MN Community Measurement
Measurement and Reporting Committee
Wednesday, May 14, 2014
Meeting Minutes

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

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed committee members and everyone introduced themselves. Tim 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 April 2014. Caryn McGeary added that she did attend the meeting last month but was a late caller and missed roll call. The notes will be changed to reflect her attendance. **Laura Saliterman made a motion to accept the minutes; Sue Knudson seconded the motion. Motion passed.**
Update: Redesign of MNHealthScores.org (MNCM's Consumer Website)	Tim Hernandez introduced Erin Ghere, MNCM's Manager of Communication and Engagement, who presented background on a plan for MNCM's redesign of *MNHealthScores.org* (MNCM's consumer and public-reporting website). MNCM sought comments from MARC members on the plan to gather end-user feedback for this project. For background, Erin described the two websites run by MNCM and how they differ. The two sites are *MNCM.org* and *MNHealthScores.org*. • *MNCM.org* was redesigned in April 2013 and serves as the main website for providers, industry stakeholders, potential funders/clients, and the media. Visits to this site have more than doubled since the redesign one year ago. • *MNHealthScores.org* is the focus of our conversation today. This is our public reporting site, and the primary audience is health care consumers. The site was originally created in 2009 and has remained largely unchanged since then. It receives about 80,000 visits annually, and that number is steadily climbing. However, while this is a meaningful number of visitors, it's quite modest when compared with the hundreds of thousands of Minnesotans who evaluate their care options each year. MNCM chose to redesign MN HealthScores for multiple reasons. First, it's our primary vehicle for engaging health care consumers with the information we report; however, we're not properly leveraging best practices on consumer engagement to meet that piece of our mission. A significant amount of research has been conducted during the past five years about how to engage health care consumers in their care, and particularly about how to make cost and quality data understandable. Redesigning the website with these strategies and best practices in mind will allow MNCM to make our data more actionable for consumers, and ultimately encourage patients to be more engaged in their care. Second, the growth and depth of MNCM's publicly reported measures is a key driver for the redesign. In 2009, MNCM primarily reported HEDIS quality data at the medical group level. Today, we publicly report 71 measures at clinic, medical group, and hospital levels on quality, cost and patient experience. Additionally, we have more than a dozen new measures that could be publicly reported for the first time over the next year. MNCM needs a website that is scalable to the rapid and continuing growth in the volume, depth and diversity of our publicly-reported measures. Finally, an upgrade in the underlying web technology will increase the content management control that MNCM staff has over the website, which will increase the efficiency of reporting new measures and provide enhanced business continuity. It is also notable that MNCM received funding from the Robert Wood Johnson Foundation through both the Aligning Forces for Quality and Total Cost of Care projects to enhance consumer engagement through the website. The project to redesign MN HealthScores commenced in late 2013 with the selection of a design and development vendor, and work began in earnest early this year. We feel that there are several keys to ensuring the success of the project. First, we selected a company called Pantheon to be our web design and development partner. They have experience with health care data displays, including working on projects with National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ) and other regional health collaboratives like MNCM. It was an important piece of our RFP process and selection to have an experienced partner helping guide us through this process – and not just experienced in web, but experienced in our business.

Second, we conducted literature reviews and market scans to identify best practices we should be following. We have accumulated more than 10 papers from *Health Affairs*, Aligning Forces for Quality, NQF, AHRQ and others that are guiding our design decisions.

The remaining keys to the success of this project are what we would like MARC's input on today. Some time ago, MARC set forth a guiding principle that end users would be involved in the creation of public reporting displays. The primary audience for this website is consumers, but we also know clinics and medical groups use it to view their own results and the results of other medical groups. Thus, our plan to gather that end-user feedback includes gathering both consumer and provider input. Consumer feedback will be gathered through user testing of the site and a focus group-type of format where we can ask broader questions. A report of these findings will be shared with MARC when it's complete. We will gather feedback from clinics and medical groups. Please note that all clinics/medical groups will get a preview of their data on the site before it launches. Additionally, prior to the website launch in September or October, we will make sure providers are aware of the planned changes and the time frame.

