DATE: June 11, 2014

TO: Denise McCabe
Quality Reform Implementation Supervisor, Health Economics Program
Minnesota Department of Health (MDH)

FROM: Dina Wellbrock
Project Manager
Minnesota Community Measurement (MNCM)

RE: 2015 Report Year, Final Recommendations
Statewide Quality Reporting and Measurement System

Please find attached the Final Slate of Proposed Measures for Physician Clinics and Hospitals that MNCM is recommending for the 2015 Statewide Quality Reporting and Measurement System (SQRMS). Delivery of these final recommendations for both physician clinic and hospitals is in accordance with II.A.1 through II.A.5 of the contract. Per II.A.1: All measures included in the Final Slates are to be publicly reported.

The preliminary recommendations for the physician clinic slate of measures were presented and approved by the MNCM's Measurement and Reporting Committee (MARC) on Wednesday, April 9; and the final recommendations for physician clinic measures were presented and approved by MARC today (the June MARC minutes will be forthcoming), per II.A.3.

Stratis Health, in collaboration with the Minnesota Hospital Association, convened the Hospital Quality Reporting Steering Committee (HQRSC) on May 19. The HQRSC, which is the designated body to identify hospital measure recommendations per II.A.3, finalized its recommendations to MNCM regarding hospital measures for SQRMS. Stratis Health prepared a formal report (enclosed) that recommends removal of the following two measures from the Critical Access Hospitals (CAH) slate of measures for SQRMS:

- AMI 7a – Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI 8a – Timing of receipt of primary Percutaneous Coronary Intervention (PCI) from the slate of measures for CAH hospitals.
  *Once the CMS rule is final, make any needed changes for PPS hospitals as part of a technical correction at a later date.

(Other measures have been removed as "active" based on prior decisions by CMS.)

While MNCM is mindful of the eight recommendation criteria (degree of impact, improvability, etc.) throughout a measure's lifecycle, the discussion of conclusions related to these criteria is appropriate for new measure recommendations and major measure redesign resulting in significant change relevant to these criteria. In recommending measure modifications for Optimal Diabetes Care, Optimal Vascular Care and Optimal Asthma Care, MNCM considered clinical research findings and evidence, as outlined in our contract (II.A.4). Since clinical research findings and evidence are the only "applicable aforementioned criteria" (II.A.5.i) for this year's recommended changes, and these recommendations have little to no bearing on the additional recommendation criteria, an analysis of the eight recommendation criteria is not warranted at this time.

Please see the summary attachments for these three measures: "Cholesterol Components for Diabetes and Vascular Measures 4-15-14", "Asthma Measure Update", and "Asthma Workgroup Lit Review Summary".

Other quality measures were not considered at this time (II.A.5).

The enclosures listed below support the final recommendations and information presented in this memo.

Enclosures:

1. 2015 Final Slate of Proposed Measures for Physician Clinics
2. 2015 Final Slate of Proposed Measures for Hospitals
3. Approved April 2014 MARC minutes
4. Approved June 2014 MARC minutes –(to be sent)
5. Hospital Quality Reporting Steering Committee: Phase II report for the Hospital Measure Recommendations for 2015, with Appendices A – F, zipped file.
6. Cholesterol Components for Diabetes and Vascular Measures 4-15-14
7. Asthma Measure Update
8. Asthma Workgroup Lit Review Summary

Minnesota Statewide Quality Reporting and Measurement System
Final Slate of Proposed Measures for **Physician Clinics**
2015 Report Year

Existing Measures

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Optimal Diabetes Care Composite: ***NQF# 0729*** ***Percent of patients with diabetes that are well-controlled*** • HbA1c (less than 8 percent) • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use if patient has diagnosis of IVD (or valid contraindication to aspirin documented if patient has IVD) • Documented tobacco free *Clinics will continue to submit LDL values in preparation for potential 2015 LDL component redesign; however, the cholesterol component will not be included in the numerator calculation for 2015 report year.	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Endocrinology	Collecting mid January 2015 to mid February 2015 on dates of service: January 1, 2014 through December 31, 2014. Data Source: MNCM	Numerator: number of patients in denominator who meet all 4 components of HbA1c, blood pressure, daily aspirin use, tobacco free during dates of service. Denominator: Adults age 18 to 75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with a diabetes ICD-9 code, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age ○ 18-25 ○ 26-50 ○ 51-65 ○ 66-75 • Diabetes Type ○ Type 1 ○ Type 2

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Optimal Vascular Care Composite: ***NQF# 0076*** ***Percent of patients with vascular disease that are well controlled*** • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use or valid contraindication to aspirin documented • Documented tobacco free *Clinics will continue to submit LDL values in preparation for potential 2015 LDL component redesign; however, the cholesterol component will not be included in the numerator calculation for 2015 report year.	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Cardiology	Collecting mid January 2015 to mid February 2015 on dates of service: January 1, 2014 through December 31, 2014. Data Source: MNCM	Numerator: number of patients in denominator who meet 3 components of blood pressure, daily aspirin use, tobacco free during dates of service. Denominator: Adults age 18 to 75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an IVD ICD-9 code, seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age ○ 18-25 ○ 26-50 ○ 51-65 ○ 66-75

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Depression Remission at 6 Months: ***NQF# 0711*** ***Percent of patients with depression that are in remission*** • Patients with major depression or dysthymia and an initial PHQ-9 score > nine whose PHQ-9 score at six months is less than 5.	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Psychiatry • Licensed Behavioral Health (if physician on site)	Collecting February 2015 on index dates: July 1, 2013 through June 30, 2014, allowing for 6 month (+/- 30 days) follow-up contact. Data Source: MNCM	Numerator: number of patients in denominator who have a PHQ-9 score less than 5 at 6 months (+/- 30 days). Denominator: Adults age 18 and older with patient visits or contacts during the measurement period with Diagnosis of Major Depression or Dysthymia, whose initial PHQ-9 score is > 9.	• Initial PHQ-9 severity bands ○ Moderate (10-14) ○ Moderately severe (15-19) ○ Severe (20 and above) • Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age ○ 18-25 ○ 26-50 ○ 51-65 ○ 66+

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Optimal Asthma Control Composite ***Percent of patients with asthma that are well controlled*** • Asthma is well controlled as demonstrated by specified assessment tools • Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months)	• Family Medicine • General Practice • Internal Medicine • Pediatrics • Allergy/Immunology • Pulmonology	Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015. Data Source: MNCM	Numerator: number of patients with asthma well controlled and not at risk for future exacerbations. Denominator: Patient ages 5 to 17 or 18 to 50, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years with visits coded with an asthma ICD-9 code, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Colorectal Cancer Screening ***Percent of patients current on colorectal cancer screening*** • Patients with colorectal cancer screening (allowable screens: colonoscopy within 10 years, sigmoidoscopy within 5 years, FOBT or FIT within the reporting period)	• Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Obstetrics /Gynecology	Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015. Data Source: MNCM	Numerator: number of patients in denominator with colorectal cancer screening. Denominator: Adults ages 50 to75, seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the prior 2 years for any reason, and seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the prior 12 months for any reason.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age ○ 51-65 ○ 66-75

