart Abstracted	QualityNet	x	
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-4 Aspirin at arrival	Chart Abstracted	QualityNet	x	
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain	OP-5 Median time to ECG	Chart Abstracted	QualityNet	x	
Inpatient Patient Experience of Care	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (≥ 500 admissions in previous year for CAH)3 item Care Transition set and 2 About You items required by CMS	Survey	QualityNet	x	
Health Information Technology (HIT)	Health information technology survey	Survey	QualityNet		

CAH Measures that would be removed

Topic	Measure	Collection method	Submission method	MBQIP required	MBQIP optional
Inpatient Acute Myocardial Infarction (AMI)	AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	eCQM/chart abstracted	QualityNet		
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 90 Complication/Patient Safety for Selected Indicators (composite) (3, 6-8, 12-15)	Claims	Billing		
30-Day Risk-Standardized Mortality Rates	MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Claims	Billing		
30-Day Risk-Standardized Mortality Rates	MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	Claims	Billing		
30-Day Risk-Standardized Mortality Rates	MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	Claims	Billing		

PPS/CAH measures that would be removed because not part of VBP, RRP or MBQIP

Topic	Measure	Collection method	Submission method	MBQIP required	MBQIP optional
Stroke	Door-to-imaging initiated time	Chart Abstracted	MN Stroke Registry		
Stroke	Door-to- needle time – time to intravenous thrombolytic therapy	Chart Abstracted	MN Stroke Registry		
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 04 Death Among Surgical Patients with Serious, Treatable Complications (Harmonized with NSC measure for FY2011)	Claims	Billing		
Agency for Healthcare Research and Quality (AHRQ) Measures	IQI 91 Mortality for Selected Medical Conditions (composite) (15,16,17,18,19,20)	Claims	Billing		
Nursing Sensitive Care Measure	Death Among Surgical Patients with Serious Treatable Complications (Harmonized with PSI 4 measure, Failure to Rescue)	Claims	Billing		
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 18 Obstetric trauma – vaginal delivery with instrument	Claims	Billing		
Agency for Healthcare Research and Quality (AHRQ) Measures	PSI 19 Obstetric trauma – vaginal delivery without instrument	Claims	Billing		
Inpatient Healthcare Associated Infections (HAI)	Central Line Associated Bloodstream Infection (CLABSI) (NICU/PICU)	Chart Abstracted	NHSN		
Vermont Oxford Network	Late sepsis or meningitis in very low birth weight neonates (Level III NICU)	Chart Abstracted	MHA		
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 6 Pediatric heart surgery mortality rate	Claims	Billing		
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 7 Pediatric heart surgery volume	Claims	Billing		
Agency for Healthcare Research and Quality (AHRQ) Measures	PDI 19 Pediatric patient safety for selected indicators composite (1,2,5,8,9,10,11,12)	Claims	Billing		

Appendix F
2016 Proposed CMS and State Hospital Measure Summary

Proposed for Minnesota Statewide Quality Reporting and Measurement System (SQRMS)
March 2015

Key:

R = Required by CMS
r = Required by State of Minnesota

V = Voluntary for CMS
v = Voluntary for State of Minnesota

S = Suspended by CMS
x = Required by MBQIP
opt = Optional for MBQIP
C = Chart abstracted measure
e = electronic clinical quality measure

