



Minnesota Statewide Quality Reporting and Measurement System: Annual Public Forum

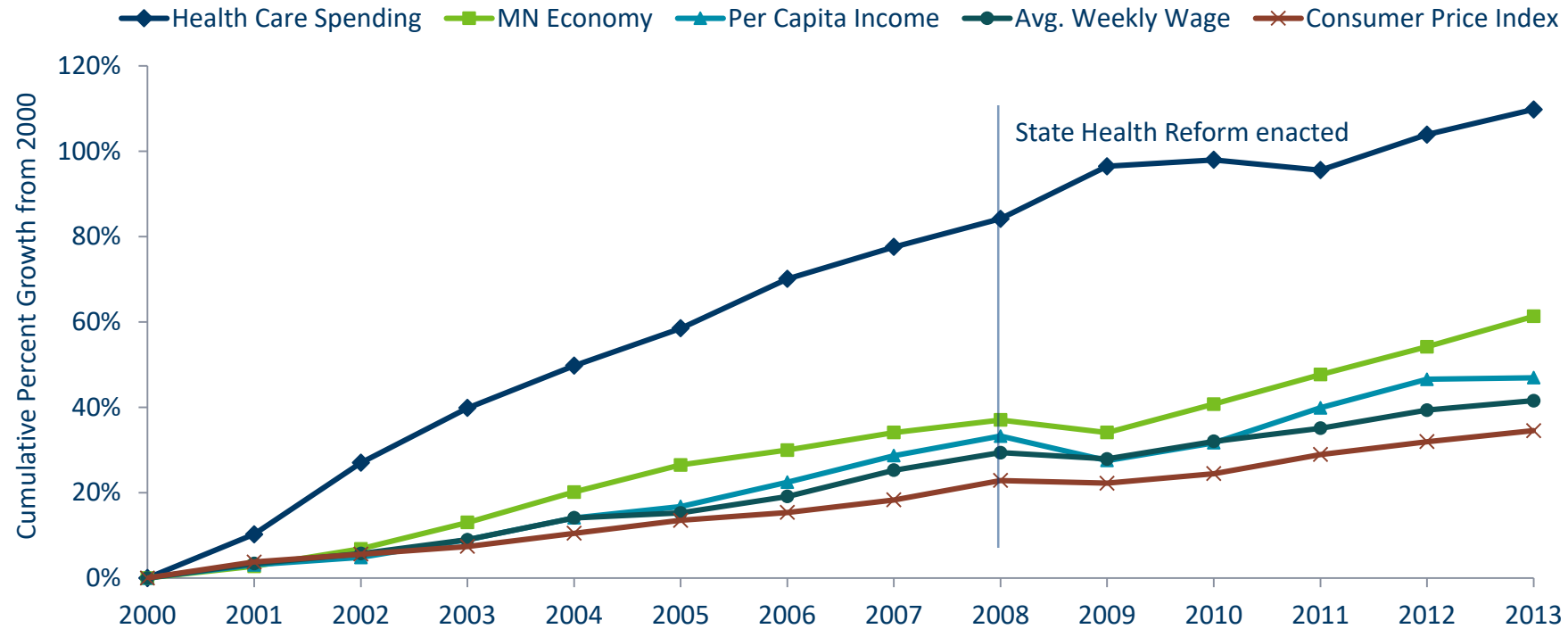
Denise McCabe | Health Economics Program Supervisor

June 22, 2017

- Context and background
- Measure set update steps, timeline, and opportunities for input
- Measure results
- Legislative changes
- How to comment
- Resources



Key Health Care Cost and Economic Indicators



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

Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; gross state product and per capita personal income data from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (Consumer Price Index for Minnesota); average weekly wages from MN Department of Employment and Economic Development.

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



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** 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, Section 62U.02

Organizational Roles

MDH	MN Community Measurement	Stratis Health	Minnesota Hospital Association
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 • Supports the Health Care Homes Benchmarking Portal 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Facilitates data collection from hospitals and data management • Submits data collected to MDH

Rulemaking and Opportunities for Stakeholder Input

- Through **July 17**, MDH invites interested stakeholders to:
 - Provide input on **physician clinic** measurement priorities and opportunities for alignment;
 - Review and comment on the Hospital Quality Reporting Steering Committee's **hospital measure** recommendations; and
 - **Submit recommendations** on the addition, removal, or modification of standardized quality measures for physician clinics and hospitals
- MDH publishes a proposed rule in September with a 30-day public comment period
- 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

DECEMBER 2016

Physician Clinic Quality Measures

Clinical Care

- Optimal Diabetes Care
- Optimal Vascular Care
- Depression Care: Remission at Six Months
- Optimal Asthma Control – Adult and Child
- Asthma Education and Self-Management – Adult and Child
- Colorectal Cancer Screening
- Maternity Care: Cesarean Section Rate
- Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening
- Pediatric Preventive Care: Pediatric Overweight Counseling
- Total Knee Replacement Outcome Measures
- Spinal Surgery: Lumbar Spinal Fusion Outcome Measures
- Spinal Surgery: Lumbar Discectomy/Laminotomy Outcome Measures

Surveys

- Patient Experience of Care Survey: Consumer Assessment of Healthcare Providers and Systems Clinician & Group 3.0 Survey (CG-CAHPS) – Adult (every-other year measure)
- Health Information Technology Ambulatory Clinic Survey

Critical Access Hospital Quality Measures

Inpatient

- Median time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate (ED-1a)
- Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate (ED-2a)
- Heart Failure 30-Day Readmission Rate (READM-30-HF)
- Pneumonia 30-Day Readmission Rate (READM-30-PN)
- Chronic Obstructive Pulmonary Disease 30-Day Readmission Rate (READM-30-COPD)
- Influenza Immunization (IMM-2)
- Elective Delivery (PC-01)
- Healthcare Personnel Influenza Immunization

Outpatient

- Median Time to Fibrinolysis (OP-1)
- Fibrinolytic Therapy Received within 30 Minutes (OP-2)
- Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate (OP-3a)
- Aspirin at Arrival (OP-4)
- Median Time to ECG (OP-5)
- Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)
- Door to Diagnostic Evaluation by a Qualified Medical Professional (OP-20)
- ED-Patient Left without Being Seen (OP-22)
- ED-Median Time to Pain Management for Long Bone Fracture (OP-21)
- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation within 45 Minutes of Arrival (OP-23)
- Safe Surgery Checklist Use (OP-25)
- Influenza Vaccination Coverage among Healthcare Personnel (OP-27)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Emergency Department Transfer Communication Composite

Hospital Quality Measures

Prospective Payment System Hospitals

- Hospital Value-Based Purchasing Total Performance Score
- Hospital Readmissions Reduction Program Excess Readmission Score
- Hospital Acquired Condition Reduction Program Score

