Minnesota Statewide Quality Reporting and Measurement System

Annual Public Forum

June 29, 2016

Denise McCabe
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MDH Minnesota Department *of* Health

Health Economics Program

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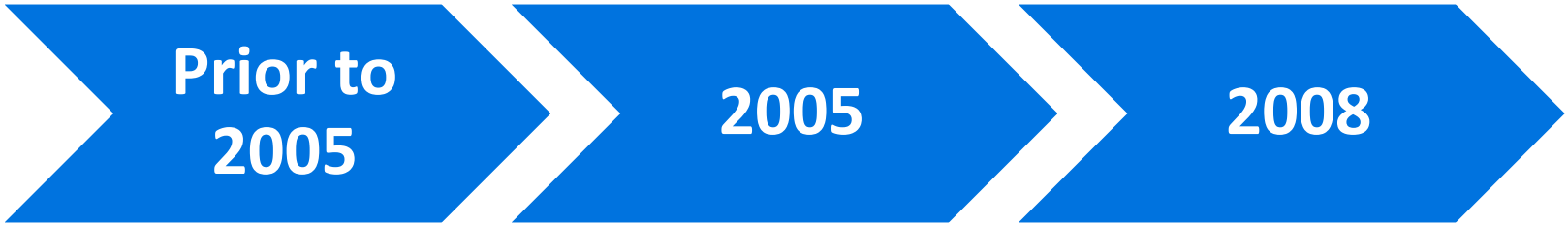
Overview

- Context and background
- Measure set update steps, timeline, and opportunities for input
- Measure results
- Health equity and legislative requirements
- Resources

Background

- Minnesota clinics, hospitals and health plans have a rich history of health care quality measurement



- Health insurers used quality measures to assess provider performance
- Measurement was burdensome and inconsistent

- MN Community Measurement established
- Better coordinate quality measurement activities, develop new measures with community support, and publicly report results

- MN Health Reform Law

Minnesota's 2008 Health Reform Law and Quality Measurement

- Establish **standards** for measuring quality of health care services offered by health care providers
- Establish a system for **risk adjusting** quality measures
- **Physician clinics** and **hospitals** are required to report
- **Health plans** may use the standardized measures; may **not** require reporting on measures outside the official set

Minnesota Statutes 62U.02

Organizational Roles

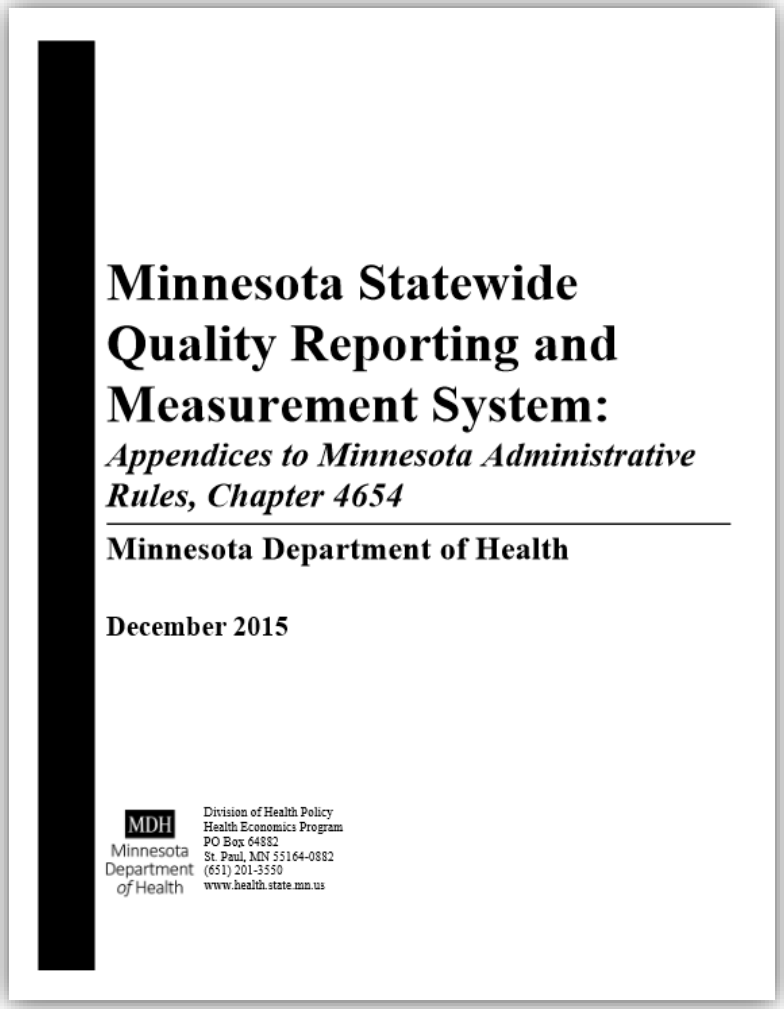
MDH	MN Community Measurement	Stratis Health	Minnesota Hospital Association
• Annually updates the Quality Rule that defines the measure set • Obtains input from the public at multiple stages of rulemaking • Publicly reports summary data • Develops vision for further evolution of the Quality Reporting System	• Facilitates data collection and validation with physician clinics and data management • Submits collected data to MDH • Works with groups of stakeholders to review and maintain measures • Develops and implements educational activities and resources • Supports the Health Care Homes Benchmarking Portal	• Develops recommendations for the uniform set of quality measures for MDH's consideration • Facilitates the Hospital Quality Reporting Steering Committee and subcommittees • Develops and implements educational activities and resources	• Facilitates data collection from hospitals and data management • Submits data collected to MDH

Rulemaking and Opportunities for Stakeholder Input

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
				1	2		3				4

1. MDH invites interested stakeholders to submit **recommendations** for standardized measures to MDH, and to comment on Stratis Health's hospital measure recommendations through **July 5**
2. MDH is holding a **public forum today** to present measure recommendations, and take questions and comments
3. MDH will publish a **proposed rule** by mid-August or September with a 30-day public comment period
4. MDH adopts the **final rule** by the end of the year

Quality Rule Appendices



Minnesota Statewide Quality Reporting and Measurement System:

Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

December 2015

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Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
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Alignment

State

Health Care Homes

Integrated Health Partnerships Demonstration

Quality Incentive Payment System

Accountable Communities for Health

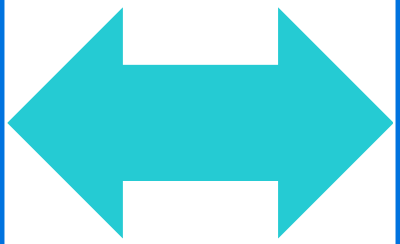
Office of Health Information Technology

Community Wellness Grant

Minnesota Stroke Registry

Minnesota Asthma Program

Health Promotion & Chronic Disease programs



Federal

Hospital Inpatient and Outpatient Quality Reporting Programs

Hospital Value-Based Purchasing

Hospital-Acquired Condition Reduction Program

Medicare Beneficiary Quality Improvement Project (MBQIP)

Meaningful Use

Physician Quality Reporting System (PQRS)

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2016 Clinic Quality Measures

Cycle A

- Optimal Diabetes Care*
- Optimal Vascular Care*
- Depression Remission at Six Months*

Cycle B

- Pediatric Preventive Care
  - Adolescent Mental Health and/or Depression Screening*
  - Overweight Counseling
- Total Knee Replacement
- Spinal Surgery