Chart Abstracted Measures

Chart Abstracted Measures *Submitted to QualityNet*	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
Inpatient Acute Myocardial Infarction (AMI)								
AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	~~V~~	R r	e/C		X			
Inpatient Stroke (STK)								
STK-1 Venous thromboembolism (VTE) prophylaxis		R	C					
STK-4 Thrombolytic therapy		R	e/C					
STK-6 Discharged on statin medication		R	e/C					
STK-8 Stroke education		R	e/C					
Inpatient Venous Thromboembolism (VTE)								
VTE-1 Venous thromboembolism prophylaxis	r	R	e/C					opt
VTE-2 ICU VTE prophylaxis		R	e/C					
VTE-3 VTE patients with anticoagulation overlap therapy		R	e/C					
VTE-5 Venous thromboembolism Warfarin therapy discharge instructions		R	e/C					
VTE-6 Hospital acquired potentially-preventable venous thromboembolism		R	e/C					
Sepsis								
Severe Sepsis and Septic Shock: Early management bundle		R	C					
Inpatient Prevention: Global Immunization Measures								
IMM-2 Influenza immunization	r	Rr	C		x			x
Inpatient Emergency Department Throughput								
ED-1 Median time from ED arrival to ED departure for ED admitted patients	~~V~~ r	R ~~r~~	e/C					opt
ED-2 Median time from admit decision to departure for ED admitted patients	~~V~~ r	R ~~r~~	e/C					opt
Outpatient Acute Myocardial Infarction (AMI) and Chest Pain								
OP-1 Median time to fibrinolysis	r	R						X
OP-2 Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival	r	R r						X
OP-3 Median time to transfer to another facility for acute coronary intervention	r	R r						X
OP-4 Aspirin at arrival	r	R r						X
OP-5 Median time to ECG	r	R r						X
Outpatient ED Throughput								
OP-18 Median time from ED arrival to ED departure for discharged ED patients	r	R						opt
OP-20 Door to diagnostic evaluation by a qualified medical professional	r	R						x

2016 Proposed CMS and State Hospital Measure Summary

Chart Abstracted Measures ***Submitted to QualityNet***	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
OP-22 ED-patient left without being seen (numerator/denominator one time per year for the previous year)	r	R						x
Outpatient Pain								
OP-21 ED-median time to pain management for long bone fracture	r	R						x
Outpatient Stroke								
OP-23 ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival)	r	R						opt

Chart Abstracted Measures ***Submitted to NHSN***	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
Inpatient Healthcare Associated Infections (HAI)								
Central Line Associated Bloodstream Infection (CLABSI) ~~(NICU/PICU for state)~~		R r		~~r~~	x		x	opt
Surgical Site Infections (SSI) following colon surgery		R r			x		x	
Surgical Site Infections (SSI) following abdominal hysterectomy		R r			x		x	
Catheter-Associated Urinary Tract Infection (CAUTI)	r	R r			x		x	opt
MRSA Bacteremia		R r			x		x	opt
Clostridium Difficile (C.difficile or CDI)		R r			x		x	opt
Healthcare Personnel Influenza Vaccination *	r	R						x
Outpatient Healthcare Associated Infections								
OP-27 Influenza Vaccination Coverage among Healthcare Personnel *	r	R						x

* Combined data submission

Chart Abstracted Measures ***Submitted to MDH through MN Stroke Registry***	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
Stroke								
Door-to-imaging initiated time	~~r~~	~~r~~						
Door-to- needle time – time to intravenous thrombolytic therapy	~~r~~	~~r~~						

Chart Abstracted Measures ***Submitted to MDH through MHA***	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
Vermont Oxford Network								
Late sepsis or meningitis in very low birth weight neonates (Level III NICU)		~~r~~		~~r~~				
Emergency Department Transfer Communication								
EDTC-1 Administrative communication	r							x
EDTC-2 Vital signs	r							x
EDTC-3 Medication information	r							x

2016 Proposed CMS and State Hospital Measure Summary

Chart Abstracted Measures *Submitted to MDH through MHA*	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
EDTC-4 Patient information	r							x
EDTC-5 Physician information	r							x
EDTC-6 Nursing information	r							x
EDTC-7 Procedures and tests	r							x
EDTC- All or None composite	r							x
Medication Orders								
Pharmacist CPOE/Verification of Medication Orders within 24 hrs *retired by MBQIP*	Δ							

