The Measurement Minute

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Inside

President's Letter

Jim Chase

I was struck by a recent article in the *New England Journal of Medicine* that cites the low rate of aspirin use in the United States for the secondary prevention of cardiovascular disease, despite strong evidence of its efficacy (Anand K. Parekh, M.D., M.P.H., James M. Galloway, M.D., Yuling Hong, M.D., Ph.D., and Janet S. Wright, M.D. Aspirin in the Secondary Prevention of Cardiovascular Disease. N Engl J Med 2013; 368:204-205). In 2007, the national rate of prescribing antiplatelet medication for people with ischemic vascular disease was less than 47%. In our Optimal Vascular Care Measure, the statewide average in Minnesota for aspirin prescribing has grown steadily since we began collecting data and is now more than 95%. We see this higher level of achievement across many of our measures, from blood pressure control, to Optimal Diabetes Care, to cancer screening. I believe that Minnesota's strong culture of measurement and quality improvement has helped lead to these better results and contributed to our being one of the healthiest states in the country. More opportunities for leadership lie ahead.

After the November elections, we now know that significant health reform at the state and federal level will proceed. The next few years will be a time of great opportunity and challenge for health care organizations and the public. Our goal at MNCM is to help our community build on its leadership position in health and health care quality and thrive in the changes ahead. In 2013 we will:

- Expand our measures to help the community address the triple aim of the health care system. Besides the release of our first state-wide measure of patient experience, we hope to make progress on aligned total cost of care measures and reporting measures that support accountable care arrangements and health care homes.
- Engage the public with information to help them improve their own health. We will expand our work with other organizations that can deliver messages effectively to the public, such as *Consumer Reports*, and develop more tools, such as our recent collaboration to create *Help and Healing: Resources for depression care and recovery*. This online toolkit aims to help patients work with their clinicians to get better results (see article on Page 4).
- Increase the credibility of our measures by enhancing the development and approval process. We must acknowledge that in order to have meaningful measures, not everyone will be happy with the results, but we can commit to:
  - Transparent processes that include broad participation of stakeholders
  - Hearing and addressing concerns, when possible
  - Minimizing unnecessary burden for data collection and use
  - Testing our measures and making changes based on the results
- Work to align the measures across the community, in federal and state health care programs, and with the State Health Insurance Exchange.
- Expand the number and type of organizations that participate in our work and support our long-term financial sustainability.

This is an aggressive agenda, and we recognize we can only do this with your help.

In this issue you will also find updates on MNCM work in measure development, public reporting of data and process improvement. 2013 will be a busy and interesting year!

The mission of MN Community Measurement is to accelerate the improvement of health by publicly reporting health care information.

Register for MNCM's 'Measurement in Motion' seminar

The complex present and promising future of measurement will be explored in the MNCM seminar "Measurement in Motion," a daylong conference on April 3 at the Earle Brown Heritage Center in Brooklyn Center. **Paul Douglas**, a storied innovator in the data-rich field of meteorology, will set the scene. **Gerry Shea**, interim president of the National Quality Forum, who has served as assistant to the president of the AFL-CIO since 1995, will highlight national issues in measurement. Other confirmed speakers include:

Paul Douglas

- Gail Amundson, MD (moderator of reactor panel), Healthcare Transformation consultant
- Julie Brunner, JD, executive director of the Minnesota Council of Health Plans
- Terence Cahill, MD, United Hospital District Clinic
- Darrell Dykes, MD, PhD, Medical and Surgical Spine Consultants of MN
- Howard Epstein, MD, chief health systems officer, Institute for Clinical Systems
- Jonathon Mathieu, PhD, director of data and research at the Center for Improving Value in Health Care (CIVHC) in Colorado
- Nancy Salazar, RN, director of care innovation and measurement at HealthPartners Clinics.
- Dale Shaller, MA, principal, Shaller Consulting Group, who has directed the National CAHPS Benchmarking Database since its inception in 1998

Hear from national experts, attend sessions that span the triple aim of cost, quality and patient experience, and contribute to a framework for measure development. Register and learn more at www.mncm.org/2013seminar .

