MN Community Measurement
Measurement and Reporting Committee
August 14, 2013
Meeting Minutes

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

Topic	Discussion
Welcome & Introductions	Howard Epstein welcomed the committee. Committee members introduced themselves. Howard also introduced guest Christina Rowland from the Robert Wood Johnson Foundation Aligning Forces for Quality Grant National Program Office at George Washington University. She was visiting MNCM as part of a site visit.
Approval of Minutes	The committee reviewed the minutes from June 2013. **Chris Norton made a motion to accept the minutes, Laura Saliterman seconded the motion. Motion passed.**
Update on hospital measures for Statewide Quality Reporting and Measurement System (SQRMS)	Erika Vetta reminded MARC that the 2014 proposed final slate of measures for physician clinics, ambulatory surgical centers and hospitals was brought forth to MARC in June 2013 for approval. The slate was then provided to the Minnesota Department of Health (MDH) under contact to create the next iteration of the Administrative Rule for the Statewide Quality Reporting and Measurement System (SQRMS) rule. Erika informed MARC that the proposed rule was released by MDH on 8/12/2013 which initiated a 30-day public comment period ending 9/12/2013. No action or approval was requested from MARC at this time. At that June meeting, MARC raised questions regarding the original recommendation to remove individual Agency for Healthcare Quality Research (AHRQ) measure indicators. The committee sought additional rationale for removal of the indicators. Staff from Stratis Health, the Minnesota Hospital Association (MHA), and MNCM then had an opportunity to further evaluate the AHRQ indicators using specific criteria. In addition, Stratis Health reconvened the Hospital Quality Reporting Steering Committee to solicit additional feedback on AHRQ indicators that were originally recommended for removal. Erika introduced Vicki Olson, Program Manager at Stratis Health who shared an update about what had transpired since the June MARC meeting. Vicki provided information about the AHRQ measures that were originally recommended for removal. The analysis conducted by staff from Stratis Health, MHA and MNCM was brought forth to the Hospital Quality Reporting Steering committee in July 2013, which had representation from physicians, quality directors, critical access hospitals, hospital systems and consumers as an additional step in the review process. Vicki stated that the analysis included consideration of NQF endorsement, suitableness for public reporting as determined by AHRQ, if the individual indicator measure was included in a composite measure, if the measure was part of CMS inpatient quality reporting, if the measure had been retired by CMS, number of hospitals impacted and additional considerations. Of the 15 measures initially recommended for removal, there were six measures that Stratis Health, MHA and MNCM staff proposed for inclusion in the slate of measures for SQRMS and those six measures were discussed with the Hospital Quality Reporting Steering committee. Vicki reviewed further analysis that was conducted for the six measures and the rationale from staff for recommending that the measures continue to be reported: • PSI 04. Rationale for keeping the measure included that a legislatively mandated study of staffing and patient outcomes will occur in 2014 and this measure would be a supportive data source to the study. • IQI 91. Rationale for keeping this measure was that, although this measure overlaps with other mortality measures, it is a composite measure and is suitable for comparative reporting. • PSI 18 and PSI 19. Rationale for keeping these measures was that this was a previous focus area for our community and relevant for small and rural hospitals. • PDI 6 and PDI 7. Rationale for keeping these measures was that this was also a previous focus area and important for children's hospitals. The Hospital Quality Reporting Steering committee discussed concerns regarding the usefulness of the measures and did not reach consensus about inclusion or exclusion of the six measures. While the committee did not change its original recommendation to only report a set of AHRQ composite indicators (PSI 90 and PDI 19), it felt that the analysis was useful. The analysis and additional comments from the committee were shared with MDH. **Questions/Comments/Discussion:** Sue Knudson stated she felt that the additional analysis was helpful and noted she was satisfied with the final outcome.
MNCM REL	Anne Snowden reviewed highlights from the document "Race, Hispanic Ethnicity and Language (REL) Reporting Plan Update and

