MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, November 11, 2015
Meeting Minutes

Members Present: Howard Epstein, Bill Nersesian, Dan Walczak, David Satin, Laura Saliterman, Bruce Penner, Chris Norton, Mark Sonneborn, Jeff Rank, Robert Lloyd, Sue Knudson, Peter Dehnel, Tamiko Morgan, Jordan Kautz, Caryn McGeary, Kris Soegaard, Allan Ross, Matt Flory, David Homans **Alternates:** Ruth Danielzuk, Denise McCabe
MNCM Staff: Anne Snowden, Gunnar Nelson, Collette Pitzen, Amy Krier, Tina Frontera
Members Absent: Tim Hernandez, Ann Robinow, Rahshana Price-Isuk, Stefan Gildemeister, Dan Trajano

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. Howard reviewed the agenda.
Approval of Minutes	The committee reviewed minutes from the October 2015 meeting. **Chris Norton made a motion to accept the minutes; Bill Nersesian seconded the motion. Motion passed.**
Recommendation on risk adjustment variables and segmentation for three Orthopedic measures – For Approval	Howard introduced the recommendation on risk adjustment variables and segmentation for three Orthopedic measures. He noted that this recommendation was coming from the Risk Adjustment and Segmentation Committee and that MARC had approved the public reporting of the three orthopedic outcome measures last month. Howard introduced Gunnar Nelson, MNCM Health Economist, to present the agenda item. Gunnar started by explaining that risk adjustment is based on idea that patients do not all have the same level of risk and clinics do not all have the same types of patients. He detailed the three measures that are included in the proposed risk adjustment plan: • Average Change in Functional Status for Lumbar Discectomy/Laminotomy • Average Change in Functional Status for Lumbar Fusion • Average Change in Functional Status for Total Knee Replacement – primary only These measures evaluate Average Change in Functional Status and not the attainment of a goal or a percentage of change. For example, if a patient's functional status score pre-operatively was a 25 and post-operatively is a 35, the change is 10. There is a maximum functional status, so there is an upper limit on average change. Gunnar clarified that these measures are NOT a measure of appropriateness. If the patient's initial functional status score is already high, it is assumed that there are still valid reasons for the surgery. Gunnar additionally noted that, as with all MNCM quality measure risk adjustment, it is Actual to Expected methodology, where the actual result, in this case the Average Change In Functional Status, does not change. Instead, a fair comparison is created and in this case, a regression model is used. Using the framework for selection of risk adjustment variables that MARC approved last month, the Risk Adjustment and Segmentation Committee evaluated all possible risk variables recommended by the Measure Development Committee. These included the standard set such as insurance product, age, gender; as well as variables specific to these measures such as initial functional status, smoking status and BMI. The framework requires that the data show empirical evidence of impact, logical clinical connection and a differential between medical groups. Unlike the previous measures the Risk Adjustment and Segmentation Committee have reviewed for potential risk adjustment, the three Orthopedic measures have relatively low sample sizes (patients who had both a pre-operative and post-operative administration of functional status tools): 2,300 for total knee replacement, 880 for lumbar fusion and 750 for lumbar discectomy/laminotomy. Based on these sample sizes, the Risk Adjustment and Segmentation Committee took a conservative approach and recommended the use of initial functional status as the sole risk adjustment variable for all three measures. The committee also recommended a re-evaluation of all variables next year using two years of data to determine if other variables would be appropriate to add in the future. For these measures, there are noticeable differences in the distribution of initial functional status of patients by medical group. The Risk Adjustment and Segmentation Committee felt that the distribution itself may be useful information for consumers and therefore also recommended publishing results segmented by initial functional status, along with volumes, so that consumers can be informed on how providers perform for patients like themselves. **<u>Questions/Comments/Discussion</u>**

