MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, November 14, 2018
Meeting Minutes

Members Present: Barb Anderson, Janet Avery, Joe Bianco, Cara Broich, Karolina Craft, Howard Epstein, Matt Flory, Sue Gentilli, Greg Hanley, Jordan Kautz, Sue Knudson, Deb Krause, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jonathan Rose, Allan Ross, Laura Saliterman, David Satin, Mark Sonneborn, Dan Trajano, Jesse Wheeler
Absent: Stefan Gildemeister, Tim Hernandez
Alternate:
MNCM Staff: Jess Amo, Liz Cinqueonce, Gunnar Nelson, Collette Pitzen, Anne Snowden, Julie Sonier, Dina Wellbrock

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. MARC members introduced themselves followed by the meeting observers.
Approval of Minutes	The committee reviewed minutes from the May 2018 meeting. Howard Epstein asked for comments on the minutes. No comments were made. **Bill Nersesian made a motion to accept the minutes; Mark Sonneborn seconded the motion. Motion passed.**
Update on MNCM's new mission statement	Howard Epstein provided an update on MNCM's new mission statement. The Board of Directors met in October 2018 to discuss the new mission statement. Howard explained the importance of revisiting an organization's mission, vision and value to ensure that it reflects the work being done within the organization. Working with a consulting agency and stakeholders around the community, a new mission statement was crafted and was unanimously approved by the board at the October meeting. The previous mission statement was "The mission of MN Community Measurement is to accelerate the improvement of health by publicly reporting healthcare information." While the previous mission statement captured the essence and purpose of MNCM at the time, the evolution of the organization called for a new mission statement. The new mission statement is "MN Community Measurement empowers health care decision makers with meaningful data to drive improvement." The board also discussed and agreed upon the Commitments to the Community: • Be a primary trusted source for health data sharing and measurement • Collaborate with our community to prioritize measures that matter most • Drive change that improves health, patient experience, cost and equity of care for everyone • Be a transparent resource for providers and patients to improve care • Partners with others to use our information to catalyze significant improvements in health • Innovate to provide meaningful data to health care decision makers • Provide national leadership in the development of measurement best practices **<u>Questions/Comments/Discussion</u>** Julie Sonier shared background on why MNCM decided to change the mission statement. While MNCM has not changed what they are doing, the primary reason for the change is to better engage stakeholders around the community who are not currently participating in the discussion. Rahshana Price-Isuk expressed support for new mission statement and said it will appeal to a broader audience.
Cost and Utilization Measures/MNCM Risk Adjustment Committee	Howard introduced Gunnar Nelson, MNCM's Health Economist, to present an update on the Cost and Utilization measures and Risk-Adjustment. A new cost report will be available on November 27 and Gunnar shared that the overall rate of healthcare cost went up 2%, which was expected based on inflation. The cost reports now have hospital outpatient locations included with radiology costs. overall total cost of care is about $575 per patient per month, after adjustment of risk and outliers. In terms of the distribution, the mode is slightly below the mean; however, it is not a clean, bell-shaped curve because there are not many medical groups below the average. Currently, cost is rated based on one standard deviation from the mean (below average, average, above average); however, the shape of the distribution makes it difficult to determine significance compared to the average. In the next year, MNCM will be looking into ways to better determine significance. While the current method is mathematically correct, it is not as useful as it could be.

