The Minnesota Statewide Quality Reporting and Measurement System (SQRMS): An Overview

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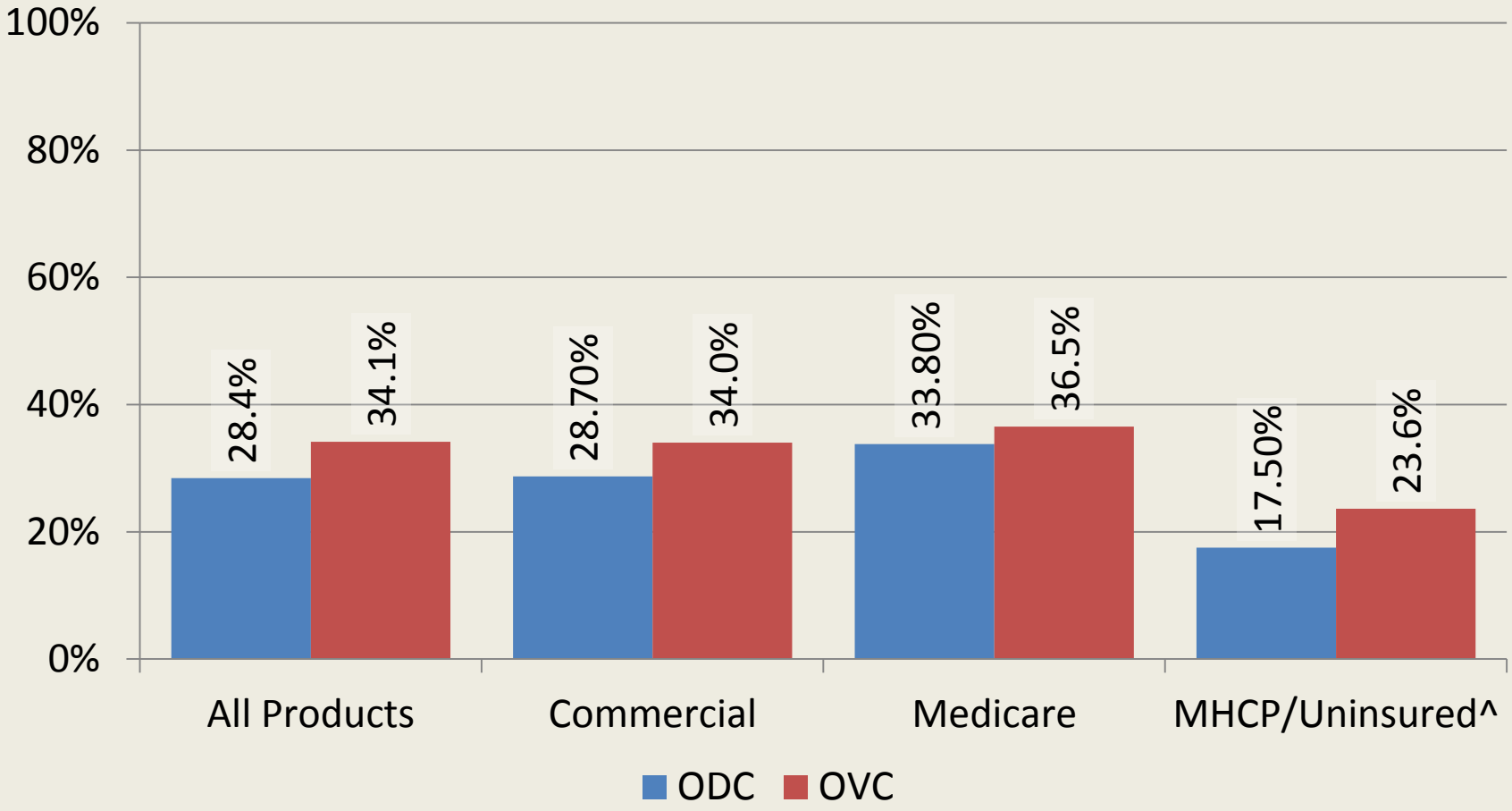
SQRMS overview