All Hospitals

- Patient Experience of Care: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Emergency Department Stroke Registry Indicators: Door-to-Imaging Initiated Time and Time to Intravenous Thrombolytic Therapy
- Mortality for Selected Conditions (IQI 91)
- Death Rate among Surgical Inpatients with Serious Treatable Complications (PSI 04)
- Patient Safety and Adverse Events Composite (PSI 90)
- Health Information Technology Survey

Alignment

State

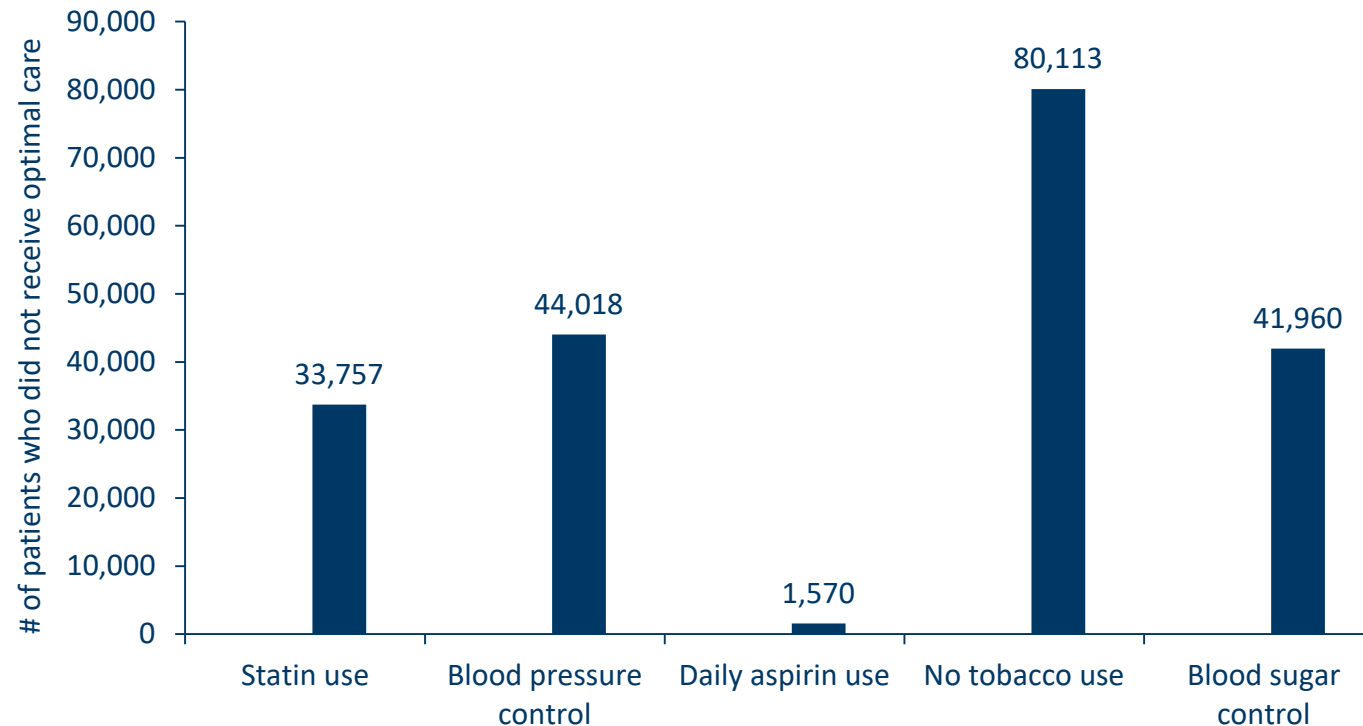
- Health Care Homes
- Integrated Health Partnerships Demonstration
- Accountable Communities for Health
- Office of Health Information Technology
- Minnesota Stroke Registry
- Asthma Program
- Health Promotion & Chronic Disease

Federal

- Merit-based Incentive Payment System (MIPS)
- Hospital Value-Based Purchasing
- Hospital-Acquired Condition Reduction Program
- Hospital Inpatient and Outpatient Quality Reporting Programs
- Medicare Beneficiary Quality Improvement Project (MBQIP)

Optimal Diabetes Care: Patients Without Optimal Care by Component

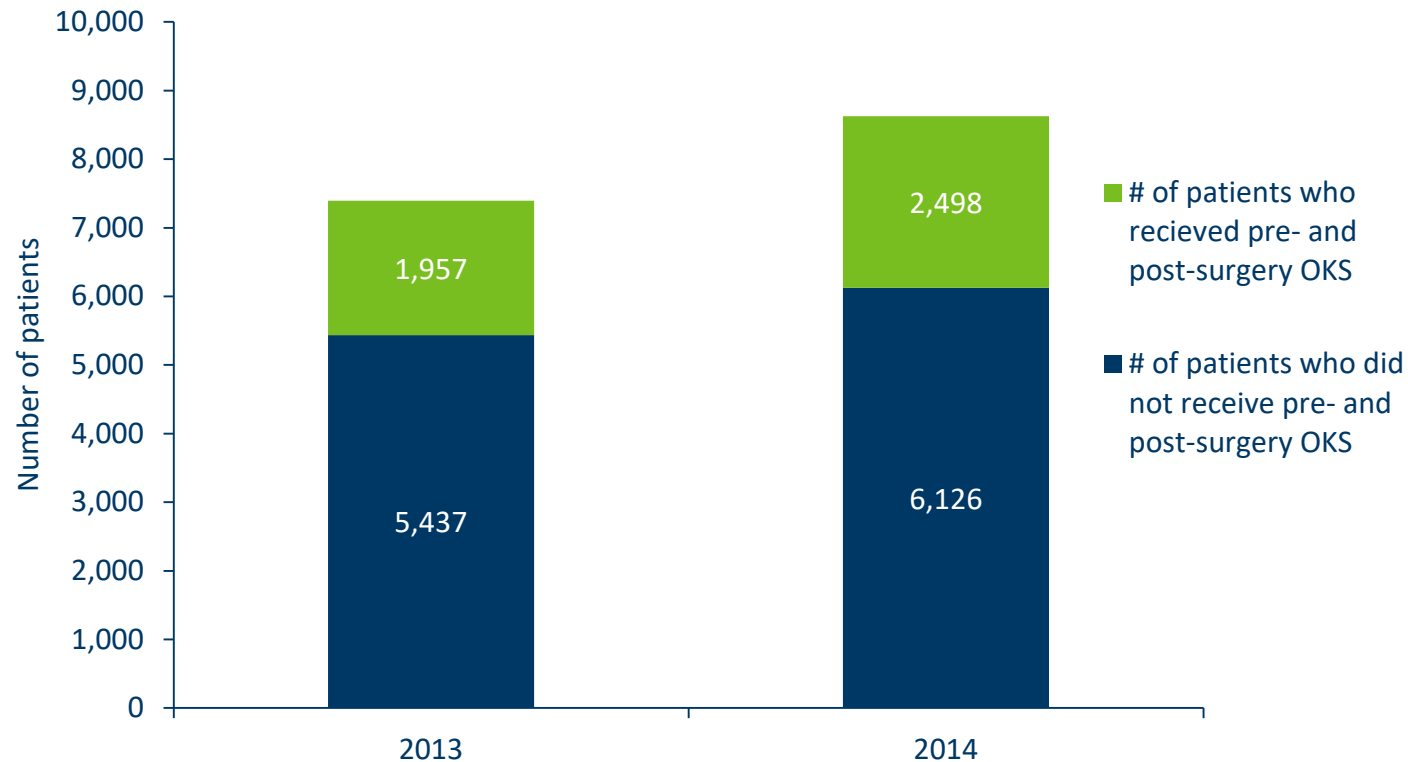
The statewide optimal diabetes care rate is lower than individual component rates because patients had to meet all five goals to have optimal diabetes care. As shown, many patients did not meet one or more optimal diabetes care goals.