As mentioned previously, in the past MARC set out principles to guide the development of data displays for public reporting. Those include using best practices for design and display; actively involving end users in the design creation; and ensuring the validity of our data. As we move forward with this project, we will continue to focus on these guiding principles.

Questions/Comments/Discussion:

Sue Knudson asked if Erin could share the high points from the literature search about presenting health care data to consumers. Erin answered that the most overarching guideline is to not force consumers to think too hard about the data. The data displays need to be designed to be understandable, preferably using words, icons, and colors to make it clear to consumers as to where a clinic/medical group falls in the measure rankings. Specifically research has been performed on how to design an understandable layout for consumers – such as which words resonate with consumers and which do not. Another key note from the research is that when you do make consumers interpret the data and numbers themselves, the consumers often misinterpret it. Research has also been conducted on exactly what types of graphics consumers misinterpret more often than others. For instance, bar graphs are more easily misinterpreted than icons.

Rahshana Price-Isuk asked how consumers/users will be chosen for the website testing. Erin explained that, first, all consumer representatives on our Board of Directors, MARC and other committees will be invited to participate. Second, several MNCM partners who work more closely with consumers, including the American Cancer Society (ACS), have offered to let us work with some of their volunteers to do testing. Finally, through our AF4Q work, MNCM has accumulated a group of consumers that will also be included in the website testing. Our goal is to have about 10 consumers participate in the website testing. Rahshana shared her concern about not including less health care savvy consumers in the testing process. Most of those mentioned are consumers who might be more apt to visit websites similar to MNCM. It is important to include both consumers who are health-focused and those who are not.

Matt Flory clarified that ACS is interested in helping provide consumers from their own list, but would also do general outreach to the community. He agreed that the consumers who participate in ACS programming are more likely to be engaged in and educated about their care, and we should think about how to reach an audience that is less engaged.

Jeff Rank added that MNCM should consider consumers with different education levels for this testing process.

David Satin commented that it will be important to keep in close contact with MNCM's Risk Adjustment committee as the redesign proceeds, since the committee could suggest changes in how rates are reported. Erin answered that Gunnar Nelson at MNCM, who staffs the Risk Adjustment committee, has been part of the redesign project team, and that website will be scalable to whatever future recommendations are made related to risk adjusting data.

Tim Hernandez asked Erin to clarify what the guiding principle of "ensuring the validity of the data" means. Erin answered that there are two aspects of that principle. First, it's critical that the data that is publicly-reported on our website is the same validated results that medical groups review prior to publishing. We have a robust testing process to ensure this is the case. Second, we need to create displays of that data that will be correctly interpreted by consumers. Even if we know that we're reporting valid and accurate data on the website, if we are displaying it in such a way that it is easily misinterpreted, we are doing a disservice. Tim's follow-up question was how MNCM would be able to determine if consumers are interpreting the data correctly. Erin answered that we will learn that through user testing.

Howard Epstein commented on the fact that NQF and ARHQ are using the same vendor for displaying data on their websites as MNCM has chosen. He asked if there is a concern about consumers moving between those sites and MNCM's site, and how similar or different are we designing ours. Will consumers have more difficulty interpreting and comparing the data between

the various websites? Erin answered that MNCM wants to create a design that is similar to these sites, but unique enough that it stands apart. During the redesign process, MNCM and design partner Pantheon have kept in mind the designs of similar health care reporting websites so that MN HealthScores is similar enough as to not confuse consumers who might be comparing information across them but still distinct.

Jim Chase added that since a significant reason for the redesign is the considerable amount of information on the site, and having many different ways to cut it and look at it, our number one priority is to not add confusion. Behind the scenes of the website are the difficult mechanics of uploading and confirming the accuracy of the data. And our challenge is to display multiple dimensions of data in the most accessible, consumer-friendly and easy-to-use way. The research says to not give a menu of data options, but give consumers some guidance on how to interpret it.