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Maternity Care- Primary C-Section Rate • Percentage of cesarean deliveries for first births *All clinics part of a medical group in which the medical group has providers who perform C-sections*	• Family Medicine • General Practice • Obstetrics/Gyn • Perinatology	Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015. Data Source: MNCM	Numerator: number of patients in denominator who had a cesarean delivery. Denominator: All live, singleton, vertex, term (≥ 37 weeks gestation) deliveries to nulliparous women performed by a medical clinic site during measurement period.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age ○ 17 and under ○ 18-20 ○ 21-25 ○ 26-30 ○ 31-35 ○ 36 and older
Patient Experience of Care Survey topics cover: • Getting care when needed / access to care • Communication • Helpfulness of office staff • Providers with an exceptional rating CG-CAHPS Clinician and Group 12-Month Survey **Measure is required every other year*	• All specialties except Psychiatry	Collecting October, 2014 to February 20, 2015. Dates of service to survey: September 1, 2014 through November 30, 2014. Sample should be sufficient to achieve a 0.70 reliability threshold; sample size calculation based on provider-scaling/clinic size according to CAHPS protocol. Data Source: MNCM	Question summary rollup into survey domains of access to care, provider communication, helpfulness of office staff, and provider rating. All patients ages 18 and older with a face-to-face visit at the clinic during the timeframe, are eligible for inclusion in the survey regardless of: • Physician specialty • Reason for visit • Duration of patient/physician relationship	Survey responses to: • Self-reported health status • Age • Education

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Health Information Technology Survey • Survey topics cover adoption of HIT, use of HIT, exchange of information, and on-line services See attached MN Ambulatory Clinic HIT Survey for complete list of questions	All Specialties	Collecting February 15, 2015 to March 15, 2015 on current HIT status. Data Source: MNCM	Question summary rollup into survey domains of adoption, utilization, and exchange of EMR data.	Not applicable – data reported as descriptive statistics only

New Measures*

*Measures in pilot testing or in the first year of implementation.

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Total Knee Replacement: ***Average change of functional status and quality of life for total knee replacement patients*** • Average post-operative functional status at one year post-operatively measured by the Oxford Knee Score tool. • Average post-operative quality of life at one year post-operatively measured using the specified health related quality of life tool.	• Orthopedic Surgery	Collecting mid April 2015 to mid May 2015 on dates of procedure: January 1, 2013 through December 31, 2013. Data Source: MNCM	Numerator: functional status (or quality of life) score at one year of patients in denominator. Denominator: pre-operative functional status (or quality of life) of adult patients age 18 and older with no upper age limit undergoing a primary total knee replacement or a revision total knee replacement during the required dates of procedure.	• Insurance Product Type: ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Body mass index (BMI) • Tobacco Status

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2015 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment

Spine Surgery:
• Average change in post-operative functional status, pain and quality of life at three months post operatively for patients undergoing lumbar discectomy/ laminotomy with a diagnosis of disc herniation as measured by the following tools: Oswestry Disability Index (ODI), Visual analog pain scale (VAS), and specified health related quality of life tool
• Average change in post-operative functional status, pain and quality of life at one year post operatively for patients undergoing any level of lumbar spinal fusion as measured by the following tools: Oswestry Disability Index (ODI) tool, Visual analog pain scale (VAS), and specified health related quality of life tool
	• Orthopedic Surgery
	• Neurosurgery
		Collecting mid April 2015 to mid May 2015 on dates of procedure: January 1, 2013 through December 31, 2013.
		
		Data Source: MNCM
			Discectomy/laminotomy:
			Numerator: The average change in the pre- to post-operative functional status, pain, and quality of life for denominator patients at 3 months.
			Denominator: Adult patients age 18 and older with no upper age limit undergoing a lumbar discectomy/ laminotomy procedure for a diagnosis of disc herniation with the date of procedure occurring within a fixed measurement period.
			Lumbar Spinal Fusion:
			Numerator: The average change in the pre- to post-operative functional status, pain, and quality of life for denominator patients at one year.
			Denominator: Adult patients age 18 and older with no upper age limit undergoing any level of lumbar spinal fusion with a date of procedure occurring with a fixed measurement period.
				Potential risk adjustment variables; dependent on model performance
				• Insurance Product Type:
				  ○ Commercial
				  ○ Medicare
				  ○ MN Government Programs and Self-pay / Uninsured
				• Body mass index (BMI)
				• Tobacco Status
				• Prior Back Surgery
				• Clinical Condition/Reason for Procedure [lumbar fusion patients only]
				
				Tentative based on pilot testing results.

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Final Slate of Proposed Measures for **Physician Clinics**
2015 Report Year

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening • Patient has a mental health and/or depression screening using specified assessment tools documented in medical record *Clinics that provide well-child visit services*	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting mid April 2015 to mid May 2015 on dates of service: January 1, 2014 through December 31, 2014. Data Source: MNCM	Numerator: number of patients in denominator with a mental health and/or depression screening documented. Denominator: Patients ages 12 to 17, seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.	N/A
Pediatric Preventive Care: Obesity/BMI & Counseling • Patient with a BMI percentile ≥85% has documentation of both physical activity and nutrition discussion, counseling or referral documented in the medical record *Clinics that provide well-child visit services*	• Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine	Collecting mid April 2015 to mid May 2015 on dates of service: January 1, 2014 through December 31, 2014. Data Source: MNCM	Numerator: number of patients in denominator with physical activity and nutrition counseling documented. Denominator: patients ages 3 to 17 with a BMI percentile ≥ 85%, seen by an eligible provider in an eligible specialty face-to-face at least once for a well-child visit during the prior 12 months.	N/A

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

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

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

MN Community MEASUREMENT
Measure Up To Better Health

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Broadway Place East, #455 • 3433 Broadway Street NE • Minneapolis, MN 55413

Date: April 16, 2014

Re: Cholesterol Components of Optimal Diabetes Care (ODC) and Optimal Vascular Care (OVC) Measures
Ad-Hoc Review Measure Development Work Group
Plans to Address New Cholesterol Guidelines

From: Beth Averbeck, MD. MNCM Work Group Chair/ Health Partners Medical Group/ MNCM Board
Collette Pitzen, MNCM Clinical Measure Developer

Summary of Plan Approved by Measurement and Reporting Committee (MARC) 4/9/2014

1. **2014 Report Year**
   - Dates of service 1/1/2013 to 12/31/2013
   - Report current measures without changes; include component LDL < 100
   - Rationale is that for 11 months of the year, the standard of practice was treating to an LDL target of < 100

2. **2015 Report Year**
   - Dates of service 1/1/2014 to 12/31/2014
   - Cholesterol component temporarily removed from numerator calculation of both measures
   - Continue to collect LDL values and date as part of the submission in preparation for the new cholesterol component as this data element could be needed to determine appropriate statin use. Patients with an LDL < 70 may not need to take a statin to reduce their cardiovascular risk.
   - ODC measure will be based on 4 components (A1c < 8.0 ▪ BP < 140/90 ▪ Tobacco Free ▪ Daily Aspirin)
   - OVC measure will be based on 3 components (BP < 140/90 ▪ Tobacco Free ▪ Daily Aspirin)

3. **2016 Report Year**
   - Dates of service 1/1/2015 to 12/31/2015
   - Plan for new cholesterol component for both measures that is focused on statin use

4. **Measure development activities for redesign of a cholesterol component**
   - Measure development work group to continue discussion for the design of a cholesterol measure following ICSI Diabetes guideline revision and release anticipated July 31, 2014. Development to align with guidelines where possible and where measurement is feasible.
   - Work group will expand its original scope to include the vascular measure cholesterol component and will enhance the composition of members with 1-2 more cardiologists. Goal is to have cholesterol components aligned across measures.

Background:
In September 2013, MARC requested a diabetes measure development work group ad-hoc review of the cholesterol component based on ongoing comments received to consider modification of the LDL component to "LDL < 100 or patient is on a statin". As work group member recruitment proceeded, the advent of the long-

awaited updated guidelines[1,2] necessitated a more extensive consideration for revision of the cholesterol/ lipid target component.