Cycle C

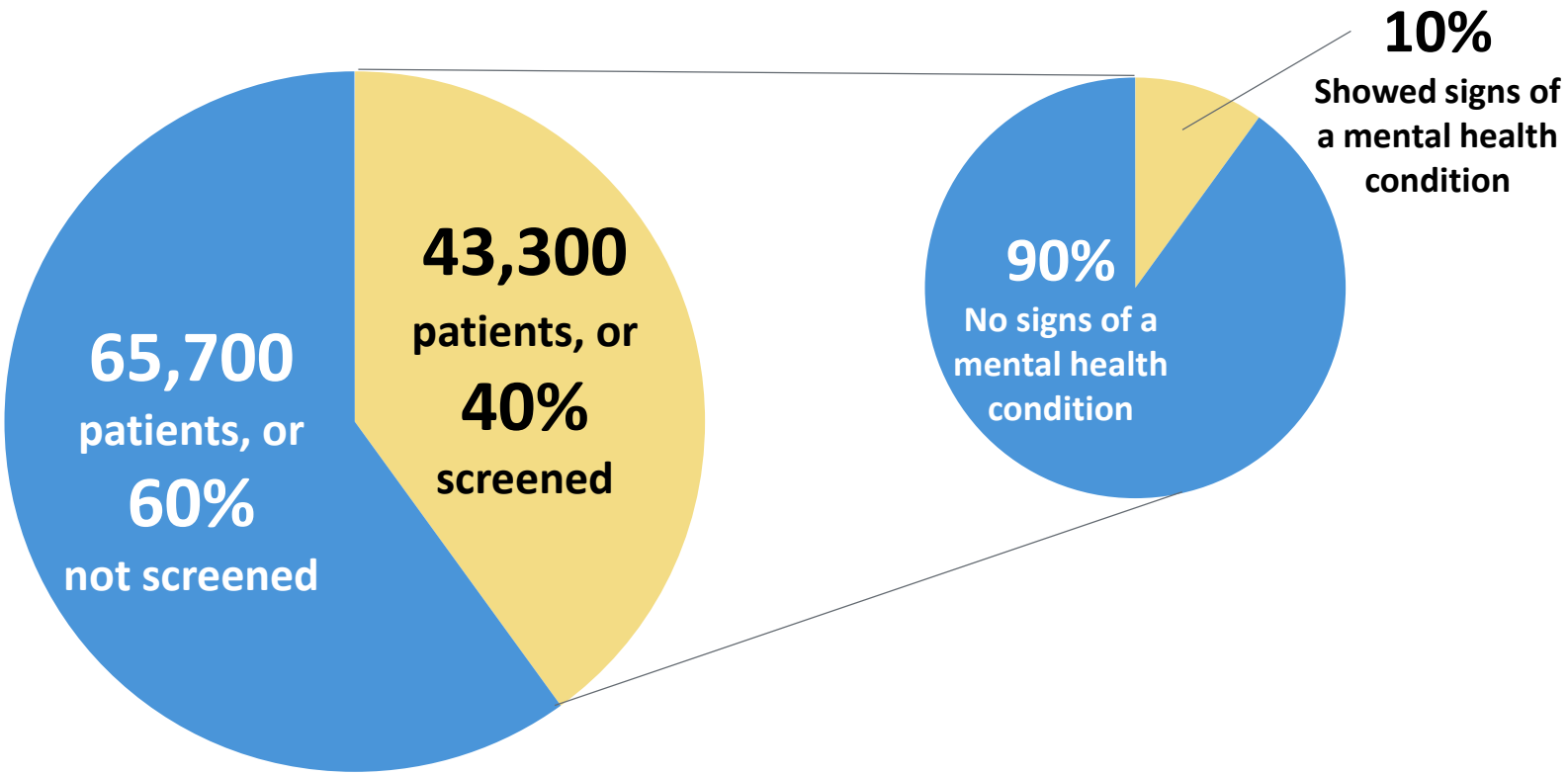
- **Optimal Asthma Control***
- **Asthma Education and Self-Management***
- **Colorectal Cancer Screening***
- **C-section Rate**

Other Measures

- Health Information Technology (HIT) Survey
- Patient Experience of Care Survey*
  (every-other year)

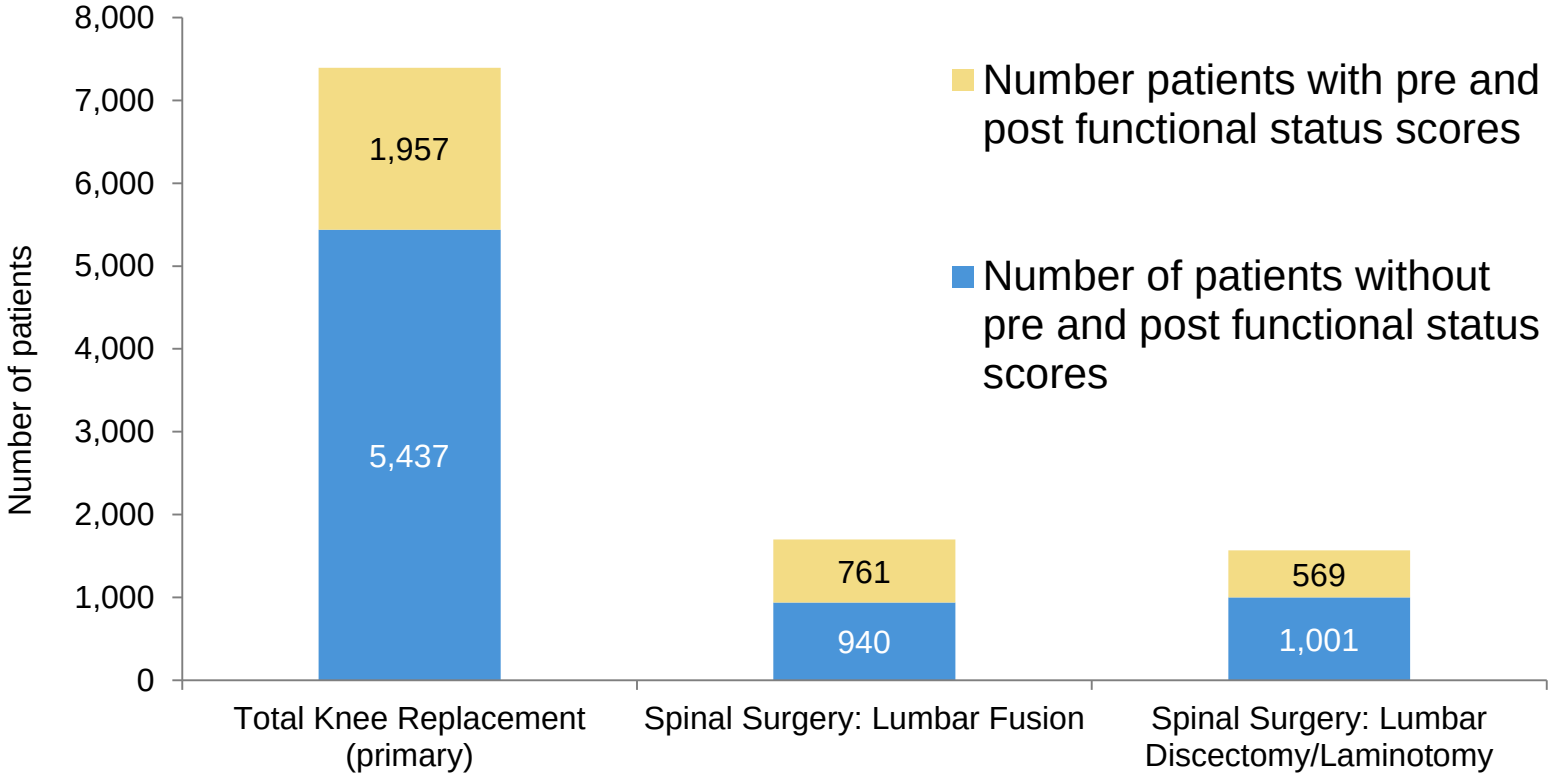
*Quality measures used for Health Care Homes (HCH) benchmarking