	Gunnar then shared updates on Episodes of Care for the 2019 Cost and Utilization measures. Episodes of Care represent the cost of care for a chronic disease (e.g., diabetes) through a year of care or from the initial diagnosis of an acute illness (e.g., ear ache) through resolving the diagnosis. MNCM will be working with 4 health plans in 2019 to ensure data uniformity, attribution and value of Episodes of Care. Overutilization measures (e.g., Star and NCQA measures) are also being discussed. Gunnar went on to discuss risk-adjustment using zip code-level socioeconomic variables. Deprivation index (patient zip code-level) was added to risk adjustment for the 2018 measures. Based on patient zip code, MNCM used the U.S. Census Bureau to find percent of households using SNAP benefits, living under poverty level, unemployed, public assistance and single female with children. The impact of using deprivation index provided more accurate expectations to clinics, resulting in more accurate rating on MNHealthScores. The deprivation index had the biggest impact on clinics in the Colorectal Cancer Screening measure, with approximately 10% of clinics receiving a different MNHealthScore. MNCM is also studying full address to see if it makes an even larger impact on ratings; however, more to come from that analysis. **Questions/Comments/Discussion** Dan Trajano asked if Gunnar had a sense of why spine MRIs are more expensive within clinics compared to hospitals. Gunnar shared that he has observed that the more complicated the procedure, the more likely it is that hospitals are either on par with the clinic rate or better than the clinic rate. Dan inquired if risk-adjusters do not work well with tertiary care, which is why it is expected that they have high resource use. David Satin commented that it is known that risk-adjustment formulas typically do not work well at the edges – the sickest people tend to be underestimated. Sue Knudson suggested that the TAG group meet to talk about the value in Episodes of Care before beginning work and that risk-adjustment methods for tertiary care also be discussed at the next TAG meeting. Julie commented that at the policy level there is a lot of interest in price transparency and added that Episodes of Care will bring value and interest at both the consumer and the policy level. Sue agreed. Howard asked how consumers would use this information because of its complexity. Gunnar explained that it is used for rating on MNHealthScores (below average, average, above average). David added that consumers would only see a single expected rate and wouldn't see what goes into calculating that rate. Greg Hanley asked if using the full address will impact the lens of the Health Equity Report. Gunnar commented that it would not impact this year, but MNCM is looking into using it with the Health Equity Report as well. Anne added that the Health Equity Advisory Council had encouraged MNCM to look at full address.
Update on Patient Experience	Howard introduced Dina Wellbrock, MNCM's Manager of Engagement and Development Programs, to give an update on Patient Experience (PE) measures. In 2017, legislation was passed that prohibited MDH from requiring a third-party vendor for data collection for any quality measure included in the SQRMS program. Due to that legislation, MDH removed PE from the 2018 Rule. In late 2017, MARC members expressed interest in exploring whether the measure could still be reported on a voluntary basis. MNCM added PE questions to the Annual Medical Group Survey, sent Spring 2018. These questions asked medical groups if PE data was still being collected on their behalf and inquired if the medical group would consider participating in future PE data submission to MNCM if burden was minimal. The results of the survey showed that 80% of respondents indicated they are continuing to collect PE data and 66% of those respondents indicated that they would consider voluntary submission. MNCM looked at the 2016 statewide PE cycle and noted that there were two survey vendors that held approximately 75% of contracts with medical groups. MNCM conducted an inventory with three vendors to learn what is being collected and to explore survey/question content, timing of survey distribution to visit, sampling and modes of distribution. Upon review of the inventory, it was discovered that widespread variation occurs across three survey vendors in terms of content, timing and distribution. Based on this review, MNCM's assessment is that there does not seem to be an opportunity at this time to gather standardized Patient Experience data for public reporting. **Questions/Comments/Discussion** Dan Trajano asked about the rationale behind the legislation. Dina commented that financial burden was likely the primary reason because each medical group had to contract with a survey vendor to collect patient experience data, which was associated with costs. Julie agreed that financial reasons contributed to the decision and added that that

	area of the legislation did not have much public discussion. Bill added that the measure was originally set up to help patients determine which clinic had the best patient satisfaction; however, patients did not tend to use this information to make decisions and, instead, would ask people within their social circles for recommendations. Howard also added that the information was not particularly useful for physicians and the clinics because the requirement for collection and reporting was every-other-year, making it difficult to address changes quickly. Sue Knudson thanked Dina and the team for this exploratory work on patient experience measures.