MNCM uses Medical Group Survey results to pursue improvements

Medical group employees have a chance to offer their perspective on MNCM's products, processes and services each year, particularly through direct feedback in our annual Medical Group Survey. 2012 was the fifth year of the survey, and 205 respondents will help inform our work going forward (response rate was 34.5%).

The survey results show that medical groups overall view MNCM as fulfilling its mission (collaborating effectively, selecting important measures, and accelerating improvement by public reporting). Medical groups rated the many tools MNCM provides to support direct data submission as very highly satisfactory. Our customer service was rated very highly as well. In addition, significantly more respondents noted they were frequently using the Health Care Quality Report (HCQR) results for internal clinical quality improvement compared with 2012.

Half of the respondents reported feeling that the HCQR results reflected their practice. Comments from those who did not feel the results reflected their practice indicate at least some respondents would prefer to see risk-adjusted rates.

Suggestions for data submission included: 1) providing data collection guides earlier; and 2) expanding definitions and terms, such as defining error message prompts during data upload. Medical group respondents asked MNCM to focus on providing any tools that can reduce the reporting burden. Respondents asked to be more involved in measure selection.

MNCM staff synthesized the results into the following recommendations:

- Improve and increase general communications to medical groups about MNCM's mission, efforts and goals.
- Identify and explore ways to reduce medical group reporting burden.
- Continue to improve the data submission process.
- Identify opportunities to increase medical group involvement and consumer awareness of MNCM.

MN Community Measurement is working through action plans for each of these recommendations, and has already made progress. For example, an area is being designated in the data portal to help new users become familiar with direct data submission. We are exploring how to reduce data entry burden, and our enhanced work group policy, adopted in 2012, will expand stakeholder involvement and increase transparency of measure selection. The next Medical Group Survey will be distributed in early spring. MNCM employees extend their sincere gratitude to everyone who responded to the 2012 survey, and whose feedback is helping us to improve.

Reporting statewide rates by race, ethnicity, language, on hold due to technical barriers

MNCM is putting on hold a plan to publicly report race and Hispanic ethnicity data for four direct data submission (DDS) measures in the 2012 Health Care Quality Report due to technical barriers that are hindering clinics from following best practices when collecting these data elements from patients.

MNCM developed the *Handbook on the Collection of REL Data in Medical Groups* in 2009. In 2010, we set the expectation that medical groups would begin to collect this information from patients and submit it to MNCM on a voluntary basis. In 2012, nearly all medical groups submitted these data elements on the majority of their patients along with the clinical data for the DDS measures. MNCM has been validating that these data elements were collected according to best practices: patients self-report this information and have the ability to select more than one race category; and no multi-racial category is used in collection. MNCM's Measurement and Reporting Committee approved a plan to report statewide rates by race and Hispanic ethnicity for four of our DDS measures as part of our 2012 Health Care Quality Report. While a large number of medical groups are following best practices, we discovered during the validation process that many of the EMRs used by medical groups do not have the capability to capture and report all race categories. For example, some EMRs capture only one race category. As a result, we must delay our reporting plans or risk misclassifying the statewide rates by race.

MNCM is a member of a multi-stakeholder REL Data Work Group, whose purpose is to establish a common framework for standardized REL data collection to reduce disparities and improve health throughout Minnesota. This work group has developed data collection principles and has made recommendations to the Health Insurance Exchange Advisory Task Force. We have learned that one effective strategy to motivate EMR vendors to provide this capability for their clients would be through a mandate. MNCM will be collaborating with this work group and others to explore opportunities to remove this barrier.

Total Cost of Care: Methodology OK'd; pilot sought in 2013

The Total Cost of Care methodology has been approved by the MNCM Board of Directors, and work has begun on researching options to create a total cost of care measurement that crosses multiple payers. MNCM is working with Johns Hopkins University and DST (software vendor for the Johns Hopkins ASC risk adjustment software) to explore the data flow and operational options. The results of this research will be reported to the Cost of Care Technical Advisory Committee. A goal is a pilot test of a Total Cost of Care measure in the second half of 2013, overseen by the Cost of Care TAG.

In addition, the updated average procedure cost information is being vetted by providers. Updated results are slated to be published on MNHealthScores.org yet this winter.

'Help and Healing' resources emphasize partnership of patients, providers to address depression

MNCM and the Minnesota Health Action Group have launched a new online toolkit to help fight depression by delivering evidence-based resources designed to improve collaboration between patients and health care providers.