- Context
- Objectives and goals
- Rulemaking and opportunities for input
- Quality measures
- Impact
- Stakeholder recommendations

Context for State health reform

- High quality in Minnesota relative to other states
- Wide variation in costs and quality across different health care providers, with no evidence that higher cost or higher use of services is associated with better quality or better health outcomes for patients
- Health care costs are rising, placing greater share of health care costs on consumers
- What tools do consumers have to choose how to spend their health care dollars?

Optimal Diabetes Care (ODC) & Optimal Vascular Care (OVC), 2009



Source: MDH Health Economics Program analysis of SQRMS data.

^MHCP are Minnesota Health Care Programs, which include Medicaid and MinnesotaCare

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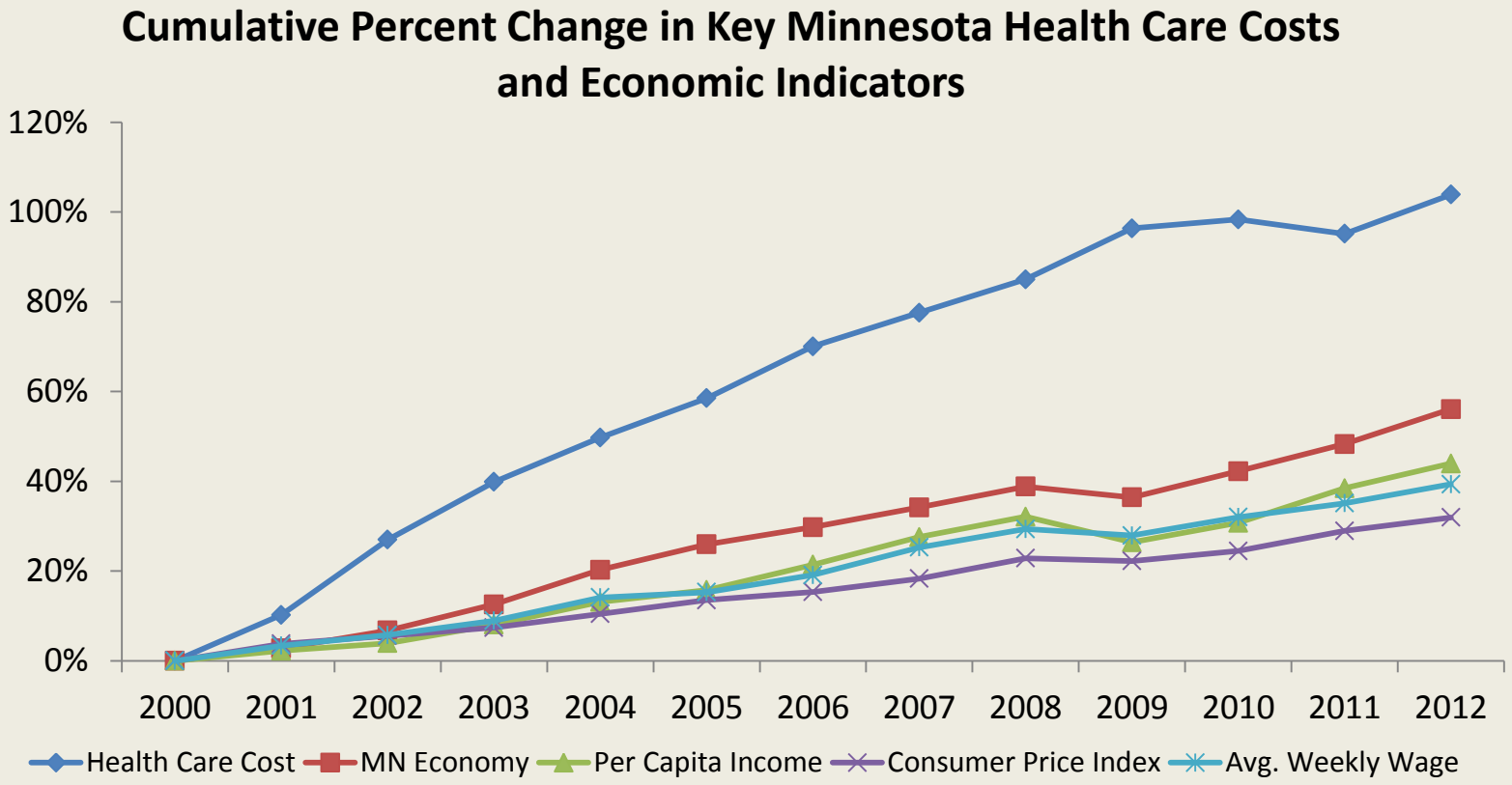
Health care growth exceeds growth in income and wages