	Referring to the small sample sizes, Bill Nersesian noted that not all Orthopedic practices are reporting their patients. Jeff Rank asked how many knee procedures are done in the state. Collette Pitzen responded that, thanks to additional data from Mark Sonneborn, she could confirm that approximately 15,000 knee replacement procedures are conducted in our state each year. Gunnar asked David Satin if he had anything to add to the discussion as chair of the Risk Adjustment and Segmentation Committee. David commented that Gunnar had covered all pertinent information but noted that if there was ever a case for segmentation, this is it. Peter Dehnel commented that he found it surprising that the only variable that had significance was the initial functional status. Jeff noted that other variables may not show enough variation between providers to be of significance. David Homans expressed curiosity as to why BMI did not show enough empirical evidence to be included in the recommendation. David Satin explained that there could be multiple reasons why; however, it is difficult to fully discern as it isn't explained by the data yet. Perhaps with larger sample sizes it can be explained in the future. Bill inquired as to the consideration of Race, Ethnicity, Language and Country of Origin (REL) factors. Gunnar explained that Orthopedic practices aren't as advanced as primary care practices with the collection and submission of those data elements, so those elements aren't reliably available for consideration. Chris Norton inquired as to what could be or is being done to encourage Orthopedic groups to submit data for these measures. Howard noted that it had only been a month since this topic was first discussed at the last MARC meeting but asked if MNCM staff had any input. Tina Frontera stated that MNCM is exploring options, though it is becoming evident that addressing non-reporting practices on the public reporting website is more complicated than it may seem. Tina said that MNCM would be able to share a more detailed plan in early 2016. Chris wondered if it would be beneficial to approach the leadership from these practices for discussion. Jeff noted that there isn't much by way of reporting incentives for these practices, mostly financial, and that isn't something that this group has at their disposal. Peter noted there may be a way to build in incentives from an insurance payer standpoint, though it would need to be a much broader discussion and a joint effort of the health plans. Sue Knudson said she felt that using appropriate language on the public reporting website to draw attention to practices that did not report would give payers more information to align incentives and that the process needs to be a collective effort. Sue additionally commented that there is a need to address this sooner than later. David Satin commented he felt this might be a Board level discussion and he urged them to use whatever levers they could to encourage participation. Kris Soegaard asked whether MARC as a committee could write a letter to the leadership of these practices. Anne commented that MNCM will consider an appropriate strategy, in lieu of MDH's compliance role and will determine ways to work together. Allan Ross asked whether there have been discussions with the practices that are not reporting. Anne commented that a few years ago when these measures were still in development, MNCM hosted a community conversation with several Orthopedic practices and the Board around why health care measurement is important for specialty groups. Further discussion is needed to determine the right approach with these specific orthopedic groups. David Homans expressed concern that, if compliance is not addressed now, there could be additional problems down the road with the introduction of additional specialty measures. **Chris Norton made a motion to approve the risk adjustment recommendation for the three Orthopedic measures as presented; Sue Knudson seconded the motion. Motion passed.**
Action Item: MNCM Slate of Measures for Reporting in 2016	Howard reminded the committee that MARC reviews the Slate of Measures for Reporting each year to make note of any changes to the measurement specifications that may occur in the coming year as well as to approve the entire slate for the next reporting year. MARC has already discussed and approved most of the information in the slate during previous conversations earlier in the year. Howard then introduced Anne Snowden, MNCM Director of Performance Measurement and Reporting, to share results of the Measure Review Committee meetings and walk through each item on the slate. **<u>Quality Measures</u>** Anne began with an overview of MNCM's Measure Review Process and shared results from the Measure Review Committee (MRC) meetings. In November 2013, MARC approved the formation of the MRC as an enhancement to MNCM's measure review process. The committee allows for increased stakeholder participation/influence and transparency/awareness of the review process. The MRC's purpose is to annually review the DDS and HEDIS measures on the MNCM slate to ensure their collection and reporting continue to be of value to the community. Limited resources are available for collecting data, measuring performance and reporting performance results; therefore, it is important to weigh the potential impact of reporting with the associated burden. While the MRC is not under the directive to retire measures that continue to be of value, retirement is explicitly considered for each measure during review.

Recommendations within the MRC's scope are to:

- Continue the measure
- Recommend further review and/or redesign of the measure
- Remove the measure from public reporting, but continue to monitor (collect and report privately)
- Retire the measure, using the following criteria:
    - Loss of measure validity
    - Loss of opportunity for improvement
    - Evidence of undesirable consequences of implementation
    - Replacement by a superior measure

Anne acknowledged the members of the MRC who also serve on MARC: Chris Norton, chair; Dan Trajano; Sue Knudsen; Rahshana Price-Isuk; Bill Nersesian; Caryn McGeary; Kris Soegaard; Allan Ross.

Anne directed MARC to review the handout containing the MNCM measures that were recommended for public reporting in 2016. The slate is arranged to more visually reflect our measurement framework, which is aligned with the National Quality Strategy and IOM's quality domains and which was reviewed and discussed at the September MARC meeting.