Mental Health Screening and Results for Adolescents Age 12-17 who had a Well-Child Visit in 2014



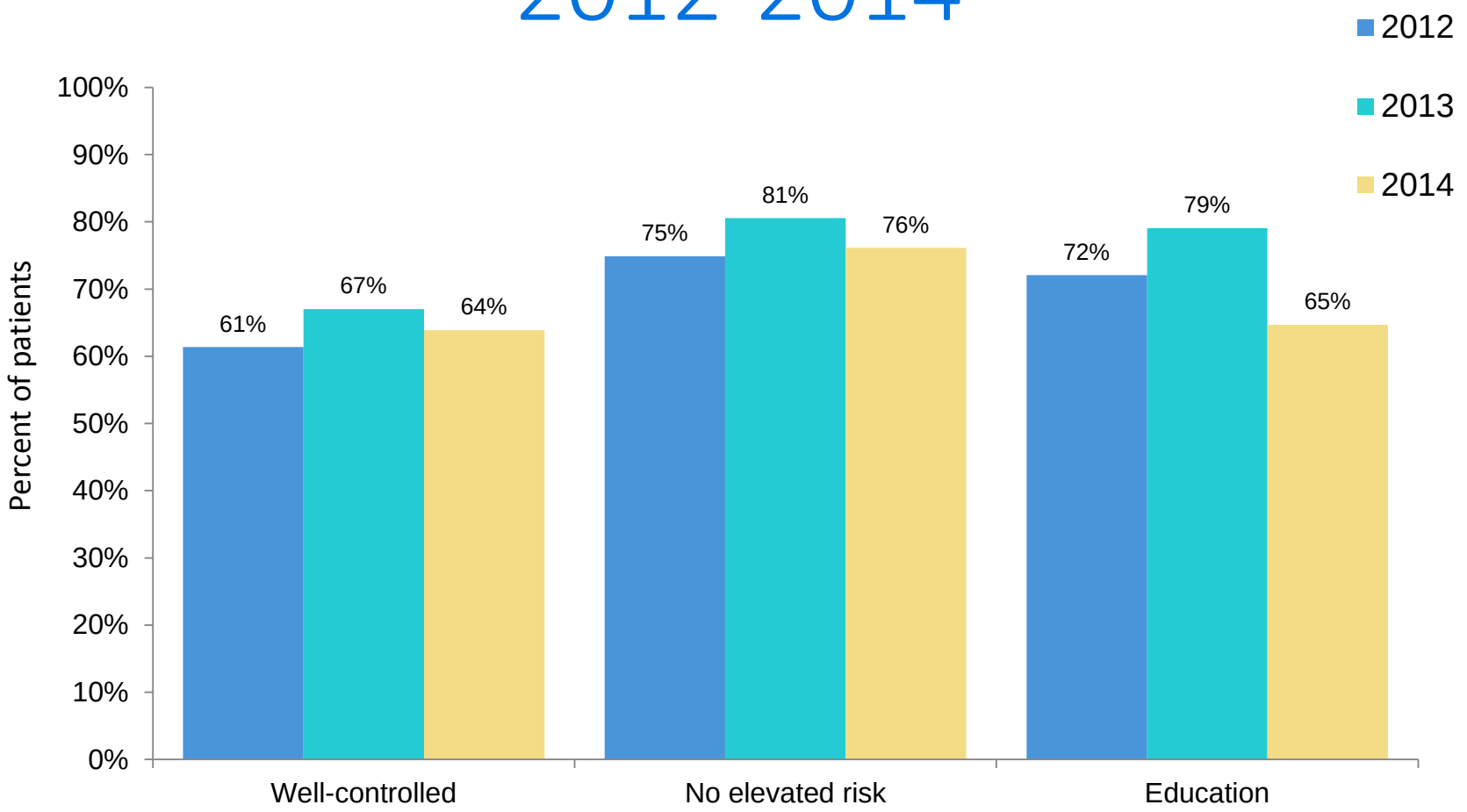
Service dates: January 1 through December 31.
Source: MDH Health Economics Program analysis of Statewide Quality Reporting System data and MN Community Measurement data, 2015.

Total Knee Replacement & Spinal Surgeries, 2013



Procedure dates: January 1 through December 31.
Source: MDH Health Economics Program analysis of Quality Reporting System data, 2016.

Child Asthma Component Measures 2012-2014



Service year: July 1 through June 30.
Source: MDH Health Economics Program analysis of Quality Reporting System data, 2016.

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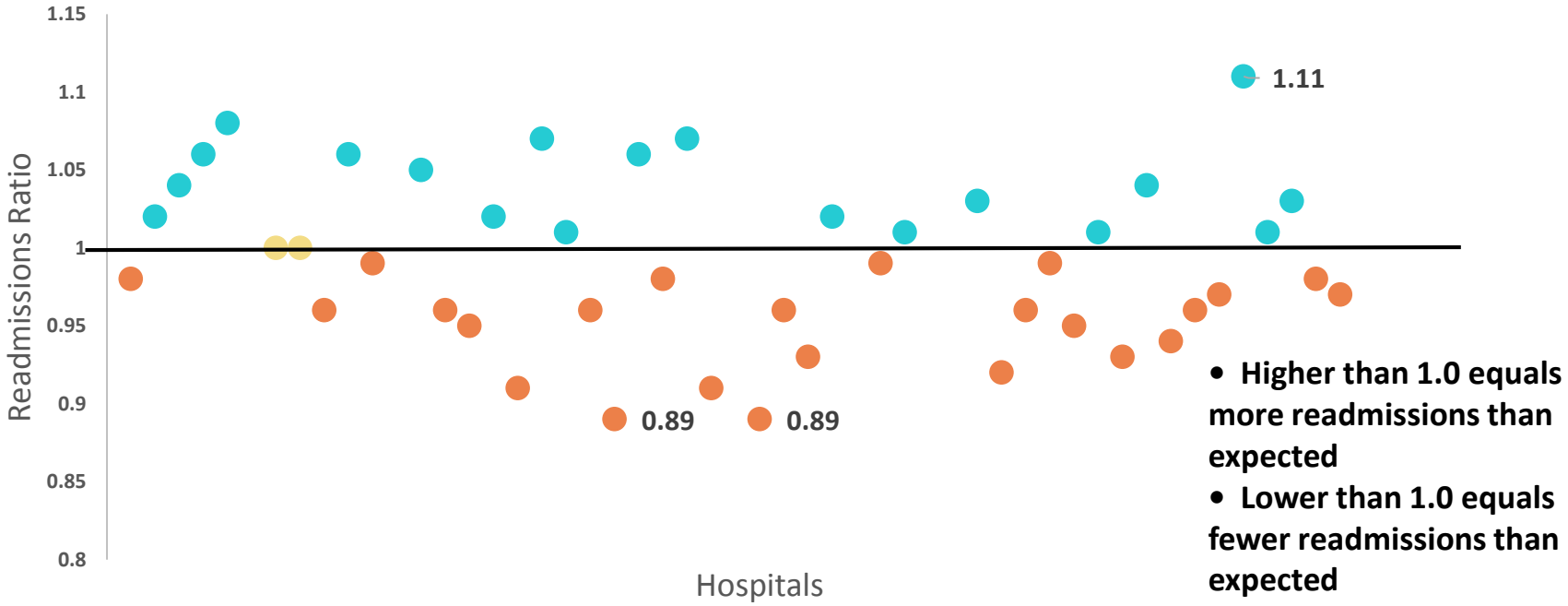
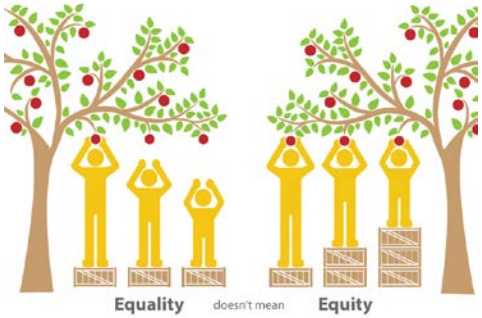
PPS Hospital Readmissions Reduction Program Composite



Composite measure includes individual 30-day readmissions measures for: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and elective total hip and total knee arthroplasty.
Discharge dates: July 1, 2011 through June 30, 2014.
Source: MDH Health Economics Program analysis of Quality Reporting System data, 2016 .