Reporting Plan Update and Proposed Revisions to Recommendations – For approval	Recommendations." She also thanked Chris Rowland and RWJF for their support of MNCM's REL data collection efforts. She noted that most recently, they provided funding for the development of automated REL charts that medical groups will be able to access in the portal for quality improvement purposes. Anne reviewed the following items for context: 1) The effort for data collection and validation of REL and Country of Origin (COO) data elements is an MNCM initiative aligning with goals of the Robert Wood Johnson Foundation's AF4Q Grant. 2) It is not a contract deliverable to MDH. 3) MNCM's REL Reporting Plan focuses on measures that use data submitted directly from clinics and does not pertain to HEDIS measures. 4) MARC approved the original REL Reporting Plan in 2011, which included the same rationale and background but a different, more aggressive timeline. At that time, MARC also established criteria that stated at least 60% of medical groups must submit REL data on the majority of their patients AND follow best practices before moving to statewide public reporting. At that time, MARC also requested to review the data display before proceeding with public reporting. In August 2012, MARC reviewed and approved the data display; and adjusted the timelines based on results from the MNCM data audit. Anne shared that the proposed updates to the plan represented a second revision to the original plan. She provided a brief history of MNCM's journey in REL data collection and included key highlights such as the development of the REL Handbook in 2009, the voluntary collection and submission of REL data, the soft "requirement" of REL data elements submission in 2011 and the validation of REL data collection process to ensure use of best practices. When the REL Reporting Plan was updated in August 2012, Linda Walling revealed that many EHRs are only able to capture one field for race and further noted that reporting multiple races from the EHR was not possible. MNCM investigated the issue of an EHR's technical inability to capture more than one race. MNCM updated its REL data validation policy with the Quality Audit Committee to include reviewing the ability of EHRs to capture and report more than one race as another indicator of best practices. MNCM found the addition of the stricter criterion significantly decreased the number of groups meeting the threshold criteria of 60%. Due to this, public reporting did not move forward in 2012. MNCM reviewed the REL data elements submitted with ODC, OVC and Depression in early 2013 and the 60% threshold was still not met. The proposed REL Reporting Plan included revisions to the timelines using a more cautious approach. The changes were: • Offer private medical group REL charts in 2013 for medical groups following best practices and hold on public reporting until 2014 when it is anticipated that the 60% threshold will be met for all REL data elements. • Offer all REL rates at once rather than staggering rates by measures as the previous plan recommended. **Questions/Comments/Discussion:** Craig Christianson asked if MNCM had communicated with EHR vendors to discuss the capture and reporting of more than one race. Anne shared that MNCM has primarily communicated with the medical groups. Most medical groups stated they had communicated, or planned to communicate, with their EHR vendors to discuss building the capacity to capture and report multiple races. Tim Hernandez shared that clinics typically have multiple priorities regarding updating EHR functions and the capturing and reporting multiple races may not be a top priority. Ann Robinow asked how medical groups intend to use this information. Anne stated that testing would occur this summer and MNCM will ask for medical group's feedback regarding how they intend to use the private medical group REL charts. **Jeff Rank made a motion to accept the entire REL Reporting Plan revisions and recommendations as presented to MARC. Chris Norton seconded the motion. Motion passed.**
Interim Progress Report on Community Transformation Grant (CTG) measure development process	Collette Pitzen provided an interim progress report regarding measure development activities for contractual work related to the CDC/MDH sponsored Community Transformation Grant (CTG). CTG is limited to 22 counties and one tribal community in Northern and Western Minnesota and there are no current plans for widespread implementation of potential measures or public reporting. MARC had requested an interim report on the feasibility and action-ability of possible measures with a potentially large denominator of patients prior to proceeding with further measure development activities. Collette acknowledged two work group members present: Matt Flory serving as a MARC/consumer representative and Cherylee Sherry, state agency representative from MDH. Collette provided an update of the work group's progress. No action or approval was requested. Collette shared that the purpose of the measure development work group was to explore ways to assess and reduce modifiable risk factors for patients seen at clinics for the following areas: tobacco use, BMI, cholesterol and blood pressure management. She noted that for the purposes of the grant, the clinic population may serve as a proxy for evaluating the impact of community interventions on population health. Collette noted that work group first clarified the measure population. The members of the work group acknowledged that they can only impact the patients seen in clinics and cannot impact other community members. The work group reviewed the possibility of

other data sources such as patient survey or community collection points. Collette shared there is a community-based effort to collect BMI, blood pressure, cholesterol and glucose. Some information currently collected by patient survey did not fit the scope of the proposed concepts and the work group decided the most reliable source of this type of data (blood pressure, cholesterol, BMI and tobacco use) would be the clinic's medical record systems.