Note: Health care costs is MN privately insured spending on health care services per person, and does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance

Sources: MDH/Health Economics Program; U.S. Department of Commerce, Bureau of Economic Analysis; U.S. Bureau of Labor Statistics; MN Department of Employment and Economic Development.

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Statutory requirements: Minnesota's 2008 Health Reform Law

- Establish standards for measuring quality of health care services offered by health care providers
- Establish a system for risk adjusting quality measures
- Physician clinics, hospitals, and ambulatory surgical centers are required to report
- Issue annual public reports on provider quality
- Minnesota Statutes, 62U.02

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Objectives and goals

- Enhance market transparency by creating a uniform approach to quality measurement
- Improve health / reduce acute care spending
- Quality measures must be based on medical evidence and be developed through a participatory process
- Public reporting quality goals:
  - Make more quality information broadly available
  - Use measures related to either high volume or high impact procedures and health issues
  - Report outcome measures or process measures that are linked to improved health outcomes
  - Not increase administrative burden on health care providers where possible

SQRMS characteristics

- SQRMS is a critical aspect of heath care reform
  - Measures inform patients of the value of provider care in Minnesota
  - They are a component of assessing overall value for the first time
- SQRMS processes are intentional and transparent
  - Community input and engagement informs MDH's development of quality measurement and reporting for the state of MN
- SQRMS is an evolving process
  - Quality measurement and reporting continually evolves based on changes in measurement science, community buy-in and community priorities

Partnership between MDH and MN Community Measurement

- MDH conducted two competitive procurements in the fall of 2008 and again in 2013, and subsequently entered into contracts with MN Community Measurement (MNCM).

- Currently, MDH has a 21-month, $1.5 million contract with MNCM as lead member of consortium that includes Stratis Health and the Minnesota Hospital Association (MHA) to carry out key activities:
  - Manage data collection activities;
  - Conduct outreach to providers;
  - Develop recommendations for SQRMS and the Quality Incentive Payment System (QIPS);
  - Support the Health Care Homes Benchmarking Data Portal; and
  - Develop adult healthy lifestyle and risk reduction quality measures for the Community Transformation Grant program at MDH

MDH & MN Community Measurement (MNCM) roles and responsibilities

MDH	MNCM
• Annually promulgates rules that define the uniform set of measures • Obtains input from the public at multiple steps of rulemaking • Publicly reports summary data • Develops vision for further evolution of SQRMS	• Facilitates data collection from physician clinics and data management • Submits data collected to MDH • Develops recommendations for the uniform set of quality measures for the State's consideration • Works with groups of stakeholders to review and maintain measures

Historical timeline

- December 2009
  - First set of administrative rules established SQRMS
- January 2010
  - Data collection for publicly reported quality measures began
  - Health plans no longer permitted to require data submission on measures outside the standardized set
- November 2010
  - MDH issued its first public report with data on the standardized measures to be publicly reported
  - First update to administrative rules
- November 2011, 2012, 2013
  - Annual updates to administrative rules