Chart Abstracted *Web-based* Measures *Submitted to QualityNet*	CAH	PPS	CMS submission	Children's	CMS incentive programs for FY2017+			MBQIP
					VBP	RRP	HAC	
Inpatient Perinatal Care								
PC-1 Elective delivery prior to 39 completed weeks gestation	r	Rr	e/C		x			opt
Outpatient *(OP 29,30,31 will begin data collection with 2nd qtr 2014 discharges)*								
OP-26 Hospital outpatient volume data on selected outpatient surgical procedures		R						
OP-29 Endoscopy/Poly Surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients (numerator/denominator one time per year)		R						
OP-30 Endoscopy/Poly surveillance: colonoscopy interval for patients with a history of adenomatous polyps – avoidance of inappropriate use (numerator/denominator one time per year)		R						
OP-31 Cataracts – improvement in patient's visual function within 90 days following cataract surgery (numerator/denominator one time per year)		V						

Structural Measures and DACA *Submitted to QualityNet*	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
Inpatient Structural Measures							
Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care		R					
Participation in a Systematic Clinical Database Registry for General Surgery		R					
Safe Surgery Checklist		R					
Inpatient Data Accuracy and Completeness Acknowledgement							
Electronic acknowledgment for FY2015 payment		R					
Outpatient Structural Measure							
OP-12 The ability for providers with HIT to receive laboratory data electronically directly into their qualified/certified EHR system as discrete searchable data		R					
OP-17 Tracking clinical results between visits		R					
OP-25 Safe surgery checklist	r	R					

2016 Proposed CMS and State Hospital Measure Summary

Surveys

Surveys *Submitted to MHA*	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
Health Information Technology (HIT)							
Health information technology survey	r	r					
Stage 2 Meaningful use Advance Directives	r	r					

Surveys *Submitted to QualityNet*	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
Inpatient Patient Experience of Care							
Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (≥ 500 admissions in previous year for CAH) includes 3 item Care Transition set and 2 About You items	r	R r		x			x

Claims Measures

Claims Measures	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
30-Day Risk-Standardized Mortality Rates							
MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	~~r~~	R r		x			
MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	~~r~~	R r		x			
MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	~~r~~	R r		x			
MORT-30-STK Stroke (STK) 30-Day Mortality Rate		R					
MORT-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate		R					
MORT-30-CABG Coronary Bypass Graph Surgery (CABG) 30-Day Mortality rate		R					
30-Day Risk-Standardized Readmission Rates							
READM-30-AMI Acute Myocardial Infarction (AMI) 30-Day Readmission Rate		Rr			x		opt
READM-30-HF Heart Failure (HF) 30-Day Readmission Rate	r	Rr			x		opt
READM-30-PN Pneumonia (PN) 30-Day Readmission Rate	r	Rr			x		opt
READM-30-HWR Hospital wide all-cause unplanned readmissions		R					opt
READM-30-TH/TKA: 30 day all-cause risk-standardized readmission rate(RSRR) for elective primary Total Hip(THA) /Total Knee Arthoplasty(TKA)		Rr			x		opt
READM-30-STK Stroke (STK) 30-Day Readmission Rate		R					opt
READM-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission rate	r	Rr			x		opt
READM-30-CABG Coronary Bypass Graph Surgery (CABG) 30-Day Readmission rate		R					opt
Inpatient Surgical Complications							
Hip/Knee Complication: Hospital-level Risk-Standardized Complication Rate (RSCR) following Elective Primary Total Hip (THA)/Total Knee Arthoplasty (TKA)		R					