Source: MDH Health Economics Program analysis of Quality Reporting System data from 2016 service dates.

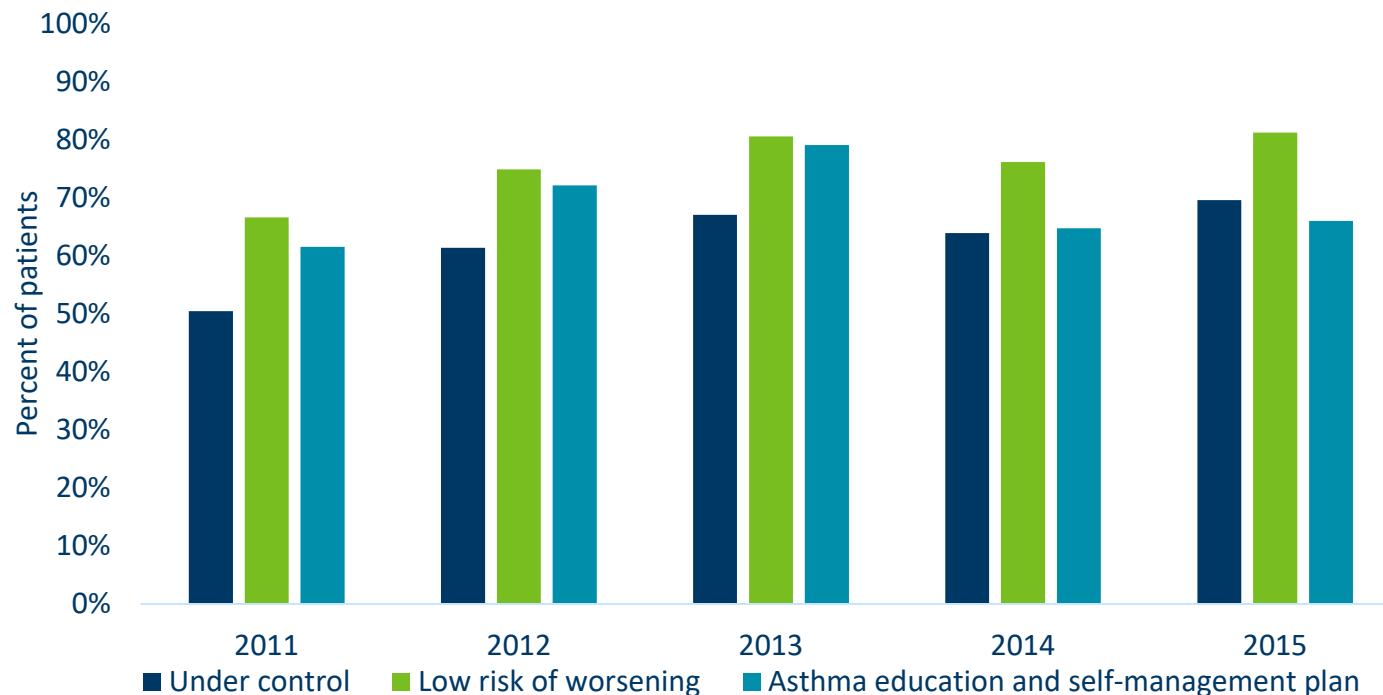
Total Knee Replacement: Functional Status Patients

Twenty-nine percent of patients who had primary total knee replacement surgery in 2014 received pre- and post-surgery OKS tests. This is a slight increase from the 2013 rate of 27%. The majority of patients are not receiving functional status tests at the appropriate times before and after surgery.



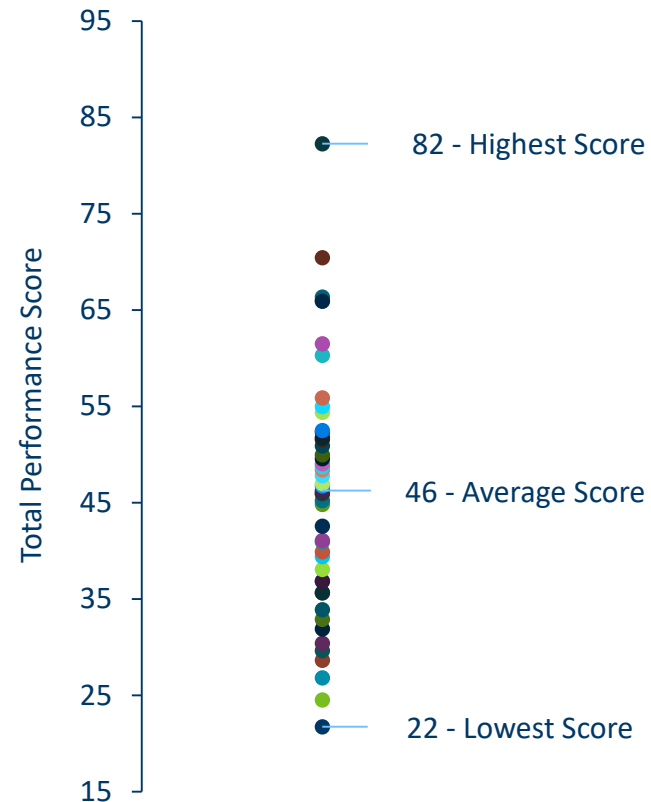
Child Asthma: Component Measures

The rates of child asthma patients who have their asthma under control, with low risk of worsening, rose steadily until 2013. After small decreases in 2014, these rates rose slightly again in 2015. The rate of child asthma patients with asthma education and a self-management plan peaked at 79% in 2013, and has since dropped to 66%.



