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

health reform MINNESOTA
A Better State of Health

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.
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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