MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, February 14, 2018
Meeting Minutes

Members Present: Barb Anderson, Janet Avery, Joe Bianco, Cara Broich, Karolina Craft, Howard Epstein, Matt Flory, Sue Gentilli, Stefan Gildemeister, Greg Hanley, Tim Hernandez, Jordan Kautz, Sue Knudson, Deb Krause, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jonathon Rose, Allan Ross, Laura Saliterman, Mark Sonneborn, Dan Trajano, Jesse Wheeler
MNCM Staff: Liz Cinqueonce, Collette Pitzen, Anne Snowden

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. Howard welcomed Bill Nersesian as his new co-chair. Bill has been a MARC member since 2014. Howard extended a special thank you to Chris Norton, whose board term ended in 2017. She will be continuing as a MARC member, but stepped down as co-chair in December 2017. Howard reviewed the MARC Charter and then introduced four new members to MARC: Sue Gentilli, large metro medical group representative; Jesse Wheeler, single specialty representative; Karolina Craft, state agency representative; Dan Trajano, health plan representative. Sue G. is the Manager of Quality and Regulatory Reporting at Allina Health Clinics. She has over 25 years of experience in quality measurement, reporting and health information management - notably at Target pharmacies and convenience care clinics as well as HealthPartners health plan. Jesse is a nephrologist and the clinical lead for quality improvement in specialties at Park Nicollet. He works directly with leadership and a wide variety of clinicians and non-clinicians throughout Park Nicollet and HealthPartners. Karolina is a Healthcare Policy and Quality Analyst at the Minnesota Department of Human Services – also known as DHS. She leads efforts on performance measurement for the Integrated Health Partnerships (IHP) demonstration and Behavioral Health Homes. She has experience using performance measurement for value-based payments, population health improvement and to address health equity. Dan is the senior medical director for the Medicare Stars and Enterprise Risk Adjustment Center of Excellence at Blue Cross and Blue Shield of Minnesota. Dan also serves as a co-chair of MNCM's Health Equity Advisory Council. Howard also welcomed seven returning MARC members: Matt Flory, Chris Norton, Sue Knudson, Mark Sonneborn, Laura Saliterman, David Satin and Stefan Gildemeister. Although the terms for these representatives ended in 2017, they reapplied and were found to be the best candidates for their respective roles. Howard reminded MARC members about MNCM's Conflict of Interest (COI) policy. All MARC members received a copy of the policy and have signed and returned the disclosure form. All MARC members were approved for full participation. Howard reminded members to notify Anne Snowden if their circumstances change during the year.
Approval of Minutes	The committee reviewed minutes from the December 2017 meeting. **Sue Knudson made a motion to accept the minutes; Chris Norton seconded the motion. Motion passed.**
Recommendations from MNCM Cancer Care Measure Development workgroup – for approval	Howard introduced Collette Pitzen, Clinical Measure Developer at MNCM to present the recommendation from the Cancer Care Measure Development Workgroup. Collette began by providing a brief overview of the measure development process. She then noted that the measure development workgroup was seeking MARC approval of final measurement specifications for implementation of the Cancer Care measures. Collette reminded the committee of the workgroup's scope: • To develop measures for oncology practices • To explore measure development activities that focus on symptom management during cancer treatment • The preference was for outcome measures that utilize patient-reported outcome tools. Refer to handouts detailing the measure specifications and results of pilot testing.

Measures:
Four measures related to symptom control during chemotherapy were tested. One process measure assesses the ability to administer the Patient Reported Outcome – Common Terminology Criteria for Adverse Events (PRO–CTCAE) tool. The outcome measures assess the control of three common symptoms of chemotherapy: pain, nausea and constipation. It was important to focus on symptoms that were actionable and having assessments that helped the healthcare team identify and manage symptoms, ideally allowing patients to complete the course of therapy and be as comfortable as possible. Patients' symptoms are assessed in cycles 1, 2 and 3 of their chemotherapy regimen, on days 5-15 of each cycle. Numerator compliance is the patient's rating of their symptoms as none or mild on a five point Likert scale. This measure construct assesses patients during the timeframe in which symptoms are most likely to occur and allows for treatment adjustment to improve symptom control over subsequent chemotherapy cycles.

Initially, patients were included in the measure only if they were newly diagnosed; however, medical groups in the pilot experienced issues with the identification of these patients as well as confusion in determining which patients needed to be assessed according to the measure. The measure development workgroup recommended changing the denominator to include all patients receiving chemotherapy since it is important to manage pain, nausea and constipation regardless of type of cancer, stage or number of regimens. Additionally, patients were only included in the denominator if their symptoms were assessed; but after receiving feedback from CMS for other quality measures about the possibility of denominator self-selection, the workgroup decided that patients who were not assessed should remain in the denominator. If a patient was not assessed during the appropriate timeframe, they are considered not in control. The denominator for all four measures is now comprised of all cancer patients, aged 18 and older, who started Cycle 1 of their chemotherapy regimen within January-June of the measurement year. Patients who discontinued their treatment or who did not have time to finish their follow-up cycles are not included in the measure for those cycles.