Jeff Rank asked how we will get the consumer to understand that there could be no significant difference between rankings such as the top third, middle third, and bottom third. The gaps between these groups are going to shrink over time, so that might not be the right display model choice. Erin agreed that we need to find a way to make the data meaningful to consumers and explain that some rankings are only a tenth of a percent different, which could be insignificant.

David Homans asked what actions MNCM anticipates consumers taking when they visit our website, and to what extent this data might influence a consumer's choice of provider, or a provider to make changes in their practice. He explained that the way the data is displayed might depend on our assumptions of how it will be used. Erin answered that MNCM believes our data is directional. The website will contain both the data and contextual information about how a consumer should use it to be more engaged with their care. Tools will also be provided to help consumers become greater advocates in their own care.

Matt Flory asked if visits to the website came at particular times of the year, or were evenly distributed. Erin responded that visits were fairly well-distributed, but that we see a large increase during the fourth quarter of the year. This is probably due to that being the primary open enrollment period for health plans. Additionally, Erin said that the day that MNCM's patient experience data was released to the public and the two to three days after (during fall 2013) were an all-time high for visits to the site. Matt also asked whether the redesigned site would be ready before fourth quarter, since that's a high traffic period, and how MNCM will drive website visits in the future. Do we want to follow the current trend or do we want to get consumers to come at different times? Erin answered that we're currently on track to launch the redesigned website in September, so it would be functional during open enrollment. Additionally, MNCM will increase its marketing efforts around the website after the launch and will be looking for opportunities to partner with other organizations to increase the community's awareness of MN HealthScores. Jim Chase added that the website also experiences more visits with the release of new data, which will not be the case when we launch the new design in September.

Tim Hernandez asked if Erin knew the percentage of visits from consumers and from providers. Erin explained that while there isn't a way to know for sure, we can make an educated guess based on visits from Google searches and from internet bookmarks. If we assume that visits from bookmarks are most likely providers who are already familiar with MNCM, and visits from Google searches are most likely consumers who aren't aware of or don't visit our site much, it break down to 60% consumers and 40% providers.

Caryn McGeary asked if we can decipher where website visits are coming from geographically (e.g., metro, rural, etc.). Erin answered that we do not know that; Google analytics does not allow for it. Geographic location could possibly be determined by looking at the actual IP addresses that visits are coming from, but MNCM has not done that type of detailed analysis.

Matt Flory commented that it might be beneficial for MNCM to attend the Diabetes Expo in the fall to test out the new website. The expo draws in a large number of diabetic patients to talk to specialists, and many could be interested in MNCM data. The key is to find venues where consumers already are, such as the Labor Health Fair, to test new innovations.

Bill Nersesian added that it might help to have a histogram of each measure's data at the top of the page to show the general distribution of clinics or medical groups for that measure. This could give consumers a visual, intuitive idea of how the data is spread out across medical group/clinic sites. He added that it would also be helpful to have a search function on the histogram to pinpoint where a specific clinic is on the curve compared to others. Jeff Rank agreed that a visual representation of this kind could be very beneficial, and it would also show that some differences between clinic rates are minuscule. Matt Flory added that for consumers who may not understand a histogram, it would be appropriate to add a short summary above or below describing the distribution.