Value-Based Purchasing Total Performance Score

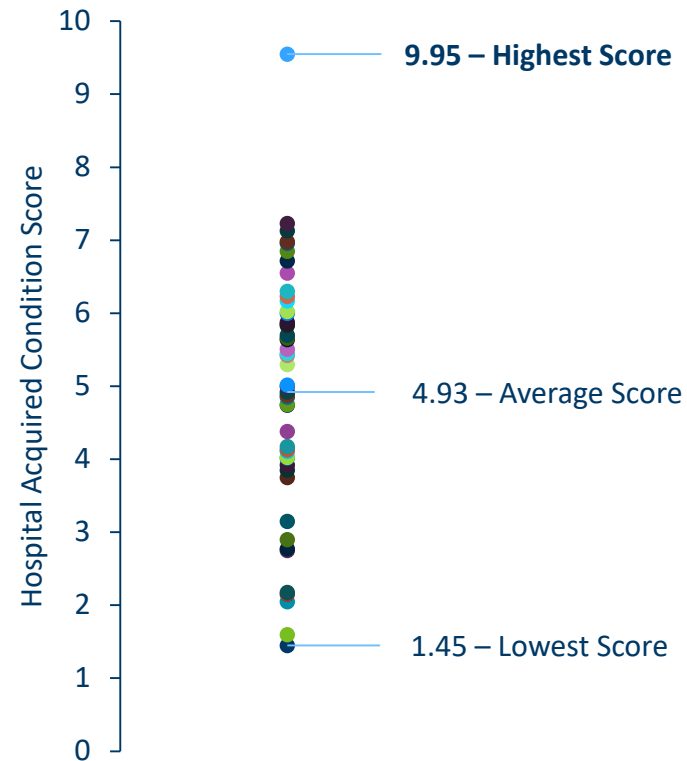
Total Performance Scores ranged from 22 to 82 for 44 Minnesota hospitals; 100 is the best possible score.



Service year varies by component: October 1, 2013 – June 30, 2015 and January 1 through December 31, 2015.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Acquired Condition Reduction Program Score

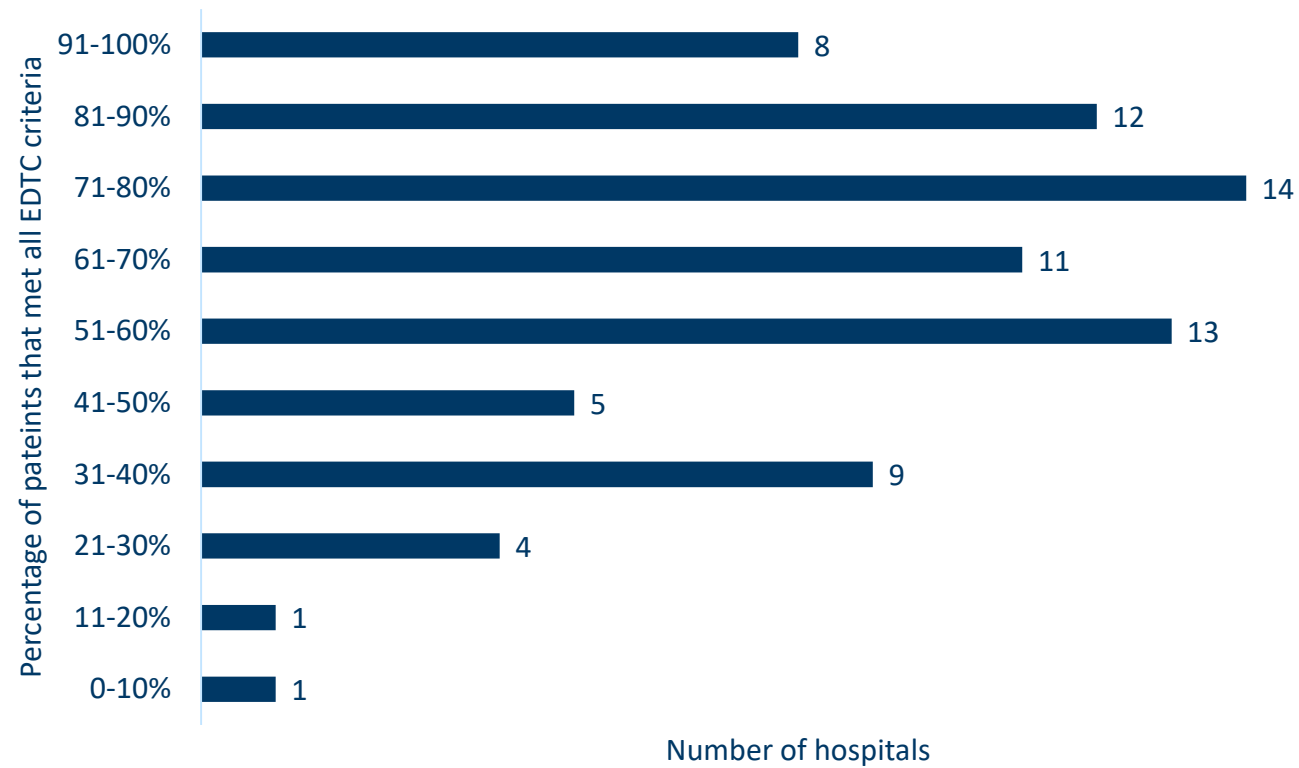
Hospital Acquired Condition Scores ranged from 9.95 to 1.45 for 50 Minnesota hospitals. Higher scores indicate a higher rate of hospital acquired conditions.



Service year varies by domain: July 1, 2013 through June 30, 2015 and January 1, 2014 through December 31, 2015.
Source: MDH Health Economics Program analysis of Quality Reporting System data.

Emergency Department Transfer Communication Composite

Sixty percent or more of patients met all measure criteria at 45 of 78 critical access hospitals.