Clinical Measures

Anne led the review of the slate by category:

Healthy People and Healthy Communities –

The MRC reviewed six measures in this category and recommended continuation of all those reviewed. Additionally, none of these measures have changes to the specifications. The measures include: Breast Cancer Screening, Childhood Immunization Status (Combo 3), Cervical Cancer Screening, Colorectal Cancer Screening, Chlamydia Screening in Women and Immunizations for Adolescents. Not reviewed by the MRC were the Adolescent Depression/Mental Health Screening and Pediatric Overweight Counseling measures, which were new in 2015 and previously approved by MARC for implementation.

Better Care – Effective and Reliable –

Within this section, all measures are continuing as last year. Of note, there are changes to the Depression Care measure suite due to the change in indexing criteria, as well as the Optimal Diabetes Care and Optimal Vascular Care measures due to the new statin use component. Finally, the new Cancer Care measure is in development and measure specifications will be brought to MARC in December for approval to move into pilot.

Better Care – Communication and Care Coordination –

There were no changes to the HIT survey for 2016 reporting.

Better Care – Patient Centered –

Anne reminded the committee that Patient Experience is an "every other year" measure. For results publicly reported in 2015, the 12-month CG-CAHPS survey was implemented. For 2016, MNCM recommends use of the CG-CAHPS 3.0 survey and will continue to report four domains: Access, Provider Communication, Courteous and Helpful Office Staff, and Rating of Provider. The 3.0 survey uses a six-month reference period instead of a 12 month reference. In addition, the 3.0 survey is shorter – two of the four domains (Access and Provider Communication) have fewer questions and won't be comparable. There will also be a 5th domain – Care Coordination composite (3 questions). The new domain composite was created by taking two questions from the core survey and one question from the PCMH version. The number of survey questions went from 34 to 31. One of the most important reasons for moving to the 3.0 survey is to align with CMS and reduce the burden of having different surveys in the field.

Better Care – Appropriateness –

In this category, the MRC reviewed and recommended continuation of all active measures with the qualification for MNCM to explore opportunities for better aligning the Maternity Care measure with other C-Section measures. Anne noted that both AHRQ and the Joint Commission have maternity measures for reporting; MNCM's measure is currently aligned with the Joint Commission.

Affordability –

The MRC recommended continuing with Total Cost of Care and Average Unit Price in 2016. Anne noted that Gunnar will be bringing an update on the cost measure suite to MARC in December, which will also include Relative Resource Use.

