MN Community Measurement
Measurement and Reporting Committee
Wednesday, April 9, 2014
Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Caryn McGeary, Chris Norton, Darin Smith, David Satin, David Homans, John Frederick, Kris Soegaard, Laura Saliterman, Mark Nyman, Matt Flory, Rahshana Price-Isuk, Stefan Gildemeister, Sue Knudson
MNCM Staff: Anne Snowden, Collette Pitzen, Dina Wellbrock, Nathan Hunkins, Rachel Mlodzik, Tina Frontera
Members Absent: Dan Walczak, Ernie Valente, Jeff Rank, Julie Krenik, Mark Sonneborn, Robert Lloyd

Topic	Discussion
Welcome & Introductions	Howard Epstein welcomed committee members and everyone introduced themselves. Howard also welcomed the observers to the meeting and reminded them that only official members of the MARC committee can participate during the discussion.
Approval of Minutes	The committee reviewed the minutes from March 2014. Tim Hernandez commented that the amount of feedback received on the Optimal Asthma Care discussion at the last meeting was higher than any previous measure and that the vast majority of the feedback was related to removing the asthma action plan. Tim received feedback from pediatric providers and school nurses, along with others. Howard Epstein commented that the staff at MNCM did an excellent job summarizing the asthma discussion. **Sue Knudson made a motion to accept the minutes; Bill Nersesian seconded the motion. Motion passed.**
Optimal Diabetes Care Measure Review Work Group Recommendations	Howard Epstein introduced this agenda item with background around the diabetes ad-hoc review workgroup. In September of last year, MARC requested an ad-hoc review of the LDL/cholesterol component of this measure based on comments to explore the modification of the LDL component to include statin use (e.g., LDL <100 or on a statin). There were fundamental guideline changes for cholesterol management published in November of 2013. These guidelines recommended no longer treating high cholesterol to a desired LDL target. In March of this year, the diabetes measure development workgroup was convened to review the LDL/cholesterol component with the additional task of considering the new guidelines. MNCM sought separate approvals from MARC: approval of the recommended plan for the Optimal Diabetes Care measure as presented; and seeking direction/approval for the cholesterol component of the Optimal Vascular Care measure. Collette first presented on the diabetes measure ad-hoc review workgroup results. In September of 2013, MARC requested an ad-hoc review of the cholesterol component for the diabetes measure based on ongoing comments received to consider modification of the LDL component to "LDL < 100 or patient is on a statin." The intent of the diabetes measure is to reduce modifiable risks and to prevent or delay long-term complications of diabetes. The measure is a patient all-or-none composite with five targets known as the D5: A1c < 8.0, blood pressure < 140/90, LDL < 100, tobacco free, and daily aspirin if the patient has cardiovascular disease. Fulfilling all five targets together versus individually significantly reduces the patient's long term risk of complications associated with diabetes. As MNCM worked to recruit the ad-hoc review workgroup members, long awaited new guidelines for cholesterol management were published. The guideline recommendations published in mid-November 2013 by the American College of Cardiology/American Heart Association were considered paradigm shifting and represented a significant change in clinical practice of treating to a LDL target that has guided treatment for many years. Unable to find supportive randomized controlled trial (RCT) evidence base for treating to specific LDL or HDL targets, the guidelines abandon any and all recommended targets based on LDL. However, there is strong RCT evidence to support the use of statin therapy to reduce atherosclerotic cardiovascular disease (ASCVD) in four "statin benefit groups" for patients 21 and older listed below: 1. Patients with ASCVD 2. Patients with LDL ≥ 190 3. Diabetics aged 40 to 75 with a LDL between 70 and 189 4. Patients without ASCVD or diabetes with a LDL between 70 and 189 but have an estimated 10 year risk of developing ASCVD that is ≥ 7.5 This information changed the scope of the workgroup's task because the initial recommendation of "LDL < 100 or on a statin" would no longer be supported by evidence and guidelines. The diabetes workgroup met on March 13th to discuss the new guidelines and determine the future direction for the cholesterol/lipid component of MNCM's diabetes measure. The workgroup was chaired by Beth Averbeck, and it consisted of three internal medicine providers, one family medicine provider, three endocrinologists, and one cardiologist plus other members representing quality improvement, data analysis, health plans, etc. Collette thanked Mark Nyman and Kris Soegaard, both MARC members, for their participation on this workgroup.

