

**MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)**

Wednesday, April 8, 2015

Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Bruce Penner, Caryn McGeary, Chris Norton, Dan Walczak, Dan Trajano, David Homans, David Satin, Jordan Kautz, Kris Soegaard, Laura Saliterman, Mark Sonneborn, Robert Lloyd, Ruth Danielzuk (alternate for Rahshana Price-Isuk), Stefan Gildemeister, Sue Knudson

MNCM Staff: Anne Snowden, Collette Pitzen, Dina Wellbrock, Jasmine Larson, Rachel Mlodzik

Members Absent: Jeff Rank, Matt Flory, Rahshana Price-Isuk, Tamiko Morgan

Topic	Discussion
Welcome & Introductions; Review MARC Charter & COIs	<p>Tim Hernandez welcomed committee members and observers. He reviewed the charter located at the bottom of the agenda. He also extended a special welcome and introduction of new committee members.</p> <p>First, Tim welcomed Jordan Kautz to the committee. Jordan is a physician from Mayo Clinic who will be serving on MARC as a large non-metro medical group representative. He is a faculty member of the Mayo Clinic Quality Academy and is well versed in many quality improvement (QI) methodologies. He will bring the perspective of a clinician as well as an educator in QI efforts in both outpatient and inpatient settings.</p> <p>Next, Tim welcomed Dan Trajano to the committee. Dan is a physician and vice president for population health at Medica. He oversees Medica's quality programs and alternative value-based payment strategies. Previously he worked at Park Nicollet serving as the senior medical director for quality and population health. Dan will serve as one of the committee's health plan representatives.</p> <p>Lastly, Tim welcomed Tamiko Morgan. Tamiko is a physician and chief medical director at Metropolitan Health Plan. She is a board-certified pediatrician and continues to practice one day a week. She is also a new member of the MN Community Measurement Board of Directors. Tamiko will serve as one of the committee's health plan representatives.</p> <p>Tim also welcomed back Kris Soegaard from the Minnesota Health Action Group, who represents purchasers/consumers, and Howard Epstein, MD from PreferredOne, who serves as a health plan representative. Both members had terms that ended last year, but applied for renewal and were found to be the best candidates.</p> <p>Tim reminded everyone that the committee strives to make their meetings and decisions as transparent as possible, but noted that only official MARC members can participate during the meeting discussion. If there are any questions or comments following the meeting, guests can email info@mncm.org.</p> <p>Finally, Tim reminded MARC members that MNCM has a Conflict of Interest (COI) policy for committees and workgroups. All MARC members have received a copy of the policy and have signed and returned the disclosure form. These forms were reviewed by a joint MNCM/Institute for Clinical Systems Improvement (ICSI) COI Review Committee. The committee's charge is to review all COI declarations and make recommendations about the management or mitigation of declared conflicts. The joint committee reviewed the COI forms from MARC members and all members were approved for full participation. Tim thanked everyone for fulfilling this requirement, noting that it is a very important process that supports and maintains our credibility. A handout of all MARC members' disclosures was provided to committee members for full transparency.</p>
Approval of Minutes	The committee reviewed minutes from the November 2014 meeting. Bill Nersesian made a motion to accept; Laura Saliterman seconded the motion. Motion passed.
Action Item: Preliminary Charter of Cancer Care Workgroup	<p>Collette Pitzen from MNCM presented the preliminary charter for the cancer care measure development workgroup. She reminded committee members that Jasmine Larson from MNCM had presented information on the impact of pursuing measure development activities for cancer patients undergoing chemotherapy and/or radiation therapy at the October 2014 meeting. At that time, MARC approved the convening of a measure development workgroup to explore this measure concept with a particular focus on management of symptoms and with a recommendation for using patient reported outcomes.</p> <p>Suggestions made at that meeting by MARC members were incorporated into the workgroup's preliminary charter. The measure development process includes several checkpoints for MARC review and approval; this review of the preliminary charter is one of those points. The measure development workgroup reviews and approves the final charter; if the workgroup recommends significant changes to the scope, those recommendations would come back to MARC for discussion and approval.</p>

Highlights from the preliminary charter included:

- The measures are for oncology practices, a specialty focus;
- The concept for exploration is symptom management during treatment;
- Preference is for outcome measures utilizing patient-reported outcome tools;
- Cancer type/s that are relatively high in volume will be selected for these measures; and,
- Alignment and collaboration with the American Society of Clinical Oncology (ASCO).