Pilot Results:
Two practices participated in the pilot. Results demonstrated that groups can successfully administer PRO tools and outcome rates demonstrate variability. There were 199 patients included in the pilot, comprising 547 cycles. The denominator for this measure is unique in that it is based on cycles of chemotherapy, not patients. The patient population was comprised of patients who ranged in age from 23 to 94, with a median age of 61.5. The PRO-CTCAE tool was made available to the practices in both English and Spanish, but is available in several other languages; 96% of the patients in the pilot were English-speakers. PRO-CTCAE administration was 54.8%. The three outcome measures: pain, nausea, constipation; had rates of 43.1%, 45.2% and 48.4% respectively.

Risk Adjustment:
There were four risk adjustment variables identified by the Workgroup for testing – age, insurance product, emetic risk and treatment intent (curative or non-curative). While risk adjustment testing could not be completed for these variables due to insufficient volume during pilot, these variables will be studied after the first year of implementation.

Provider Burden and Experience during Pilot:
The practices participating in the pilot did not build the PRO tool into their EMR (as recommended by MNCM, since changes can be made after pilot), which made it difficult to incorporate into their clinic workflow, store and extract data. The practices indicated that burden would be reduced when the tool is incorporated into their EHR. The two clinical risk adjustment variables (emetic risk and treatment intent) require translation of the order type of the chemotherapy regimen; however, the workgroup determined that these variables are important for testing.

Summary of Changes:
Due to the complexity of determining whether a patient is newly diagnosed and the importance of symptom control for all, the workgroup recommended expanding the denominator to include all adult patients. They also recommended modifying the denominator construct to include patients who were not assessed. The guidance to determine emetic risk was changed from Multinational Association of Supportive Care in Cancer (MASCC) to the American Society of Clinical Oncology (ASCO). The Chemotherapy Biologic Value Set CPT codes were evaluated and updated.

Recommendations:
For the 2020 Report Year (dates of service 1/1/2019 to 12/31/2019):

- Publicly report four measures:
    - Symptom Severity Assessment During Chemotherapy (process; PRO tool administration)
    - Symptom Control During Chemotherapy: Pain (outcome)
    - Symptom Control During Chemotherapy: Nausea (outcome)
    - Symptom Control During Chemotherapy: Constipation (outcome)
- Index Period – Cycle 1 Day 1 date of chemotherapy occurs within January-June of the measurement period

- Measure Denominator – All adult cancer patients.
  - Patients who were not assessed during Day 5 -15 of the chemotherapy cycle remain in the denominator and are counted as if their symptoms are not in control
  - Patients who discontinue treatment are removed from the denominator
- Guidance for determining the emetic risk source was changed from Multinational Association of Supportive Care in Cancer (MASCC) to the American Society of Clinical Oncology (ASCO)
- The four measures tested are feasible and demonstrate variability and opportunity for improvement. The workgroup supports future submission for consideration of use in CMS's Quality Payment Program.

Questions/Comments/Discussion:

Matt Flory commented that this measure, with its focus on quality of life for all cancer patients, can help reframe the conversation for patients who received a cancer diagnosis from "Am I going to die?" to "How am I going to live?". This can provide hope for the patients. He also suggested that this measure will be especially useful for consumers, as they can determine how to choose care, based upon factors that will directly affect them. Rahshana Price-Isuk commented that public reporting these measures is especially important when addressing health disparities, so that all patients can choose the clinic that is closest to them and still receive optimal care.

Jonathon Rose inquired whether patients' adherence to physicians' recommendations were identified. Collette explained that that information was not collected. While interesting to know and evaluate multiple variables, it's important to be aware of the potential burden of data collection. Howard further clarified that MARC has discussed patients' responsibility vs. providers' responsibility and ultimately, MARC has determined that the care team is expected to work together with the patient to achieve optimal outcomes.

Dan Trajano shared that he is concerned that providers may not focus on other aspects of the patient's care and could unintentionally treat patients with less aggressive chemotherapy in order to ensure high rates for symptom control, particularly nausea. He wondered if other measures of cancer care such as cost, variation in treatment, remission and longevity should be reported in conjunction with these patient-reported measures to ensure that providers are treating their patients according to best practices for all areas of care. Dan also expressed concerns about this measure being included in CMS' Quality Payment Program, due to the lack of balance with reporting on this particular aspect of care. Howard Epstein asked if other measures had been researched. Collette confirmed that these concerns were discussed by the workgroup at length. It is also important to note that even regimens that were labeled low emetic risk had patients that experienced nausea, and the workgroup felt that it was important to continue with the measure to address these symptoms. Collette explained that a measure development workgroup could be funded to investigate and develop these measures in the future.

