MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, May 9, 2018
Meeting Minutes

Members Present: Barb Anderson, Janet Avery, Joe Bianco, Cara Broich, Karolina Craft, Howard Epstein, Sue Gentilli, Greg Hanley, Deb Krause, Bill Nersesian, Chris Norton, Allan Ross, Laura Saliterman, David Satin, Dan Trajano, Jesse Wheeler
Absent: Matt Flory, Stefan Gildemeister, Jordan Kautz, Sue Knudson, Rahshana Price-Isuk, Jonathan Rose, Mark Sonneborn
Alternate: Joe Saccoman for Tim Hernandez
Guests: Beth Averbeck, Dave Klocke (Blood Pressure Redesign Workgroup)
MNCM Staff: Liz Cinqueonce, Collette Pitzen, Anne Snowden, Julie Sonier, Lindsey Ziegler

Topic	Discussion
Welcome & Introductions	Bill Nersesian called the meeting to order and welcomed committee members, Blood Pressure Redesign Workgroup members and observers. MARC members introduced themselves followed by the meeting observers.
Approval of Minutes	The committee reviewed minutes from the February 2018 meeting. Bill Nersesian asked for comments on the minutes. No comments were made. **The February 2018 meeting minutes were accepted.**
Update on Blood Pressure Component Redesign Workgroup for ODC/OVC measures (per newly released revised guidelines)	Bill Nersesian introduced Collette Pitzen, Clinical Measure Developer at MNCM and Beth Averbeck, Blood Pressure Redesign Workgroup Chair, to present the recommendations from the Blood Pressure Redesign Workgroup. Collette explained that the Blood Pressure Redesign Workgroup met in April to explore the following: 1. Evaluate and discuss recent changes in guidelines and evidence surrounding blood pressure (BP) targets for patients with diabetes and vascular disease. Based on this evaluation, determine the best BP component targets for the composite Optimal Diabetes Care (ODC) and Optimal Vascular Care (OVC) measures. 2. Assess the feasibility of including out-of-office blood pressures for use in measurement. Collette reviewed the current blood pressure guidelines. 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 greater than or equal to 130/80 mmHg. It is estimated that 46 percent of the adult population are hypertensive under the updated definition. 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 (AAFP) has formally declined endorsement of the new ACC/AHA guidelines. Additionally, Collette noted that the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) measure, Controlling High Blood Pressure (CBP), will follow the JNC8 guideline target of blood pressure is in control at less than 140/90 mmHg. The workgroup decided no changes should be made to the component blood pressure target of less than 140/90 within the ODC and OVC measures. Some key considerations in the discussion included an evaluation of the SPRINT (Systolic Blood Pressure Intervention Trial) study. The study design called for the withdrawal of treatment in asymptomatic patients in the conservative-treatment arm, which does not match clinical practice. Additionally, methods for obtaining a quiet, resting blood pressure (best practice) are used in clinical research studies, but may not be realistic in a busy clinic setting. The study excluded patients with diabetes and only showed a 0.5% difference in the primary outcome of mortality between the intensive-treatment group and the standard-treatment group. The workgroup also discussed the ACCORD (Action to Control Cardiovascular Risk in Diabetes) study. While this study included diabetic patients, it showed little benefit for BP targets below 140/90 mmHg. The workgroup's primary concern in setting a lower target BP for measurement and accountability for all patients was that it may put some patients at risk of serious side effects from treatment. While all agree that a lower blood pressure is better for the patient if it can be achieved safely, the workgroup did not think that the risks were adequately addressed within the new guideline. The workgroup also shared concerns about the current lack of consensus among the various guideline writing groups and the medical community. The second task of the workgroup was to evaluate out-of-office blood pressure monitoring for use in measurement. The ACC/AHA conducted a systemic review as part of their guideline development and recommended its use in the diagnosis of hypertension and for the process of medication titration. Beth provided information about recent measure changes nationally and HealthPartners' experience with out-of-office BP monitoring. NCQA's updated Controlling High

Blood Pressure measure specification now includes one type of out-of-office blood pressure: "Remote monitoring device BP readings directly transmitted to the provider may be included. Documentation in the medical record must state that the reading was taken by an electronic device, transmitted directly to the provider and interpreted by the provider." Beth added that one of the workgroup members, Karen Margolis, completed pilot testing of this technology and shared her experiences and difficulties in incorporating the readings into the electronic medical record (EMR).