Hospital Measures

	Anne stated that MARC previously approved the proposed slate of hospital measures for SQRMS; however, a change in MNCM's current contract with MDH meant the Hospital Reporting Steering Committee (convened by Stratis Health), a multi-stakeholder committee that includes hospital representatives, is now solely responsible for reviewing and approving the proposed hospital measures for SQRMS. MARC continues to have responsibility for approving MNCM's entire slate of measures for public reporting, which includes both ambulatory and hospital measures. In general, the hospital measures recommended for public reporting by MNCM in 2016 are those not already publicly available on Medicare's Hospital Compare website and are a subset of the hospital measures recommended for SQRMS. **Retired Measures** Anne concluded her presentation by identifying measures that have been retired (e.g., ASC measures, Use of Appropriate Medications for People with Asthma), as well as measures that were moved off the slate because there are no current plans for data collection or submission or the measure development concept had been withdrawn (e.g., Optimal Risk Reduction, Colonoscopy Quality). **Questions/Comments/Discussion** David Satin asked for a refresher on the status of asthma measure after MARC voted to remove the Asthma Management Plan component from the composite measure. Anne relayed that MDH chose to include the Asthma Management Plan in SQRMS as a stand-alone measure. As the contractor, MNCM continued to collect those data in 2015 and supply MDH with any data required under the contract. However, MNCM is not publicly reporting the results of the stand-alone asthma measure. Jeff Rank noted the small number of measures under Better Care – Appropriateness. He inquired whether there was any exploration happening in terms of additional measures. Anne explained that the primary care community has voiced concerns about the addition of new measures. Jeff noted the availability of specialty measures that could be considered. Tina noted that the development of a Relative Resource Use measure, considered a Utilization measure not an Appropriateness measure, is getting close and Gunnar will present a recommendation to MARC in December. Howard stated that some providers were evaluating some of the Choosing Wisely recommendations which could fall under Appropriateness so they could have some broader support. David Satin noted that the LOWN Institute also does good work which could be researched. Sue Knudson commented that the article from *The New Yorker* ("Overkill", Atul Gawande, May 2015) that referenced the CMS study of over-use areas addresses a lot of the same topics. Jeff stated that his practice collects data on the appropriateness of their procedures and noted that he felt it wasn't difficult to do. Dan Walczak noted that, from a health plan perspective, some of the topics they are interested in are behavioral health, physical medicine, radiation/oncology, as well as orthopedics. He feels there is room for expansion into those areas. **Matt Flory made a motion to approve MNCM's Slate of Measures for Reporting in 2016 as presented; Chris Norton seconded the motion. Motion passed.**
MNCM REL Reporting Plan Update and Proposed Revisions to Recommendations – For Approval	Howard again introduced Anne to present an update on and proposed revisions to the Race, Ethnicity and Language (REL) Reporting Plan that MARC previously approved in 2013. Anne began the presentation by summarizing the proposed REL Reporting Plan revisions for MARC consideration: • Public reporting of medical group level results by Race, Hispanic Ethnicity, Preferred Language and Country of Origin for specific DDS measures with proposed timelines. • Stratification and public reporting of statewide rates by race and Hispanic ethnicity for the four Patient Experience of Care domains in 2015; regional rates by race only. Anne reminded the committee of the history behind MNCM's REL data collection and reporting: • The effort to collect and validate race, Hispanic ethnicity, preferred language and country of origin (REL) data elements as part of the ambulatory clinical quality measures is a MNCM initiative. It has been a priority for more than seven years and is reflected in MNCM's vision statement: "MNCM will drive change that improves health, patient experience, cost and equity of care for everyone in our community." • This updated plan focuses on measures that use data submitted directly from clinics and now includes patient experience; it does not pertain to the HEDIS measures. • MARC approved the original REL Reporting Plan in 2011 and an update in 2013. Some key milestones were noted in the evolution of the REL Reporting Plan: • The REL Handbook was developed in 2009 as a guide for medical groups in the collection of REL data. • Groups were asked to voluntarily collect and submit these data in 2010 along with the clinical data, with submission becoming a MNCM requirement in 2011. • MNCM has been validating the collection process utilized for these data to ensure data were collected following best practices.

Anne summarized activities that have occurred since the plan was approved by MARC two years ago:

- In 2013, MNCM offered private medical group charts through the MNCM Data Portal to medical groups following Best Practice; MNCM didn't stratify results at a statewide level because the threshold of at least 60% of groups following Best Practice hadn't been met.
- In 2014, the reporting threshold was met and MNCM moved forward with statewide and regional results stratified by REL for five measures. This information was provided in MNCM's first-ever *Health Equity of Care Report*. MNCM also continued to provide private REL charts to medical groups.

Going forward, MNCM proposes the following revisions to the plan:

- In 2015, continuation of private medical group REL charts for those groups following best practices; public reporting at statewide and regional levels; with the addition of medical group level reporting.
    - Medical group level reporting will follow the same reporting rules already in place for other measures:
        - Results will be displayed from high to low
        - Minimum patient count thresholds must be met for reporting (i.e., 30 patients per race/ethnicity/language/COO by reportable entity)
        - Results will be displayed with confidence levels
        - For information to be displayed in a chart, there must be at least nine to ten entities meeting the minimum patient count threshold for a given REL/measure category.
        - This information will be explained in the methods section of the *Health Equity of Care Report*. Additionally, tables in the back of the report will include reportable medical groups by REL category. This will allow transparency of all reportable groups regardless of whether a chart is created.
- Also in 2015, Race and Hispanic ethnicity will be reported at the statewide level for patient experience, as those data elements are collected through the survey. Each of the four domains will be reported for a total of eight charts. For example, for the "Access to Care" Domain, statewide results will be reported by race category. For regional results, each of the four domains will be reported but only for race. Counts are too small for the Hispanic ethnicity by region. Displays will mirror the clinical measures.
- In 2016, the two Pediatric Preventive Care measures will be added to the reporting plan.
- In 2017, MNCM proposes adding three six-month depression measures; and evaluating the inclusion of 12 month depression measures. Additionally, evaluating medical group level reporting for patient experience survey results.

Anne noted that the Depression measures are not introduced to the plan until 2017 because of the technical changes in the measure being implemented in 2016. Additionally, the Maternity Care measure is not included in the reporting plan because the Measure Review Committee recommended that measure for re-evaluation, so it is prudent to wait until that is completed to consider its inclusion in the REL reporting plan.