Rulemaking and opportunities for stakeholder input

1. MDH invites interested stakeholders to submit recommendations for the addition, removal, or modification of measures to MDH by June 1
2. MNCM submits preliminary measure recommendations to MDH mid-April; MDH opens public comment period
3. MNCM and Stratis Health submit final measure recommendations to MDH by June 1; MDH opens public comment period
4. MNCM and Stratis Health measure recommendations are presented at a public forum toward the end of June
5. MDH publishes a new proposed rule by mid-August with a 30-day public comment period
6. Final rule adopted by the end of the year

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Measure criteria

Recommendations must address how addition, removal, or modification of a quality measure relates to one or more of the following criteria:

- Social and individual impact of the clinical condition
- Gap between current practices and evidence-based practices for the clinical condition
- Relevance of the quality measure to a broad population
- The measure has been developed, accepted, or approved through a national consensus effort
- Likelihood to demonstrate a wide degree of variation across providers
- The measure is valid and reliable

Recommended physician clinic measures

Measures	Reporting
• Optimal diabetes care • Optimal vascular care • Depression remission at six months • Health information technology survey	Reporting in January/February 2015 on 2014 dates of service
• Optimal asthma control • Colorectal cancer screening • Primary c-section rate	Reporting in July/August 2015 on July 2013 through June 2014 dates of service
• Patient experience of care	Reporting in 2015 on Sept. – Nov. 2014 dates of surveying
• Total knee replacement	Reporting in April/May 2015 on 2013 dates of procedure

• Spine surgery
  • Lumbar discectomy/laminotomy
  • Lumbar spinal fusion
	Reporting beginning in April/May 2015 on 2013 dates of procedure

• Pediatric preventive care
  • Adolescent mental health and/or depression screening
  • Obesity/BMI and counseling
	Reporting beginning in April/May 2015 on 2014 dates of service

Recommended hospital measures

- CMS Hospital Compare inpatient and outpatient measures
- Agency for Healthcare Research and Quality (AHRQ) indicators
- Patient experience of care (HCAHPS)
- The Joint Commission
- Vermont Oxford Network (VON)
- National Healthcare Safety Network (NHSN)
- Minnesota Stroke Registry indicators
- Health Information Technology (HIT) survey

Public recommendations

- One community organization and one individual recommended that MDH collect data on social determinants of health.

- One physician recommended that MDH reduce reporting burden.

How is SQRMS making a difference?

- Informs providers and patients about the quality of care

With daughter Riley, 7, at her side, Kim Warne tested her blood sugar. She and her husband credit the staff at the CentraCare clinic with helping them get their Type II diabetes under control.

CentraCare Clinic in Becker, MN:
Looking at the scores, posted online by a group called MN Community Measurement, Barnett says she and her colleagues made up their minds: "We need to do something to change this." Two years later, the Becker clinic was rated second-best in the state for diabetes care, with a score of 60 percent.