2016 Proposed CMS and State Hospital Measure Summary

Claims Measures	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
Agency for Healthcare Research and Quality (AHRQ) Measures							
PSI 04 Death Among Surgical Patients with Serious, Treatable Complications (Harmonized with NSC measure for FY2011)	~~r~~	R~~r~~					
PSI 18 Obstetric trauma – vaginal delivery with instrument	~~r~~	~~r~~					
PSI 19 Obstetric trauma – vaginal delivery without instrument	~~r~~	~~r~~					
PSI 90 Complication/Patient Safety for Selected Indicators (composite) (3, 6-8, 12-15)	~~r~~	R r		x		x	
IQI 91 Mortality for Selected Medical Conditions (composite) (15,16,17,18,19,20)	~~r~~	~~r~~					
PDI 6 Pediatric heart surgery mortality rate	~~r~~	~~r~~	~~r~~				
PDI 7 Pediatric heart surgery volume	~~r~~	~~r~~	~~r~~				
PDI 19 Pediatric patient safety for selected indicators composite (1,2,5,8,9,10,11,12)	~~r~~	~~r~~	~~r~~				
Nursing Sensitive Care Measure							
Death Among Surgical Patients with Serious Treatable Complications (Harmonized with PSI 4 measure, Failure to Rescue)	~~r~~	R~~r~~					
Cost Efficiency							
Medicare Spending per Beneficiary		R r		x			
Acute Myocardial Infarction(AMI) Payment per Episode of Care		R					
Heart Failure(HF) Payment per Episode of Care		R					
Pneumonia(PN) Payment per Episode of Care		R					
Outpatient Imaging							
OP-8 MRI lumbar spine for low back pain		R					
OP-9 Mammography follow-up rates		R					
OP-10 Abdominal CT - use of contrast material		R					
OP-11 Thorax CT - use of contrast material		R					
OP-13 Cardiac imaging for preoperative risk assessment for non-cardiac low risk surgery		R					
OP-14 Simultaneous use of brain computed tomography (CT) and sinus computed tomography (CT)		R					
OP-15 Use of brain computed tomography (CT) in the emergency department for atraumatic headache ***Public reporting deferred by CMS***		R					

CMS Incentive Program Measures

Composite Measures	CAH	PPS	Children's	CMS incentive programs for FY2017+			MBQIP
				VBP	RRP	HAC	
Value-based Purchasing (VBP) Program							
Total Performance Score		r		x			
Readmission Reduction Program (RRP)							
Excess Readmissions Score		r			*		
Hospital Acquired Condition (HAC) Program							
Total HAC Score		r				x	

*currently there is a total payment adjustment based on excess readmission but no readmissions score. The proposal is to count each readmission measure with excess readmissions as one.

Electronic Clinical Quality Measures eCQM

Electronic Clinical Quality Measures (eCQM)

Electronic Clinical Quality Measures *Submitted to QualityNet*	National Quality Strategy Domain	Included in Inpatient Quality Reporting Program?	Also a chart-abstracted measure?
Inpatient Acute Myocardial Infarction (AMI)			
AMI-2 Aspirin prescribed at discharge	Clinical Process/Effectiveness	voluntary	No
AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	Clinical Process/Effectiveness	required	Yes
AMI-8a Timing of receipt of primary Percutaneous Coronary Intervention (PCI)	Clinical Process/Effectiveness	voluntary	No
AMI-10 Statin prescribed at discharge	Clinical Process/Effectiveness		No
Inpatient Pneumonia (PN)			
PN-6 Initial antibiotic selection for CAP in immunocompetent patient	Efficient Use of Healthcare Resources	voluntary	No
Inpatient Surgical Care Improvement Project (SCIP)			
SCIP-Inf-1 Prophylactic antibiotic received within one hour prior to surgical incision	Patient Safety	voluntary	No
SCIP-Inf-2 Prophylactic antibiotic selection for surgical patients	Efficient Use of Healthcare Resources	voluntary	No
SCIP-Inf-9 Urinary catheter removed on postoperative day 1 (POD 1) or postoperative Day 2 (POD 2) with day of surgery being day	Patient Safety	voluntary	No
Inpatient Stroke (STK)			
STK-2 Discharged on antithrombotic therapy	Clinical Process/Effectiveness	voluntary	No
STK-3 Anticoagulation therapy for atrial fibrillation/flutter	Clinical Process/Effectiveness	voluntary	No
STK-4 Thrombolytic therapy	Clinical Process/Effectiveness	required	Yes
STK-5 Antithrombolytic therapy by end of hospital day 2	Clinical Process/Effectiveness	voluntary	No
STK-6 Discharged on statin medication	Clinical Process/Effectiveness	required	Yes
STK-8 Stroke education	Patient and Family Engagement	required	Yes
STK-10 Assessed for rehabilitation	Care Coordination	voluntary	No
Inpatient Venous Thromboembolism (VTE)			
VTE-1 Venous thromboembolism prophylaxis	Patient Safety	required	Yes
VTE-2 ICU VTE prophylaxis	Patient Safety	required	Yes
VTE-3 VTE patients with anticoagulation overlap therapy	Clinical Process/Effectiveness	required	Yes
VTE-4 VTE Patients receiving unfractionated Heparin with dosages/platelet count monitored by protocol or nomogram	Clinical Process/Effectiveness	voluntary	No
VTE-5 Venous thromboembolism Warfarin therapy discharge instructions	Patient and Family Engagement	required	Yes
VTE-6 Hospital acquired potentially-preventable venous thromboembolism	Patient Safety	required	Yes
Inpatient Emergency Department Throughput			
ED-1 Median time from ED arrival to ED departure for ED admitted patients	Patient and Family Engagement	required	Yes
ED-2 Median time from admit decision to departure for ED admitted patients	Patient and Family Engagement	required	Yes
Outpatient Emergency Department Throughput			
ED-3 Median Time from ED arrival to ED departure for discharged ED patients	NA	not included/ OPmeasure	No
Inpatient Perinatal/Neonatal Care			
PC-1 Elective delivery prior to 39 completed weeks gestation	Clinical Process/Effectiveness	required	Yes
PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice	Clinical Process/Effectiveness	voluntary	No