Howard Epstein asked Tina Frontera if there is a plan to show quality, patient experience, and cost measures side-by-side, with an overall 'check mark' or judgment type of visualization across all three, on the website. Tina answered that MNCM will be displaying quality, patient experience, and cost in multiple views on the website; however, an overall 'check mark' or score across all three is not in the process yet. Jim Chase added that MNCM does not have a roll-up of quality scores so a side-by-

	side comparison is tricky, although we could do it with cost and patient experience. One idea would be to prioritize, when people have not selected something, what measure might best represent overall quality in a side-by-side view. We could consider something like the three quality measures that are viewed most often, or that have most variation, to give people multiple views of the data. Howard Epstein asked when consumers are looking up specific quality metrics, would there be an opportunity to incorporate Choosing Wisely recommendations and other patient-facing information for their reference. Erin answered that the website will include that type of patient-centered content from our partners and other programs, such as Choosing Wisely, to help consumers make informed decisions about their care. An update will be brought to the committee in late summer or fall.
Optimal Asthma Care Measure Reporting Plan Update and Additional Considerations	Next, Howard Epstein introduced Jasmine Larson, Minnesota Community Measurement's Manager of Measure Development. Jasmine presented some additional information for MARC to consider regarding the Optimal Asthma Care measure. MARC reviewed the asthma measure in March and made a decision to remove the written asthma management plan component from the composite measure. At that time, MARC did not discuss the impact of that decision on the remaining measure. The intent of this discussion was not to revisit or reconsider the decision made at the March meeting. If the committee determines there are no changes needed to the two component asthma composite measure, there will be no action taken; however, if the committee decides to make modifications on the measure construct, we will need to call for a motion. Jasmine reminded MARC members that they had requested an ad-hoc review of the asthma measure in response to feedback received from the National Quality Forum during MNCM's 2012 submission for measure endorsement. NQF endorsed measures are considered the gold standard for healthcare measurement due to the rigorous and consensus-based review that each measure receives prior to receiving endorsement, and in order to maintain it. NQF endorsement of MNCM measures increases the likelihood of their inclusion in federal programs, which benefits our community by ensuring alignment between local and national quality measurement programs and minimizing burden for providers. NQF endorsement also demonstrates to our community that the measures are evidence-based, valid and in tandem with the delivery of care. Jasmine summarized the factors influencing the future of the existing two-component asthma composite measure, either constructed as-is or by potentially separating the components into stand-alone measures. In the interest of full disclosure, she shared that the asthma measure workgroup did not discuss or consider separating the composite measure for reporting, due to the fact that their recommendation to MARC was to leave the three component composite measure unchanged. In regards to the asthma measure and NQF specifically, while NQF's Steering Committee did not recommend the composite measure for endorsement due to unresolved concerns regarding the written asthma management plan and risk of exacerbations components, the committee enthusiastically supported the asthma control component of the measure, specifically for the reason that it is a patient reported outcome. The Steering Committee encouraged submission of this component as a stand-alone measure; however, due to NQF's requirement that endorsed measures have plans for public reporting or accountability applications of some nature, combined with MNCM not reporting the individual components of the measure, MNCM remains unable to proceed in that direction. It is MNCM's experience from participating as members of NQF Steering Committees that feedback received during previous endorsement submissions weighs heavily in future endorsement applications. The expectation has been that measure developers either make changes to measures based on the feedback, or provide rationale or additional evidence to support the measure remaining unchanged. Additionally, it is worth noting that the patient reported outcome component of this measure has been recommended for inclusion in the ACO Shared Savings program, PQRS, Physician Compare and Value Based Payment Modifier, but pending NQF endorsement of the component. Other asthma measures are under consideration for the federal rule as well; however, the recommending body has expressed a clear preference for MNCM's patient reported outcome. NQF endorsement aside, it is worth considering whether a two component composite measure for asthma control makes sense. Not all chronic conditions are suited to composite performance measures. Other composite measures (such as diabetes and vascular) include multiple intermediate outcomes that are all desired in the optimal management of chronic disease when direct measurement of the disease outcome itself is challenging, whereas the two components of the asthma measure are in fact both direct evaluations of asthma outcomes. Conversely, while separating the composite measure would create one very strong stand-alone measure (control) it would also create one of uncertain strength (risk of exacerbations). The asthma workgroup considered NQF's feedback regarding the risk of exacerbations component and ultimately reached consensus on a recommendation that no changes be made to its construct. Views from both sides of the argument were shared and discussed, but they did reach consensus on their recommendation. Of note, as currently constructed, a composite measure inclusive of this component or this component as a stand-alone measure is unlikely to receive NQF endorsement as previously shared; however, this component is also not currently under consideration for the federal rule.