The workgroup agreed that this technology is forward thinking and would be desirable; however, they wondered about feasibility and the current use of this technology. Among workgroup members representing numerous practices, no one is using or aware of colleagues' use of this remote technology. Additionally, the workgroup had concerns about the application of the specifications with ambulatory blood pressure (ABP) readings; where over 100 BP readings are obtained over 12 to 24 hours. NCQA's current guidance of taking the lowest systolic and lowest diastolic reading would not be appropriate clinically. The workgroup directed MNCM staff to provide feedback to NCQA, recommending that in the case of ABP, the average daytime BP be used for measurement. Collette shared this feedback with NCQA.

NCQA's typical process with new or modified measures is to pilot test changes. MNCM will continue our methodology alignment with CBP HEDIS measure, but the workgroup agreed that it would be better to wait and allow testing to occur with the out-of-office blood pressure. As NCQA seeks NQF re-endorsement of this measure, the new source of BP readings will undergo validity and reliability testing.

Recommendations:

- **Blood Pressure Targets Remain at less than 140/90 for ODC and OVC measures (unchanged)**
  - Encourage individualized goals for those patients who may benefit from BP target less than 130/80
- **Most recent blood pressure obtained during an office visit (unchanged)**

  - MNCM will:
    - Survey medical groups for actual use, transmission and storage of BPs into the EHR
    - Monitor NCQA's experience with remote transmission from BP devices
    - Provide feedback to NCQA about ABP recording average day-time BP values

Questions/Comments/Discussion

Bill asked whether the workgroup decision was unanimous. Collette confirmed that consensus was reached by the workgroup. Beth added that the workgroup had the benefit of reviewing actions/decisions from other entities, including NCQA and ICSI. Measures are constructed and supported by evidence and guidelines, but in the current state of conflicting guidelines and the controversy among specialty societies, it is not likely that the measure construct would be criticized for continuing with a BP target of less than 140/90 mmHg.

Howard inquired whether CMS (Centers for Medicare and Medicaid Services) would agree with the workgroup's recommendation. Beth shared that NCQA is the measure steward for the Controlling High Blood Pressure HEDIS measure, which is currently included in CMS's programs including the Star Ratings program. The Measures Application Partnership (MAP), which is the coordinating group that makes measurement recommendations to CMS, offered conditional support for MNCM's measures (ODC and OVC), dependent on a review of the new guidelines. David commented that it would be unlikely for CMS to reject MNCM's measures since there isn't full agreement on guidelines and several reputable measurement experts are not recommending the lower target.

Bill inquired whether the decision to use the less than 140/90 target would be a disservice to patients. David commented that while less than 130/80 is better for individual patients, these measures need to reflect the risks of over-treatment, and less than 140/90 will help the patients at the highest risks of complications. Dan expressed concerns that the target of less than 140/90 could cause physicians to treat to the target and not individualize treatment for patients who could benefit from lower goals. Allan added that providers will continue to individualize treatment targets, depending on the patient. Beth confirmed that many patients in the diabetes and vascular measures have blood pressure readings of less than 130/80 currently. David suggested incorporating language that encourages individual goal setting to a lower BP target when appropriate for the patient.

David offered some additional thoughts about using the daytime average BP obtained via ABP monitoring, as the daytime average would include active and resting blood pressure readings. Guidelines and studies are based upon office visit blood pressure readings, obtained while the patient is resting. Jesse commented that ambulatory blood pressure readings are often used for diagnosis, which in the Controlling High Blood Pressure HEDIS measure may mean the readings are recorded before patients would be included in the measure.