The work group also determined the feasibility of collecting data from a large denominator of patients. This type of measure is different from a condition or disease-based measure like diabetes because it reflects more of the intent of a population-based measure. The work group plans to recommend using established patient visit criteria: two face-to-face visits within the last two years and at least one face-to-face visit within the measurement period. The visit criteria ensures that the patients will be established patients and seen during the measurement year. They also want to recommend that MDH consider allowing sampling to occur regardless of how long an EHR has been in place at a medical group.

In order to assess both the feasibility and action-ability of potential measures, the work group needed to consider not only the actual physical ability to pull the core data elements, but also what additional data elements would be needed to construct a feasible, actionable measure. To accomplish this task, the work group discussed potential measures.

The work group discussed the feasibility of extracting the following four data elements from a clinic's EHR: Blood Pressure, BMI, Tobacco Use and Cholesterol. Most of the work group felt that the data elements would be feasible to extract and through its continued discussions hope to leverage existing methods and definitions. Many EMR systems are currently programmed to pull this type of information. Regarding blood pressure, the work group agreed that it would be feasible to pull this data and had initially discussed targets of less than 140/90 and use of the hypertension diagnosis code to stratify data. For tobacco use status, the work group shared that this data would be feasible to extract from an EHR and the work group showed interest in a tobacco-free component. The work group also shared that it would be feasible to pull the BMI data. All of these components are requirements of the Meaningful Use national program.

Regarding cholesterol, the work group also felt it would be feasible to pull the cholesterol data, but determined to not move forward with a cholesterol measure component. Collette noted that, unlike chronic conditions like diabetes and known vascular disease, there is no single cholesterol target or guideline for the general population. Multiple factors need to be considered to determine best strategy for patients and appropriate levels of LDL. Cardiovascular events are not solely dependent on cholesterol levels and from a general population perspective, the majority of patients who have a cardiac event have "normal" cholesterol levels. For example, a higher LDL may be acceptable if there are also higher, protective HDL levels. The work group decided to not pursue cholesterol as a component for measure development for the following reasons: 1) The value of cholesterol is not necessarily a predictive value of future ischemic vascular disease; 2) Risk calculators can underestimate the lifetime risk of developing cardiovascular disease; 3) The action-ability of using risk calculators to predict CHD can sometimes lead to emphasis being placed in the wrong direction. Risk scores that are low can give the patient a false sense of security and higher risk scores can contribute to providers and patients feeling pressured to initiate statins; 4) Data collection burden is large to collect all required elements for the Meaningful Use measure including a Framingham Risk Score; 5) The cost of obtaining additional cholesterol components beyond direct LDL and possibly initiating statins may be high; and 6) The work group felt there was no value in implementing a process measure regarding cholesterol levels.

Collette shared that the work group determined to continue measure development activity surrounding the variables of blood pressure, tobacco use and BMI for the adult population of eligible denominator patients seen at clinics. They will not pursue measure development of cholesterol targets.

Questions/Comments/Discussion:

Cherylee Sherry provided some additional background information about CTG. Ann Robinow asked if this was a longitudinal study since the purpose of the grant is to review how a measure would affect modifiable risk factors. Cherylee stated that this is not a longitudinal study and data from the ODC/OVC measures will be used as baseline data.

Jeff Rank asked why a cholesterol measure would not be included if part of the purpose of the grant is to reduce hyperlipidemia. Cherrylee shared that there will be other actions taken to address modifiable risk factors. Tobacco use, BMI and blood pressure are anticipated to have an effect on cholesterol and hyperlipidemia. Rahshana Price-Isuk asked whether not including cholesterol in the measure will affect the grant. Cherrylee said that they plan to share with CDC the results of the feasibility and action-ability review.

Jeff Rank asked if patients with diabetes will be excluded from the measure. Collette shared there is not a plan to exclude diabetic or hypertensive patients from this measure because they currently share the same targets, such as BP < 140/90. As the work group continues its measure development activities, it will take into consideration exclusions that make sense given targets for blood pressure, tobacco use and BMI.