	Based on suggestions made during MARC's March meeting, MNCM intends to continue collecting data for the Written Asthma Management Plan component as an optional, voluntary process measure as part of the asthma care set of measures. This data would be available to medical groups through the data portal for internal quality improvement activities. **Questions/Comments/Discussion:** Jim Chase added that one of MNCM's goals as an organization is alignment, especially since Medicare is moving rapidly into using measures for value-based purchasing. The measures do not have to become NQF endorsed, but there are benefits to pursuing this. Since there is national interest in using our patient-reported asthma measure (specifically the control component) most notably by Medicare, reporting the two components separately would allow us to be better aligned to what NQF is looking for in an asthma measure. Bill Nersesian reported that NQF had difficulties with ED visits and hospitalizations having the same weight in the measure. Hospitalizations are seen as having more gravitas than ED visits since the patient is considered more ill when they are hospitalized. NQF questioned how MNCM could allow one hospitalization and still categorize the patient's asthma as under control which is what the current definition allows for. Bill suggested changing the measure specifications to state that one hospitalization would remove a patient from the numerator while one ED visit would not. Sue Knudson asked if it is an option to report each of the two individual components as well as the composite measure. Jasmine answered that reporting the two individual component measures and the composite measure is certainly an option for reporting. Sue added that this would not add more burden to providers since this data is already submitted to MNCM. Kris Soegaard commented that Minnesota has been a forward-looking community so we have been a test bed of measure development. It seems like now with an eye to all of these other considerations, we end up having to backtrack. Going forward, these issues need to be taken into consideration at the time the measure is being developed. David Satin agreed with Kris Soegaard's comments and gave the example of the health plans aligning their P4P programs from the ground up. He added that it is unclear how alignment and NQF endorsement fits into whether MNCM reports this measure as a composite or as two separate component measures. Jasmine answered that historically MNCM has not reported the components of this measure. If it is found that the composite measure adds value to our community, then if we were to move any measure forward on a national scene, the composite measure would be the measure to pursue further. On the practical side, we need to have a credible plan for public reporting of a component if we are just bringing a piece of the composite measure through endorsement. Rahshana Price-Isuk added that from a clinical standpoint, she believes that it is appropriate to report the measure components separately. Stefan Gildemeister asked if there is something in the data we collect that can inform our decision on reporting this measure as a composite or by component. Jasmine noted that because the measure is an all-or-none composite, we have data elements provided for both an asthma control score during the measurement year as well as the ED and Hospitalization counts. In 2013, of the 88,000 patient records that we received for this measure, approximately 20,000 were removed from the numerator because they did not have an asthma control score. An additional 20,000 patient records were taken out of the denominator since they did not have the ED and/or hospitalization fields populated. There was an overlap of approximately 8,000 that did not have either an asthma control score or the ED/hospitalization fields populated. That leaves approximately 55,000 patients that had both data fields populated in the data submission. As far as what the individual scores would be with the different potential constructs, Jasmine did not have that data available but would be willing to provide it to the committee if they find value in it. She suggested that both local and national interest should be considered when determining how a measure is reported. She shared that there are other measure development organizations that are planning to submit asthma control measures to NQF knowing that CMS has a high degree of preference for NQF endorsed measures in their national programs. Jim Chase commented that if this measure is reported as a composite, the average score will be lower since the measure is all or nothing. Composite measures tend to highlight where the gaps are at a higher level than component measures. Howard Epstein asked if the decision to use the composite or separate components would impact the spread of performance results between clinics. Jasmine noted that there is more spread in the control component than in the ED/Hospitalization component. David Homans added that there might be confusion for consumers if MNCM does not use the same measure as CMS. Jasmine commented that in the event that CMS includes an asthma measure that is not a MNCM measure, there would be different reporting requirements.