Source: Star Tribune, July 30, 2011

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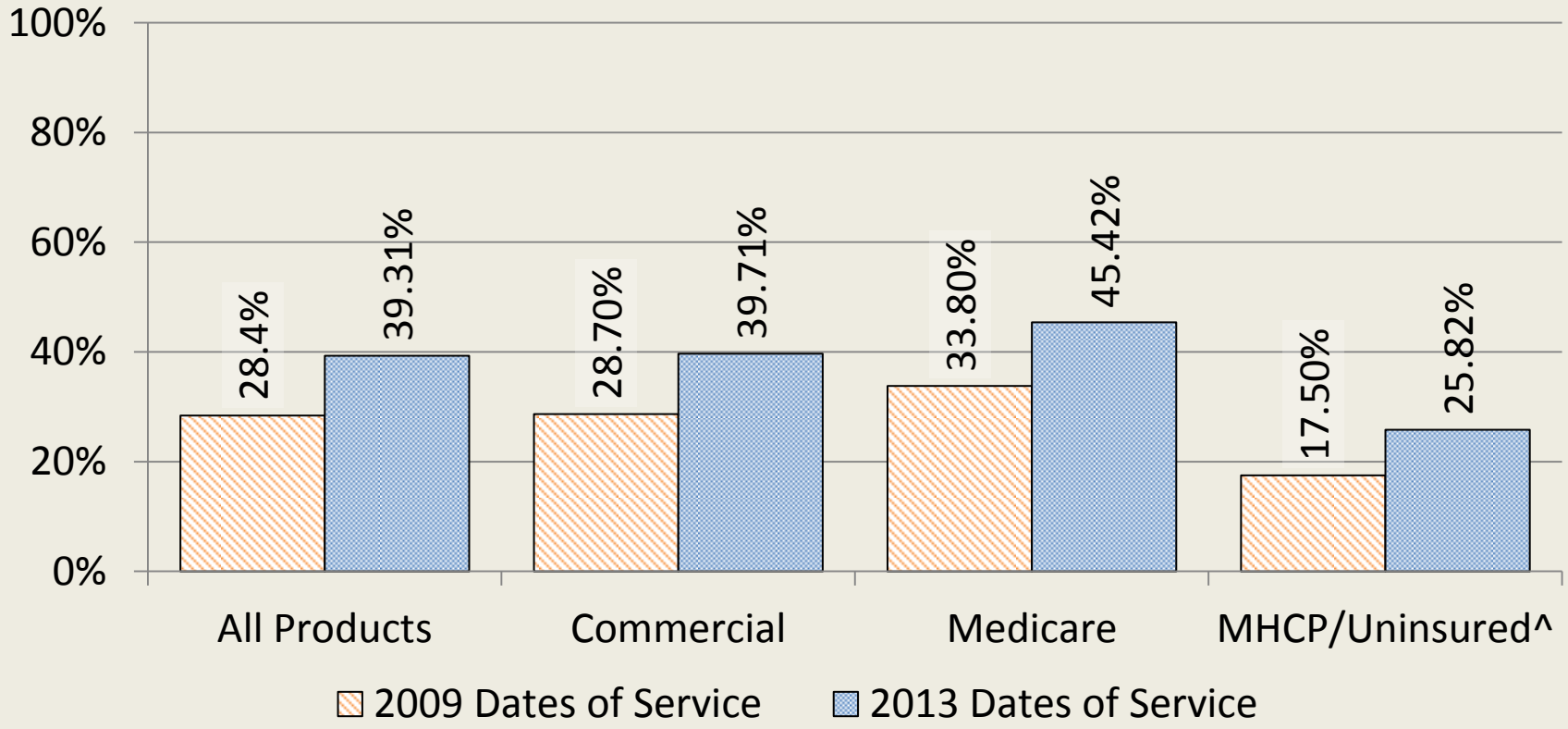
Optimal Diabetes Care