Janet Avery questioned the measures' ability to capture survival rates and treatment outcomes in the context of curative versus non-curative treatment. Collette confirmed that while they do not have the data on survival rates for the patients in the pilot, due in part to the timeframe needed for that data; it is known that if symptoms are in better control patients are more likely to complete the treatment as planned. Chris Norton commented that, as a cancer survivor and as one who continues to work with cancer survivors, control of pain and nausea is extremely important to patients and often impacts whether the patient continues with their treatment or not. She added that patients' concerns about side effects are often their top priority.

Sue Knudson inquired whether the highest performing clinic for administration of the tool had insight into how to integrate the tool into clinic workflows, in order to increase the feasibility of widespread implementation. Collette indicated that the clinic was unable to pinpoint their methods, but that MNCM will continue to work with them to determine how they achieved higher rates.

Jordan Kautz asked whether there was discussion to determine a baseline level for these symptoms since pain, nausea and constipation can be a consequence of the disease. Collette confirmed that extensive discussion occurred around this topic and the workgroup concluded that these symptoms are important to manage, regardless of source.

Tim Hernandez asked whether there were exclusions for this measure. Collette noted that there were no exclusions; however, patients who do not complete cycles of treatment are not counted for those cycles.

Bill Nersesian commented that there could be an inverse correlation between good control of pain and poor control of constipation, as constipation is a side-effect of pain medicines like opioids. Bill also suggested that measuring three cycles per patient may introduce bias, as patients with better control are more likely to continue, which would mean that the rate of control would be slightly elevated over what is actually true. Chris commented that often symptoms are worse in later cycles of chemotherapy, which may help alleviate this bias. Bill responded that there could be also

	survival bias, as the patients who remain in the measure are those who survive and that these biases are important to note in reporting and understanding the measures. Stefan Gildemeister inquired whether lessons from the depression measures and the orthopedic measures were incorporated into this measure. Collette clarified that the term "index event" is similar; however, the event for this measure is more concrete and easier for clinics to identify. Additionally, oncology practices have been inquiring about patients' symptoms regularly, which helps with implementation of the tool in clinical workflows. Chris asked whether outstate practices were included in the pilot. Collette noted that all four clinics were located in the metro region. Sue Gentilli asked how the measure construct dealt with patients who only had their third cycle within the measurement period. Collette explained that only patients who had cycle 1 day 1 within the first six months of the measurement year would be included in the measure. Tim Hernandez inquired whether the recommendation includes the risk adjustment variables. Collette confirmed that the measure development workgroup identified four potential risk adjustment variables: treatment intent, emetic risk, age and insurance product which will be studied once the volumes allow. **Janet Avery made a motion to reject the recommendation. The motion did not receive a second. Motion failed.** **Rahshana Price-Isuk made a motion approve the recommendation as presented. Chris Norton seconded the motion. Motion passed.**
Update on Blood Pressure Component Redesign Work Group for ODC/OVC measures (per newly released revised guidelines)	Collette provided a brief update on potential measure redesign for the blood pressure components of the Optimal Diabetes Care and Optimal Vascular Care measures. The American College of Cardiology (ACC) and the American Heart Association (AHA) released updated guidelines for the diagnosis and management of hypertension late last year that identify hypertension as blood pressure above 130/80 mmHg, making 130/80 the new 140/90. The current MNCM blood pressure component target for measures is less than 140/90 mmHg. These updated guidelines are conflicting with JNC8 recommendations and there is significant controversy within the specialty societies and the community. The American Academy of Family Practice has formally declined endorsement of the new ACC/AHA guidelines. Additionally, Collette noted that the National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness Data and Information Set (HEDIS) measure, Controlling High Blood Pressure, was released for public comment recently. Pending public comment, it appears that this HEDIS measure will follow the JNC 8 guideline target of blood pressure is in control at less than 140/90 mmHg. MNCM is currently recruiting a workgroup to review the guidelines and determine the most appropriate target for the blood pressure component of these measures. Collette will bring more information back to MARC as the workgroup completes their review process.
Introduction to MNCM's Streamlined Quality Data Submission (SQDS) Project	Howard introduced Liz Cinqueonce, MNCM's new Chief Operating Officer, who provided a brief introduction to the new Streamlined Quality Data Submission project. Liz shared that the Streamlined Quality Data Submission project has three goals. First, to reduce provider burden associated with submitting data for quality purposes. Second, to increase the timeliness of the feedback that is returned to providers and medical groups. Third, to increase efficiencies on both the provider side and internally within MNCM. A future update will provide more information after providers have been interviewed to confirm the drivers of provider burden and identify areas of improvement including ways to submit data, improve systems and workflows, and other aspects.
Meeting Adjournment	The next meeting will be Wednesday, March 14. Bill adjourned the meeting.

Next Meeting: Wednesday, March 14, 2018