One of the decisions the workgroup needed to make was either to re-design the cholesterol component or to completely remove this component from the composite measure. Several other measure developers with a cholesterol component related to a LDL target have chosen to retire a measure or remove a component of a measure with a LDL component. The workgroup decided that cholesterol management was too important to remove completely from a measure aimed at reducing modifiable risk factors.

Measure development should not occur ahead of the guidelines. Additionally, there is some controversy and conversations occurring on a national level about the recommended changes, in particular the use of the new CVD risk estimator developed by the ACC/AHA. The workgroup proposed to move forward with a re-design of this component with a thoughtful, staged approach. Part of this approach involves review of the updated ICSI diabetes guidelines currently undergoing revision and taking into account the various new guideline suggestions. This guideline is scheduled for release by July 31, 2014.

The recommendations for the diabetes measure are as follows:

1. For 2014 Public Reporting (2013 dates of service) — Scheduled to be published on MNHealthScores in 2014, the workgroup recommended that the current measure (all five components inclusive of the component for LDL < 100) be reported without change or modification. Rationale for proceeding with reporting the current measure was that 11 months of the measurement period were under the previous guidelines that supported treating to an LDL target. The workgroup recommended that the results be reported with a footnote or additional annotation explaining the new guidelines/ goals for patients.

2. For 2015 Public Reporting (2014 dates of service) — Scheduled for reporting on MNHealthScores in 2015, the workgroup recommended that no new cholesterol component be incorporated into the numerator and that the numerator component LDL < 100 be suppressed. Components of the diabetes numerator will be:
    a. HbA1c < 8.0
    b. Blood Pressure < 140/90
    c. Tobacco-free
    d. Daily Aspirin if cardiovascular disease and no contraindications

    The workgroup recommended continuing collection of LDL values and date as part of the submission as these data elements could be needed to determine appropriate statin use. Patients with an LDL < 70 may not need to take a statin to reduce their cardiovascular risk. Currently, 25% of the reported diabetic population has a LDL level < 70.

3. The workgroup requested to reconvene in August of 2014 (following the revision of the ICSI Diabetes guidelines due for publication on 7/31/2014) allowing for any new measure development to align with guidelines.

4. The workgroup will plan for a new cholesterol component of the composite measure related to diabetic patients being prescribed (ordered) a statin. This construction will be communicated to medical groups early since they will need time to plan for and implement changes related to a new cholesterol component based on statin use. If a new component is feasible, it will be implemented for 2015 dates of service (1/1/2015 to 12/31/2015).

Questions/Comments/Discussion:

Mark Nyman commented that the guidelines are becoming more evidence-based. It is known that if a patient's risk is high enough and he or she is on a statin, it is beneficial for their well-being. The LDL component does not hold the same role it did in the past in regards to a patient's care. Now the new guidelines suggest that a patient with a LDL > 100 and on a statin is receiving good care. The challenge for future measurement is how to assess when a patient is at a high enough risk to be on a statin. It will also be challenging to incorporate the patient's view on their risk level and their thoughts on their threshold limit.

Kris Soegaard added that there was a good amount of discussion regarding the controversy around the new guidelines during the workgroup meetings. The workgroup discussed the side effects related to statins and the concept of shared decision making. The controversies around the new guidelines will become forefront as more patients become eligible to be on statins.

Mark Nyman added that in the future if MNCM continues to follow the new guidelines, we will want to assess whether or not the patient is on a lipid medication and will need some type of marker for risk specific to the patient.

Sue Knudson asked what the implications of changing this measure would be since it has had NQF endorsement for three years. Collette commented that the diabetes measure has been stable for three years. MNCM is due for a maintenance review (occurs every three years) and that is being phased. NQF, anticipating the arrival of new guidelines, had communicated with MNCM early in the year that they did not expect maintenance applications until the new guidelines were released and

wanted to allow measure developers time for redesign if needed. This measure is not slated for re-endorsement until December 2014, and NQF informed MNCM that they are flexible with that date.