Measure Alignment Efforts with WCHQ	Bill introduced Anne Snowden, MNCM's Director of Performance Measurement and Reporting, to provide an update on measure alignment with the Wisconsin Collaborative for Healthcare Quality (WCHQ). WCHQ is MNCM's sister organization in Wisconsin. Measure alignment is an MNCM strategic priority to reduce burden. MNCM has made strides to align with organizations at the national level. For example, MNCM has fully aligned with NCQA's Colorectal Cancer Screening measure: QPP #113. Additionally, MNCM has partnered with NCQA to expand MNCM's depression measures suite to include adolescents, which will begin during the 2020 report year. And MNCM currently has 11 measures included in federal programs. At the regional level, MNCM is currently discussing alignment opportunities with WCHQ. WCHQ uses both HEDIS and MNCM measures and will sometimes tweak the specifications slightly, which makes the measures incomparable. achieving measure alignment will be particularly helpful for organizations operating in both states. MNCM met with WCHQ in July 2018 to discuss future alignment efforts. MNCM and WCHQ agreed to focus alignment efforts on three measures. The first is Colorectal Cancer Screening, which is an NCQA measure. MNCM shared with WCHQ what was done in Minnesota to achieve alignment with NCQA's measure. The other two measures were the Optimal Diabetes Care and Optimal Vascular Care measures, which are both NQF-endorsed. In terms of differences, WCHQ is currently using the old visit counting method for both measures, while MNCM is using the new established patient criteria and diagnosis on the active problem list. MNCM also has a more extensive list for statin and aspirin/antiplatelet numerator exceptions. WCHQ's staff and committees support the concept of alignment and will review the measures with a final decision expected by the end of 2018. **Questions/Comments/Discussion** Bill asked why MNCM started with Wisconsin for regional alignment efforts. Anne explained that some of the large health care organizations in our community have clinics in both Minnesota and Wisconsin. These organizations have expressed strong interest in measure alignment to assist them with enterprise and community comparability. Dan agreed that alignment is important and that MNCM has an important voice to influence national measurement. As an example of this influence, Anne noted that MNCM provided feedback to NCQA regarding the need to add specific preventive service CPT codes to the Colorectal Cancer Screening measure value set. Based on MNCM's feedback, NCQA agreed to include those CPT codes in their value set for this measure.
MNCM's Current/Future Patient Reported Outcome Measures	Bill introduced Collette Pitzen, MNCM's Clinical Measure Developer, to discuss current and future patient report outcome (PRO) measures. PRO measures collect information directly from the patient without alteration or interpretation from the provider. Some measure constructs work better with PRO tools (e.g., function, pain, symptoms), while others fit better with clinical variables (e.g., weight, blood pressure). PROM is the validated measure tool, while PROM-PMs are the measures that are built from the PROM. MNCM currently has 7 PROM-PM populations: depression, asthma, spine fusion, spine discectomy/laminotomy, total knee replacement, depression screening, symptom control during chemotherapy. Within those measures, there are 18 outcome measures and 8 supporting process measures. Process measures illustrate the rate at which the tool is being administered to the appropriate patient population. Seven of the measures are NQF-endorsed and 11 measures are in CMS's QPP program. The Depression suite has 4 outcome measures; remission and response at six and twelve months. There are also 3 supporting process measures. Several measures are NQF-endorsed and included in QPP (ACO, e-CQM, and MIPS) and SQRMS. The PRO tools that are used for the measure are the PHQ-9 and the PHQ-9M. The PHQ-9 is validated for screening, diagnosis and outcomes. The PHQ-9M is a slight modification (three words) of the tool for adolescents. The Depression suite has gone through redesign to incorporate adolescents in the measures. With the inclusion of adolescents, the PHQ-9M was added as a tool; however, it's important to note that there is no restriction of tool by age and medical groups can choose which tool(s) they use for their population. Other changes include exclusions and the expansion of the follow-up window to +/- 60 days. Due to the longitudinal nature of the measure, these changes will be reflected in the 2020 report year.