2014 Legislative Session: Stratification

- **Requirement**
 - Develop an implementation plan for stratifying measures based on race, ethnicity, language, and other-socio-demographic factors
- **Results**
 - Stratify five quality measures by race, ethnicity, preferred language, and country of origin
 1. Optimal Asthma Control – Adult
 2. Optimal Asthma Control – Child
 3. Colorectal Cancer Screening
 4. Optimal Diabetes Care
 5. Optimal Vascular Care



Stratifying Health Care Quality Measures Using Socio-demographic Factors

Minnesota Department of Health
Report to the Minnesota Legislature 2015

March 2015

2014 Legislative Session: Risk Adjustment

- **Requirement**
 - Assess whether the risk adjustment methodology creates potential harms and unintended consequences for patient populations who experience health disparities and the providers who serve them, and identify changes that may be needed
- **Results**
 - The risk adjustment methodology does not appear to cause financial harm to providers who serve disadvantaged populations, or their patients
 - To potentially improve risk adjustment, MDH and the community need new risk factor data with a strong link to quality measure outcomes and data

Quality Reporting System Risk Adjustment Assessment

REPORT TO THE MINNESOTA LEGISLATURE

2017 Legislative Session: Measurement Framework

- **Requirement**
 - Develop a measurement framework in consultation with stakeholders by mid-2018 that:
 - Identifies the most important elements for assessing the quality of care,
 - Articulates statewide quality improvement goals,
 - Ensures clinical relevance,
 - Fosters alignment with other measurement efforts, and
 - Defines the role of stakeholders

MDH will provide updates on the Quality Reporting System measurement framework initiative—including opportunities for input—and additional information on changes through Quality Reporting System announcements, our website, and other methods

Quality Reporting System Website

Health Care Quality Measures

Home

Publications

Measures

Rule Update

Hospital Quality Reporting Steering Committee

Quality Incentive Payment System

About

Minnesota's Health Reform Initiative

Home

MNsure provider networks

Quality, cost and payment reform

News, events and



Annual Quality Rule Update

[Minnesota Statutes, section 62U.02](#) requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. To implement the collection of quality measurement data, the Minnesota Department of Health (MDH) has developed the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System), 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 quality measure data, while health plans may only require providers to submit data on those measures that are part of the standardized set.

Submitting Comments

- MDH invites interested stakeholders to:
 - Provide input on **physician clinic** measurement priorities and opportunities for alignment;
 - Review and comment on the Hospital Quality Reporting Steering Committee's **hospital measure** recommendations; and
 - **Submit recommendations** on the addition, removal, or modification of standardized quality measures for physician clinics and hospitals.
- Interested persons or groups must submit recommendations, comments, and questions by **July 17** to:
 - Denise McCabe, Minnesota Department of Health
 - PO Box 64882, St. Paul, MN 55164-0882
 - (651) 201-3550, fax: (651) 201-201-5179
 - health.reform@state.mn.us



Minnesota Statewide Quality Reporting and Measurement System

- www.health.state.mn.us/healthreform/measurement

Subscribe to MDH's Health Reform Announcements to receive updates

- www.health.state.mn.us/healthreform/announce

Submit comments during our open comment period through July 17

- www.health.state.mn.us/healthreform/ruleupdate

2018 Hospital Measures

Sarah Brinkman, MA, MBA, CPHQ

**Statewide Quality Reporting and Measurement
System (SQRMS) Public Forum**

June 22, 2017

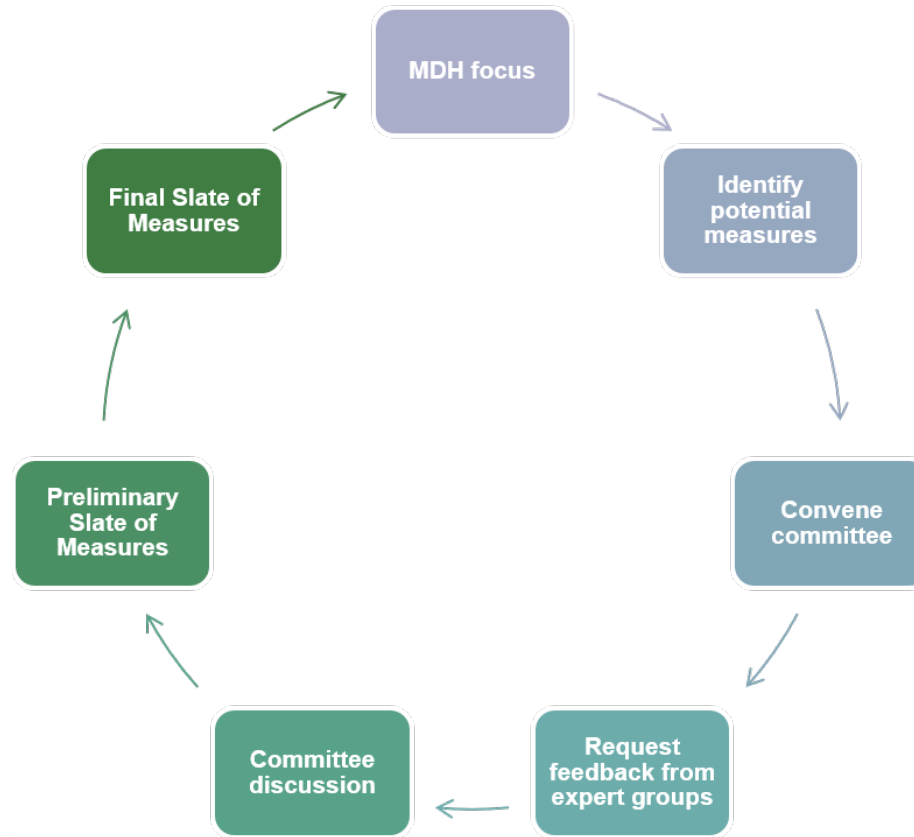


Objectives

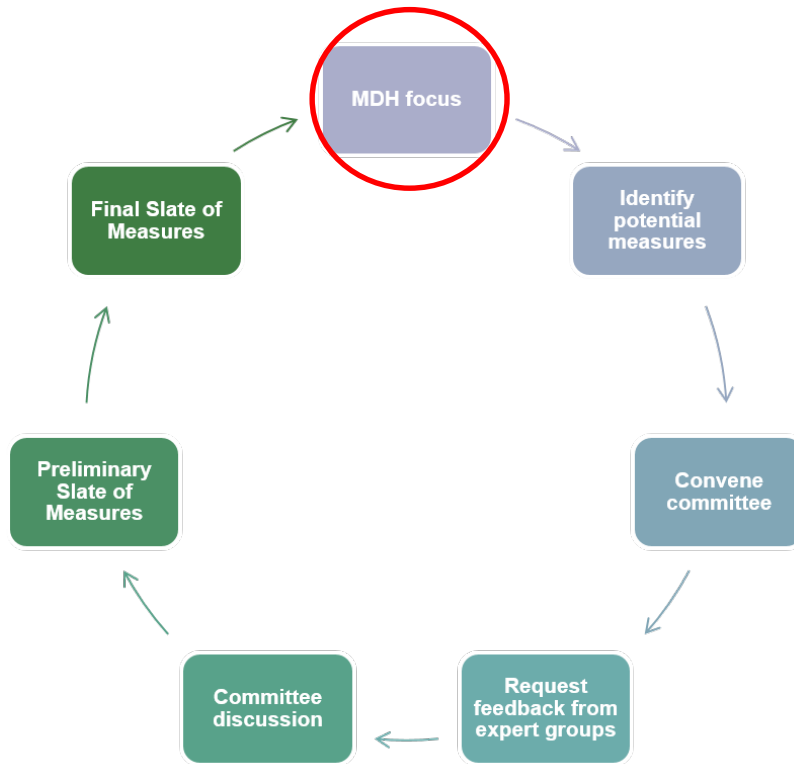
- Review the process used for developing 2018 hospital measure recommendations
- Review outcomes of Patient Safety Workgroup
- Review changes to 2018 hospital measures