Sue Knudson added that this change in definition causes significant disruption in health plan applications (e.g., pay-for-performance, BTE), and we need to be planning internally for how to apply these new baselines. This change introduces new work. Collette commented that MNCM does have the ability to recast data in D4 if it is needed to calculate measure improvement. It is not possible for MNCM to recast a future new cholesterol component based on new guidelines since this information (e.g., statin prescribed) is not available from previous years of data collection.

Bill Nersesian asked when you move to an outcome (LDL level) to a process (statin use), would providers get credit for the amount of statin taken each day. He also questioned whether the literature is robust enough to distinguish between different statins. The difficulty of abstracting this data from EMRs/paper charts also needs to be considered when dealing with these new guidelines. The workgroup will have to assess these questions at a later time.

Ann Robinow added that this situation is similar to when the HbA1c target changed from less than 7 to less than 8 a few years ago. When we are measuring these intermediate outcomes, as technology changes, we will eventually have to change; ideally having measures that are closer to a desired reduction in long term outcomes. Ann added that MNCM should consider more measures with patient-reported outcomes that are more durable across changes in reporting.

David Homans added that if reporting becomes more patient-centered, it will make the process more complex. He believed this change will be a work in progress.

John Frederick questioned whether there is still value in reporting the composite measure for 2014 dates of service when we know that data will not be as valuable. Tim Hernandez added that many medical group contracts with health plans are based on the five diabetic components (P4P is based on D5). With D4, the baselines would either have to be recast or medical groups might get a pass. Howard Epstein believed that there is still value in publicly reporting this data for 2014 dates of service since we are still trying to move the needle on the care of diabetic patients.

Bill Nersesian made a motion to accept the recommendations from the workgroup. Rahshana Price-Isuk seconded the motion. Motion passed.

Collette transitioned to discussing the Optimal Vascular Care measure recommendations; where based on new guidelines and evidence, an LDL target of < 100 is no longer appropriate. This measure consists of four components which are identical to the Optimal Diabetes Care measure including a cholesterol component of < 100. With the new guidelines, patients who are 21 years of age and older with cardiovascular disease are expected to be on a statin. There is incentive to align the vascular and diabetes measures; it would be very difficult to have different expectations for each measure because there is patient crossover between the measures (18% of diabetic patients have IVD).

The workgroup, originally tasked with exploring the cholesterol component of the diabetes measure, asked for MARC support in how to approach the review of the Optimal Vascular Care measure's LDL component. Several options were presented:

1. The current diabetes ad-hoc review workgroup would expand their scope to include the re-design of the vascular measure as well. Currently the workgroup consists of three internal medicine providers, one family medicine provider, three endocrinologists, and one cardiologist.

2. The diabetes ad-hoc review workgroup would increase its membership to add one to two more cardiologists to examine the issue further and incorporate changes to the vascular measure when it re-convenes in August following the ICSI guideline release. The workgroup recommended this option.

3. A new, separate measure development workgroup would be recruited to address the cholesterol component of the vascular measure. The workgroup did not recommend this option.

Questions/Comments/Discussion:
Tim Hernandez asked if ICSI is revising the vascular guidelines. Collette answered that ICSI is working on vascular revisions at this time.

Sue Knudson made a motion to accept the recommendation from the workgroup to expand the current diabetes ad-hoc review workgroup to include one or two more cardiologists to examine the Optimal Vascular Care measure. Stefan Gildemeister seconded the motion. Motion passed.