The measure development work group met in March to discuss the new guidelines and determine the future direction for the cholesterol/ lipid component of MNCM's diabetes measure. After thoughtful consideration of new guidelines that focus on statin use and discourage targeting treatment to achieve certain cholesterol levels, the work group concluded that cholesterol management for the reduction of cardiovascular risk was too important to remove completely from the composite measure aimed at reducing modifiable risk factors. The group is proposing to move forward with a redesign of this component in a thoughtful, staged approach.

What Can Medical Groups Do to Plan for Anticipated Changes?

Please understand that the measure development work group's discussion and decisions are a work in progress concluding in a recommendation due to MARC this fall. Groups have inquired what they can do to help prepare for any potential data submission related to changes.

Suggestions based on preliminary measure discussions:

1. Review EMR medication/ order system to identify the defined statin drug list; be prepared for the following data elements for submission:
   - Explore your system's medication prescribing (order) to anticipate mapping a statin drug name for future submission. Current list of statins (ACC/AHA November 2013) includes the following:

▪ Atorvastin	▪ Lovastatin	▪ Rosuvastin
▪ Fluvastatin	▪ Pitavastin	▪ Simvastatin
▪ Fluvastatin XL	▪ Pravastatin	

   - Date of the most recent order (prescription) for statin
   - Patient's daily prescribed dose in milligrams (in a separate field)
     - Dose/ level of statin may or may not be part of the final measure construct
2. Think about potential ways to capture defined contraindications especially for statin allergy, intolerance or drug-drug interaction as these contraindications are not definable by diagnosis codes and will rely on EMR based fields. Please note that there is additional definition that will occur based on later guideline release in 2014. The current thoughts around contra-indications are subject to change following the measure development work group's review and measure design occurring in 2014.

If you have any questions, please feel free to contact MN Community Measurement at support@mncm.org.

[1] American College of Cardiology/ American Heart Association Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults November 12,2013

[2] ATPIII, the Adult Treatment Panel for the Detection, Evaluation and of High Blood Cholesterol had not released an update since 2004. The National Heart Lung Blood Institute transitioned the responsibility for guideline development to the American College of Cardiology and the American Heart Association.

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

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

The recommendations for the diabetes measure are as follows:

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

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

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

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

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

Questions/Comments/Discussion:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions/Comments/Discussion:

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

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

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

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

The revised workgroup recommendations are as follows:

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

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

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

Next Meeting: Wednesday, May 14, 2014

Optimal Asthma Care

The Minnesota Department of Health and MN Community Measurement work closely together to conduct a community input process to help select and update measures that are used in the Statewide Quality Reporting and Measurement System.

The measure review process

MNCM and MDH strive to continually assess the value of quality measures utilized by the community and stakeholders. The process relies heavily on empirical evidence and community input as we consider changes to measure specifications. This process is directed by MNCM's Measurement and Reporting Committee (MARC), a subcommittee of our Board of Directors, and is supported by measure-specific development workgroups. MARC and the workgroups are made up of a broad spectrum of stakeholders, including physicians, health plans, consumers, purchasers, data analysts, and quality improvement professionals. MARC considers recommendations from measure development workgroups and has the ultimate responsibility of making decisions regarding measure specifications and reporting requirements.

Recent changes to asthma measurement

In the fall of 2013, the MARC commissioned an advisory committee to review the Optimal Asthma Care measure and make recommendations for potential changes. There has been a strong divide in the community concerning the inclusion of the written asthma management plan in the measure. After much discussion, the advisory committee recommended to the MARC that the asthma plan should continue to be included in the Optimal Asthma Care Measure. In March 2014, MARC reviewed recommendations from the workgroup and considered empirical evidence and the data collection burden before deciding to remove the written asthma management plan component from the Optimal Asthma Care composite measure. The MARC and the workgroup process allowed diverse perspectives to be heard and carefully considered before arriving at this decision. While everyone in the community may not agree with each decision of the MARC, we believe this transparent, multi-stakeholder process allows us to have an aligned set of measures that everyone can use which benefits patients, providers and the community.

MARC's decision to remove the written asthma management plan component from the composite measure is in no way an indication that the asthma plan is not an important activity to perform in clinical practice. Rather, the decision is a commitment to ensure that quality measurement reporting has a strong basis in empirical evidence with a preference for measuring outcomes, as those are the reasons patients seek care and why providers deliver care. Process measures offer greater value in aiding quality improvement activities, and MNCM may offer the written asthma management plan component as an optional stand-alone measure for providers to use to support those internal efforts.

Next steps

MARC's recommendations will be forwarded to the MNCM Board of Directors for approval and considered by MDH during the rule making process for mandatory reporting in the Statewide Quality Reporting and Measurement System (SQRMS).

OPTIMAL ASTHMA CARE WORKGROUP

Written Management Plan Literature Review

Summary

January 2014

Please review the materials below and contact Jasmine Larson at 612-746-4514 or jlarson@mncm.org for comments, suggestions and ideas for improvement.

Search Strategy:

- Cochrane Database: Asthma AND (wap OR waap OR aap OR written OR plan); 2002 – present (January 15, 2014); Systematic Reviews, Trials: 650 records returned; 3 relevant records
- PubMed: Asthma AND (wap OR waap OR aap OR written OR plan); 2007 – present (January 15, 2014); Clinical Trials, Meta-Analysis, Randomized Control Trials, Research Support, Review, Systematic Reviews; Human subjects; English only: 404 records returned; 10 relevant records

LITERATURE REGARDING WRITTEN MANAGEMENT PLANS				
Abbreviation	Conclusion	Title	Authors	Publication
Bohgal (2006)	The evidence suggests that symptom based WAP are superior to peak flow WAP for preventing acute care visits although there is insufficient data to firmly concluded whether the observed superiority is conferred by greater adherence to the monitoring strategy, earlier identification of onset of deteriorations, higher threshold for presentation to acute care settings, or the specific treatment recommendations. We did not find any trial examining the benefit of providing versus not providing a written action plan to children with asthma. [Systematic Review]	Written action plans for asthma in children	Bhogal SK, Zemek RL, Ducharme F	Cochrane Database Syst Rev, 2006; 3: CD005306.
Burrill (2009)	Whilst there is good evidence for [written asthma management plans] in adults (grade A), evidence is lacking in children and worryingly hospitalisations may be increased in those receiving written management plans. [Review]	Towards evidence based medicine for paediatricians. Do written asthma action plans reduce hospital admissions?	Burrill R, Carroll W	Arch Dis Child; Sep 2009;94(9):742-3
Ducharme (2011)	Provision of a written action plan significantly increased patient adherence to inhaled and oral corticosteroids and asthma control and physicians' recommendation for maintenance fluticasone and medical follow-up, supporting its independent value in the acute-care setting. [Randomized Control Trial]	Written action plan in pediatric emergency room improves asthma prescribing, adherence, and control	Ducharme F, Zemek R, Chalut D, et al	Am J Respir Crit Care Med, Vol 183 pp 195-203, 2011
Fassl (2012)	Implementation of the asthma CPM (care process model) was associated with improved compliance with CAC-3 and with a delayed, yet significant and sustained decrease in hospital asthma readmission rates, validating CAC-3 as a quality measure. Due to high baseline compliance, CAC-1 and CAC-2 are of questionable value as quality measures. [Research Support, Observational Study] Note: CAC-1: Children's Asthma Care measure: %age of patients who received beta agonists CAC-2: Children's Asthma Care measure: %age of patients who received systemic steroids CAC-3: Children's Asthma Care measure: %age of patients discharged with a home management plan of care, inclusive of: quick reliever and controller, follow-up appointment, trigger control, written action plan.	The Joint Commission Children's Asthma Care Quality Measures and asthma readmissions	Fassl B, Nkoy F, Stone B, et al	Pediatrics, 2012; 130:482-491