2018 Hospital Measures Recommendation Process

Recommendation Process



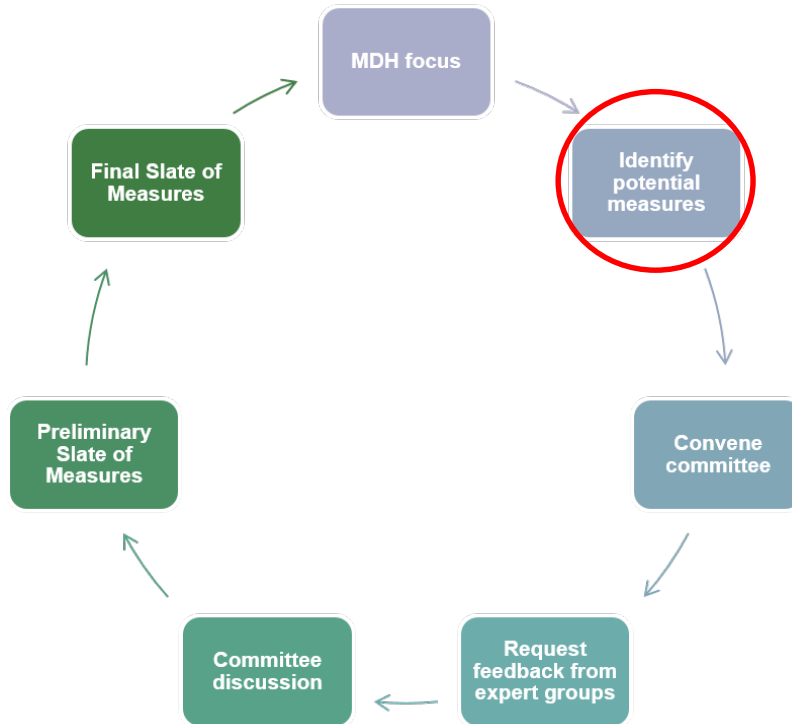
MDH Focus



Find a balance:

- Meaningful hospital quality measurement
- Federal alignment
- Minimize reporting burden

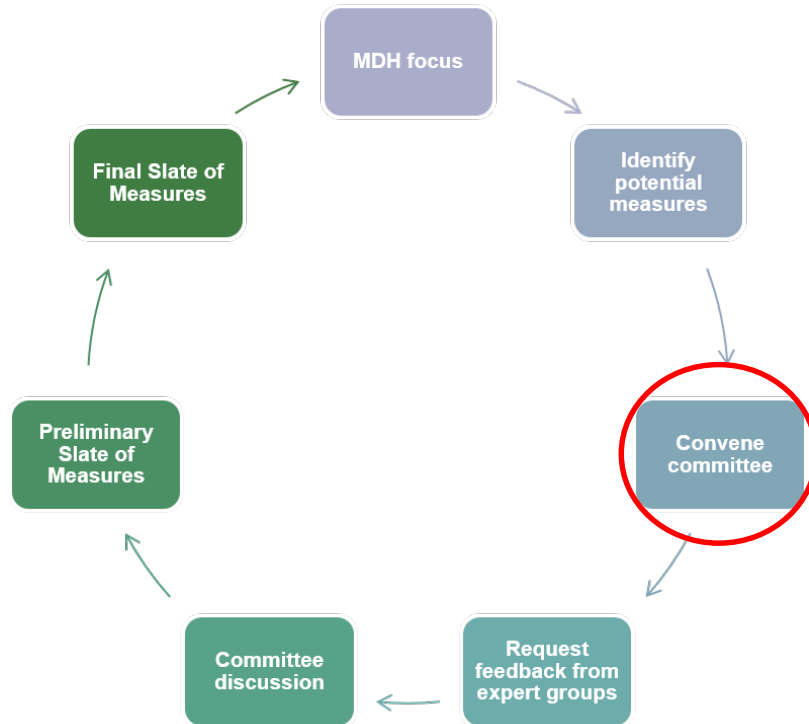
Identify Potential Measures



Measures to consider:

- Outpatient & Ambulatory Surgery CAHPS
- *C. difficile* (CAHs)
- MRSA (CAHs)

