MN Community Measurement
Measurement and Reporting Committee
Wednesday, June 12, 2013
Meeting Minutes

Members Present: Tim Hernandez (co-chair) Howard Epstein (co-chair), Ann Robinow, Betsy Clough, Caryn McGeary, Chris Norton, Darin Smith, David Homans, David Satin, Ernest Valente, Jeffrey Rank, John Frederick, Kris Soegaard, Laura Saliterman, Linda Walling, Mark Sonneborn, Matt Flory, Robert Lloyd, Rahshana Price-Isuk, Stefan Gildemeister, Sue Knudson, Terry Cahill
MNCM Staff: Alison Helm, Tina Frontera, Anne Snowden, Collette Pitzen, Erika Vetta
Members Absent: Craig Christianson
Guests: Vicki Olson

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed the committee. Committee members introduced themselves. Tim welcomed new committee member, Rahshana Price-Isuk from Neighborhood Healthsource Clinics. Rahshana replaced Deb Mielke as a MARC member representing safety net clinics. Betsy Clough is leaving Gundersen Lutheran so she will no longer be able to serve on MARC as the medium, non-metro medical group representative. This will be her last meeting. To fill this opening, MNCM will be soliciting nominations from medical groups through an upcoming article in Measurement Minute, MNCM's e-newsletter.
Approval of Minutes	The committee reviewed the minutes from April 2013. **David Satin made a motion to accept these minutes, Linda Walling seconded the motion. Motion passed.**
Final Slate of measures for Statewide Quality Reporting and Measurement System (SQRMS) including hospital measures – For approval	As part of MNCM's contractual obligation with the Minnesota Department of Health (MDH), each year, MARC reviews and approves the recommended final slate of measures for reporting to be used for the next iteration of mandatory measurement for the Statewide Quality Reporting and Measurement System (SQRMS). The proposed final slate of measures is for the 2014 reporting year, reflecting 2013 dates of service. At the April MARC meeting, Erika Vetta brought forth a preliminary slate of measures for clinics and Ambulatory Surgical Centers (ASC), and it was approved by MARC. Since then, MDH convened a public comment period for the preliminary slate of measures. MDH shared the public comments they received during this period with MNCM in order to incorporate any necessary changes before MNCM recommends the final slate of measures to MDH. After MNCM submits recommendations on the final slate to MDH, MDH will convene a public forum on June 26, 2013 as an opportunity to solicit public comments before moving forward with drafting the Rule, to be released August 15 when a 30-day public comment will be convened. The final Rule is expected to be published in November. Each measure set was reviewed by MARC separately: ambulatory surgical centers, physician clinics, and hospitals. The Maternity Care: Primary C-Section Rate measure was reviewed separately from the other physician clinic measures. **<u>Ambulatory Surgical Centers measures:</u>** Erika noted that MARC approved the ASC measures (Prophylactic IV Antibiotic Timing, Surgical Site Hair Removal, and Hospital Transfer/Admission) in April 2013, and no public comments were brought forth for these measures. Erika reviewed the dates of service, data elements, and specified the numerator and denominator for each measure. Only the Hospital Transfer/Admission measure, an outcome-based measure, is proposed to have a risk adjustment component that is based on the American Society of Anesthesiologists (ASA) physical status risk categories. **<u>Question/Comments/Discussion for Ambulatory Surgical Centers:</u>** Jeff Rank shared that he feels the measures are fairly easy measures to report. Erika reminded the committee that MNCM has connected with the MN ASC Association (MNASCA) to discuss measures and possible gaps in care. **Linda Walling made a motion to accept the recommendations as presented by MNCM staff. Mark Sonneborn seconded the motion. Motion passed.** **<u>Physician Clinics measures:</u>** Erika reviewed that the suggestions and feedback gathered at the April 2013 MARC meeting were incorporated including 1) Separating General Practice as its own specialty, 2) Making dates consistent 3) Providing clarity where it was noted by this committee, and 4) Separating the measures into existing measures and those in pilot phase with the intent to move into implementation. Erika shared that there were not many public comments for physician clinic measures; however, the majority of comments received were related to the Maternity Care: Primary C-Section Rate measure. **David Satin made a motion to accept physician clinic measures (maternity was excluded from this vote) with changes as recommended by MNCM. Ann Robinow seconded the motion. Motion passed.**