FitzGerald (2010)	All patients should receive a structured education program emphasizing the need for ongoing maintenance treatment, even when control is achieved. Patients should also be provided with a written action plan that clearly explains which additional anti-inflammatory therapy should be taken if asthma symptoms worsen. [Review]	Achieving asthma control in patients with moderate disease	FitzGerald M, Shahidi N	J Allergy Clin Immunol 2010; 125:307-11
Gibson (2002)	Education in asthma self-management which involves self-monitoring by either peak expiratory flow or symptoms, couple with regular medical review and a written action plan improves health outcomes for adults with asthma. Training programmes that enable people to adjust their medication using a written action plan appear to be more effective than other forms of asthma self-management. [Systematic Review]	Self-management education and regular practitioner review for adults with asthma	Gibson PG, Powell H, Abramson MJ, et al	Cochrane Database Syst Rev, 2002; 3: CD001117
Janson (2009)	Our results show that individualized asthma self-management education attenuates the usual decrease in medication adherence and improves clinical markers of asthma control. [Randomized Controlled Trial]	Individualized asthma self-management improves medication adherence and markers of asthma control	Janson S, McGrath K, Covington J, et al	J Allergy Clin Immunol 2009; 123:840-6
Kaya (2009)	Introduction of self-management plans (including personal action plans) improved illness control and quality of life in asthma patients. Use of the peak flow meter and the presence of higher Rotter's Internal and External Locus of Control Scale and lower Beck Depression Inventory scores can be used to predict compliance with the action plans. [Randomized Controlled Trial]	Self-management plans for asthma control and predictors of patient compliance	Kaya Z, Feyza E, Mine O, et al	J Asthma, Apr 2009
Morse (2011)	Among children admitted to pediatric hospitals for asthma, there was high hospital level compliance with CAC-1 and CAC-2 quality measures and moderate compliance with CAC-3 measure but no association between CAC-3 compliance and subsequent ED visits and asthma-related readmissions. [Observational Study] Note: CAC-1: Children's Asthma Care measure: %age of patients who received beta agonists CAC-2: Children's Asthma Care measure: %age of patients who received systemic steroids CAC-3: Children's Asthma Care measure: %age of patients discharged with a home management plan of care, inclusive of: quick reliever and controller, follow-up appointment, trigger control, written action plan.	Hospital-Level compliance with asthma care quality measures at children's hospitals and subsequent asthma-related outcomes	Morse R, Hall M, Fieldston E, et al	JAMA, Oct 2011, Vol 306, No 13
Patel (2012)	Women without an AAP were less likely to initiate discussions with their physicians, take medication as prescribed, and own a peak flow meter to monitor asthma, all considered important self-management behaviors. They were also less satisfied with their care. Not having an AAP may affect interactions between patient and physician and clinical outcomes. [Randomized Controlled Trial]	Asthma action plans and patient satisfaction among women with asthma	Patel M, Valerio M, Sanders G	CHEST 2012; 142(5): 1143-9

Sunshine (2011)	WAP use during the previous year was not associated with improved outcomes compared with non-use. Additional studies are needed to assess the long-term, independent benefit of this universally recommended intervention. [Research Support, Quasi-Experimental Design]	Written action plan use in inner-city children: is it independently associated with improved asthma outcomes?	Sunshine J, Song L, Krieger J	Ann Allergy Asthma Immunol. 2011;107:207-13
Wolf (2002)	Learning self-management strategies related to asthma prevention or attack management can help improve children's lung function and feelings of self-control, as well as reduce school absences and days of restricted activity and decrease emergency room utilization. There were no differences in the risk or frequency of hospitalizations between usual care and care supplemented with self-management education. These types of more rare and serious events may be beyond the ability of education to influence. While more research is needed to make direct comparisons between different types of interventions, the limited evidence currently available suggests that in general, self-management education works well for persons with moderate-to-severe asthma as well as for those with mild-to-moderate asthma. Peak flow-based educational strategies generally show greater effects than symptom-based strategies. Beneficial effects on measures of physiological function were apparent within six months, but benefits did not become fully apparent on measures of morbidity or healthcare utilization until 7 to 12 months following enrolment in an educational program. [Systematic Review]	Educational interventions for asthma in children	Wolf F, Guevara JP, Grum CM	Cochrane Database Syst Rev, 2002;
Zemek (2008)	Although there are limited data to firmly conclude that provision of an action plan is superior to none, there is clear evidence suggesting that symptom-based plans are superior to peak-flow based plans in children and adolescents. [Systematic Review]	Systematic review of randomized controlled trials examining written action plans in children: what is the plan?	Zemek RL, Bhogal SK, Ducharme FM.	Arch Pediatr Adolesc Med, Feb 2008; 162(2): 157-163.

Some notes about high vs low quality evidence:

- Cochrane Systematic Reviews are considered the gold standard for systematic review and are generally high quality evidence.
- Randomized Controlled Trials (RCT's) are generally considered high quality evidence.
- Observational studies vary in quality and are generally considered lower quality than systematic reviews and RCT's.
- Quasi-experimental studies differ from RCT's in that participant assignment is not random. These studies are typically of higher quality evidence than observational studies, but not as high as RCT's.

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for Hospitals
2015 Report Year

Existing Measures

CMS Measures	Dates of Service	Data Elements
Acute myocardial infarction (AMI) / heart attack process of care measures for applicable hospital discharge dates* • Fibrinolytic therapy received within 30 minutes of hospital arrival (AMI-7a) • Primary PCI received within 90 minutes of hospital arrival (AMI-8a) **Discontinue reporting AMI 7a and 8a for Critical Access Hospitals only. Make any needed changes for PPS hospitals as part of a technical correction at a later date once the CMS rule is final*	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the hospital compare acute myocardial infarction (AMI) / heart attack process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures Calculated rate
All heart failure (HF) process of care measures for applicable hospital discharge dates • Evaluation of LVS function (HF-2)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the hospital compare heart failure process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measures • Calculated rate

Minnesota Statewide Quality Reporting and Measurement System
FINAL Slate of Proposed Measures for Hospitals
2015 Report Year

CMS Measures	Dates of Service	Data Elements
Pneumonia (PN) process of care measures for applicable hospital discharge dates • Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients (PN-6)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the hospital compare pneumonia process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the target in the quality measures • Calculated rate
All surgical care improvement project (SCIP) process of care measures for applicable hospital discharge dates • Prophylactic antibiotic received within one hour prior to surgical incision * (SCIP-Inf-1a) • Prophylactic antibiotic selection for surgical patients (SCIPInf-2a) • Prophylactic antibiotics discontinued within 24 hours after surgery end time * (SCIP-Inf-3a) • Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose (SCIP-Inf-4) • Urinary catheter removed on postoperative day 1 or postoperative day 2 with day surgery being day zero (SCIP-Inf-9) • Surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period (SCIP-Card-2) • Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery (SCIP-VTE-2)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the hospital compare surgical care improvement project (SCIP) process of care quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