Health Equity



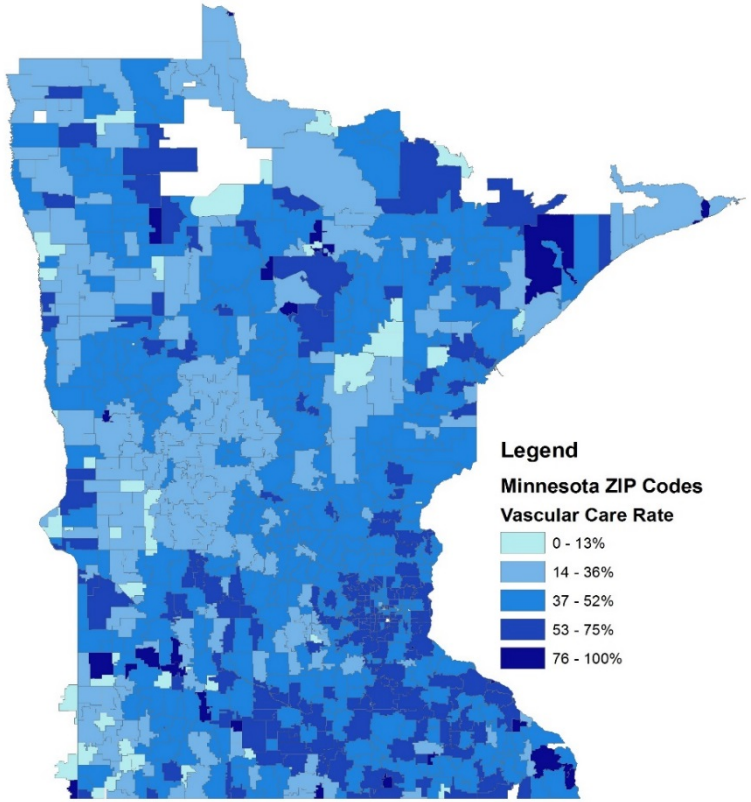
"…the commissioner shall ***stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures****, and stratifying additional measures to the extent resources are available."* Minn. Stat. 62U.02

Quality Measures	Dates of Service	Data Submission Dates
1. Optimal Asthma Control – Adult 2. Optimal Asthma Control – Child 3. Colorectal Cancer Screening	07/01/2016 – 06/30/2017	07/01/2017 – 08/15/2017 **NEXT YEAR**
4. Optimal Diabetes Care 5. Optimal Vascular Care	01/01/2017 – 12/31/2017	01/01/2018 – 02/15/2018

Stratification Example

- **Stratification enables the identification of health care disparities** for different patient groups based on some characteristic
- MDH can **better meet community needs** by designing more targeted interventions
- **Communities impacted by health disparities** can use data to address disparities

Vascular Rates by ZIP Code



Source: MDH Health Economics Program analysis of Quality Reporting System data.

Website


MDH Minnesota Department of Health
HOME
TOPICS
ABOUT US
Health Care Quality Measures
Home
2010 Report
Adopted Rule - December 2015
Recommendations
Measurement and Reporting Committee
Hospital Quality Reporting Steering Committee
Quality Incentive Payment System
About
Minnesota's Health Reform Initiative
Home
MNsure provider networks
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Update
Statewide Quality Reporting and Measurement System Risk Adjustment Assessment
MDH has been directed by the Legislature to assess the Quality Reporting System risk adjustment methodology to identify changes that may be needed to alleviate potential harm and unintended consequences of the existing methodology for patient populations who experience health disparities and the providers who serve them.

Submitting Comments

- MDH invites interested stakeholders to:
  - Submit recommendations on the addition, removal, or modification of standardized quality measures for 2017 reporting; and
  - Review and comment on the Hospital Quality Reporting Steering Committee's measure recommendations for 2017 reporting.
- Interested persons or groups must submit recommendations, comments, and questions **by July 5** to:
  - Denise McCabe, Minnesota Department of Health
    - P.O. Box 64882, St. Paul, MN 55164-0882
    - (651) 201-5530; fax: (651) 201-201-5179
    - health.reform@state.mn.us

Resources

Minnesota Statewide Quality Reporting and Measurement System	• www.health.state.mn.us/healthreform/measurement
Subscribe to MDH's Health Reform list-serv to receive updates	• www.health.state.mn.us/healthreform
Submit comments during our open comment period through July 5	• www.health.state.mn.us/healthreform/measurement/recommendations

Contact Information

- For questions about the Statewide Quality Reporting and Measurement System, contact:

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651.201.3569

Hospital Measure Recommendations

Vicki Tang Olson, Stratis Health

2017 Statewide Quality Reporting and Measurement System (SQRMS)

June 29, 2016

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Objectives

- Share the process used for 2017 hospital measures recommendations
- Review recommended changes to the 2017 hospital slate of measures

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2016 Hospital Measures Recommendation Process

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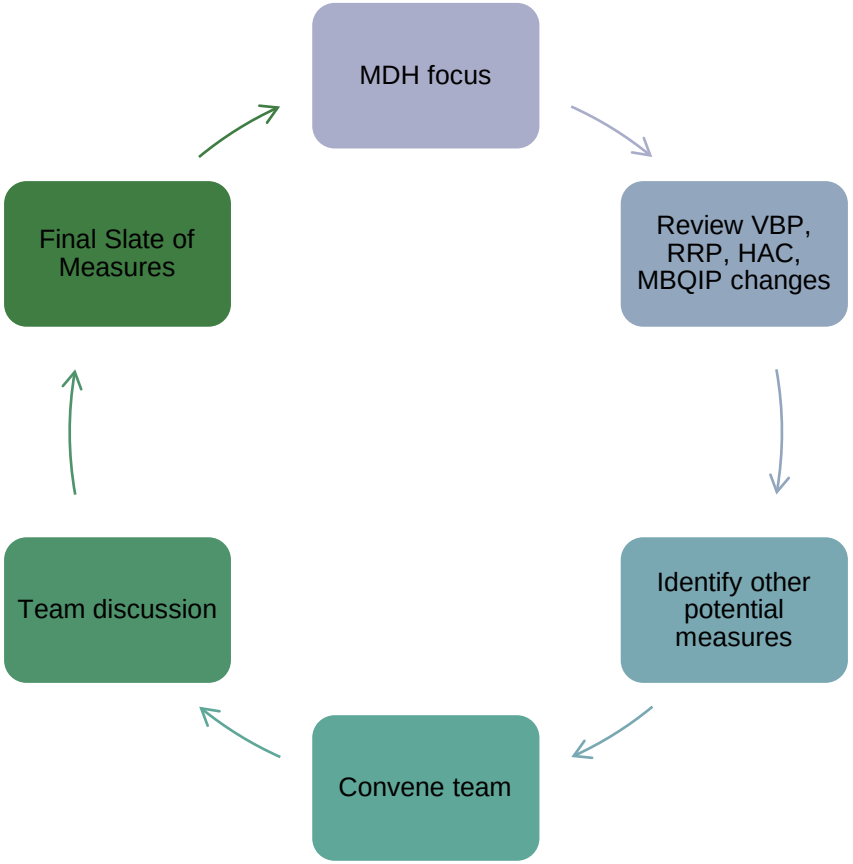
Recommendations Process