It was additionally noted that these measure development activities are funded by MNCM and are not currently included in the Statewide Quality Reporting and Measurement System (SQRMS). However, there is the potential to receive funding for pilot testing of measure(s) developed through the Patient Centered Outcome Research Institute (PCORI) and the opportunity to partner and build on measure development work with the ASCO. These measure(s) will rely on voluntary participation from oncology practices. The cancer care measure development workgroup will be chaired by Nicole Hartung, from Minnesota Oncology and Hematology. The first meeting will be in two weeks.

Questions/Comments/Discussion:

Bill Nersesian asked Collette to provide an example of the type of measure the workgroup might consider. Collette indicated that some preliminary work to review several standardized tools used to capture and quantify symptoms during cancer treatment has been done. Ideally, one of these validated tools could be used to build a performance measure. However, the workgroup has not convened; these reflect decisions that are to be made during the measure development process.

Tim Hernandez asked if MNCM had performed any preliminary queries of oncology practices to determine whether they are interested in developing/participating in this measure, given that it will be voluntary collection. Collette indicated there was an overwhelming response from volunteers interested in participating on the workgroup, and that MNCM is hoping this translates to successful measure development and implementation.

Howard Epstein commented that as much as MARC needs to support patient-reported outcome measures, in general, he thinks there is an opportunity here to look at specific process measures as well - especially around resource utilization and evidence-based medicine. ASCO has strongly endorsed certain over-utilization measures through the *Choosing Wisely* campaign. He suggested adding overuse measures to the scope of the workgroup. Chris Norton asked if this addition would complicate or distract the workgroup's progress in the development of a new measure. Collette indicated that overutilization could be a topic for the workgroup to consider; however, the concept approved in October for this workgroup was very focused on outcomes for symptom management during chemotherapy and/or radiation therapy. Adding other measure concepts, types or data sources could slow the workgroup's process. This additional concept could be part of a second phase or alternate path of development.

Tim Hernandez asked who decides if there should be changes to a workgroup's scope. The preliminary charter is based on both the impact presented to MARC and the discussion of the measure concept that occurs at MARC, so the scope that is the starting point for measure development activities is in MARC's control. Jasmine Larson suggested that in parallel to this, foundational work could be done around the utilization topic to prepare for a potential future or alternate round of measure development. David Satin commented that he believes this suggestion is reasonable, since this would be our first measure development activity with this specialty.

David then asked if there is readily available data on outcomes for these symptoms and the tools utilized. Collette answered that while there is not much in terms of existing measures, there is supportive literature demonstrating the distribution of symptoms with given cancer populations. The workgroup has a large task ahead of them including validating between 10-15 tools to pick the best tool to measure the outcome. Tim Hernandez commented that oncologists will probably feel a bit of culture shock regarding this reporting, similar to how other providers have felt previously. He believes that a utilization measure is an important next step, and suggests informing the workgroup about MARC's thoughts and considerations for the future.

Howard Epstein shared that there could be some opportunity to focus specifically on over-utilization and appropriate testing/treatments with a separate workgroup, or building off of other workgroups' efforts, and that there may be future Robert Wood Johnson Foundation (RWJF) grants for regional improvement related to this topic. Dan Trajano added that there could be another venue to look at over-utilization, claims-based measures, such as the Total Cost of Care database specifically looking at cancer resource utilization.

Chris Norton made a motion to accept the preliminary charter of the Cancer Care workgroup; Dan Trajano seconded the motion. Motion passed.

**Action Item:
Preliminary Slate of
Recommended
Measures for
Statewide Quality
Reporting and
Measurement System
(SQRMS): Physician
Clinics**

Dina Wellbrock from MNMCM presented the preliminary slate of recommended measures for physician clinics for the 2016 Statewide Quality Reporting and Measurement System (SQRMS). These recommendations inform the annual state administrative rule-making process by which measures are selected for required clinic reporting. The cover letter included a timeline of the rule-making process and scheduled milestones. The final slate of measure recommendations for SQRMS will be brought to the June MARC meeting. Dina reminded MARC members that this process is separate from the MNMCM slate of measures for public reporting, which is brought to MARC for review and approval annually in September.