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CMS Measures	Dates of Service	Data Elements
Outpatient acute myocardial infarction (AMI) and chest pain Measures. The hospital outpatient process of care measures include the following measures related to acute myocardial infarctions (AMI) and chest pain emergency department care: • Fibrinolytic therapy received within 30 minutes of emergency department (ED) arrival (OP-2) • Median time to transfer to another facility for acute coronary intervention (OP-3) • Aspirin at arrival (OP-4) • Median time to ECG (OP-5)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the outpatient acute myocardial infarction (AMI) and chest pain quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Outpatient surgery department measures The hospital outpatient process of care measures include the following measures related to hospital outpatient surgery care: • Timing of antibiotic prophylaxis (OP-6) • Prophylactic antibiotic selection for surgical patients (OP-7)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the outpatient surgery department quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All prevention global immunization process of care measures for applicable hospital discharge dates • Influenza immunization-overall rate (Prev-Imm-2)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the inpatient prevention global immunization quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measures • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

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CMS Measures	Dates of Service	Data Elements
All mortality outcome of care measures for applicable hospital discharge dates • Acute myocardial infarction (AMI) 30-day mortality rate (MORT-30-AMI) • Heart failure (HF) 30-day mortality rate (MORT-30-HF) • Mortality pneumonia (PN) 30-day mortality rate(MORT-30-PN)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	CMS calculates using claims data. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Early elective deliveries - Early elective delivery prior to 39 completed weeks of gestation (PC-1) process of care measure for applicable hospital discharge dates	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the early elective delivery process of care quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the measure • Numerator: Number of patients with elective deliveries • Calculated rate

AHRQ Measures	Dates of Service	Data Elements
Mortality for selected conditions composite measure. (IQI-91) This composite measure includes the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) related to hospital inpatient mortality for specific conditions: • Acute myocardial infarction (AMI) mortality rate (IQI 15) • Congestive heart failure (CHF) mortality rate (IQI 16) • Acute stroke mortality rate (IQI 17) • GI Hemorrhage mortality rate (IQI 18) • Hip fracture mortality rate (IQI 19) • Pneumonia mortality rate (IQI 20)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the mortality for selected conditions composite measure and for each of the mortality for selected conditions composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Death among surgical inpatients with serious treatable complications (PSI 4) – This measure is used to assess the number of deaths per 1,000 patients having developed specified complications of care during hospitalization.	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the death among surgical inpatients with serious treatable complications (PSI 4) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in each of the quality measure • Calculated rate

AHRQ Measures	Dates of Service	Data Elements
Obstetric trauma – vaginal delivery with instrument (PSI 18) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 instrument-assisted vaginal deliveries.	Discharge Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the obstetric trauma – vaginal delivery with instrument (PSI 18) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate
Obstetric trauma – vaginal delivery without instrument (PSI 19) – This measure is used to assess the number of cases of obstetric trauma (3rd or 4th degree lacerations) per 1,000 without instrument assistance.	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the obstetric trauma – vaginal delivery without instrument (PSI 19) quality measure. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate

AHRQ Measures	Dates of Service	Data Elements
Patient safety for selected indicators composite measure. (PSI-90) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Pressure ulcer (PSI 3) • Iatrogenic pneumothorax (PSI 6) • Selected infections due to medical care (PSI 7) • Postoperative hip fracture (PSI 8) • Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT) (PSI 12) • Postoperative sepsis (PSI 13) • Postoperative wound dehiscence (PSI 14) • Accidental puncture or laceration (PSI 15)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the patient safety for selected indicators composite measure and for each of the patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
Pediatric Heart Surgery Mortality Rate measure (PDI 6) This measures the number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: Pediatric patients undergoing surgery for congenital heart disease • Numerator: Number of in-hospital deaths in pediatric patients undergoing surgery for congenital heart disease • Calculated rate
Pediatric Heart Surgery Volume measure (PDI 7) This measures the number of in-hospital congenital heart surgeries for pediatric patients.	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the pediatric patient for selected indicators: Volume: Pediatric patients undergoing surgery for congenital heart disease

AHRQ Measures	Dates of Service	Data Elements
Pediatric patient safety for selected indicators composite measure. (PDI-19) This composite measure includes all of the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators related to hospital inpatient mortality for specific conditions: • Accidental puncture or laceration (PDI 1) • Pressure ulcer (PDI 2) • Iatrogenic pneumothorax (PDI 5) • Postoperative hemorrhage or hematoma (PDI 8) • Postoperative respiratory failure (PDI 9) • Postoperative sepsis (PDI 10) • Postoperative wound dehiscence (PDI 11) • Selected infections due to medical care (PDI 12)	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for the pediatric patient safety for selected indicators composite measure and for each of the pediatric patient safety for selected indicators composite measure component indicators. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate

Other Measures	Dates of Service	Data Elements
Late Sepsis or Meningitis in Neonates (Vermont Oxford Network) Measures the infection rate for inborn and outborn infants meeting certain age and weight requirements. *Specification Information:* Late Sepsis or Meningitis in Very Low Birth Weight Neonates Specifications: Vermont Oxford Network.	2014 dates of service	Hospitals must submit data for the pediatric patient for selected indicators: • Denominator: inborn and outborn infants meeting criteria (see full specifications) • Numerator: Infection criteria (see full specifications) • Calculated rate.
Central line-associated bloodstream infection (CLABSI) event This measure is used to assess the infection rate of patients with a central line-associated bloodstream infection (CLABSI) event by inpatient hospital unit. *Specification Information:* Central Line-Associated Bloodstream Infection (CLABSI) Event Specifications: Center for Disease Control and Prevention	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals with neonatal intensive care unit (NICU) and/or a pediatric intensive care unit (PICU) must submit data for the central line-associated bloodstream infection (CLABSI) event by neonatal and pediatric intensive care units. This data includes the following information for each intensive care unit: • Denominator: Number of patients meeting the criteria for inclusion in the quality measure. • Numerator: Number of patients meeting the targets in the quality measure • Calculated rate.
Patient experience – This measure is used to assess patients' perception of their hospital care using a national survey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). *(This measure is not required for hospitals with less than 500 admissions in the previous calendar year.)*	2014	Consumer assessment of healthcare providers and systems hospital (HCAHPS) survey

All ED throughput process of care measures for applicable hospital discharge dates ED Measure: Transfer Communication • Administrative communication (NQF 0291) • Vital signs (NQF 0292) • Medication information(NQF 0293) • Patient information(NQF 0294) • Physician information(NQF 0295) • Nursing information(NQF 0296) • Procedures and tests(NQF 0297) *Specification Information:* Transfer Communication Measure Specifications, University of Minnesota Rural Health Research Center.	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the transfer communication quality measures. This data includes the following information: • Denominator: Number of patients meeting the criteria for inclusion in each of the quality measures • Numerator: Number of patients meeting the targets in each of the quality measures • Calculated rate
All ED/ inpatient stroke registry process of care measures for applicable hospital discharge dates • Door-to-imaging performed time • Door-to-needle time to intravenous thrombolytic therapy *Specification Information:* Emergency Department Stroke Registry Process of Care Indicator Specifications. Minnesota Stroke Registry.	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for patients discharge from the emergency department or inpatient with diagnosis of ischemic stroke, subarachnoid hemorrhage, intracerebral hemorrhage, ill-defined stroke (MN Stroke Registry specifications). This data includes the following information: • Number of minutes for defined steps in patient flow.
Median time from ED arrival to ED departure for admitted ED patients (ED-1a) Median time from admit decision time to ED departure time for admitted patients (ED-2a) *These measures are voluntary only for CAH hospitals.*	Discharge dates Third Quarter 2014 (July – September 30) through Second Quarter 2015 (April – June 30)	Hospitals must submit data for each of the emergency room throughput quality measures. This data includes the following information: • Number of minutes for defined steps in patient flow