Preliminary Slate of Recommended Measures for Statewide Quality Reporting and Measurement System (SQRMS): Physician Clinics	Dina Wellbrock presented the preliminary slate of recommended measures for the 2015 Statewide Quality Reporting and Measurement System (SQRMS) for physician clinics. She noted that MNCM has a new two year contract with the Minnesota Department of Health (MDH) to continue to support the work of SQRMS for MDH. A bullet-point listing of the Rule-making process was included in the cover letter along with dates when MDH solicits community input on the preliminary slate. The final SQRMS slate will be presented in June. **Existing measures:** Dina reviewed the existing measures and highlighted the changes. The first measure in the preliminary slate was Optimal Diabetes Care. The ad-hoc diabetes workgroup recommended removing the LDL component from the 2015 measure. This means that the LDL component will not be included in the calculation of the composite; however, medical groups will need to continue to collect and submit LDL values and dates because these data elements could be needed for the future LDL component. The other components remain unchanged. The Optimal Vascular Care Composite measure is following suit with the Diabetes measure. The LDL component has been removed from the 2015 slate. Again, this means that the LDL component will not be included in the calculation of the composite; however, medical groups will need to continue to collect and submit LDL values and dates because these data elements could be needed for the future LDL component. All other specifications remain unchanged. The Depression Remission at Six Months measure remained unchanged from last year. The Optimal Asthma Care Composite measure underwent an ad-hoc measure review in January of this year. The recommendations from the workgroup were brought to MARC, and MARC elected to remove the asthma action plan as a component of the measure. The slate reflects that change. The Colorectal Cancer Screening measure has not changed since last year. The Maternity Care-Primary C-section measure is the percent of cesarean deliveries for first births. The measure was altered in 2013 to be reported at a medical group level, not at a clinic level. All clinics that are part of a medical group with providers performing C-sections are included in this measure. The Patient Experience of Care survey is currently active this year with the measurement period from 9/1/14 to 11/30/14. Only psychiatry specialties are excluded from this survey. Eligibility criteria for implementing the survey have changed in that a provider scaling table is now used. Adult patients ages 18 and older, who had a face-to-face encounter during the measurement period are to be included for sampling. The risk adjustment variables are taken from the survey and include age, education, and self-reported health status. The Health Information Technology survey assesses the phases of adoption, utilization, and exchange of information through a clinic's EHR. All clinics are required to complete this web survey annually. **New measures:** The "New Measures" section of the slate includes measures that are in pilot as well as those currently in first year implementation. The first new measure is the Total Knee Replacement measure which begins in April 2014. The measure reports the average one year post-operative change of both functional status and quality of life for patients who underwent either a primary total knee replacement or a revision. The procedure dates for the 2015 slate occur during 2013 with data collection starting in April 2015 to allow for follow-up. The patient population consists of adults ages 18 and older with either type of knee replacement in 2013. The risk adjustment variables are primary payer type, BMI, and tobacco status. The Spine Surgery measures will begin their first year of implementation starting in 2015. There are two populations of patients for this measure set; lumbar discectomy/laminotomy patients who are assessed at three months post-operatively and lumbar spinal fusion patients who are assessed at one year post-operatively. Each population is assessed with the same three measures reflecting the average change between pre-operative and post-operative status for function, pain and quality of life. Dates of procedures occur in 2013, with data collection starting in April of 2015. The population is stratified by adult patients ages 18 and older who either underwent a discectomy/laminotomy or had lumbar spinal fusion during 2013. The risk adjustment variables are primary payer type, BMI, and tobacco status. There are two pediatric preventive care process measures that will begin in 2015. The first measure is Adolescent Mental Health and/or Depression Screening. This measure reports the percent of adolescents who had a mental health and/or