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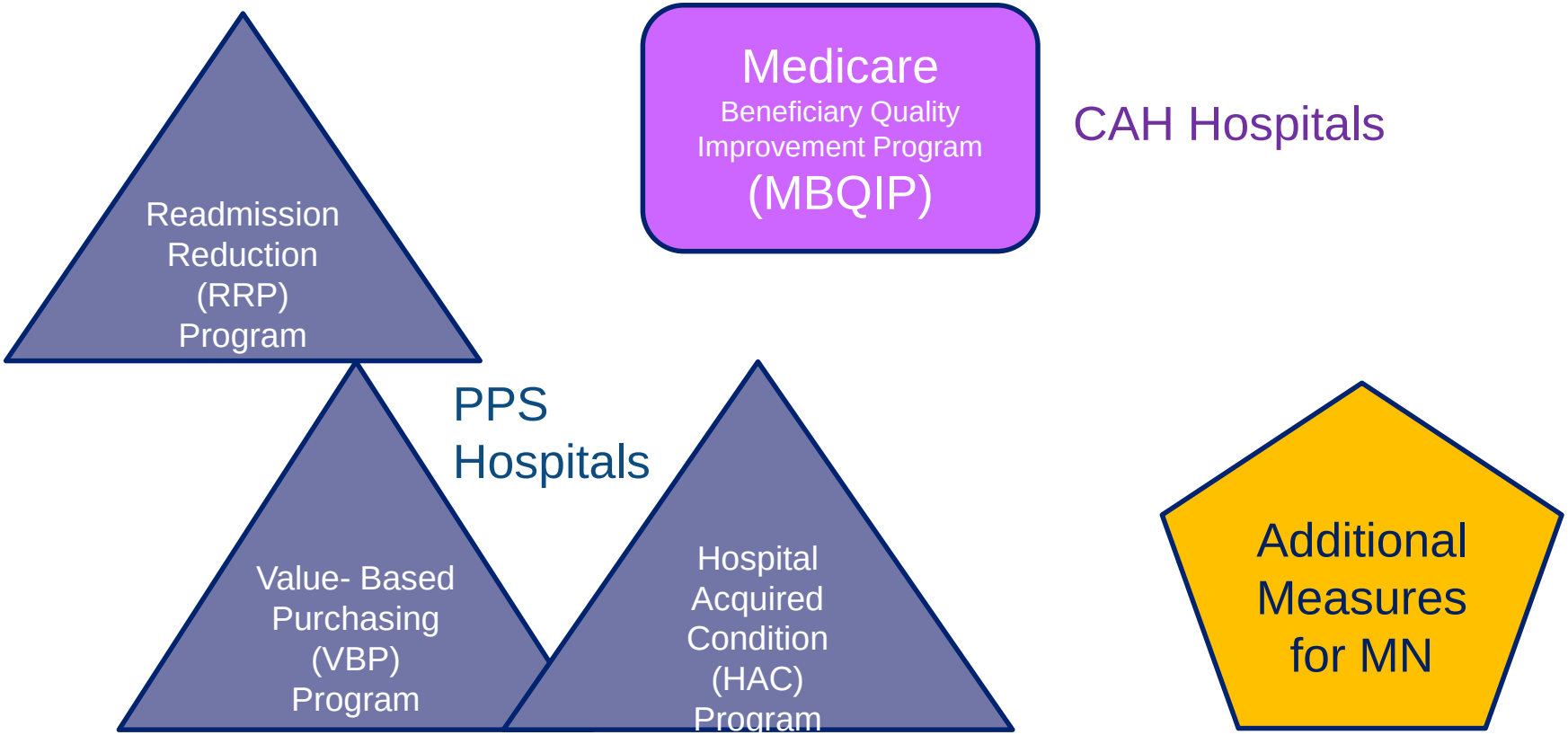
2017 Hospital Recommended Slate of Measures

Hospital Slate of Measures



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PPS Measures Alignment with VBP, RRP and HAC programs

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Value-Based Purchasing

- FY2017
  - o Total Performance Score
  - o Unweighted and weighted domain score for clinical process of care, patient experience of care, outcome and efficiency
  - o Measure scores

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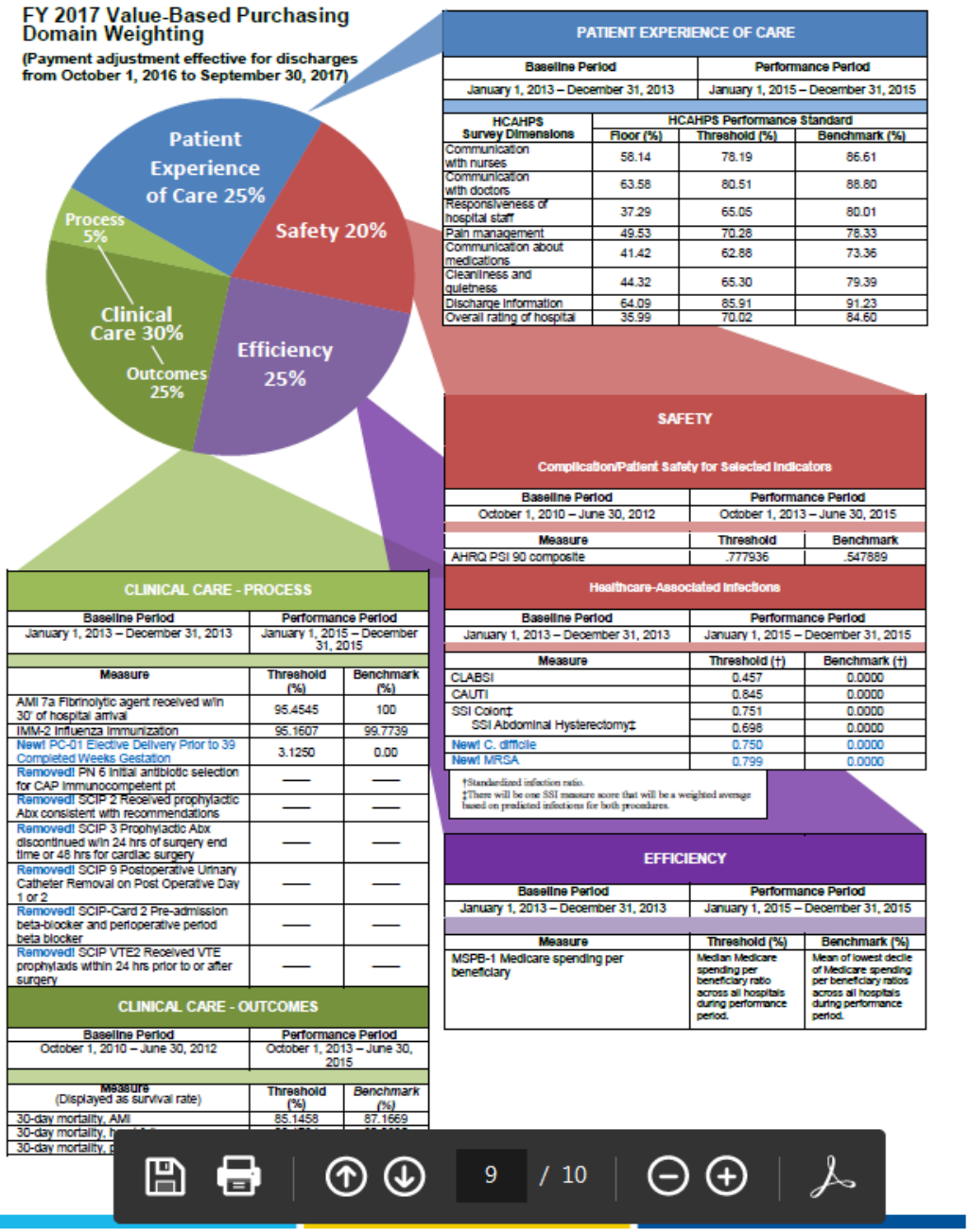
FY2017 VBP Fact Sheet