Health Information Technology (HIT) This survey is used to assess ***a hospital's*** adoption and use of Health Information Technology (HIT) in ***its*** clinical practice. *Specification Information:* 2013 AHA Annual Survey Information Technology Supplement, Health Forum, L.L.C. with MN-Specific Additional Questions.	2014	Survey

Submission Deadlines for Hospitals
Data Submission for Centers for Medicare & Medicaid Services (CMS) and The Joint Commission, Hospital Compare Measures

Inpatient Quality Measures
Discharge Dates; Data Submission Deadline
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015
First Quarter, 2015: January 1 – March 31; August 15, 2015
Second Quarter, 2015: April 1 – June 30; November 15, 2015

Outpatient Quality Measures
Discharge Dates Data Submission Deadline
Third Quarter, 2014: July 1 – September 30; February 1, 2015
Fourth Quarter, 2014: October 1 – December 31; May 1, 2015
First Quarter, 2015: January 1 – March 31; August 1, 2015
Second Quarter, 2015: April 1 – June 30; November 1, 2015

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Data Submission for Inpatient Quality Indicators (IQI), Patient Safety Indicators (PSI), and Pediatric Patient Safety Indicators (PDI), Agency for Healthcare Research and Quality
Discharge Dates; Data Submission Deadline
All 2014 Dates of Service April 28, 2015

Data Submission for Vermont Oxford Network (VON)
Discharge Dates: Data Submission Deadline
All 2014 Dates of Service June 30, 2015

Data Submission for the Centers for Disease Control and Prevention (CDC) / National Healthcare Safety Network (NHSN)-Based Healthcare-Associated Infection (HAI) Measures
Event Dates; Data Submission Deadline
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015
First Quarter, 2015: January 1 – March 31; August 15, 2015
Second Quarter, 2015: April 1 – June 30; November 15, 2015

Data Submission for Minnesota Stroke Registry Indicator
Discharge Dates Data; Submission Deadline
Third Quarter, 2014: July 1 – September 30; February 15, 2015
Fourth Quarter, 2014: October 1 – December 31; May 15, 2015
First Quarter, 2015: January 1 – March 31; August 15, 2015
Second Quarter, 2015: April 1 – June 30; November 15, 2015

Recommendations for 2015 SQRMS Hospital Measures

Phase II, May 30, 2014

Contact: Vicki Olson, Program Manager, Stratis Health
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This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

Stratis Health, based in Bloomington, Minnesota, is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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Appendices

Hospital Quality Reporting Steering Committee Summary of Recommendations for 2015 Hospital Measures – Phase II

I. Phase II process

The Hospital Quality Reporting Steering Committee held a conference call on May 19, 2014. This public call was announced in the Minnesota Health Reform update and contact information was given to receive details as to call-in information. There were 3 observers on the phone call in addition to ex-officio member from MDH, MNCM and MHA (See Appendices A-C for Charter, Members and Minutes)

Given the tight timeframe for measure recommendations this year, the Stratis Health proposed process encourages a more thoughtful and intense focus on development of measures using expert workgroups over 6-8 months for each topic area (See Appendices D and E for Topics and Structure) These workgroups would inform the Hospital Quality Reporting Steering Committee.

Based on feedback from the hospitals questioning the value for low volume measures, AMI 7a and 8a were discussed for removal. No new or revised measures were recommended for the 2015 Hospital Quality Reporting slate of measures. Instead, the Hospital Quality Reporting Steering Committee started a discussion of recommend topics, workgroups, workgroup membership and deliverables for the 2016 measures recommendation process.

II. 2015 Hospital Measures Recommendations

During our call, the committee recommended the removal of the following two measures from the critical access hospital (CAH) slate of hospitals measures for SQRMS:

- AMI 7a – Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI 8a Timing of receipt of primary Percutaneous Coronary Intervention (PCI) from the slate of measures for CAH hospitals.

The rationale was based on low volume (no cases in all 79 CAH hospitals in Hospital Compare release of December 2013 and April 2014), and reducing measurement burden and to align with the national quality program for CAH (the Medicare Beneficiary Quality Improvement project (MBQIP), which does not include any AMI inpatient measures.

The outstanding question during committee discussion was what the recommendation for these two measures should be for PPS hospitals (i.e., all other acute care non-VA adult hospitals). In the CMS IPPS proposed rule published May 15 in the federal register, AMI 7a continues to be required for PPS hospitals and AMI 8a is proposed to be removed from the inpatient reporting program but is on the voluntary electronic clinical quality measure list. Since there are other measures that are also in this situation, it would probably be less confusing to the hospitals if we wait for the final rule to be published in August and review all these measures that will be removed but are on the voluntary reporting list for PPS hospitals at our October steering committee meeting. Any recommendations could be handled at that time through a technical correction once approved by MDH. As a result, no change was recommended at this point.

Hospital Quality Reporting Steering Committee Summary of Recommendations for 2015 Hospital Measures – Phase II

The committee members gave their response by email and 14 agreed with the recommendation, four did not respond. Therefore, the recommendation for SQRMS hospital changes for 2015 would be:

Remove two measures for CAH from the hospital slate of measures:

- ***AMI 7a – Fibrinolytic therapy received within 30 minutes of hospital arrival***
- ***AMI 8a - Timing of receipt of primary Percutaneous Coronary Intervention (PCI)***

See Appendix F for Recommendations Detail.

Appendix A

Hospital Quality Reporting Steering Committee Charter

Hospital Quality Reporting Steering Committee
Committee Charge
May 2014

The Minnesota State Legislature passed significant Health Care Reform legislation into law in 2007 and 2008. As part of this legislation, the MN Statewide Quality Reporting and Measurement System was established. The measures are reviewed annually and additions or deletions are made. The goal is to create a uniform approach to quality measurement in Minnesota to enhance market transparency and improve health care quality.

Minnesota Community Measurement is leading a consortium of organizations to make recommendations to the state regarding the design and implementation of the public reporting and incentive payment system. As part of this consortium, Stratis Health, in collaboration with the Minnesota Hospital Association, will convene and facilitate the Hospital Quality Reporting Steering Committee to make recommendations to MN Community Measurement regarding measures to be used for hospitals as part of the MN Statewide Quality Reporting and Measurement System.

The focus for additional measures in 2010 was on pediatric measures. In 2011, The Minnesota Department of Health was focused in looking at rural sensitive measures and clinically enhanced AHRQ indicators. The focus in 2012 was evaluating existing measures and processes, but not adding any new measures. Last year, a perinatal and stroke measure were added and several measures were removed.

Committee Charge

The committee is charged to recommend any modifications to and/or removal of the existing slate of required measures for 2015 Hospital Measures for the MN Statewide Quality Reporting and Measurement System. The hospitals affected include PPS, CAH and Children's hospitals. Recommendations regarding deletions or updated specifications to the current measures are within the scope. Clinic measures and Ambulatory Surgery measures are out of scope. The steering committee will recommend changes in the measures in an advisory capacity to MN Community Measurement; final decision-making rests with the MN Department of Health. The committee will:

1. Review existing measures to make recommendations for alignment with other required measures. Recommended changes to the existing measure set should consider two criteria:
    a. Alignment should drive change to patient-centered outcomes and improvement.
    b. Alignment should streamline reporting to reduce burden.