2016 Proposed CMS and State Hospital Measure Summary

Electronic Clinical Quality Measures *Submitted to QualityNet*	National Quality Strategy Domain	Included in Inpatient Quality Reporting Program?	Also a chart-abstracted measure?
HTN Document Given to Patient/Caregiver Healthy Term Newborn	Patient Safety	voluntary	No
EHRI-1a Hearing Screening Prior to Hospital Discharge	Clinical Process/Effectiveness	voluntary	No
Children's Asthma Care (CAC)			
CAC-3 Home Management Plan of Care (HMPC) document given to patient/caregiver	Patient and Family Engagement	voluntary	No

Future CMS measures

CY2018 Outpatient

Outpatient Unplanned Hospital Visit
OP-32 Facility 7-day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Measures under Consideration

Will be updated February 2015

Hospital Inpatient Quality Reporting MUC 2014

MUC ID	Measure Title	CMS Domain

Hospital Outpatient Quality Reporting MUC 2014

MUC ID	Measure Title	CMS Domain

Hospital Value-Based Purchasing MUC 2014

MUC ID	Measure Title	CMS Domain

Hospital Readmission Reduction Program MUC 2014

MUC ID	Measure Title	CMS Domain

Hospital Acquired Condition Reduction Program MUC 2014

MUC ID	Measure Title	CMS Domain

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4/8/2015

This material was prepared by Stratis Health, under contract with the Minnesota Community Measurement funded by the Minnesota Department of Health.

Appendix G

2016 Proposed PPS Measures; CAH Measures

Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

2016 Required Measures for PPS Hospitals - Proposed April 2015

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Measure	*Collection method*	*Submission method*	*VBP*	*RRP*	*HAC*	*Population*
Clinical Care - Process						
AMI-7a Fibrinolytic therapy received within 30 minutes of hospital arrival	eCQM/chart abstracted	QualityNet	x			All payer
IMM-2 Influenza immunization	Chart Abstracted	QualityNet	x			All payer
PC-01 Elective delivery prior to 39 completed weeks gestation	eCQM/chart abstracted	QualityNet	x			All payer
Clinical Care - Outcome						
MORT-30-AMI Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Claims	Billing	x			Medicare
MORT-30-HF Heart Failure (HF) 30-Day Mortality Rate	Claims	Billing	x			Medicare
MORT-30-PN Pneumonia (PN) 30-Day Mortality Rate	Claims	Billing	x			Medicare
Patient Experience of Care						
Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)	Survey	QualityNet	x			All payer
Safety						
PSI 90 Complication/Patient Safety for Selected Indicators (composite) (3, 6-8, 12-15)	Claims	Billing	x		x	Medicare
Central Line Associated Bloodstream Infection (CLABSI)	Chart Abstracted	NHSN	x		x	All payer
Catheter-Associated Urinary Tract Infection (CAUTI)	Chart Abstracted	NHSN	x		x	All payer
Surgical Site Infections (SSI) following colon surgery	Chart Abstracted	NHSN	x		x	All payer
Surgical Site Infections (SSI) following abdominal hysterectomy	Chart Abstracted	NHSN	x		x	All payer
Clostridium Difficile (C. difficile or CDI)	Chart Abstracted	NHSN	x		x	All payer
MRSA Bacteremia	Chart Abstracted	NHSN	x		x	All payer