FY 2017 Value-Based Purchasing Domain Weighting

(Payment adjustment effective for discharges from October 1, 2016 to September 30, 2017)

PATIENT EXPERIENCE OF CARE

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

HCAHPS Survey Dimensions	HCAHPS Performance Standard		
	Floor (%)	Threshold (%)	Benchmark (%)
Communication with nurses	58.14	78.19	86.61
Communication with doctors	63.58	80.51	88.80
Responsiveness of hospital staff	37.29	65.05	80.01
Pain management	49.53	70.28	78.33
Communication about medications	41.42	62.88	73.36
Cleanliness and quietness	44.32	65.30	79.39
Discharge information	64.09	85.91	91.23
Overall rating of hospital	35.99	70.02	84.60

SAFETY

Complication/Patient Safety for Selected Indicators

Baseline Period	Performance Period
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015

Measure	Threshold	Benchmark
AHRQ PSI 90 composite	.777936	.547889

Healthcare-Associated Infections

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

Measure	Threshold (†)	Benchmark (†)
CLABSI	0.457	0.0000
CAUTI	0.845	0.0000
SSI Colon‡	0.751	0.0000
SSI Abdominal Hysterectomy‡	0.698	0.0000
New! C. difficile	0.750	0.0000
New! MRSA	0.799	0.0000

†Standardized infection ratio.
‡There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

CLINICAL CARE - PROCESS

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

Measure	Threshold (%)	Benchmark (%)
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	95.4545	100
IMM-2 Influenza Immunization	95.1607	99.7739
New! PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	3.1250	0.00
Removed! PN 6 Initial antibiotic selection for CAP immunocompetent pt	—	—
Removed! SCIP 2 Received prophylactic Abx consistent with recommendations	—	—
Removed! SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	—	—
Removed! SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	—	—
Removed! SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	—	—
Removed! SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery	—	—

CLINICAL CARE - OUTCOMES

Baseline Period	Performance Period
October 1, 2010 – June 30, 2012	October 1, 2013 – June 30, 2015

Measure (Displayed as survival rate)	Threshold (%)	Benchmark (%)
30-day mortality, AMI	85.1458	87.1669
30-day mortality, h		
30-day mortality, p		

EFFICIENCY

Baseline Period	Performance Period
January 1, 2013 – December 31, 2013	January 1, 2015 – December 31, 2015

Measure	Threshold (%)	Benchmark (%)
MSPB-1 Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period.

Hospital Acquired Conditions Program Score

- FY2017
  - Total HAC score
  - Domain 1 score
  - Domain 2 score
  - Measure scores

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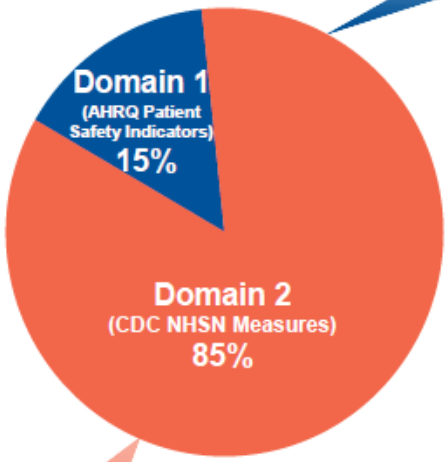
FY2017 HAC Fact Sheet

FY 2017 HAC Reduction Program Domain Weighting and Measures
(Payment adjustment effective for discharges from October 1, 2016 – September 30, 2017)



DOMAIN 1	
	Performance Period July 1, 2013 – June 30, 2015
AHRQ* PSI 90 Measure	**Score 1-10**
PSI 3 Pressure ulcer rate	
PSI 6 Iatrogenic pneumothorax rate	
PSI 7 Central venous catheter-related blood stream infection rate	
PSI 8 Postoperative hip fracture rate	
PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Wound dehiscence rate	
PSI 15 Accidental puncture and laceration rate	

*The Agency for Healthcare Research and Quality

DOMAIN 2	
	Performance Period January 1, 2014 – December 31, 2015
CDC NHSN* Measures	**Average Score 1-10**
CLABSI SIR rate	**1-10+**
CAUTI SIR rate	**1-10+**
SSI Colon Abdominal Hysterectomy	**1-10†**
MRSA	**1-10**
CDI	**1-10**

*Centers for Disease Control and Prevention National Healthcare Safety Network

+ FY2017 will continue to use data from ICU locations only. FY2018 will include data from pediatric and adult medical ward locations in addition to data from adult and pediatric ICU locations.

†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

New standard population data will not be used until FY2018.

Readmissions Reduction Program

FY2017

- ➢ Discharges from July 1, 2012 to June 30, 2015
- 30-day Readmissions Acute Myocardial Infarction (AMI),
- 30-day Readmissions Heart Failure (HF)
- 30-day Readmissions Pneumonia (PN);
- 30-day Readmissions Chronic Obstructive Pulmonary Disease (COPD)
- 30-day Readmissions Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)
- 30 day Readmissions Coronary Artery Bypass Graft (CABG) surgery