2. Review existing measures to make recommendations for rural relevance. Recommended changes to the existing measure set should consider two criteria:
   a. Likelihood of CAHs to produce adequate volume to support measure reporting.
   b. Relevance of the measure to services provided at CAHs.
3. Recommend a slate of 2014 hospital measures for the MN Statewide Quality Reporting and Measurement System to MN Community Measurement by May 2013. Topic specific workgroups may convene as necessary to develop recommendations for the Committee's consideration. Measure additions, removals, or modifications should relate to one or more of standard criteria for all SQRMS recommendations.

The group will will convene a face-to-face (with conference call option) for one meeting to accomplish the tasks for 2014, and submit a summary report and recommendations by May 31, 2014. The process for 2015 will start in October 2014 with meetings in October 2014 and January 2015 to consider measures and make final decisions in February and March to put forth a slate of measures by April 1, 2015. A follow-up meeting will convene in May 2015 to consider the comments made during the informal comment period and to launch the 2016 process which will start with an October 2015 meeting.

MDH has defined the recommendation criteria and process described below.

Recommendations for publicly reported quality measures in SQRMS must be developed in consideration of what information will aid consumers, employers, and other health care purchasers in their comparison of physician clinics and hospitals, and decision making. At a minimum, quality measure recommendations for public reporting and quality improvement will adhere to, and include discussion of conclusions related to, each of the criteria outlined below. It is understood that different measures may relate more to some criteria than others, and that the Hospital Quality Reporting Steering Committee may choose to consider additional criteria. In recommending measures, the Contractor must consider MDH's strong preference for outcome, patient-reported outcome (or functional status), and electronic measures. In recommending measure modifications and removals, the Hospital Quality Reporting Steering Committee should consider clinical research findings and evidence, and the results of previously collected quality measure data.

Recommendation criteria:

- Degree of impact. The magnitude of the individual and societal burden imposed by a clinical condition being measured by the quality measure, including disability, mortality, and economic costs.
- Degree of improvability. The extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in the clinical processes.
- Degree of inclusiveness. The relevance of a measure to a broad range of individuals with regard to: age, gender, socioeconomic status, and race/ethnicity; the generalizability of quality improvement strategies across the spectrum of health care conditions; and the capacity for change across a range of health care settings and providers.
- National consensus. The measure has either been developed or accepted/approved through a national consensus effort (e.g., the National Quality Forum).

- Degree of performance variation. The measure performance rates show a wide degree of variation across the health care system.
- Degree of validity and reliability. The extent to which the measure is valid and reliable.
- Degree of alignment. The measure is aligned with other state and national quality measurement, improvement, and reporting initiatives, and does not duplicate existing efforts.
- Degree of reporting burden. The reporting burden is reasonable in balance with the previous criteria.

Written preliminary and final quality measure recommendations for SQRMS must, at a minimum:

- Clearly convey in writing (1) the extent to which each measure meets the applicable aforementioned recommendation criteria, (2) how the concordance with measurement criteria addition, modification, or removal of each quality measure, and (3) what process was used to determine concordance with each criterion.
- Include quality measures that were considered but ultimately not recommended for addition, modification, or removal, and the supporting justifications.
- As part of articulating the process used, explain the stakeholder input employed and include a summary of any concerns or objections that stakeholders raised during the recommendation process.
- Include a description of each quality measure: name, data elements (i.e., denominator, numerator), specification information, measurement time period, data submission dates, the entity to which the data is reported (e.g., Contractor, Minnesota Hospital Association, Centers for Medicare & Medicaid Services, etc.), National Quality Forum (NQF) number (if applicable), and technical description.

Appendix B

Hospital Quality Reporting Steering Committee Members

Members

Name	Organization	Representation
Shaina Witt, MA	American Heart Association (AHA)	Disease advocacy/ consumer organization
Peter Benner	Former AFSCME Council 6 Executive Director	Consumer/Labor
Carolyn Pare	Minnesota Health Action Group	Purchaser leadership
Terry Crowson, MD	HealthPartners	Health plan leadership
Larry Lee, MD	Blue Cross Blue Shield	Healthplan leadership
Laurie Drill-Mellum, MD, MPH	MMIC	Physician risk insurer
Marie Dotseth, MHA	Minnesota Alliance for Patient Safety (MAPS)	Patient safety leadership
Hugh Renier, MD	Essentia Health System	PPS/CAH health system medical leadership
John Kvasnicka, MD	HealthEast Health System	PPS health system medical leadership
Steve Meisel, PharmD	Fairview Health System	Health system, patient safety leadership and pharmacy
Demeka Campbell, MD	Regions	Hospitalist
Allie Coronis	Allina Health	PPS hospital regulatory
Kathy Geier, RN, BS, CPHIMS	HealthEast Health System	PPS hospital regulatory
Judy Bernhardt, RN, MSN	St. Luke's Hospital Duluth	PPS hospital quality
Darrell Carter, MD	Community Medical Centers PA, Granite Falls	CAH medical leadership, CALS
Mary Mayer, RN	Perham Memorial Hospital and Home	CAH hospital operations
Cheryl Hurbig, RN	St Francis Healthcare Campus	CAH quality leadership
Tammy Suchy, RN	TriCounty Hospital	CAH quality leadership

Appendix C

Hospital Quality Reporting Steering Committee Minutes

Meeting name: **SQRMS Hospital Quality Reporting Steering Committee Conference Call**
Date: May 19, 2014
Present:

Topic	Discussion/Decision	Follow-up: Who/What/When
1. Welcome and introductions. Supporting materials: • Mini-bios	Last year, this format was developed to share background and expertise among fellow steering committee members.	Please update/provide mini bios and send to Patty Dokken
2. Background on Hospital Quality Reporting Steering Committee and committee charge. Supporting materials: • 2014 Hospital Quality Reporting Steering Committee Charge	Jennifer reviewed history & background of committee and committee charge. This will be the 6th year of the hospital measures. Today's meeting will be finalizing recommendations for the 2015 slate of measures. For the 2016 measures process, we will start that discussion today and steering committee meetings will be held periodically throughout the year.	Membership will continue through December 2015.

3. Review meeting goals and desired outcome	Jennifer reviewed meeting goals: • Agree on final slate of hospital measures to recommend to the state for 2015 reporting • Agree on expert group structure and process to review measures for 2016 reporting	
4. Review current measures, process for stakeholder input on potential topics and clarify committee priorities in measure review and recommendations Supporting materials: • 2014 Hospital Measure Summary • Key Areas and Potential New Measures to Support Improvement • Hospital Quality Reporting Structure • SQRMS Hospital Recommendations detail	The 2014 Hospital Measure Summary is a summary of the current hospital measures required by both CMS- inpatient and outpatient programs and SQRMS. The key areas and potential new measures are captured from past steering committee meeting discussions and an analysis of gaps in alignment with the HEN(hospital engagement network) and CMS measures. The Hospital Quality Reporting Structure has the topic areas listed and in some of the cases, expert groups that we could tap into for stakeholder input The SQRMS Hospital Recommendations detail is an excel spreadsheet that includes all the evaluation criteria and is a format that expert clinical groups can summarize their feedback and recommendations.	There was interest in seeing the SQRMS hospital measures in a single view instead of the CMS/SQRMS view. They are summarized in the Minnesota SQRMS Rule Appendices. Jennifer will send out to the steering committee members. The topics of patient safety culture and mental health access were identified as priorities. Marie Dotseth confirmed that being involved in looking at measures and evaluating patient safety performance aligns with MAPS role and future direction. Other discussion included making linkages between hospital measures and other healthcare system measures, how to leverage and support the SIM grant in looking more broadly and building in accountability for health, choosing valid and reproducible measures. We will continue this discussion of priorities at our October meeting. Other areas can be added to the discussion.