	The asthma measure is a composite outcome measure, consisting of a control component as determined by the PRO tool and patient-reported hospitalizations/ER visits. The measure is stratified by adults and children and includes the following PRO tools: ACT, C-ACT, ACQ and ATAQ. The measure is currently included in the QPP-MIPS and SQRMS programs. This is an example of a PRO-based target measure with more than one approved tool. There are no changes planned for this measure. The lumbar spine measures have two populations – discectomy/laminotomy and fusion. These measures are currently constructed as an average change from pre- to post-op status for functional status, pain and quality of life. There are 10 outcome measures and 12 supporting process measures. The functional status measure is NQF-endorsed with a plan of submitting the other measures for endorsement after redesign. 6 of the measures are included in the QPP-MIPS and SQRMS programs. The PRO tools that are used for these measures are the ODI, VAS Pain Scale and PROMIS-10. These measures are currently in redesign and a workgroup meeting is scheduled for November 28, 2018. MNCM received feedback from CMS and noted that it can be difficult to create a benchmark from an average change measure and recommended consideration of a target-based measure which can also remedy issues related to missing assessments/ denominator self-selection. Additionally, the workgroup will discuss expanding the disc/lami denominator and the usability of the quality of life tool in day to day clinical practice. If the workgroup reaches consensus, changes to the fusion measure could occur in the 2019 report since it is merely a re-calculation and does not require any changes to the denominator. However, with potential expansion of the disc/lami denominator, changes may not occur until the 2021 report year. The total knee replacement (TKR) measure has two populations – primary and revision TKR and measures patient outcomes at two points in time – 3-month post-op and 1-year post-op. There are 6 outcome measures and 6 supporting measures. The function status measure is NQF-endorsed and is included in the QPP-MIPS and SQRMS programs. The current PRO tools that are used are OKS and PROMIS-10. A workgroup will be convening in early 2019 to discuss moving towards a target-based measure, retiring the 3-month measures and usability of the quality of life tool. If the workgroup reaches consensus of a pure target-based measure, there is opportunity for consideration of inclusion of additional tools like the KOOS Jr. tool. The KOOS Jr. tool, not available at the time of the workgroup's selection of functional status tool in 2010, is currently used in the Joint-Commission Accreditation Program. These changes do occur, they will not come into effect until the 2020 or 2021 report year. The adolescent mental health/depression screening is an adaptation CMS's Screening for Clinical Depression and Follow-Up Plan. The adaptation is to allow for mental health screening as well as depression screening. This measure includes adolescents aged 12 – 17 and is a process measure (screen and record results). The measure is included in SQRMS and no changes are anticipated for this measure. There are currently 12 tools that are included in the measure; however, only 6 tools are used. 43% of tools used are the PHQ-9/PHQ-9M tools. The Symptom Control During Chemotherapy measure is based on symptoms of nausea, pain and constipation. The measure contains 3 outcome measures and 1 supporting process measure. This measure will begin reporting during the 2020 report year. MNCM plans to submit the measure to CMS for the QPP and seek NQF endorsement. The PRO tool that is used for the measure is the National Cancer Institute's PRO-CTCAE tool. Each question is validated individually, which allows for selection of questions of specific symptoms. **Questions/Comments/Discussion** Sue Knudson asked if the workgroup will be vetting the impact of adding the KOOS Jr. to the TKR measure for risk-adjustment and comparison if different tools are used. Collette noted that it would not be different than the risk-adjustment that is done for the asthma measure, which is based on the results from the different tool. Sue also suggested giving regular updates on any changes to measures so that medical groups can begin implementing new tools in preparation. Anne added that if the KOOS Jr. is added as a tool for TKR, it wouldn't replace the OKS – it would merely include medical groups that are using the KOOS Jr.
Meeting Adjournment	**The next meeting is Wednesday, December 12.** Bill also announced that he will be stepping down from Fairview at the end of the year and will no longer be a co-chair for MARC. Bill expressed his appreciation for the committee and thanked the committee for their work. Howard thanked him for his work and his years of service. Howard adjourned the meeting.

Next Meeting: Wednesday, December 12