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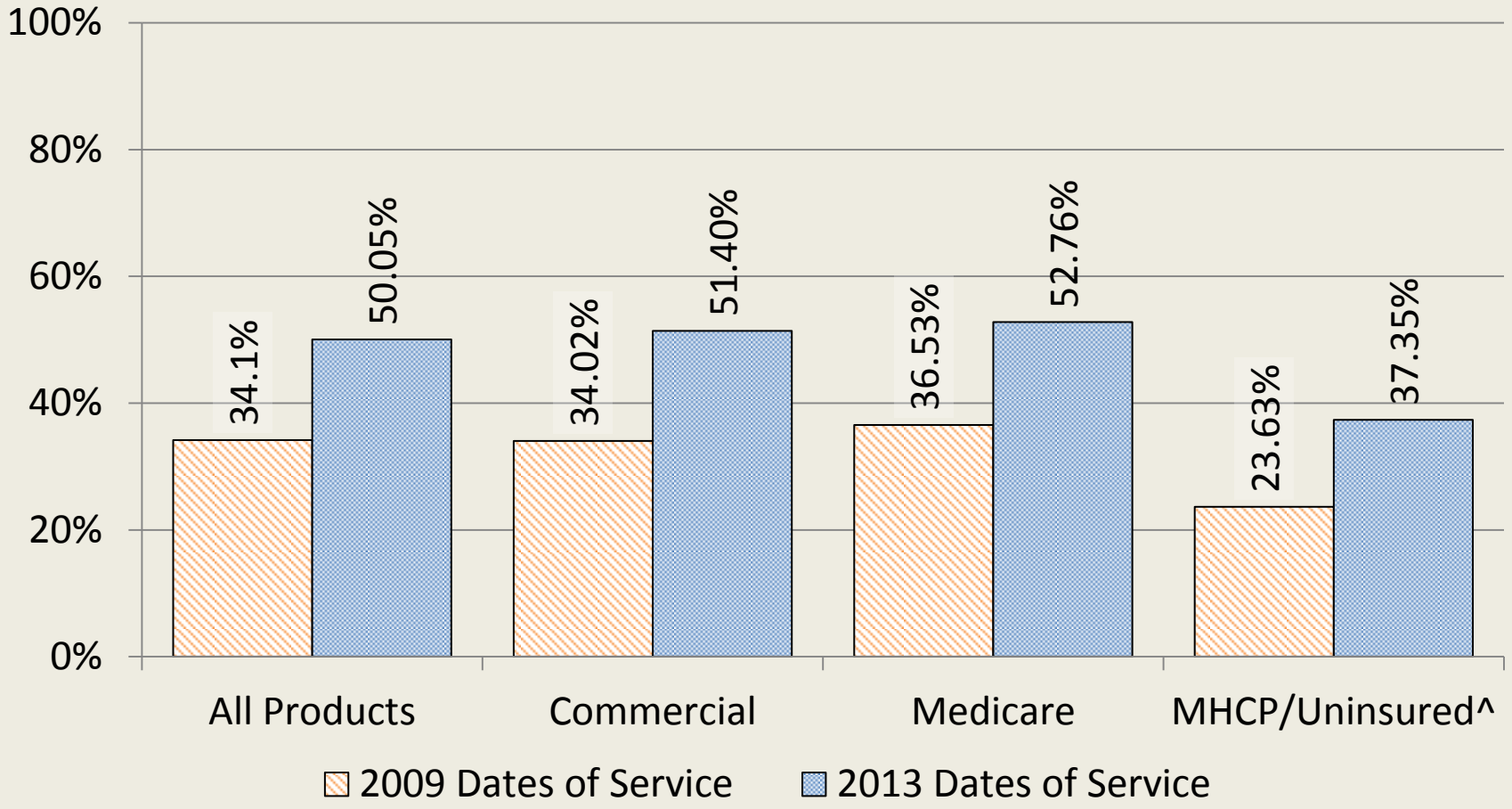
Optimal Vascular Care



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SQRMS quality measures for Health Care Homes (HCH) and non-HCH by year

	Year	HCH Certified	Not HCH Certified	Percentage Point Difference (positive # represents higher HCH quality)†	p-value*
Colorectal Cancer					
Optimal Screening	2010	70.9%	62.6%	8.3	<.0001
	2011	71.6%	66.3%	5.3	<.0001
Depression					
Remission at 6 months	2011	26.4%	25.0 %	1.4	0.0477
	2012	26.7%	26.7 %	0.0	0.9217
Average follow-up	2011	26.2%	21.7 %	4.5	<.0001
	2012	27.4%	25.2 %	2.2	<.0001
Asthma					
Optimal Care	2011	42.3%	23.2 %	19.1	<.0001
Average Care	2011	63.2%	41.7 %	21.5	<.0001
Diabetes					
Optimal Care	2010	40.2 %	39.4 %	0.8	<.0001
	2011	43.8 %	37.5 %	6.3	<.0001
	2012	40.9 %	37.5 %	3.4	<.0001
Average Care	2010	81.6 %	81.1 %	0.5	<.0002
	2011	83.1 %	80.3 %	2.8	<.0001
	2012	81.9 %	80.5 %	1.4	<.0001
Vascular					
Optimal Care	2010	45.4 %	41.8 %	3.6	<.0001
	2011	56.6 %	47.2 %	9.4	<.0001
	2012	53.6 %	48.0 %	5.6	<.0001
Average Care	2010	80.7 %	78.7 %	2.0	<.0001
	2011	85.9 %	81.7 %	4.2	<.0001
	2012	84.8 %	82.3 %	2.5	<.0001