	depression screening during an eligible visit. Dates of service will occur during 2014, with data collection beginning in April 2015. The patient population for this measure includes adolescents ages 12 to 17 years old seen by an eligible provider for a well-child visit during 2014. The second pediatric preventive care measure is the percent of pediatric patients with BMI percentile >85% that have documentation of counseling for both physical activity and nutrition provided to patients. The dates of service are in 2014, with data collection beginning in April 2015. The patient population is patients ages 3 to 17 with a well-child visit by an eligible provider during 2014. Again, there is no risk adjustment applied to this process measure. **Questions/Comments/Discussion:** Stefan Gildemeister asked for a recap on the rationale for reporting C-sections by medical group instead of by hospital. Collette answered that the C-section measure was originally developed to be reported at a clinic-level because hospital-based C-section rates may not be helpful to consumers. Many of the OB/GYN practices within a care system function as a department and a provider is actually going to many clinics, and clinic level attribution can make the data look very unusual. A medical group that has some clinics with family practice providers had previously not reported their clinic level rates as their C-section rate would be zero. Moving to a medical group rate ensures a more accurate denominator for the medical group's OB/GYN providers who receive referrals for C-sections. David Satin asked how MNCM handles situations where OB/GYNs perform C-sections for another medical group's patients. Collette stated that the prenatal care flag was created to remedy this issue. If a medical group did not provide prenatal care for a patient that received a C-section at a facility with their medical group, the patient is removed from the numerator and the denominator for that medical group. Kris Soegaard commented that reporting at a medical group level does not necessarily help a consumer make a decision about their physician. Matt Flory agreed and added that clinic level reporting is more useful to consumers. David Homans asked if there was discussion around attributing patients by office building for CG-CAHPS since different specialties have different patient experience levels. Dina answered that medical groups have the option to over sample by specialty for CG-CAHPS. Dina noted that the minimum number of returned surveys has been set at 150 completed surveys based on our experience from the 2012 survey. Stefan Gildemeister asked about the pilot results for the Total Knee Replacement measure. Collette commented that the pilot results have not yet been brought to MARC for review. The pilot participation for this measure set was very low, and there were issues with medical group's ability to implement the patient-reported outcome tools in their clinical work flows. It was planned to be a staged-pilot implementation because of the length of time required to implement the patient-reported outcome measure tools. The work group will be assessing the data submitted in April/May 2014 to make determinations on the measures. The work group recommendations will then be brought back to MARC for consideration. As an aside, patient-reported outcome tool administration has been very successful in the spine measure pilots with rates approaching expected administration levels for both pre-operative and post-operative assessment. Howard Epstein asked for a reminder as to when the MNCM measure review committee will be meeting to assess the current measures. Anne Snowden commented that due to scheduling issues, this subcommittee of MARC will convene this Friday. Any changes made during this meeting will be brought to MARC when the final SQRMS slate is reviewed in June. In the future, this committee will meet before the preliminary SQRMS slate is brought to MARC. Stefan Gildemeister commented on primary payer distinction for risk adjustment in the preliminary slate. He would like to see distinction between MN Government programs and the un-insured instead of them being combined as they are currently in the preliminary slate. Howard Epstein reminded MARC that a committee was formed to assess risk adjustment procedures which included discussion around payer type. Tim Hernandez added that changing to an Optimal Vascular Care measure with three components is a change and will affect contracts, pay-for-performance, etc. Sue Knudson asked to amend the timeline to reflect that the vote on the final SQRMS slate in June will take into consideration the MARC subgroup recommendations. **David Homans made a motion to accept the preliminary slate of recommended measures for SQRMS; Laura Saliterman seconded the motion. Motion passed.**
Health Care Homes (HCH) Care	Tim Hernandez introduced the next agenda item by stating that MNCM has been under contract with the Minnesota Department of Health to convene a workgroup to develop a Health Care Homes-specific measure or measures related to care