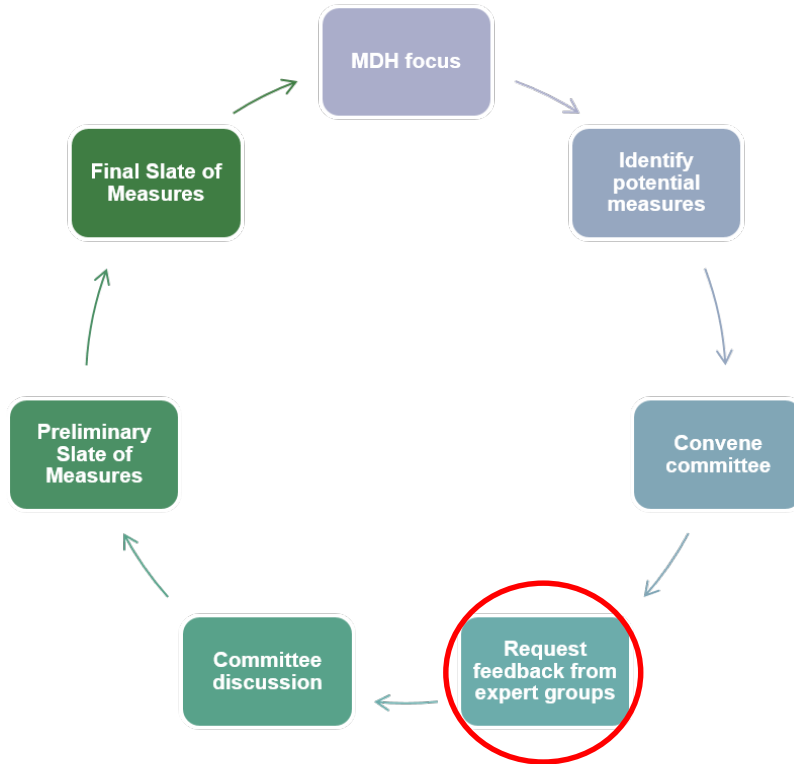
Convene Committee



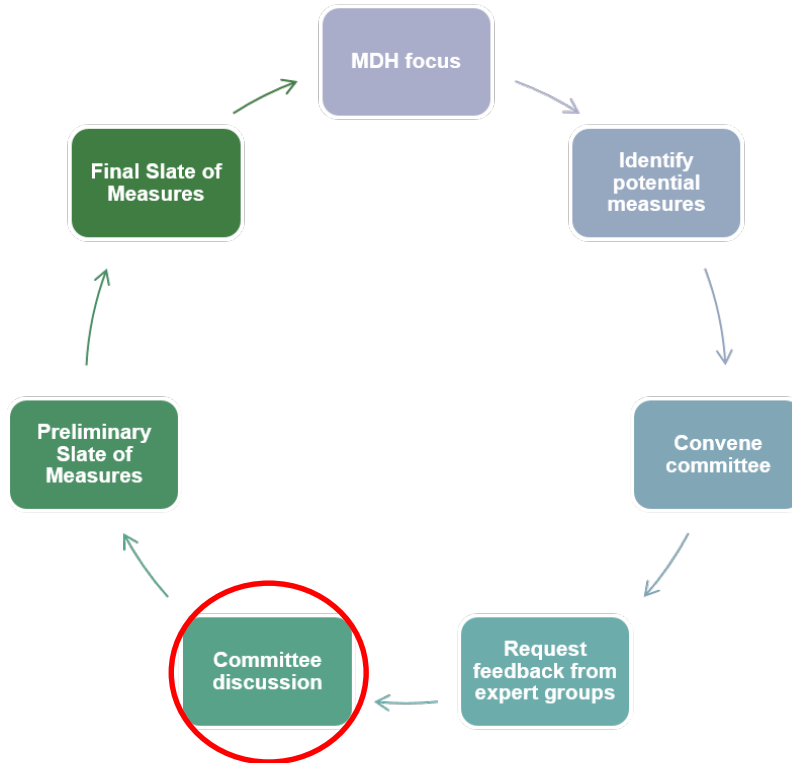
- PPS and CAH Representatives:
 - Quality & Patient Safety
 - Physician Leaders
 - Informatics
 - Operations
 - Pharmacy
- Consumer advocacy
- Physician Risk Insurer
- Health Plan
- Employer/Purchaser
- Public/County Purchaser

Feedback from Expert Groups

Recommendation from Patient Safety Workgroup

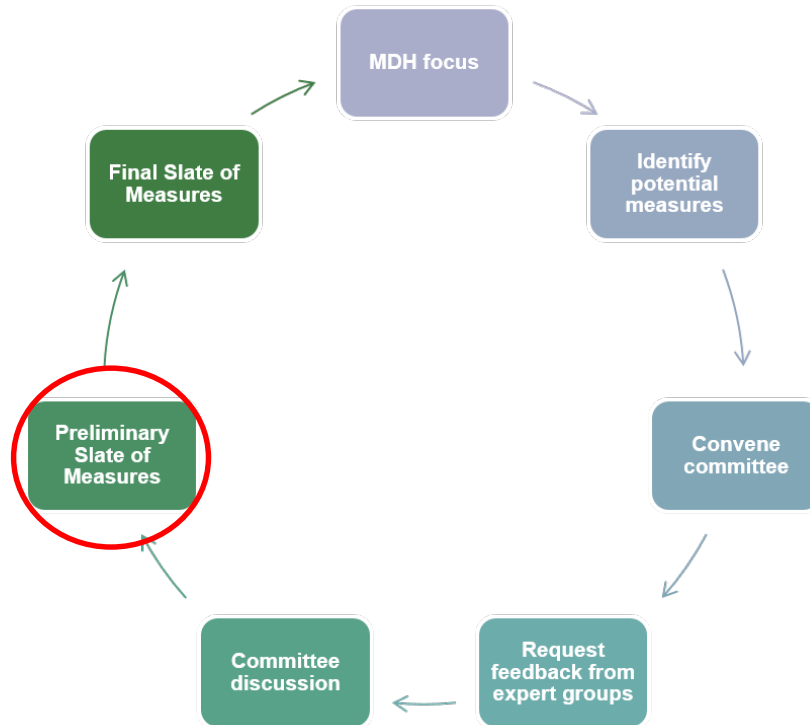


Committee Discussion



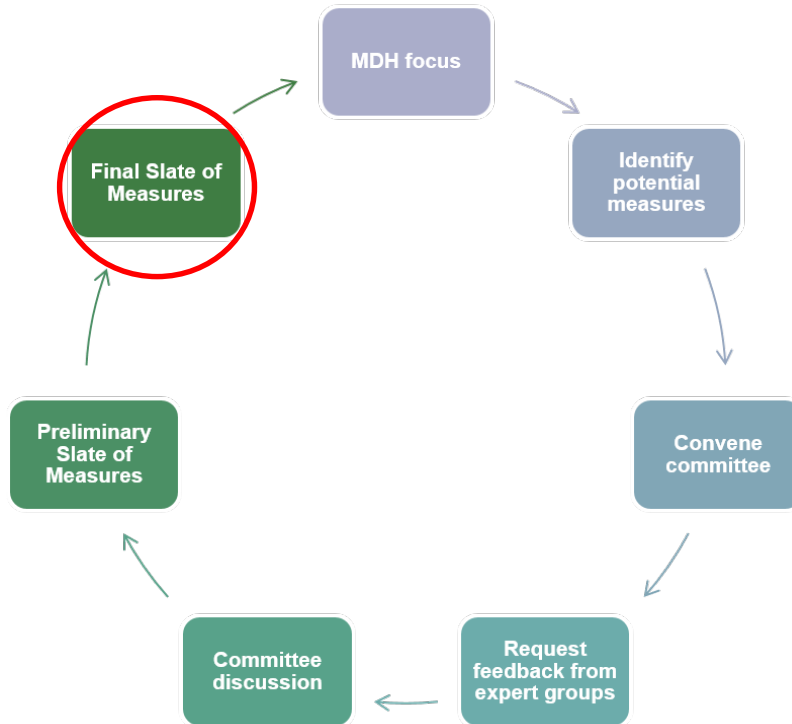
- Consideration of potential new measures
- Considerations for removing measures:
 - PSI-04
 - PSI-90
 - IQI-91

Preliminary Slate of Measures



Recommendation to MDH to not make any changes to requirements for hospitals in 2018.