Maternity Care: Primary C-Section Rate:

The majority of the public comments received by MDH addressed the Maternity Care: Primary C-Section Rate measure. In addition to the public comment period, there were medical groups that directly reached out to MNCM to share comments about the measure. MNCM contacted the original maternity care measure development workgroup regarding several of the proposed changes (update below) and the workgroup supported proceeding with these changes.

Erika reviewed the proposed changes. The first change pertained to data submission. Currently the measure is reported at a clinic level and all clinics with providers on staff who perform C-sections are required to submit data for deliveries (vaginal and cesarean) meaning a clinic that has no providers who perform C-sections is not required to submit data. Reporting measures at clinic site level is currently required for measures developed for use in SQRMS. Clinics that do not have a provider who performs C-sections would always have a 0% C-section rate because any woman needing a C-section would need to be referred to another clinic, so these clinics did not submit data in 2012 data submission.

Based on MNCM's experience with this first-year measure, MNCM learned that there are some unique attribution issues in reporting a procedural-based measure, and clinic level rates can be misleading when OB/GYN providers are splitting their time between two or more clinics. MNCM recommended that, in the future, this measure be reported at a medical group level, reflecting the care of the medical group, not an individual clinic. Reporting at a medical group or practice level would mean all nulliparous deliveries completed by a medical group would be included in the data submission and thus would provide more accurate rates for this measure because there would not be potential distortion related to attribution. In order to calculate an accurate rate at the medical group level, clinics that had not previously submitted their vaginal deliveries (because no one at the clinic performed C-sections) would need to submit their deliveries to provide a more accurate denominator of deliveries for the entire medical group. In order to support the proposed change in how the measure is reported, MNCM is recommending that the following be added to the SQRMS slate of proposed measures in order to prepare groups for submission in 2014: "All clinics part of a medical group in which the medical group performs C-sections will be required to submit deliveries for this measure."

The second change pertained to exclusions. Currently, all live, singleton deliveries to nulliparous women are included in the denominator. During MDH's recent public comment period, medical groups provided feedback in terms of additional exclusions related to breech (non-vertex) fetal position, preterm deliveries and other variables for high-risk pregnancies. Some comments suggested alignment with the Joint Commission (JCAHO) hospital-based NTSV (Nulliparous, Term, Singleton, Vertex) C-section rate measure, which has emerged as a national standard and in 2014 will be required for hospital JCAHO accreditation. During the development process for the MNCM maternity measure, the work group initially considered a "low-risk" C-section measure but encountered barriers in defining "low-risk", "high-risk", and appropriateness. The current measure is focused on a broad, overall C-section rate measure for only nulliparous (first birth) women. In order to better align with the JCAHO NTSV measure, the MNCM measure development work group recommended the addition of two exclusions: 1) non-vertex (fetal malposition) births and 2) pre-term deliveries (less than 37 weeks gestation). The addition of the pre-term exclusion will remove some high-risk pregnancies related to maternal or fetal risk resulting in prematurity; thus reducing the denominator. MNCM and MDH were able to work together to add language excluding non-vertex births for 2013 data submission, but the changes recommended at the meeting were for the 2014 rule which reflects data to be collected in 2014.

Erika also provided an additional update regarding the measure rate calculation. There is a prenatal care component to this measure whereby a patient who had a C-section, but received no prenatal care from the medical group of the delivering provider, receives a prenatal care flag 2 and has been removed from the numerator only. Feedback was provided that this deflates the rate. MNCM staff and the measure development work group discussed this issue and plan to proceed with revising the rate calculation for 2013 data submission that will exclude a patient with a prenatal care flag 2 from both the numerator and denominator.