Coordination Measures (2): Measure Development Work Group Recommendations	coordination for the purposes of quality improvement, evaluation, and re-certification of Health Care Homes. This workgroup brought forth measure specifications which were approved by MARC in February of 2013 to move forward for pilot testing. Nathan Hunkins informed MARC that the workgroup settled on two measures for quality improvement purposes: Advance Care Planning and Follow-up After Hospital Discharge. **Advance Care Planning** Collette provided an overview of the Advance Care Planning measure. For the numerator, a patient must have evidence (documentation) of advance care planning (ACP) in their medical record at their health care home clinic. The denominator includes patients aged 65 and older; and there are no exclusions. The intent of the measure is to promote discussion with patients about their wishes and options at the end of life and provide the ability to assist in communicating a patient's wishes across different settings of care. Pilot participation was excellent and included eight medical groups representing 68 clinics (56,764 patients). The rate of having ACP documentation in a medical record was 32.1%, and there was variability between medical groups/clinics, demonstrating opportunity for improvement. Two components of the ACP were tested during the pilot: the patient's wishes are outlined and the patient's decision-maker is defined. The workgroup did not want to introduce unnecessary burden by collecting individual fields to capture details about wishes or the types of wishes documented, or if a decision maker was indicated. The workgroup also did not want to dictate a particular form or advance directive. During the pilot, the component of decision-maker proved to be problematic. The biggest concern was the POLST (Physician Order's for Life Sustaining Treatment), an AMA sponsored tool that outlines a patient's wishes but does not have a place to designate a decision maker. Many medical groups said "No, no ACP" if the POLST was used because it did not contain the information about the decision maker. Although it is extremely important to designate a decision maker, the workgroup decided to focus measurement efforts on the documentation of patient wishes as the key component of any advance care plan documentation that is used for this measure. After careful consideration of the intent of the measure, to encourage conversations about end-of-life issues with patients and to have the patient's wishes communicated, the workgroup recommended the following modifications: 1. Remove component designated decision maker. 2. Allow a DNR/DNI (do not resuscitate/ do not intubate) order to be included as numerator compliant; indicates that discussion did occur with patient and/or family about the patient's wishes. The specifications will be enhanced to include examples of the types of forms or documentation that can be used to meet the intent of ACP, and additional guidance/ resources will be provided to groups in terms of best practice for advance care plan discussions and documentation. Additional considerations will be added in the measure specifications indicating that the workgroup feels that a designated decision maker is a part of best practice, but that it will not be measured/included in the numerator at this time. The measure development workgroup recommended that this measure be considered for use in quality improvement and may be used for the purposes of health care home clinic evaluation and certification processes. **Follow-up After Hospital Discharge** This measure reports the percentage of patients with selected clinical conditions that have a follow-up telephonic/electronic contact within three days of discharge OR a follow-up face-to-face visit with a health care provider (physician, physician assistant, nurse practitioner, nurse, care-coordinator) within seven days of hospital discharge. The denominator includes adult patients who are discharged from the hospital during the measurement period and have one of the following clinical conditions: heart failure, ischemic vascular disease, chronic obstructive pulmonary disease, and/or pneumonia (ages 65 years and older only). Exclusions for this measure include: death during hospital stay, transferred to another acute or transitional care facility after discharge, and hospitalization is observation status (hospital outpatient). During the development process, the workgroup started with a denominator of all patients aged 65 years and older with face-to-face visit. After further thought and discussion, the workgroup decided to narrow the denominator to only those patients with select clinical conditions who are considered most at risk for potentially avoidable readmission. Additionally, the workgroup added the numerator component for telephonic or electronic contact to allow innovation and not drive an increase in costs associated with requiring a face-to-face visit. During pilot, a pneumonia age criterion was added to continue focusing on patients more at risk. The pilot had excellent participation including six medical groups, representing 87 clinics (9,089 patients). The average rate of follow-up after discharge was 70.2%. The range of rates by medical group and clinic demonstrate variability and some

opportunity for improvement. The majority of the patients (80%) meeting the numerator criteria did so with a face-to-face visit within seven days of discharge. Twenty-four percent of patients had a face-to-face visit after telephonic contact. Approximately 20% of patients had only a telephonic/electronic contact within three days. The most frequent interval between discharge and follow-up for face-to-face visits was within two days and within one day for telephonic contact. The average number of days does demonstrate opportunity for improvement (10.4 days for face-to-face visits and 9.5 days for telephonic contact).

The pilot demonstrated the impact of new Joint Commission hospital accreditation rules requiring the transmission of transition of care record within 24 hours of discharge. Medical groups were pleasantly surprised at the sudden turn-around in the timely receipt and the volume of notifications of discharge.

Telephonic encounter types proved difficult for some pilot participants. The use of the telephone encounter within the various EMR's varies significantly and some were not able to delineate actual contacts with patients. The measure will need to include more structure/ definition around what is acceptable to include for telephonic encounters. As a result of this issue, in future submissions, medical groups will need to complete an attestation during the denominator certification process for telephone encounters.