Anne stated that public reporting of the REL segmented results will be in the annual *Health Equity of Care Report* and not on the consumer-facing website. She also mentioned that the Risk Adjustment and Segmentation Committee will be studying REL as a variable for potential use in risk adjustment in 2016.

Questions/Comments/Discussion

Jeff Rank asked how the *Health Equity of Care Report* is disseminated. Anne responded that the report is posted on MNCM's corporate website (mncm.org) and shared with the community at large.

Chris Norton asked how often patients are asked to provide this data when they visit a clinic. Anne indicated that generally patients are only asked once, but if a practice has made changes to their collection process or procedures, the patient may need to be asked again. Sue Kundson noted two instances, staff training and technical systems, where changes may result in the need for a patient to be asked for the information more than once.

David Satin noted that the *Health Equity of Care Report* got more attention than the regular *Health Care Quality Report* last year and said it was actually used as a teaching tool in the University of Minnesota's medical school. He also commented that the Risk Adjustment and Segmentation Committee is in the very early stages of looking at this, but in principle supports the work.

David Homans commented that, in terms of this data as well as patient reported outcome measures, this committee needs to begin to consider patient burden in data collection.

David Satin asked whether there would be risk adjustment of this data within the segmentation. Anne stated there would not be risk adjustment within the segments.

	Peter Dehnel asked what the barriers to collection of REL data have been up to this point. Anne commented that EMRs were not programmed consistently to capture the selection of more than one race. Additionally, it has taken groups time to adopt the collection and reporting of these data. Mark Sonneborn asked for clarification on how the data will be presented, particularly whether there would be analyses to compare one REL category against another within a medical group (the measure rate result for white patients compared to Asian patients within the same medical group). Anne noted that these comparisons are available to medical groups in the MNCM Data Portal. While these comparisons would not be directly depicted in the report, the charts in the report would show the medical group rates by category compared to the overall statewide average for the measure as well as the statewide average for the specific category. Tamiko Morgan commented that she thinks this is great work, is excited about it and thinks it is another step toward understanding disparities and increasing equity. Kris Soegaard asked for confirmation that the data would be reported at the medical group level. Anne confirmed that and added that evaluation was done on reporting at the clinic level, but it was determined that the population counts were not sufficient to meet reliability standards. David Satin expressed concern that without risk adjustment, medical groups serving a poorer population of a certain racial group compared to medical groups serving a wealthier population of the same racial group could appear to be employing racist practices. Howard Epstein stated that those factors can be explained in report form. He agreed that it is a sensitive topic and that we don't currently have all the answers, but concurred with Tamiko that it is important work and it is evident the amount of work that has gone into this reporting. He added that hopefully this data will help the community have these difficult conversations about disparities as it is already starting to inform public policy. David Satin commented that he's in support of the project but would like the report to explain that we know the "what" of the data, but not the "why" of disparities. Jeff and Tina commented that finding the "why" of disparities is why it is important for the Risk Adjustment and Segmentation Committee to address REL segmentation. Anne commented that there is always a give and take around risk adjustment and segmentation; that it is important to call out disparities where they exist so they can be addressed and juxtaposed with the provider view of fairness and leveling the playing field. Finding a balance between those two issues, particularly when dealing with an issue as sensitive as race and ethnicity, is very difficult. David Homans noted that this isn't just about being fair to medical groups; but is also about avoiding punitive repercussions incurred by this data so thoughtfully framing the data is important. Matt Flory asked if most groups were following Best Practice for collection of these data elements. Anne stated that the majority of groups, in the high 70%s, are following Best Practice. Howard commented that REL data collection being a part of Meaningful Use and HIT adoption has helped encourage implementation. Ruth Danielzuk asked whether community entities have been engaged in this process. Anne commented that during the work on the first *Health Equity of Care Report,* MNCM had reached out to Voices for Racial Justice but they were helping MDH with its Equity Report and therefore didn't have the resources to assist MNCM as well. MNCM also engaged people who were part of patient advisory committees for ICSI and medical groups as well as members of the Board and MARC that have been doing disparities work. Ruth commented that the Minnesota Association of Community Health Centers is open to supporting the work being done by MNCM. **Jeff Rank made a motion to approve MNCM's REL Reporting Plan and the Proposed Revisions to Recommendations as presented; Chris Norton seconded the motion. Motion passed.**
Meeting Adjournment	Howard Epstein reminded MARC members that the next MARC meeting will be Wednesday, December 9.

Next Meeting: Wednesday, December 9, 2015