The committee unanimously accepted the workgroup's recommendation as presented.

Federal Funding Opportunity for Measure Development	Howard introduced Julie Sonier, MNCM's President. Julie shared that MNCM is responding to a CMS MACRA Funding Opportunity: Measure Development for the Quality Payment Program. CMS is using this RFP to fund work that develops, improves, updates, or expands quality measures for use in the Quality Payment Program. Under this funding opportunity, CMS is prioritizing the following types of measures: • Outcome measures, including patient-reported outcome and functional status measures • Patient experience measures • Care coordination measures • Measures of appropriate use of services, including measures of over use. On April 11, MNCM held a webinar with MNCM Board members and MARC members to provide an overview of our initial thinking on the scope of our proposal and to solicit feedback. We are currently moving forward with a proposal that: refines and improves several existing MNCM measures; proposes development of new patient-reported outcome measures for hip replacement and heart failure; proposes development of new measures related to opioid safety in partnership with ICSI; and develops electronic clinical quality measures (eCQMs) for several existing MNCM measures to reduce the burden associated with extracting and reporting data. CMS has extended the original deadline for proposals to May 30. The awards will be in an amount up to $2 million per year; applicants may apply for 1-3 years of funding depending on the scope of the proposal. **Questions/Comments/Discussion** Howard asked whether MARC would see more work if the opportunity was approved. Julie confirmed that both national and local participation would be welcomed. Deb commented that an anxiety measure had been mentioned during the webinar and asked about the status. Julie confirmed that this measure is not included in the proposal due to concerns about feasibility.
MNCM's Streamlined Quality Data Submission (SQDS) Project	Howard then introduced Liz Cinqueonce, MNCM's Chief Opportunity Officer, to present an update on the Streamlined Quality Data Submission (SQDS) Project. Liz introduced Will Muenchow, MNCM's Director for Information Technology and Data Systems, who will lead the SQDS work. The project is focused on finding new ways to increase the benefits and lessen the burden of quality reporting. Over the course of the last five months, MNCM evaluated drivers of provider burden in quality measurement, which reviewed data elements collected for measurement, technical assistance and questions raised by providers while participating in the direct data submission (DDS) process, as well as other feedback from providers on key areas of concerns. MNCM has identified barriers to providing more timely feedback to providers and a range of drivers that create difficulties for providers while submitting data, including extracting data from EMRs. As part of the feedback process, MNCM has identified differences in issues that affect providers, depending on provider type and size. MNCM is currently researching solutions that are both technical and technical assistance in nature. MNCM's goal is to roll-out the technical improvements needed by December of this year. **Questions/Comments/Discussion** Howard asked if the SQDS project will better engage specialty providers. Liz confirmed that the project will be developed to help all data contributors. Dan commented that the data submitted through DDS is utilized by health plans as well and expressed concerns about maintaining the validity and usability of the data for health plans as this project continues. Liz confirmed that the purpose of this project is so that the data is useful for multiple parties, including payors. She added that the validity and accuracy of the data will be monitored and maintained as the transition occurs. The new system will likely run in tandem with the current DDS process, to allow for comparison and validity analysis before the new system is fully implemented. The data system will be designed to allow for utility across every sector that stands to benefit from it.
MNCM Annual Seminar Update	Liz provided an update on the 2018 MNCM Annual Seminar, which will be held Wed, September 12, 2018 at the Earle Brown Heritage Center. The keynote speakers will be Jan Malcolm, Commissioner at MDH; Tara McMullen, Senior Data Analyst at the Centers for Medicare and Medicaid Services; and Daniel Wolfson, Executive Vice President and COO ABIM Foundation, "Choosing Wisely." Additionally, MNCM requested proposals from the community to see how data is being used, and the seminar will feature breakout sessions and panels created from these proposals.
Meeting Adjournment	The next meeting will be Wednesday, June 13. Howard adjourned the meeting.

Next Meeting: Wednesday, June 13, 2018