Question/Comments/Discussion for Maternity Care: Primary C-Section Rate:

David Satin asked for clarification about the delivering providers' C-section rate and how use of the prenatal care flag could impact the rate. Are the delivering providers, who do not provide any prenatal care, dinged for a C-section? Collette verified that a medical group/clinic only submits data for the deliveries that their providers perform, and the prenatal care flag indicates if prenatal care (defined as at least one prenatal visit prior to onset of labor) was provided to the patient. Collette also verified that providers who do not provide prenatal care (prenatal care flag 2) do not currently have that C-section included in their numerator.

Jeff Rank and Ann Robinow expressed concern that removing patients who did not have prenatal care with the delivering provider's medical group/clinic will skew the data. Collette shared that during the measure development process there were early discussions about the idea of attributing the C-section to the clinic/ provider who provided the "majority of the prenatal care." There was some interest in having this kind of measure so that all clinics that provided prenatal care would have a C-section rate. However, one of the barriers was that when a provider refers a high-risk patient to an OB/GYN specialist prior to delivery, the referring provider may not necessarily know the outcome of that delivery, which could be either a vaginal delivery or a C-section. To require clinics that provided the majority of prenatal care submit data about the outcome of delivery is not technically feasible. Due to this, it was decided that clinics/ providers would submit data for those mothers for whom they performed the delivery. MARC did review this issue in November of 2011. Collette shared that analysis of the use of the prenatal care flag 2 in 2012 data submission was lower

than expected. She also noted that the patients who did not receive prenatal care from the delivering provider's medical group/clinic would be removed from both the numerator and denominator, as this is a more accurate way of calculating the rate.

Laura Saliterman shared that the issue is significant and she feels reporting skewed data is not useful for consumers. She also shared that she does not feel that data collection should be asked of medical groups when it is known there are flaws in the measure and when data collection is a burden. David Satin shared that if it is a small percentage of patients that will not be counted, communication should be presented to help people understand the measure. Linda Walling asked if the intention was to capture the scheduled C-sections. Collette shared the intention was to highlight the variation of the C-section rates since the rate has been increasing in the past years. She also shared that, nationally, this is a hospital-based measure, so attribution to a clinic or medical group is not an issue. Jeff Rank asked if the cost of collecting this data is worth seeing if there is a variation in the data. David shared that he feels he needs to know the numbers before he can make a decision.

Collette shared that the delivering provider is currently asked (if able) to indicate what clinic the referral came from and shared that it is burdensome for medical groups to provide this data element and only about half of medical groups populate this data field. David Homans shared that providing better care is the intention and that knowing where/to whom the handoff of a patient occurs is important. Collette verified that this would require data submission to occur for all mothers for which prenatal care was provided regardless of delivery and then to indicate if a referral was made for delivery, which would be a major redesign of the measure. Terry Cahill shared that it is not reasonable to ask clinics to provide this information in addition to what they are already providing for this measure. Tim Hernandez shared he feels that this may be one of the reasons that the measure was developed this way.

Ann Robinow asked if to the intent was to engage where/when prenatal care was given to a patient and that those providers who performed C-sections for patients for whom they did not provide prenatal care should be held accountable. Collette shared that, currently, the only existing measures for C-Section rates use hospital data and report rates by hospital which does not provide actionable data for consumers trying to select a provider for their prenatal care. David Homans shared that he feels getting this attribution correct for this measure will assist MNCM in the future as more procedure-based measures are attributed to clinics (for example: Total Knee Replacement).

Rahshana Price-Isuk and David Homans asked if it would be possible to move forward with data collection, but not publicly report the data. Erika shared that data could be collected, but MDH would make the decision as to whether to publicly report the rates for SQRMS. Stefan Gildemeister shared that MARC could make a recommendation to MDH to not publicly report this data. Sue Knudson shared that it would also be helpful to know the resource burden of this measure from medical groups/clinics and that this should be made part of the measure development process.