Measure	*Collection method*	*Submission method*	*VBP*	*RRP*	*HAC*	*Population*
Efficiency						
Medicare Spending per Beneficiary	Claims	Billing	x			Medicare
Readmissions						
READM-30-AMI Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	Claims	Billing		x		Medicare
READM-30-HF Heart Failure (HF) 30-Day Readmission Rate	Claims	Billing		x		Medicare
READM-30-PN Pneumonia (PN) 30-Day Readmission Rate	Claims	Billing		x		Medicare
READM-30-TH/TKA: 30 day all-cause risk-standardized readmission rate(RSRR) for elective primary Total Hip(THA) /Total Knee Arthroplasty(TKA)	Claims	Billing		x		Medicare
READM-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission rate	Claims	Billing		x		Medicare
READM-30-CABG Coronary Bypass Graph Surgery (CABG) 30-Day Readmission rate	Claims	Billing		x		Medicare
Health Information Technology						
Health information technology survey	Survey					All Payer
End of Life						
Stage 2 Meaningful Use Advance Directive Measure	EHR	HIT survey				All Payer
CMS Incentive Programs Composite Measures						
Total Performance Score (TPS)	None	None	x			Combined
Readmission Reduction Program (number of measures w/excess readmissions) (RRP) Score	None	None		*		Medicare
Total Hospital Acquired Conditions (HAC) Score	None	None			x	Combined

*currently there is a total payment adjustment based on excess readmission but no readmissions score. The proposal is to count each readmission measure with excess readmissions as one.

Statewide Quality Reporting and Measurement System Required Measures for Critical Access Hospitals - Proposed April 2015

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Measure	*Collection method*	*Submission method*	*Population*
Inpatient			
IMM-2 Influenza immunization	Chart Abstracted	QualityNet	All payer
PC-1 Elective delivery prior to 39 completed weeks gestation	eCQM/chart abstracted	QualityNet	All payer
VTE-1 Venous thromboembolism prophylaxis	eCQM/chart abstracted	QualityNet	All payer
ED-1 Median time from ED arrival to ED departure for ED admitted patients	eCQM/chart abstracted	QualityNet	All payer
ED-2 Median time from admit decision to departure for ED admitted patients	eCQM/chart abstracted	QualityNet	All payer
Outpatient			
OP-1 Median time to fibrinolysis	Chart Abstracted	QualityNet	All payer
OP-2 Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival	Chart Abstracted	QualityNet	All payer
OP-3 Median time to transfer to another facility for acute coronary intervention	Chart Abstracted	QualityNet	All payer
OP-4 Aspirin at arrival	Chart Abstracted	QualityNet	All payer
OP-5 Median time to ECG	Chart Abstracted	QualityNet	All payer
OP-18 Median time from ED arrival to ED departure for discharged ED patients	Chart Abstracted	QualityNet	All payer
OP-20 Door to diagnostic evaluation by a qualified medical professional	Chart Abstracted	QualityNet	All payer
OP-21 ED-median time to pain management for long bone fracture	Chart Abstracted	QualityNet	All payer
OP-22 ED-patient left without being seen (numerator/denominator one time per year for the previous year)	Chart Abstracted	QualityNet	All payer
OP-23 ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival)	Chart Abstracted	QualityNet	All payer
OP-25 Safe surgery checklist	Web entry	QualityNet	All payer
Infection			
Catheter-Associated Urinary Tract Infection (CAUTI) (hospital wide)	Chart Abstracted	NHSN	All payer
Healthcare Personnel Influenza Vaccination (combined with OP-27)	Chart Abstracted	NHSN	All payer
OP-27 Influenza Vaccination Coverage among Healthcare Personnel (combined with HCP)	Chart Abstracted	NHSN	All payer
ED Transfer Communication			
EDTC-1 Administrative communication	Chart Abstracted	MHA	All payer
EDTC-2 Vital signs	Chart Abstracted	MHA	All payer
EDTC-3 Medication information	Chart Abstracted	MHA	All payer
EDTC-4 Patient information	Chart Abstracted	MHA	All payer
EDTC-5 Physician information	Chart Abstracted	MHA	All payer
EDTC-6 Nursing information	Chart Abstracted	MHA	All payer
EDTC-7 Procedures and tests	Chart Abstracted	MHA	All payer