Called the *Help and Healing* toolkit, this resource provides evidence-based treatment guidance for professionals and easy-to-use resources to assist in depression recovery. The goal is to help people who have depression get better, faster by fostering collaboration between patients and providers. The toolkit includes patient and provider talking points, treatment planning, self-management techniques, and information to help providers measure treatment outcomes.

The *Help and Healing* project was developed by a working group of clinicians and related experts, including patient advocates and employer representatives. The materials have been used and proven successful in Minnesota clinics, and were reviewed and approved by the team of experts.

"We believe the successful treatment of depression depends on the collaboration between the provider and the patient," said Diane Mayberry, a nurse and director of business development at MN Community Measurement, who co-managed the toolkit creation. "The tools included for this project have been demonstrated to help address depression."

The *Help and Healing* toolkit builds on DIAMOND, the Institute for Clinical Systems Improvement (ICSI) initiative. DIAMOND emphasized the concept of collaborative care, which aims to improve the treatment of depression by enhancing the partnership between the provider and the patient.

The project was made possible through a grant from the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative, the foundation's signature effort to lift the overall quality of health care in targeted communities throughout the country, reduce racial and ethnic disparities, and provide models for national reform.

MNCM data part of *Consumer Reports* coverage

Some MNCM quality data is being published nationwide in the next issue of *Consumer Reports*.

Consumer Reports' March issue, on newsstands this month, includes a rating of several cancer screening tests. MNCM data showing the range of colorectal cancer screening rates for primary care providers in Minnesota (for all patients regardless of insurance type) is included in the nationally distributed publication, along with data from Wisconsin and Massachusetts. The new article marks the second time MNCM data has been published in *Consumer Reports*. (A special insert containing MNCM data on optimal diabetes and optimal vascular care was published in Minnesota and surrounding its borders in the October 2012 issue and can be found on online at http://www.mnhealthscores.org/news/assets/CR-MNCM%20insert%20FINAL.pdf)

Consumer Reports has been working with MNCM, and similar organizations in Massachusetts and Wisconsin, to increase awareness and use of robust health care data.

MNCM, ICSI pursue partnering to manage conflicts of interest

MNCM has been exploring ways to improve our internal processes, including measure development. One of the next steps to improve our measure development process is an enhanced, standardized process for assessing potential conflicts of interest for members of our measure development work groups and committees. Since July 2012, MNCM employees have been working with the Institute of Clinical Systems Improvement's (ICSI) Conflict of Interest (COI) committee to test the process of reviewing declared conflicts of interest from MNCM's measure development work groups against ICSI policies and best practices. Members of the ICSI COI committee, as well as MNCM staff, indicated that the process worked well for the MNCM measure development work groups. MNCM has been in discussions with ICSI about creating a joint COI review committee that would apply a standard COI review process across workgroups and committees for both organizations. The boards of both organizations support this effort. While the COI review process will be shared, each organization will have its own COI policy and MNCM has developed a new COI Policy for board approval in February.

Additional steps to improve the measure development process include the development of a new policy that outlines ideal measure development work group composition and describes the new role of the external chairperson, work group member expectations for participation, and a consensus-based decision-making process. MARC approved both the measure development work group policy and a detailed measure development process flow chart in November 2012.

PQRS program now includes some key Stage 1 Meaningful Use measures

MNCM's Physician Quality Reporting System (PQRS) program has undergone some important enhancements this year. Continuing our four-year partnership with the Wisconsin Collaborative for Healthcare Quality (WCHQ), MNCM and WCHQ are now able to submit a medical group's clinical quality measures (CQMs) for Stage 1 Meaningful Use, along with its PQRS data. MNCM is pleased to offer this capability as we continue to make strides towards aligning data submission programs to reduce administrative burden on medical groups. For the January 2013 data submission under way, MN Community Measurement is excited to offer the following programs for groups participating in PQRS:

- PQRS measure calculation and submission to CMS
- Reporting for the Medicare EHR Incentive program (Stage 1 Meaningful Use CQMs)
- Reporting to CMS's E-Prescribing program
- Creation of direct data submission files for both the Minnesota Optimal Diabetes Care and Optimal Vascular Care measures

MARC seeks safety net representative

MNCM's Measurement and Reporting Committee (MARC) has an opening for a new member to represent safety net medical groups. The new member will replace a current member who is resigning due to a job change. Safety net medical groups will be best represented by a person who has a nursing background, a physician or is some other member of a care team, who also has measurement and quality improvement experience. Contributing to the racial or ethnic diversity of the MARC is always beneficial as well.