Terry Cahill stated he believes that data for this measure is difficult to capture and that there are many different reasons a C-section may be performed. In addition, he shared that the right of the patient to request a C-section will always be an option and his concern is this measure may affect the perception of quality for C-sections. Anne Snowden reminded the committee that this was a first-year measure and that reviewing results from the first year of data collection and adjusting the measure is typical for a new measure. Stefan Gildemeister commented that undercounting C-sections while still seeing variation might be indicative and that although it may not show the full picture, there could still be value to collecting this information.

David Homans made a motion to accept the changes as recommended by MNCM staff with the suggestion to hold on public reporting until further data analysis was completed. Rahshana Price-Isuk seconded the motion. Eleven members voted in favor of the motion; five voted against the motion; three abstained from voting. Motion passed.

After meeting follow-up:
Data on the use of the prenatal care flag 2 (defined as no prenatal care provided by the medical group that performed the delivery)

- Dates of delivery between 7/1/2011 and 6/30/2012
- 62 medical groups reporting; 20,427 deliveries
- 4.7% (951) of deliveries were indicated as no prenatal care provided by the medical group.
- Distribution of use of prenatal care flag 2:
  39% (24) groups had a use rate < 1.0%
  40% (25) groups had a use rate between 1.0 and 4.9%
  15% (9) groups had a use rate between 5 and 10%
  6% (4) of groups had a use rate > 10%

Hospital Measures Review:
MNCM led a consortium that included Stratis Health and the Minnesota Hospital Association (MHA). As part of this consortium, Stratis Health, in collaboration with MHA, convened the Hospital Quality Reporting Steering Committee and facilitated discussions leading to recommendations to MNCM regarding hospital measures for SQRMS. Erika introduced Vicki Olson from Stratis, a co-chair of this committee, and acknowledged Mark Sonneborn, a MARC member, for his work on the Hospital Quality Reporting Steering Committee as well.

The committee consisted of representatives from hospitals, consumers and health plans with a charge to review existing hospital measures and make recommendations for the 2014 slate of measures. Criteria for measure selection included alignment with other required measures considering that alignment should drive change to patient-centered outcomes and streamlining reporting to reduce burden. The committee was also charged with making recommendations regarding rural relevance, addressing Critical Access Hospitals (CAHs) and their volume of cases for measures.

Erika reviewed the measures currently included in SQRMS which include CMS, AHRQ, HCAHPS, and Vermont Oxford Network measures as well as other types of measures such as stroke and ED/Transfer Communication. The Hospital Quality Reporting Steering Committee reviewed the existing measures and provided recommendations for retiring and adding measures for 2014.

The Hospital Quality Reporting Steering Committee recommended adding Early Elective Deliveries, a perinatal care measure for both PPS (prospective payment system) and CAHs. This measure will be required by CMS for PPS hospitals for the first time. There is also a DHS policy that will require data collection from CAHs as well. Rate variation exists and this measure was deemed valid and reliable.

Three CMS measures were recommended for removal including 1) Surgery Patients with Recommended Venous Thromboembolism and Prophylaxis Ordered and 2) Troponin Results for Emergency Department Acute Myocardial Infarction Patients or Chest Pain Patients. These two measures were retired by CMS this past fall and MDH has already communicated that these measures no longer need to be collected beginning with this current collection year. The third measure recommended for removal was the 3) Inpatient Emergency Department Throughput measure. The committee recommended removing this measure as it is based on time, and there are currently no specific standards for this measure resulting in the inability to make meaningful comparisons for quality improvement purposes.

The Hospital Quality Reporting Steering Committee also recommended removing the Joint Commission measure Children's Asthma Care measure. There was very low volume for this measure and, based on the committee's review criteria, did not meet the magnitude or relevance criteria.

The Hospital Quality Reporting Steering Committee also recommended that hospitals be required to only submit the AHRQ composite measures: Patient Safety Indicator (PSI90) composite and Pediatric Patient Safety Indicator (PDI19) as opposed to the individual AHRQ indicator measures. The committee noted that while initially useful to have MN hospitals reporting all of the AHRQ measures, claims measures may have reliability issues since chart abstraction is not required. The two composite measures are more broadly relevant and useful when compared to the individual indicator measures. In addition, the PSI90 measure is the only composite measure required by CMS as part of inpatient quality reporting and is also included in the value-based purchasing program. It was felt that the PDI19 composite measure reflects the focus to include pediatric relevant measures.