Final Slate of Measures



- Public Forum
- Proposed Rule
- Comment Period
- Final Rule

Exploring New Measures: Patient Safety

Priority Areas Identified in 2015

- Federal alignment to composite measures – CMS and HRSA
- Cost/Spending
- Readmissions
- End of Life
- Patient Safety
- Mental/Behavioral Health

Patient Safety

- Hospital Quality Reporting Steering Committee recommended development of a composite measure for PPS and CAH hospitals
- Patient safety workgroup was chartered and explored options

Options

Workgroup articulated three options:

1. Comprehensive safety composite inclusive of clinical care and harm measures, as well as organizational and system characteristics
2. Patient safety composite measure focused on clinical care and harm
3. Do not develop or adapt anything new, recognizing that there are already a number of safety measures and composites

Current Status

- Wide variation in opinions and lack of consensus
- Unable to make a recommendation to MDH at this time
- Tabled for further discussion

2018 Hospital Recommendations

2018 Recommendations

Measures to add:

- None

Measures to remove:

- None

Questions?

Sarah Brinkman, Program Manager

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sbrinkman@stratishealth.org

www.stratishealth.org

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.





Clinical Quality Measure Changes for 2018

Report Year

June 22, 2017

Dina Wellbrock

Manager, Accounts, Communications and Programs

MN Community Measurement

MN Community Measurement

- Accelerating the improvement of health through public reporting
- Our 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





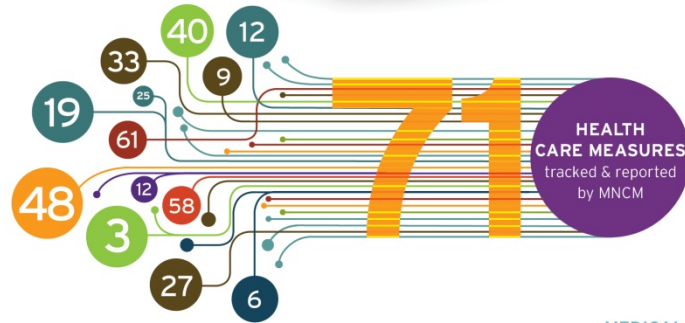
2,700
LIFE YEARS SAVED
with a 1% increase
in colorectal cancer
screening rates in
Minnesota

MEASURING QUALITY
**MNCM by the
Numbers**

MNCM work
was referenced in
77
NATIONAL AND LOCAL
ARTICLES AND INDUSTRY
PUBLICATIONS



1.5
million
PATIENTS included in
Total Cost of Care measure



313
MEDICAL GROUPS REGISTERED
to submit data to MNM



1,600
CLINICS REGISTERED
to submit data
to MNM





Reviewed Today

- Why are there changes in 2018?
- Optimal Asthma Control
- Colorectal Cancer Screening
- Maternity C-Section
- Peds Overweight Counseling
- Support going forward

CMS Quality Payment Program

MIPS for 2018

 Quality	 Improvement Activities	 Advancing Care Information	 Cost
Replaces PQRS.	New Category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.



Colorectal Cancer Screening

- Adapted from NCQA's HEDIS measure
- Dates of Service – “mid year” for Cycle C
- Initial modifications necessary moving from claims to encounter measure
 - Visit counting
 - Exclude CT colonography
 - Exclude deceased patients

Colorectal Cancer Screening: Alignment

- QPP#113 is in the MIPS program
- NCQA's recent update to include CT colongraphy and FIT-DNA match
- Misalignment:
 - MNMCM's exclusion for deceased patients
 - Visits: NCQA includes both new and established office and home visits

Measure Specification Changes

1. Remove exclusion for death for CRC during measurement period
 - Low impact: only 5% have annual screening
2. Expand encounter type criteria for CRC to include new patient office and home visits
 - Low impact: patient population seen more regularly
3. Apply to 2018 Report Year
4. Approved by MARC April 2017

Optimal Asthma Control

- Developed by MNCCM
- Dates of Service – “mid year to mid year” for Cycle C

Operational Changes

1. Modify dates of service for both CRC and OAC to calendar year to fit MIPS specifications
2. Move submission to Cycle A
 - MIPS deadline is March 31
3. Apply to 2018 Report Year
4. Approved by MARC April 2017

(Loss of trending for one year)

Measure Review Committee

- Subcommittee of MARC
- Annual review of measures towards continuation, refer for review, transition to monitoring or retirement
 - Uses National Quality Forum endorsement criteria
- MRC meeting occurred June 5th for DDS measures
- Recommendations presented to MARC June 14th

MRC Recommendations

- Continuation of 5 DDS measures:
 - ODC, OVC, OAC, Colorectal, Peds/Adol Mental Health
- Retire:
 - Maternity C-Section
 - Peds Overweight Counseling
- Apply to 2018 Report Year

MARC approved recommendations

Rationale for Retirement

Maternity C-Section

- True acceptable rate is unknown
- Some improvement in first 2 years, flat for past 3 years
- Burdensome to collect, 76% require manual abstraction

Peds Overweight Counseling

- Topped out measure at 90%
- Process measure, not outcome
- Questionable impact on health behaviors/outcomes

Summary of 2018 Changes

1. Retire Maternity C-section measure
2. Retire Pediatric Overweight Counseling measure
3. Modify Colorectal Cancer Screening to remove death exclusion, add new patient and home visits, DOS calendar year, report in Cycle A
4. Modify Optimal Asthma Control to DOS in calendar year, report in Cycle A



Support

1. Will allow for MIPS submission to CMS from DDS cycle A
2. Registration will open November 1st, guides posted in October
3. Cycle A submission timelines will be staggered to accommodate various reporting requirements, details TBD

Thank You!

- Dina Wellbrock
- Manager, Accounts, Communication and Programs
- Email: wellbrock@mncm.org
- Support: support@mncm.org, 612 746-4522



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[Linkedin.com/company/mn-community-measurement](https://linkedin.com/company/mn-community-measurement)



Physician Clinic Measure Questions

1. Should MDH maintain, suspend, or remove the **Cesarean Section Rate** quality measure from mandatory reporting?
2. Should MDH maintain, suspend, or remove the pediatric **Overweight Counseling** quality measure from mandatory reporting?
3. Should MDH shift the reporting timeline for the **Optimal Asthma Control, Asthma Education and Self-Management, and Colorectal Cancer Screening** quality measures from mid-year to the beginning of the year, to be aligned with MN Community Measurement and support timely reporting under the Merit-Based Incentive Payment System? Additionally, to accommodate this change to the reporting schedule, should MDH postpone the fielding of the annual **Ambulatory Health Information Technology Survey** from February to September?

Questions and Comments



Thank you!

Denise McCabe

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651-201-3569