Both slates are informed by the work of MNMCM's Measure Review Committee (MRC), a subcommittee of the MARC. This committee was formed in 2013 to increase stakeholder involvement and transparency of the measure review and maintenance process. Chris Norton is the committee chair, and it is staffed by Jasmine Larson. Other MARC members who are on the MRC include Allan Ross, Caryn McGeary, Dan Trajano, Kris Soegaard, Rashana Price-Isuk, Sue Knudson and Bill Nersesian. The MRC has responsibilities for annual measure review and makes recommendations to MARC regarding next steps. Their recommendations can be one of the following: continue the measure without change; elevate to a higher review; transition to monitoring; or retire a measure.

Dina noted that the MRC recommended continuation of all reviewed measures. There were no measures recommended for evaluation of a higher review, transition to monitoring or retirement at this time. She then reviewed the existing measures and highlighted changes. There are no new measures on the preliminary SQRMS slate for 2016.

The first measure in the preliminary slate was the Optimal Diabetes Care composite measure. The use of a statin was added as a component of this measure, making it again a "D5." The other components remain unchanged.

The Optimal Vascular Care composite measure is following suit with the Diabetes measure. The use of a statin was added as a component of this measure, making it again a "V4." The other components remain unchanged.

The measure specifications for Depression Remission at Six Months remain unchanged from last year. However, a technical adjustment to the measure will be made in 2016. Going forward, any visit with an elevated PHQ-9 result following a patient's 13-month measurement period will also require a diagnosis of depression or dysthymia to be indexed.

Last year, MARC elected to remove the written asthma management plan as a component of the asthma measure. As a result, there are now two components of the Optimal Asthma Control measure:

- 1) well-controlled asthma as measured by the appropriate control tool score and
- 2) patient being at low risk for exacerbations as measured by patient-reported hospitalization/ED visits during the measurement period.

The Colorectal Cancer Screening measure has not changed since last year.

The Maternity Care: Primary C-section measure has not changed since last year.

The Total Knee Replacement measure has not changed since last year. However, it should be noted that the previously approved transition to the PROMIS Global 10 tool will be effective for the 2017 report year.

The spine surgery measures have not changed since last year. However, it should be noted that the previously approved transition to the PROMIS Global 10 tool will be effective for the 2017 report year.

The pediatric preventive care process measures have not changed since last year.

The biannual Patient Experience of Care survey will include the measurement period of September 1, 2016, through November 30, 2016. The survey measures four domains using the recommended CG-CAHPS survey. Only psychiatry specialty practices are excluded. Eligibility for the survey has not changed from last year.

The Health Information Technology survey assesses the phases of adoption, utilization and exchange of information through a clinic's Electronic Health Record (EHR). All clinics are required to complete this web survey annually.

Questions/Comments/Discussion:

Tim Hernandez commented that the MRC was chartered through the MNMCM Board of Directors to discuss the issue of burden since there has been much talk from providers (particularly primary care providers) about working to alleviate some of the measurement burden. As we are adding measures, we need to thoughtfully consider retiring measures too. Tim said he appreciates the good work of the MRC.

Stefan Gildemeister asked how it is decided which measures on the MNMCM slate will also be included on the SQRMS slate. He questioned whether or not there is more opportunity for alignment between the two slates. Jasmine Larson answered that the recommendations each year for the SQRMS slate take into account many factors such as historical decisions and investment of local stakeholders. The inclusion of each measure in various programs, locally and nationally, is part of the information reviewed by the MRC. In the most recent MRC meeting, the depression suite of measures was discussed as far as each individual measure's use in various programs. The recommendation for the SQRMS slate to continue with the Depression Remission at Six Months measure for 2016 reporting is based on local work that is ongoing in the community although national programs include the 12 month measure. However, this does not rule out the possibility of a transition in the future. Stefan further asked if there is a need for both the six and 12 month measures in the SQRMS slate. Jasmine answered that the recommendation for the SQRMS slate to continue only with the Depression Remission at Six Months measure is in part respecting the work of the community and also in consideration of the MRC's discussion regarding the measure set.