A recommendation was also made to hold off one year on publicly reporting the Emergency Department Transfer Communication measure. This measure does not currently align with the NQF endorsed measure. There was a lot of discussion around this measure and the Hospital Quality Reporting Steering Committee did not discount the value of this measure, but expressed the importance in having a valid and meaningful measure. More work will be done around this measure with the University of Minnesota, the NQF measure owner, to discuss revisions for this measure. Hospitals will still be encouraged to submit data voluntarily for QI purposes in 2014 and will be required in 2015.

Questions/Comments/Discussion for Hospital Measures:

Sue Knudson asked about the rationale for retiring the AHRQ measures and if community use of measures was taken into account. Vicki Olson from Stratis shared that the health plans did have representation on the Hospital Steering Committee, but that inventory of community use of measures was not conducted. Sue Knudson shared disappointment about the recommendation to retire the AHRQ measures. Sue Knudson shared that these measures will not be transparently reported if they are not required by SQRMS and that she would like to see the AHRQ measures kept in the slate since an inventory was not conducted. Sue also suggested that an inventory of community use be taken into consideration in the future.

Erika reminded the committee that the hospital measures on the slate of measures are recommendations from the Hospital Steering Committee with hospital representatives and experts in their field. David Satin noted that he trusts the members of the Hospital Quality Reporting Steering committee that these measures should be retired.

Tim Hernandez shared that the Board is looking at overall burden and there are many important items/measures, but the feasibility of measuring must also be considered.

Ann Robinow shared that she was uncomfortable with the retirement of some of the AHRQ measures, that she felt they are the closest outcome measures available, and she would want to know more about why they are being retired before voting to approve the recommendations. Mark Sonneborn shared that CMS does not report the AHRQ measures. Ann then asked if there were substitutes for the retired AHRQ measures. Mark shared that the volume for these measures are very low. Collette noted that another criterion for recommending keeping or retiring a measure is the action-ability of the measure.

	David Satin made a motion to accept the recommendations as presented to the committee. Jeff Rank seconded the motion. Five members voted yes and seven members voted no. Motion did not pass. Mark Sonneborn shared that there is little burden for hospitals to collect the AHRQ measures that are proposed for retirement, but that it is a burden to collect data for the CMS. Sue Knudson shared that the AHRQ measures are in the public domain and stated she would like the AHRQ measures that are proposed for retirement to be kept in the slate of measures for transparency reasons. David Satin mentioned he would like to know why the measures are being retired by AHRQ and CMS. **Sue Knudson made a motion to accept the recommendations for the hospital measure slate but to only retire the AHRQ measures that have low volume as determined by MNCM staff. Nine members voted yes, two members voted no and one member abstained from voting. Motion passed**. **Other General Questions/Comments/Discussion** David Homans asked if Patient Experience (PE) data was reported by clinic site. Erika confirmed that the mandate is for clinic level reporting. He also asked how useful clinic level reporting of patient experience results is for consumers given some clinic sites house several specialties that may have PE rate variations between departments. Erika noted that requiring each department within a clinic site to survey each department separately would increase costs for clinics/medical groups and that MDH, when including PE in the Administrative Rule, took cost into consideration. Sue Knudson asked if it would be possible to aggregate data by specialties rather than by clinic site. Erika noted that during registration clinics have been advised to survey at the clinic level for the patient experience survey and the HIT survey. Anne Snowden also noted that it may be possible to conduct testing with consumers to determine if reporting PE results by specialty would be useful. Anne also shared that MNCM is currently developing a specialty filter on the website for the PE results that will allow consumers to sort by specialty. Laura Saliterman suggested adding text to the website to help consumers better understand what they are viewing.

Next Meeting: Wednesday, August 14, 2013 at 7:30-9:00 am