Craig Christianson shared his concerns about using a clinic-based population as a proxy for the general population because patients that visit a clinic may reflect a selection bias. Tim Hernandez re-capped the discussion that occurred in October surrounding the issue

	of public health domain measures. Ideally, the whole population would be measured rather than only patients seen at a clinic, but the feasibility of the measure needs to be reviewed and that was the task of the work group. Stefan Gildemeister clarified that the measurement piece is a small portion of the grant. The majority of the grant aims at a larger problem and seeks to make changes to impact risk factors in the community, but the causal effect may be unknown. Cherrylee mentioned that the CTG grant has multiple parts and this is one component under the clinical community connection component. Sue Knudson noted that the work group provided information that MARC requested regarding the feasibility of the measure. She also asked if the work group planned to leverage existing definitions and measures for data collection in order to not create burden for clinics. Collette shared that the work group is committed to leveraging existing definitions and EHR programming and that the work group is still discussing options. Howard Epstein asked if the work group reviewed the feasibility of data collection in ways other than face-to-face visits at a clinic since the data elements also reside outside of the clinic. For example, community health workers may collect these data. Collette shared that it was determined that the best sources of data were available in the clinic record. Howard then asked if the work group considered possible unintended consequences of measures that may utilize data collection methods outside of clinics. For example, collecting data from community health workers may increase costs associated with increased utilization of community health workers. Collette clarified that the measures under consideration rely on patients who visit the clinic (visit criteria) and will not require that patients be seen. Rahshana Price-Isuk asked if it was possible for clinics that had the resources to do a community outreach day with community health workers to collect the data from patients. Collette stated that the work group did explore that possibility, but did not feel it was feasible to collect the data on an ongoing basis from a community source.
Interim progress report on Total Cost of Care (TCOC) measure development process	Gunnar Nelson provided an interim report on the Total Cost of Care (TCOC) measure. The process to develop a TCOC measure began in April 2012. In December 2012, the TCOC measurement committee delivered methodology specifications that were approved by MARC and the MNCM Board of Directors. The next step was to design and test how the data would be created. Gunnar shared that the TCOC design flow will include data produced by the health plans and MNCM will combine data for a multi-payer system analysis. MNCM will not be able to access patient-level data and health plans will not have access to other health plan's claims. Gunnar also stated there will not be provider burden for creating the data file but there will be a burden for vetting the data. By request, attribution reports will be produced by health plans for individual medical groups. Gunnar also indicated that the next steps prior to public reporting include completing a test by pulling the health plan data, reviewing overall medical group blinded results and having 5-10 medical groups review the data and report findings to MARC and the Board of Directors. These steps will help inform counts of patients lost to follow up, uncover any potential bias, and ensure a reasonable distribution. Gunnar also shared that webinars and direct communications to medical groups will be conducted to educate medical groups about the Total Cost of Care measure. A summary analysis will be available for MARC and the Board of Directors after testing is completed. **Questions/Comments/Discussion:** Jeff Rank asked if CMS provided data. Gunnar noted that the data is only for commercial insurance. Ann Robinow asked how similar this measure is to Provider Peer Grouping (PPG) which MDH has been working on. Stefan Gildemeister shared that PPG is moving forward. He noted they are facing similar challenges such as determining risk adjustment models and fair/reasonable metrics but that PPG also include a Medicare/Medicaid focus which is an additional challenge. Another difference is that MNCM will be able to conduct provider verification of attribution. David Satin asked what information would be included in the final report provided to a medical group. Gunnar shared that the report would include information about the total cost of care and the ranking of medical groups. Since the data is based on administrative claims, the attribution will be at the medical group level and not the clinic level. Laura Saliterman asked if MNCM will proceed with public reporting of TCOC while incorporating quality measures data; she feels it would be useful to review the total cost of care data in that context. Gunnar shared that the project scope is to align with patient experience and quality measures and this will be part of testing. Gunnar stated it is important to explore any medical group characteristics which may affect the total cost of care. Ann Robinow stated she feels this will provide information about cost effectiveness and may affect the unit price as well as patient management. Jeff Rank stated that he feels the cost of care does not indicate the quality or outcome of care. Laura Saliterman shared that analysis of various types of patients as well as cost would be meaningful given that patient population/mortality may be masked by the cost of care. John Fredrick shared that the health plan perspective is to develop a standardized way to measure the cost of care.

Next Meeting: Wednesday, September 11, 2013 at 7:30-9:00 am