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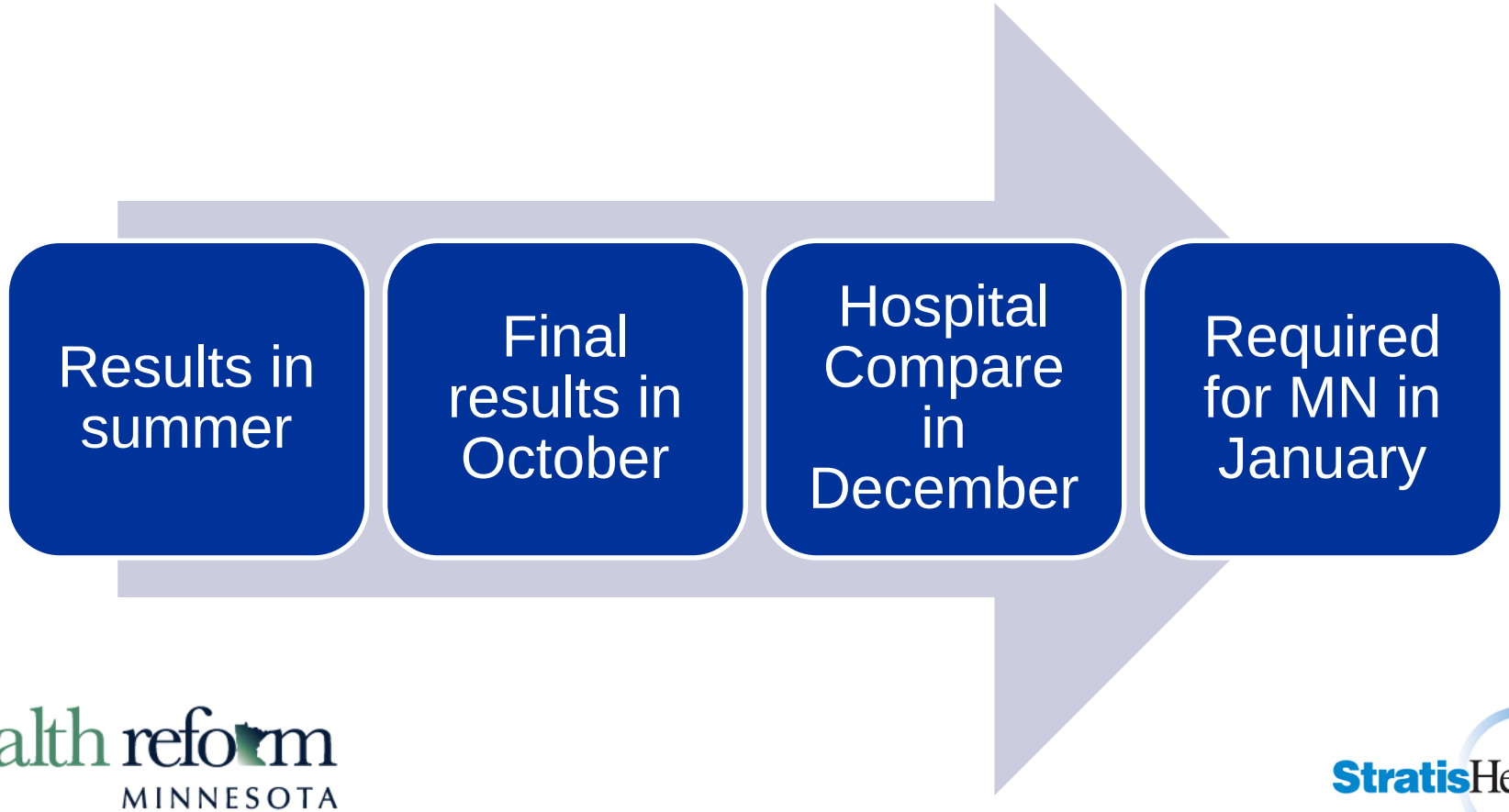
Readmissions Composite Score

Summary of weighted excess readmissions score

Composite score = (AMI Cases x excess ratio) + (Pneumonia Cases x excess ratio) + (Heart Failure Cases x excess ratio) + (Hip/Knee Cases x excess ratio) + (COPD Cases x excess ratio) + (CABG Cases x excess ratio)

Data Submission of VBP, RRP and HAC results



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Alignment of Individual Measures for CAH

Inpatient Measures - CAH

- ED-1a Median time from ED arrival to ED departure for admitted ED patients
- ED-2a Median time from admit decision time to ED departure time for admitted patients
- Catheter associated Urinary Tract Infection (CAUTI) event
- PC-01 Early elective deliveries
- Imm-2 Influenza immunization

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Outpatient Measures - CAH

OP-1 Median time to fibrinolysis

OP-2 Fibrinolytic therapy received within 30 minutes of emergency department

OP-3 Median time to transfer to another facility for acute coronary intervention

OP-4 Aspirin at arrival

OP-5 Median time to ECG

Outpatient Measures - CAH

- OP-18 Median time from ED arrival to ED departure for discharged ED patients
- OP-20 Door to diagnostic evaluation by a qualified medical professional
- OP-21 ED-median time to pain management for long bone fracture

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Outpatient Measures Continue - CAH

- OP-22 ED-patient left without being seen
- 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.
- OP-25 Safe surgery checklist
- OP-27 Influenza Vaccination Coverage among Healthcare Personal (combined with HCP)

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30 Day Readmissions Continue - CAH

- Heart Failure
- Pneumonia
- Chronic Obstructive Pulmonary Disease

All PPS/CAH Hospitals

Measures Continue

- HCAHPS Patient Experience of Care
- Minnesota Stroke Registry Indicators
  - Door-to-imaging initiated time
  - Door-to-needle time to intravenous thrombolytic therapy
- AHRQ IQI 91 Mortality for Selected Conditions
- AHRQ PSI 90 Patient Safety for Selected Indicators
- AHRQ PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Complications
- HIT Survey

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End of Life Measure

- Reported through question on Health Information Technology (HIT)
- 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

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Future measures

Patient Safety Composite

- Continue focus on composite measures
  - Helpful to consumers who may not understand individual measures
  - Helpful to hospitals if there is access to individual measure performance to support improvement
- Identified as a priority by the Hospital Quality Reporting steering committee

Patient Safety Composite

2015-16

- Subgroup met
- Identified drivers
- Clarified assumptions

2016-17

- Develop framework
- Identify measures
- MAPS presentation

2017-18

- Determine weighting
- Test calculation
- Provide recommendation

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Questions?

Vicki Olson, Program Manager

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www.stratishealth.org

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StratisHealth

Stratis Health 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.

Prepared by Stratis Health under contract with Minnesota Community Measurement funded by the Minnesota Department of Health.

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Changing Established Patient Criteria for DDS Measures

June 29, 2016

Dina Wellbrock
Project Manager
MN Community Measurement

MN Community Measurement

MNCM Mission:

- Accelerating the improvement of health through public reporting

MNCM Vision:

- To be the primary trusted source for health data sharing and measurement
- To drive change that improves health, patient experience, cost and equity of care for everyone in our community
- To be a resource used by providers and patients to improve care
- To partner with others to use our information to catalyze significant improvements in health

Collaborative effort of providers, hospitals, purchasers, government, consumers and health plans

MN Community MEASUREMENT
Measure Up To Better Health

MNCM by the Numbers

Reviewed Today

- Background
- What is “established patient criteria”?
  - How is it used?
- Why change recommended?
- MARC review / Pilot testing
- Other considerations
- When will it take affect?

Background

Optimal Diabetes Care and Optimal Vascular Care measures first developed by HealthPartners in 2003 using health plan enrollment data

Measure stewardship transferred to MNCM with data reported by practices from evolving EHR

- Concerns over inappropriate attribution
- Pilot in 2007 proved use of CPT Evaluation & Management (E&M) codes too burdensome

What is established patient criteria?

- Visit counting criteria developed to establish a patient to a medical group
  - Looks at number of visits for condition as well as for any reason over past 2 measurement periods
- Only applies to certain clinical measures
- Measures include Optimal Asthma Control, Optimal Diabetes Care, Optimal Vascular Care, and Colorectal Cancer Screening

Example of Current Criteria

Patient seen by an eligible provider in an eligible specialty for a face-to-face visit for the condition at least two times during the last two measurement periods

AND

Patient seen by an eligible provider in an eligible specialty for a face-to-face visit for any reason at least one time during the current measurement period.

Recommended Change

Move to established patient criteria utilizing "established patient" E & M CPT codes to link the patient to the clinic/group.

Example: "new patient" E & M codes are 99201, 99202, 99203, 99204, 99205

"Established patient" codes are 99211, 99212, 99213, 99214, 99215

Also makes use of conditions present on the problem list

Why Change?