EDTC- 8 All or None composite	Chart Abstracted	MHA	All payer

Measure	*Collection method*	*Submission method*	*Population*
Patient Experience of Care			
Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (≥ 500 admissions in previous year)3 item Care Transition set and 2 About You items	Survey	QualityNet	All payer
Readmissions			
READM-30-HF Heart Failure (HF) 30-Day Readmission Rate	Claims	Billing	Medicare
READM-30-PN Pneumonia (PN) 30-Day Readmission Rate	Claims	Billing	Medicare
READM-30-COPD Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission rate	Claims	Billing	Medicare
Health Information Technology			
Health information technology survey	Survey	Online link	All payer
End of Life			
Stage 2 Meaningful Use Advance Directive Measure	EHR	HIT survey	All payer

Appendix H
MNCM/Stratis Health Brief: Cross-Setting Ambulatory and Hospital, and Patient Safety Measurement

MN Community Measurement
Measure Up To Better Health
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StratisHealth

RE: Cross-Setting Ambulatory and Hospital, and Patient Safety Measurement

MN Community Measurement (MNCM) and Stratis Health are pleased to provide follow-up to our conversation and e-mails on the topics of Cross-Setting Ambulatory and Hospital Measurement and a Composite or Index Patient Safety Measurement. MNCM and Stratis Health have a long history of working together. Together, we believe we can create measures that are impactful and meaningful. This letter provides information on the importance of these proposed new directions in measurement, as well as how the work would be accomplished through our continued partnership.

Continued Coordinated Partnership

MNCM and Stratis Health are unique organizations that leverage organizational expertise and stakeholder networks to maximize community participation and support. Specifically, MNCM's knowledge of the measure development process, measurement landscape, characteristics of strong measurement and potential barriers to community acceptance, are critical considerations in successful development and testing. Stratis Health's expertise in the area of quality improvement, patient safety, experience using measurement and evidence-based practices to develop improvement projects informs the feasibility and usability of any measure under consideration. Both organizations have oversight committees.

Cross-Setting Measurement: Ambulatory and Hospital Measures

Why Measure?
Quality measurement in health care initially developed over the past decade with setting-specific measures, such as measures specific to acute care or ambulatory care. However, measurement needs have evolved in recent years to accommodate new approaches to care delivery. Measures are needed today which are more comprehensive and patient-centered, extend across the continuum of care, and support new payment models that incorporate Total Cost of Care and Accountable Care contracts. The emerging care delivery and payment models are beginning to encompass population health and to help address health equity.