The measure development workgroup recommended that this measure be considered for use in quality improvement and may be used for the purposes of health care home clinic evaluation and certification processes. Due to the potential variability in the denominator based on medical group's ability to capture discharges that they are notified of, the workgroup recommended that this measure not be used for purposes of benchmarking (clinic-to-clinic comparison) for the health care home re-certification process. (The clinic system is not the true source of hospital discharge data). The workgroup felt that this measure had significant merit as a care coordination measure.

For future consideration, in order to have a measure suitable for consideration for accountability or public reporting (for follow-up visits after hospitalization or hospital readmission), the best source of this information is an all payer claims database which contains all hospital discharges and all visits regardless of location.

Questions/Comments/Discussion:

Tim Hernandez asked since this measure development is through a contract with the Minnesota Department of Health (MDH), could MDH theoretically decide to use this measure in a different way or for re-certification. Nathan Hunkins answered that MDH sought the feedback from MARC because of its multi-stakeholder representation, experiences with measurement and for their determination of merit in regards to improvement purposes. The HCH performance measurement committee will also review the pilot results. After this review, the results will be sent out to each HCH clinic to gain more comment around burden and expectations for implementation. It is the HCH program's ultimate decision as to whether or not the measures will be included as part of their evaluation/re-certification process and if they will be recommended to the Commissioner of Health.

David Statin asked if this workgroup will reconvene in a month or so to revise these measures or is this report their final product. Collette answered that this is the workgroup's recommendation for going forward. All of MNCM's new measures will enter into a measure review process with MNCM's subcommittee on an annual basis. Based on Collette's comments, David Statin recommended that next time this measure is under review, the committee should be composed of a geriatric physician and bioethicist (a greater hospice presence). Collette shared MNCM's process step for establishing a balanced and relevant workgroup composition, and his comments will be considered.

Sue Knudson added that the recommendation for Advance Care Planning should be revised to clarify that the workgroup is not recommending this measure for public reporting.

Sue Knudson added, for the Follow-up After Hospital Discharge denominator certification process, would it be reasonable to say "good faith efforts" in the attestation to give the medical group accountability but also knowing the practical issues have to be considered. Collette commented the attestations are outlined in the recommendation, but the phrase "good faith efforts" is not used. This text will be added to the denominator certification process for clarity.

The revised workgroup recommendations are as follows:

1. Advance Care Planning: The measure development workgroup recommended that this measure be considered for use in quality improvement and may be used for the purposes of health care home clinic evaluation and certification processes and is not recommended for public reporting purposes. Documentation of an advance care plan in the patient's chart during the measurement year is required for a patient that is seen in the measurement year.

   David Satin made a motion to accept the workgroup recommendations for the Advance Care Planning measure,

	Sue Knudson seconded the motion. Rahshana Price-Isuk asked if the "patient wishes" component included the situation where the patient states they want everything possibly done for their care. Collette answered that any documentation of a patient wish is acceptable for this measure. **Motion passed.** 2. Follow-up After Hospital Discharge: The measure development workgroup recommended that this measure be considered for use in quality improvement and may be used for the purposes of health care home clinic evaluation and certification processes. Due to the potential variability in the denominator based on medical group's ability to capture discharges that they are notified of, the workgroup recommended that this measure not be used for public reporting and/or purposes of benchmarking (clinic-to-clinic comparison) for the health care home re-certification process. The attestation form used during the denominator certification process will be enhanced to include the good faith effort. Nathan Hunkins further explained that there are two components to benchmarking: clinic-to-clinic comparison and improvement component which looks at trend over time for each clinic site. The workgroup decided that the clinic-to-clinic comparison component is not appropriate here, but the improvement component is appropriate for this measure. **Bill Nersesian made a motion to accept the workgroup recommendations for the Follow-up After Hospital Discharge measure; David Homans seconded the motion. Motion passed.**

Next Meeting: Wednesday, May 14, 2014