The MARC is a committee of the board with a broad membership of community stakeholders. The committee recommends both measurement priorities and specifications to the MNCM Board of Directors and also recommends guiding principles and/or policies for MNCM's public reporting of measures. The MARC will be supported by measure development work groups established by MNCM staff at the direction of the MARC. These work groups recommend draft measurement specifications and data collection plans. MARC members may be asked to serve on a work group.

The MARC meets monthly. Members are required to attend/actively participate in at least 75% of meetings. Members serve a two-year term and have a three-term limit. While it is possible for a member currently serving in an open position to nominate himself or herself again, MNCM is also mindful of recruiting new members so other community stakeholders have an opportunity to participate.

Interested candidates may be nominated in the following ways:

- An email notification will be sent in February to all safety net medical group contacts listed in the MNCM Data Portal to request nominations and provide details about timelines for submitting nominations.
- Candidates who meet preferred criteria may contact info@mncm.org for nomination details. After nominations close, MNCM will convene a committee to review nominations and appoint the new member. The nomination committee will consist of the current MARC co-chairmen and MNCM staff. After selections are made, all nominees and those selected as new members will be notified.

MNCM welcomes new team members

Gunnar Nelson

Gunnar Nelson is the value economist for MN Community Measurement. He has 26 years of experience in health care cost analysis and public reporting of provider evaluations. He created the Definity Health Buyers Guide, the first nationwide hospital quality and commercial cost transparency website. He has developed Total Cost of Care program analyses for local health plans. For MN Community Measurement he has worked on multi-payer Total Cost of Care methodology and risk adjustment processes. Gunnar holds a bachelor of science in economics from the University of Minnesota.

Paul Strebe

Paul Strebe, the newest MNCM employee, started Feb. 4. He is taking on a new role at MNCM as the program developer and manager. He has more than 15 years in public and private sector health care purchasing, with the last 10 spent developing and implementing unique insurance products/programs. Most recently, he oversaw health management program development and marketing at Medica, where he helped create consumer engagement strategies.

Board news

Departures

MN Community Measurement said goodbye to a long-standing board member in December 2012: Nathan Moracco, who represented state government, served on the Finance Committee. Nathan served two, two-year terms for MN Community Measurement, providing leadership during a period of rapid growth and change for the organization. We thank him for his leadership and service.

Patty Dennis, MNCM board member, will be leaving the board in conjunction with her departure from Medica, where she has served as vice president and general manager of Health Management. Patty served on the MNCM Board of Directors since 2008, and has also been a part of the board's Quality Audit Committee. Many thanks to Patty for her leadership and service.

MNCM welcomes new board member

Scott Leitz

Scott Leitz is assistant commissioner of health care at the Minnesota Department of Human Services (DHS). Working with a budget of more than $5 billion, he oversees Minnesota Health Care Programs, which include Medical Assistance, MinnesotaCare and General Assistance Medical Care. DHS is one of the largest health care purchasers in the state, serving more than 700,000 program enrollees. Leitz is responsible for eligibility and benefit policy, state MinnesotaCare operations, provider contracts and payment systems, and health reform initiatives in publicly funded programs. He was appointed to his post in January 2011. He has 16 years of experience in the health care and public health fields. Prior to this position, he was director of public policy for Children's Hospitals and Clinics of Minnesota. Leitz has also held several positions at the Minnesota Department of Health over the course of his career, most recently serving as assistant commissioner, where he oversaw the development, passage, and implementation of Minnesota's landmark 2008 health reform act. He previously served as health policy division director, health economics program director, federal relations coordinator and research economist.

He has a bachelor's degree in economics and mathematics from the University of Wisconsin-Eau Claire and a master's in public affairs from the University of Minnesota's Humphrey Institute of Public affairs.

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Measure Up To Better Health

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