*p-values of <.0001 indicate statistically significant annual comparisons between HCH and non-HCH clinics (there is less than 1 chance in 10,000 that these results would have occurred randomly.)
†Difference in percentage points calculated by subtracting the non-HCH performance percentage from the HCH performance percentage (e.g. for Colorectal Cancer Optimal Screening, 70.9 - 62.6 = an 8.3 percentage point difference.)

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Source: Evaluation of Health Care Homes: 2010-2012, Minnesota Department of Health, Minnesota Department of Human Services, University of Minnesota, Report to the Minnesota Legislature, January 2014.

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Patient experience of care and health care quality

	Appointment urgent	Appointment routine	Doctors appointment within 15	Phone during	Phone After	Provider explain	Provide questions/ concerns	Provider listen	Provider respect	Knows med history	Time spent
Optimal Diabetes	-.016	**.130****	**.125***	**.108***	.086	**.108***	.086	.021	.077	**.138****	.030
HbA1C control	.024	**.0161****	.095	**.126***	-.025	**.109***	.062	.016	.021	**.106***	.072
LDL cholesterol	-.052	-.029	.052	-.074	.029	.025	-.001	.032	.001	-.004	.016
Blood pressure control	-.057	.047	-.040	-.001	-.020	**.142****	**.118***	.078	.092	**.245****	**.100***
Daily aspirin	-.030	.077	.037	.071	-.012	.074	.036	-.015	.030	**.141****	.010
Tobacco free	.016	.066	**.102***	**.163****	.016	**.146****	.023	.030	.037	.048	.031
Optimal Vascular	-.014	**.099***	**.112***	-.004	.014	.050	.016	.043	.054	.057	.070
LDL cholesterol	.036	**.156****	.023	.041	.014	.050	.016	.043	.054	.057	.070
Blood pressure control	-.084	.007	.009	**-.107***	-.063	.012	.026	-.002	.003	.050	.030
Daily aspirin	-.013	.088	.088	-.028	.071	.010	-.024	-.065	-.030	.030	-.042
Tobacco free	**-.107***	**-.114***	-.053	-.038	.000	.019	-.072	-.048	.075	.078	-.071
Optimal Asthma	.045	**.160****	**.227****	.060	-.050	**.182****	**.148****	**.113***	**.129****	**.162****	**.122***
Well controlled	.009	**.142****	**.216****	.029	-.070	**.150****	**.098***	**.103***	**.096***	**.149****	.071
No elevated risk of exacerbations	.024	**.142****	**.227****	.033	-.096	**.114***	.064	.078	.070	**.133****	.053
Written asthma management plan	.027	**.139****	**.194****	.067	-.070	**.130****	.093	.087	.084	**.163****	.055

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**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
Source: MDH Health Economics Program analysis of SQRMS data.