Sue Knudson, a member of the MRC, said this issue was discussed during the most recent MRC meeting. The six month depression measures are used consistently by local payers, the MN Department of Health (MDH), Minnesota Bridges to Excellence, etc., while the 12 month measures are adopted into some national programs. In addition, data for the MNMCM depression measures are submitted in one file and the MNMCM Data Portal calculates results for all measures (6 and 12 months); thus, there is no additional burden to data submission for the medical groups. In light of that, the MRC wanted to continue to see if they can get more harmony between national and regional programs. Kris Soegaard added that MRC also discussed that the further out a provider goes with depression treatment, the more likely they will lose patients to follow-up.

Tim Hernandez commented that one of the things to consider is the overall breadth of measures required of primary care physicians, which is another part of burden that is difficult to assess. Every measure seems to have value to somebody. When the measures are considered together, the front-line reality is that providers can only keep so much in their perspective when providing care to patients. Many of these measures require development of robust systems to keep them in the forefront. In other words, we need to consider the big picture and determine which measure(s) could be removed if this is found necessary.

Stefan Gildemeister asked whether the changes to the depression measures will allow tracking of performance over time. Jasmine noted that the technical change will not allow apples-to-apples comparisons to previous years; however, it was felt that this technical improvement is of such value to the measure that it is worth the loss of trending for one year.

Stefan then asked whether or not the collection of race, Hispanic ethnicity, preferred language and country of origin (REL) data should be included in the SQRMS slate. Anne Snowden noted that MNMCM's contract with MDH no longer includes providing recommendations for risk adjustment variables. In addition, she said that recommendations and measure specifications include only the specific data elements required for calculating results for a measure.

Tim Hernandez asked Stefan if he could provide a summary on how MDH handled the asthma recommendations from MARC and the reconciliation process it went through when making its final decision. He noted that, this year, medical groups will still be required to submit data on the asthma action plan, but it will be considered a stand-alone measure. Stefan mentioned that a communication to medical groups went out the previous day regarding this decision. There are still strongly held opinions in the community about whether the asthma action plan is a valid and helpful tool in contributing to improvement. He said we had the unique experience where the asthma workgroup came forward with a recommendation to MARC to retain the asthma action plan, and MARC decided against it. The timeline provided in the MARC packet details the lengthy process of public comments where the Commissioner of Health hears different perspectives on the issue. In the end, the Commissioner's decision to move forward with the asthma action plan as a separate stand-alone measure was based on five factors: an analysis of empirical data indicating asthma control for patients that received an asthma action plan; parallel research by Health Care Homes that seemed to suggest causality in the relationship between the presence of an asthma action plan and asthma control; endorsements at the state and national level for the asthma action plan as part of a set of best practices/guidelines; the Commissioner's review of feedback; and the alignment of the asthma action plan with population health initiatives around reducing disparities. These reasons together resulted in the Commissioner's decision to retain the asthma action plan in the 2015 Administrative Rule.

Laura Saliterman asked if there was any consideration of segmenting the stand-alone asthma action plan measure by age category (adult vs. pediatric). Stefan said the data did not show significant differences between the effects of the asthma action plan on the two age categories. That being said, he believes that it would be beneficial to explore whether the asthma action plan is more effective for a specific population.

David Satin asked why OBGYN was listed under the required specialties for Colorectal Cancer Screening measure. Jasmine Larson answered that there are OBGYNs that are primary care providers for women. David then asked why OBGYNs are not required to report for the Depression Remission at Six Months measure. Collette answered that OBGYNs have the option to report for this measure, but it is not required. David Homans commented there has been ample work on postpartum