The State of Minnesota, through the Statewide Quality Reporting & Measurement System (SQRMS) program, reports on a portfolio of hospital and clinic measures, and should continue to do so to help support a culture of transparency and quality. In addition, there is an opportunity and need to add to SQRMS reporting joint or coordinated measures across the continuum of care ("cross-cutting measures") in response to the changing care delivery and payment environment. Priorities identified by MNCM and Stratis Health, in their quality measurement work with multi-stakeholder groups, include cross-cutting measures in care transitions, advance care planning and time-critical care. These are areas prime for cross-cutting measurement in Minnesota, building on the RARE Campaign for care transitions, the work of Honoring Choices Minnesota and the Health Care Homes program for advance care planning and AHA Mission Lifeline and the MN Stroke Registry. These areas also reflect National Quality Strategy and CMS measurement priorities.

Patient Safety Composite or Index

Why Measure?

Patient safety consistently emerges as a high priority for both health care delivery organizations and for patients and families. There are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system; nor do today's clinical safety measures reflect the growing body of research related to organizational properties and systems which are essential for safety. Today's measures tend to be condition-specific or harm-specific (e.g., surgical site infection, falls, sepsis), and do not include how reliable a hospital's care is, or whether the culture is set up for reliability and learning.

To make patient safety hospital measurement meaningful and comprehensive, and more understandable to consumers, SQRMS could build upon the reporting individual hospital safety measures with reporting of a multi-faceted patient safety index or composite measure. The index or composite could include a balanced set of process, outcome, and structural measures and can be derived from existing measures and indices and put together in a combination to meet community needs. This aligns with the national measures from CMS and also aligns with suite, composite and/or outcomes measurement that MN Community Measurement has developed in the ambulatory setting.

How We Partner

MNCM and Stratis Health currently partner in a variety of ways. For the development of measures, we would collaborate utilizing Stratis Health's extensive knowledge of hospital-based measurement and MNCM's experience with successful measure development and implementation. This includes MNCM providing guidance regarding the important measure development factors for consideration and Stratis Health providing hospital-based priorities when developing a new measure concept. MNCM's established measure development process would be utilized with Stratis Health and MNCM co-facilitating. Per the MNCM measure development process, an external chairperson with clinical expertise would be selected for the workgroups. Since attribution will be hospital, clinic or other provider based, both the Stratis Health Hospital Quality Reporting Steering Committee (HQRSC) and MNCM's Measurement

and Reporting Committee (MARC) would be utilized to solicit stakeholder feedback and approval of the measures concepts. For both the Cross Setting and Safety Composite or Index Measure, a measure concept (which draws upon existing measures in developing a new composite or index) would be brought to the Committees, workgroups formed, methodology developed and agreed upon and then the measure tested. The entire measure development process would take approximately 18 to 24 months.

Feasibility

In an environment of constrained resources, the measurement directions recommended above are feasible if some of the current reporting is simplified. Specifically, the Stratis Health team has suggested moving to a hospital reporting framework which reports two existing measure sets – the CMS Value-Based Purchasing (VBP Total Performance Score) for PPS hospitals and the HRSA Medicare Beneficiary Quality Improvement Project (MBQIP) set of measures for CAH hospital. By utilizing this pair of comprehensive national measures, time and resources are available to pursue the cross-setting and safety composite measures recommended.

This approach for hospitals would not have been possible even just a couple of years ago, but is today. The CMS VBP Total Performance Score is a single number reflective of a combination of process measures, outcome measures, patient experience of care measures, and efficiency/cost measures. The process and patient experience are both all payer measures, while the outcome and cost measures are Medicare-specific. There is wide variation in the Total Performance Score of Minnesota's 50 PPS hospitals, which indicates room for improvement and distinction between them.

For the Total Performance Score and the MBQIP measures, some up front design work would be required but no additional or separate data collection would be required since it is all already done by CMS or the State flex coordinator at MDH. SQRMS could add some additional analysis to the public report as well, showing the variation across hospitals and the comparison to both MN and national results. Similarly, MBQIP for critical access hospitals includes a balanced mix of measures relevant to rural small volume facilities.

In total, all this activity can occur and can continue in a coordinated way as we have for several years for MDH with Stratis as a subcontractor to MNCM through its Health Care Quality Measurement contract.

In conclusion, we believe that together we can create measures in these arenas that are meaningful and impactful. We look forward to your thoughts and future discussion.