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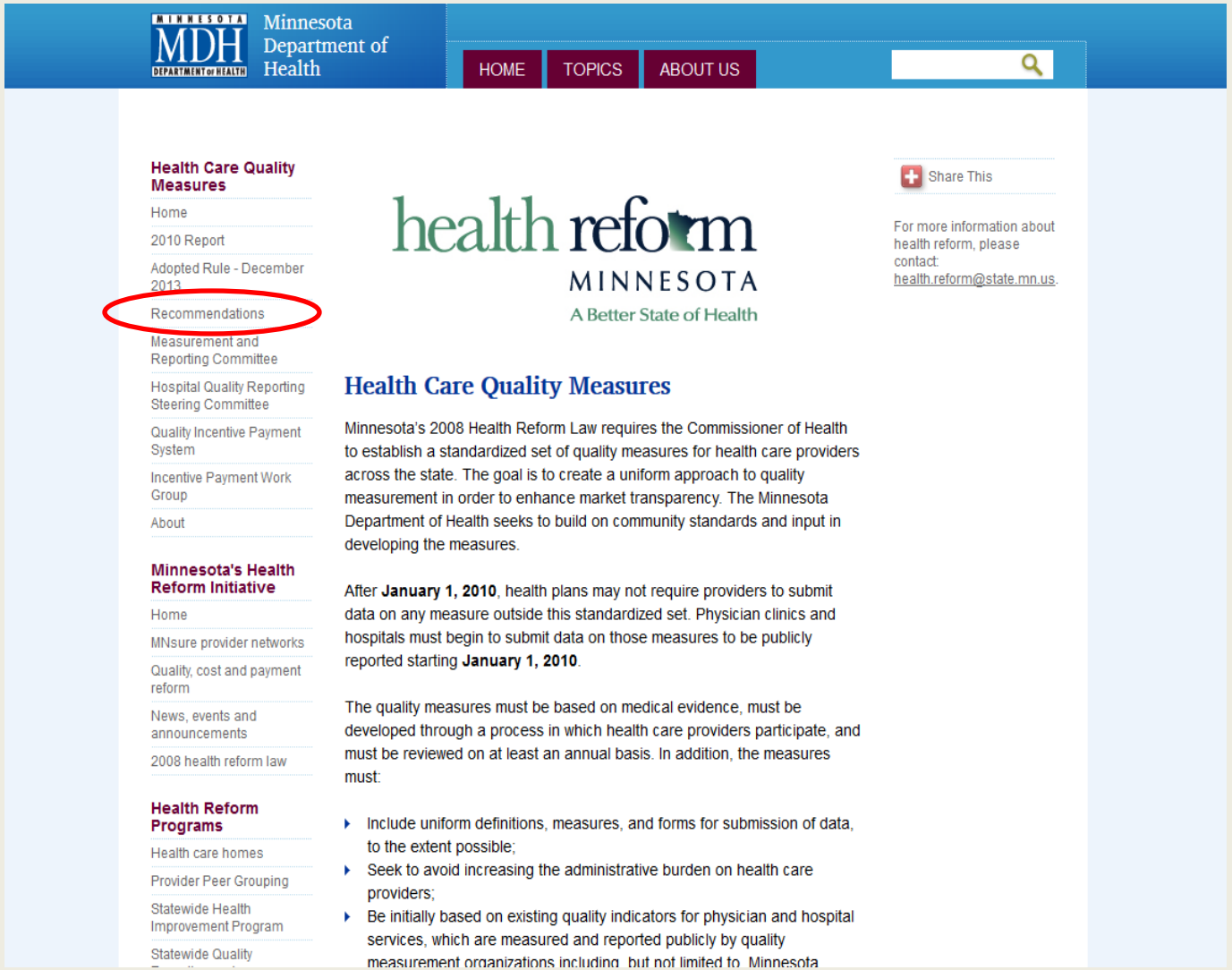
SQRMS website



Resources

- Subscribe to MDH's Health Reform list-serv to receive weekly email updates at:
  www.health.state.mn.us/healthreform
- Minnesota Statewide Quality Reporting and Measurement System (SQRMS):
  www.health.state.mn.us/healthreform/measurement/index.html
- MN Community Measurement: www.mncm.org
- Stratis Health: www.stratishealth.org/index.html

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Questions and discussion

- Questions and comments from the audience