	Stephan Gildemeister added that we need to focus on who our target audience is for this measure when we are deciding on how to report it. He believes composites are easier to interpret for consumers, although providers prefer component reporting since it provides more detail. He added that we should not worry about alignment with CMS until we know what measure they will be using for asthma unless we have enough evidence right now to help inform our decision. We need to look at the data to see how patients are best performing and whether performance on individual component measures inform the patient regarding the care they receive from their provider. Mark Nyman added that we could look at last year's data to see how the spread of data compares for the two reporting format options. He asked if there is a different way to report the data in a composite measure that would satisfy NQF. He suggested recasting last year's data to see if and how the results change. Laura Saliterman added that she believes one of the issues with the asthma measure is that the ACT is asking about a patient's experience over the past four weeks. The tool is looking to see if the patient is in good control based on the physician's efforts. The ED/Hospitalizations component reflects results that may be out of the physician's control (example: acute illness). The ED/Hospitalization component may not be as good of a measure to determine how a provider is performing. She believes there is some value in separating the two components in terms of patients being able to evaluate the quality of care they are receiving from their provider, specifically because it better differentiates between those factors more directly under the provider's control. Jim Chase added that, if possible, MNCM would like to move forward with submitting the control component to NQF for endorsement. There may be other things we can do with the measure in the future related to how we would change the other component but that would take some time and additional committee work, and we need to get back to NQF relatively shortly about this issue. He looked for agreement from MARC that it is ok to report the two components separately for this measure in the same sense that is done for the diabetes measure. The additional question is whether we would also report the asthma composite measure. From NQF's perspective, public reporting doesn't mean we must put both aspects of the measure on the website as the first view. We may still choose to only report the composite, but we need to be able to say that we have results on each component and are willing to share it publicly. Tim Hernandez commented that it was very useful to hear from Jasmine that of the 88,000 in the denominator, we are essentially eliminating almost half of them because there was a data point missing. Of the remaining 54,000 patients that had data elements in all of the required fields, changing the construct of the risk of exacerbation component to not allow for a hospitalization only moved 200 patients out of the numerator. This was not a substantial change. Tim added that as the measure review committee assesses these measures annually, they should review the impact of each component. If the impact is very small and the burden is fairly significant to report this component, we should evaluate the value. Rahshana Price-Isuk commented that she has more patients that are compliant for both the ED and Hospitalization components but their asthma is still out of control. She questioned the utility of this component in her management and adjustment of medications in her office. Sue Knudson added that reporting the component measures offers flexibility in raising the bar locally and nationally. Mark Nyman asked if MNCM will report the process measure of administering the asthma control test. Jasmine answered that it has not been discussed to report a measure of administering the asthma control test. MNCM could consider providing a feedback loop to providers in the data portal about their rates of successful administration of the patient reported outcome tool. Anne Snowden added that this addition would not need MARC approval since it is a quality improvement feedback tool. Mark Nyman why we report the administration of the PHQ-9 for depression and not the administration of the action control test for asthma. Jasmine answered the depression utilization measure is a process measure that has proven utility in demonstrating provider's ability to follow-up with a patient population that is at great risk for falling off the radar and not receiving the follow-up that they need. This measure is endorsed by NQF as a paired measure with the depression outcome measures and is also included in Meaningful Use. Tim Hernandez added that the depression utilization measure is a measure of a clinic's follow up systems whereas with the asthma measure, it may be truly just a point of service outcome measure. David Homans added that it would be interesting to ask the consumers that will participate in the website testing how they feel about reporting this measure as a composite and/or by two component measures. **Jeff Rank made a motion to separate out the two elements of the previous composite asthma measure and publicly report both component measures as well as the composite measure. Matt Flory seconded the motion. Motion passed.** **Meeting adjourned.**

Next Meeting: Wednesday, June 11, 2014