depression and suggested that at some point MARC discuss whether it is appropriate to include this type of depression in this measure. He added that screening is done on pregnant women, and providers try to predict whether some medications will have negative effects on postpartum mothers. Tim Hernandez commented that from an ICD-9 standpoint, postpartum depression has a different code than general depression. Anne Snowden commented that this type of depression is not part of the current specifications. Howard Epstein commented that there is an issue of general screening of the OBGYN population. Postpartum depression is unique and no less important, but it has a different clinical course that may not be appropriate for inclusion in a major depressive disorder measure. Tim followed by saying that this depression measure is an improvement measure. If an OBGYN did not manage a patient's depression, then he believes it is not appropriate to measure them. Dan Trajano agreed with the point, and said he believes some OBGYNs are treating general depression which could be teased out from postpartum depression. If OBGYNs are responsible for reporting under the Colorectal Cancer Screening measure, he questions why they would not be responsible for reporting under the depression measure too. Ann Robinow agreed and commented that if research was done on the percentage of patients prescribe SSRIs by provider type, OBGYNs would have a high percentage compared to other provider types. Howard asked Jasmine if this discussion would be brought back to the depression workgroup. Jasmine answered that we could certainly engage in a discussion with the workgroup chair since there is not a full workgroup active right now. Jasmine indicated that we would look at the history of decisions around the depression measure and discuss the issue with the workgroup chair between now and the final SQRMS slate.

Sue Knudson commented that during the last MRC meeting, the different age category requirements for this colorectal cancer screening were discussed. According to guidelines, colorectal cancer screening for African Americans and American Indians should start at age 45. She noted that many organizations are already running their internal measures this way. MRC did not address the issue during this round of review, but it will be discussed in future meetings. Howard commented that, in parallel to this conversation, he believes NCQA has taken this same approach with HEDIS measures. In other words, NCQA is continuing to evaluate this issue for their Colorectal Cancer Screening measure, and the measure will remain at age 50 for all populations.

David Satin commented that in the future, the colorectal cancer screening measure could be segmented into more than one measure based on screening requirements; that we would not need to risk adjust by REL but instead use stratification. Anne Snowden commented that our Colorectal Cancer Screening measure is a direct adaptation of the HEDIS colorectal cancer screening measure. NCQA has not made a move towards this change. It would be more difficult for them to do so since their data is claims-based, and to date the health plans are not collecting REL data in a standard way. That said, Anne said MNMCM will contact NCQA about the possibility of revising their Colorectal Cancer Screening HEDIS measure to include stratification by age and race. At some point MNMCM could steer in a different direction, but we are currently aligned with NCQA's measure.

Laura Saliterman commented that MNMCM's Risk Adjustment Committee is making huge strides and will have recommendations for MARC that may impact some of this discussion. She believes at this point, MARC should wait and see what the Risk Adjustment Committee brings forward. Anne Snowden added that MNMCM is in the process of studying the impact of REL data elements on risk adjustment. Whether results will be risk adjusted using REL data is still to be determined.

David Homans commented that Park Nicollet defined what primary care meant in their organization, and the OBGYN specialty elected not to be primary care by their definition. Bill Nersesian commented that his organization talked to many OBGYNs about this issue as they were deciding whether to become an Accountable Care Organization because primary care doctors have patients attributed to them and can only be listed under one network, whereas other specialists do not have patients attributed to them and can be listed in multiple networks. The OBGYNs seemed to like it both ways. His organization reimburses primary care providers higher in ACO because they do more work. It also seems that there is a slight difference between rural and metro area OBGYNs. There is more competition in the metro area and the majority of the OBGYNs seem to practice some primary care. In rural areas where an OBGYN can be the only one within 20-30 miles, they mostly practice just their specialty. He suggested keeping things simple.

Dan Trajano commented that the discussion should be framed around whether or not OBGYNs provide the primary treatment for depression and not around if they should be considered primary care providers. He believes OBGYNs do provide this care in many cases. He would strongly advocate that MARC considers adding them to this measure. Jasmine Larson said this discussion will be taken back to the workgroup chair.

Dan Walczak made a motion to accept the preliminary slate of recommended measures for SQRMS; Sue Knudson seconded the motion. Motion passed.

Meeting Adjournment

Howard Epstein thanked everyone for attending the meeting and informed them that the next meeting will occur on Wednesday, May 13. Meeting adjourned.

Next Meeting: Wednesday, May 13, 2015