- Visit counting criteria excludes some patients
  - IVD example
- Increased consistency and standardized use of CPT E & M codes over time
- New measures recently implemented successfully using CPT codes for patient identification3
- DDS Technical Advisory Committee feedback:
  - query simplification
  - cleaner billing data
  - Improved alignment with PQRS & MU

Presentation to MARC

- At May 2015 MARC meeting: Recommendation to change to E & M established patient codes
  - Preliminary approval
  - requested pilot testing on impact of change

Pilot testing goals:

- comparison of visit counting to CPT code methodology
- Understand impact on denominators
- Understand impact of combination of problem list and/or visit diagnosis codes

MN Community MEASUREMENT
Measure Up To Better Health

Pilot Testing Results

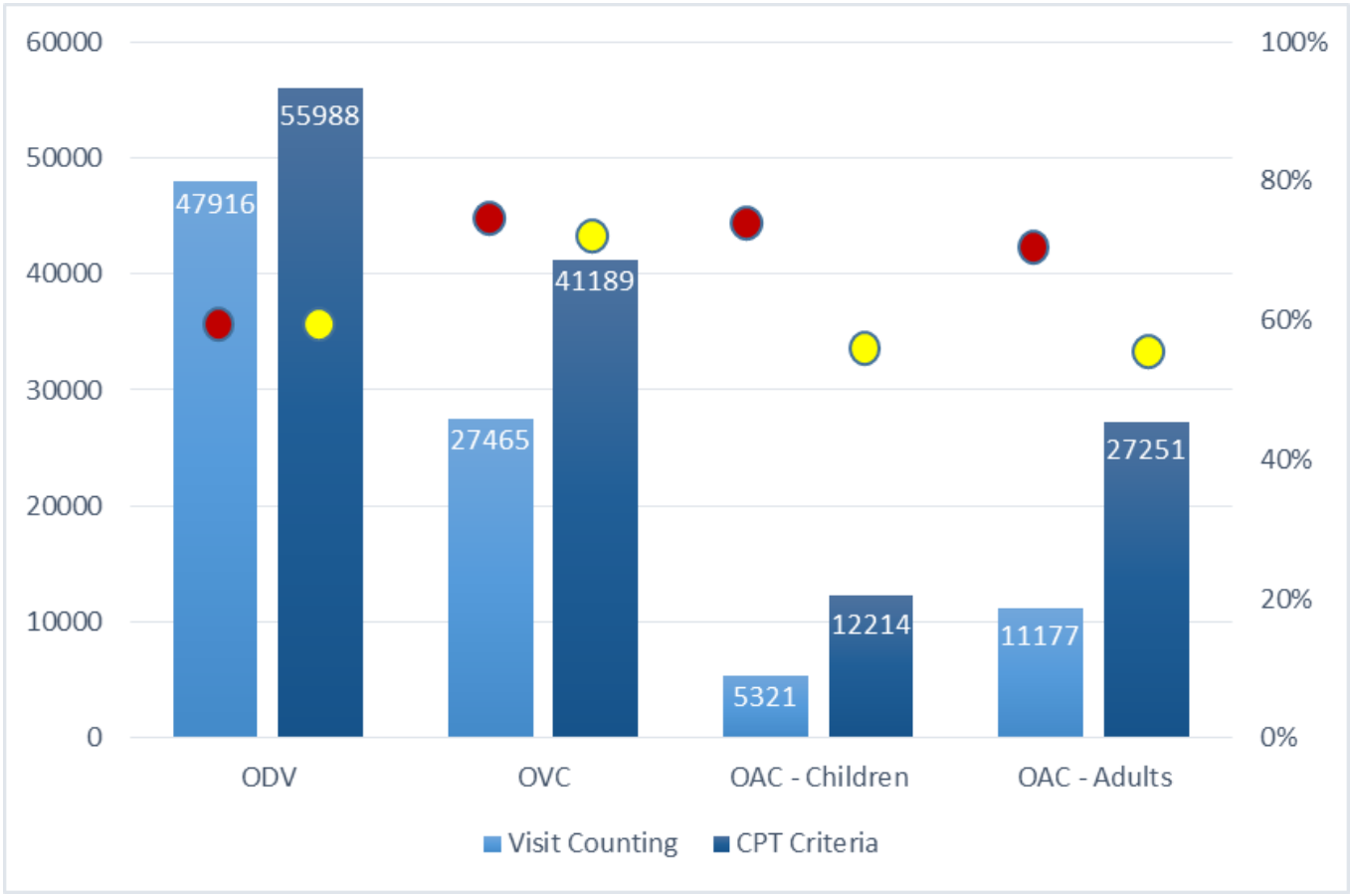
Conducted in Fall 2015 with over 340,000 patients across 4 measures

<u>Findings (presented to November 2015 MARC)</u>

- Urgent Care visits are inappropriately pulled into denominator
- Using problem lists to identify conditions in conjunction with diagnosis codes is accurate; impacts denominator

  (asthma and vascular most impacted)
- Colorectal Cancer Screening – population based measure needs to include preventive services CPT codes

Impact on Denominators and Rates



Revised Established Patient Criteria Based on Pilot

<u>For ODC, OVC, and OAC measures</u>

Patient had an office visit performed or supervised by an eligible provider in an eligible specialty as an established patient for any reason at least once during the measurement period (CPT 99211, 99212, 99213, 99214, 99215, and

ODC, OVC: 99395, 99396, 99397

OAC: 99392, 99393, 99394, 99395, 99396)

Revised Established Patient Criteria Based on Pilot, cont.d

For ODC, OVC, and OAC measures

Patient had condition coded for any contact during the measurement period AND/OR had condition present on active problem list at any time during the measurement period (query checks both sources).

Revised Established Patient Criteria Based on Pilot, cont.d

For Colorectal Screening measure

Patient had an office visit performed or supervised by an eligible provider in an eligible specialty as an established patient for any reason at least once during the measurement period (CPT 99211, 99212, 99213, 99214, 99215, 99396, 99397, 99386, 99387, G0402, G0438, G0349).

Table View of CPT/HCPCS Code by Measure

CPT Code	CPT Description	Optimal Diabetes Care	Optimal Vascular Care	Optimal Asthma Control – Adults	Optimal Asthma Control – Children	Colorectal Cancer Screening
99211	Office or other outpt visit evaluation & management of established pt (10 min)	•	•	•	•	•
99212	Office or other outpt visit evaluation & management of established pt (20 min)	•	•	•	•	•
99213	Office or other outpt visit evaluation & management of established pt (30 min)	•	•	•	•	•
99214	Office or other outpt visit evaluation & management of established pt (45 min)	•	•	•	•	•
99215	Office or other outpt visit evaluation & management of established pt (60 min)	•	•	•	•	•
99392	Periodic comprehensive preventive medicine established pt; ages 1 to 4				•	
99393	Periodic comprehensive preventive medicine established pt; ages 5 to 11				•	
99394	Periodic comprehensive preventive medicine established pt; ages 12 to 17				•	
99395	Periodic comprehensive preventive medicine established pt; ages 18 to 39	•	•	•		
99396	Periodic comprehensive preventive medicine established pt; ages 40 to 64	•	•	•		•
99397	Periodic comprehensive preventive medicine established pt; ages 65 and older	•	•			•
99386	Initial comprehensive preventive medicine new pt; ages 40 to 64					•
99387	Initial comprehensive preventive medicine new pt; ages 65 and older					•
HCPCS Code	**HCPCS Description**					
G0402	Initial preventive services exam new beneficiary first 12 months Medicare enroll					•
G0438	Annual wellness visit, personalized prevention plan of service; initial visit					•
G0439	Annual wellness visit, personalized prevention plan of service; subsequent visit					•

Revised Established Patient Criteria Based on Pilot, cont.d

Exclusions

Patients with only urgent care (UC) visits during the measurement period

Other Considerations

One year loss of ability to trend performance

Timeline

If adopted by MDH: Change to established patient criteria recommended to begin for Report Year 2017 (2016 Dates of Service).

Preliminary communication regarding the change sent December 15, 2015 through *Measurement Minute* to all clinics.

Contact

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Questions?

Public Comment Themes

- Modifications to clinic measures
- Critical access hospital reporting requirements
- New measurement: Tobacco Use – Screening & Cessation Intervention