5. Discussion regarding any recommendations for changes to current slate of measures for 2015	The only stakeholder input we have received relates to the issue of low volume measures. AMI 7a and 8a have 0 cases for critical access hospitals. The question was raised about CMS removing these measures for PPS hospitals.	Vicki Olson will research the proposed IPPS rule and will draft a recommendation for the AMI 7a and 8a measure removal. Jennifer will send out for committee member's approval.
6. Next steps	Recommendations will be sent to MNCM by May 31, 2014	Next steering committee meeting will be scheduled for October.

Appendix D

Key areas and Potential New Measures to Support Improvement

health reform
MINNESOTA
A Better State of Health

Key Areas and Potential New Measures to Support Improvement

These are areas that have been identified for future measures or evaluation of current measures through previous year's Hospital Quality Reporting efforts.

Readmissions
Since readmissions are a major focus nationally and in Minnesota, and there is not a measure included in the current slate of SQRMS; this was identified last year as a major priority.

There is currently a workgroup from the RARE campaign that includes MDH – Health Economics, ICSI, MHA, Stratis Health, and MNCM to develop a measure from the all payor database that will give MN hospitals more information on readmissions to another facility. Currently, they are receiving information from MHA using the 3M potentially avoidable admissions grouper. This would build and leverage the current readmissions efforts
in Minnesota. Other options would be to evaluate the current 30 day readmission CMS measures:

- Hospital wide readmissions
- Acute myocardial infarction
- Heart Failure
- Pneumonia
- Hip/Knee
- Stoke
- COPD

Mental/behavioral health
In the 2013 Hospital Quality Reporting Steering Committee, the area of mental and behavioral health was identified as a potential area of development. Access was identified as a major issue but there is also a new CMS reporting program for Inpatient Psychiatric programs that includes the HBIPS measure set.

Patient Safety
There have been six areas of patient safety identified in previous Hospital Quality Reporting discussions:

- Nurse-sensitive conditions will be informed by work underway in 2013, which includes a legislatively-mandated study. In May 2013, the Minnesota legislature passed HF 588, which includes a provision instructing the Minnesota Department of Health to create a working group "to study correlation between nurse staffing levels and patient outcomes" which will inform future Committee efforts.
- Falls, particularly falls with harm have been included in the MHA roadmap and the current Hospital Engagement Network work. This includes some but not all of the hospitals so there would be some advantage of requiring reporting as part of SQRMS.

- Pressure ulcers have been included in the MHA roadmap and the current Hospital Engagement Network work. This includes some but not all of the hospitals so there would be some advantage of requiring reporting as part of SQRMS. Pressure ulcers are part of a claims based AHRQ indicator that rolls up into the PSI-90 composite, part of both value-based purchasing and hospital acquired conditions incentive programs.
- Safety culture, as assessed by the AHRQ safety culture survey or another instrument (it could be a structural measure that has a yes/no response, or could be a measure of improvement between measurement periods, etc.).
- Infections – the Committee remains interested in hospital-acquired infections, but recognizes that hospitals currently report infection measures as required by a separate statute (62J), passed by the Minnesota legislature prior to the 2008 law that launched the SQRMS system. CHAIN has been involved in providing recommendations and in 2013 aligned the PPS hospital reporting to include the CMS required measures:
    - CLABSI
    - CAUTI
    - SSI – colon
    - SSI – abd hyst
    - MRSA
    - CDI

  For critical access hospitals, the measure changed in 2014 to hospital-wide CAUTI.

  Immunization for healthcare personnel for both inpatient and outpatient measures is another measure to consider to align with CMS measures.
- Adverse drug events - such as INR levels or glucose levels.

Other CMS Measure Alignment

- Inpatient and outpatient Stroke measures
- Inpatient VTE
- Outpatient ED throughput
- Outpatient Pain
- Outpatient procedures
    - Imaging
    - Endoscopy
    - Cataracts
- Mortality
    - Stroke
    - COPD
- Cost
    - MSPB
    - AMI payment
- Inpatient surgical complications

Medicare Beneficiary Quality Improvement Program (MBQIP)

- CPOE pharmacist verification of orders

Potential Development of new measures

- Spending measure, percent of repeat test by referral center after transfer
- End of life care, such as percent of hospice use or palliative care
- Time critical care, such as the development of an ED composite measure that assesses key standards of care for time sensitive care (STEMI, sudden cardiac arrest, stroke) or use of 12 lead EKG by EMS staff
- Patient engagement, such as one or more structural measures used as part of the Partnership for Patients work

General process issues

- Put volume limit on CMS measures (less than five)
- Ending measures – after second quarter or fourth quarter
- Performance – where are measures reported publically

Appendix E

Hospital Quality Reporting Structure

Hospital Quality Reporting Structure

With clinical expert groups

Hospital Quality Reporting Steering Committee

Request

Input

MN Alliance for Patient Safety (MAPS)? or MHA patient safety committee?

- Nursing Sensitive measure (PSI 04)
- *CMS Hip/Knee Complication Rate*
- *CMS VTE measure set*
- *Patient Safety Culture Structural measure*
- *Falls, Pressure ulcers, adverse drug events*, PSI 3

Stroke Registry Advisory Committee

- *Stroke Measure set*

MHA OB Group

- PSI 18 & 19 OB Trauma
- *PC-02 C-section rate*

MHA Pediatric Group

- PDI 6 & 7, 19 Pediatric heart surgery, Complications

Collaborative for Reducing HAIs Network (CHAIN)

- *CMS NHSN Infection measures*

RARE Readmissions Measurement Committee

- *Readmissions measure*

New Committees?

CAH Low volume
AMI, HF, PN, SCIP

Mortality
CMS 30 day stroke,
CMS 30 day COPD,
IQI 12 (CABG),
IQI 30 (PTCA)

Spending
Medicare Spending per Beneficiary(MSPB),
AMI payment,
Outpatient efficiency

- *Duplicate procedures for transferred patient*

Mental/Behavioral Health
HBIPS set

- *Access*

End of Life Care
Hospice utilization,
% advance directives,

Time Critical Care –
sudden cardiac arrest,
STEMI,
Stroke,
Trauma,
Sepsis

Pt Engagement
Structural measures

Key

- Committee/Ad hoc workgroup
- Established measure
- New development measure

Italics = not currently part of SQRM*S*

Hospital Quality Reporting Steering Committee
Summary of Recommendations for 2015 Hospital Measures

Appendix F
2015 Hospital Recommendations Detail

Measure name for each measure considered	Numerator
AMI 7a – Fibrinolytic therapy received within 30 minutes of hospital arrival	https://www.qual ntentServer?c=Pa netPublic%2FPage id=12287
AMI 8a - Timing of receipt of primary Percutaneous Coronary Intervention (PCI)	https://www.qual ntentServer?c=Pa netPublic%2FPage id=12287
AMI 7a – Fibrinolytic therapy received within 30 minutes of hospital arrival	https://www.qual ntentServer?c=Pa netPublic%2FPage id=12287
AMI 8a - Timing of receipt of primary Percutaneous Coronary Intervention (PCI)	https://www.qual ntentServer?c=Pa netPublic%2FPage id=12287

Denominator	Measure Owner	Where would specifications be found?	Where would measure be submitted?	Considered for addition, modification, or removal ?	**Degree of impact.** The magnitude of the individual and societal burden imposed by a clinical condition being measured by the quality measure, including disability, mortality, and economic costs.
litynet.org/dcs/Co ıge&pagename=Q e%2FQnetTier4&c 73564870	CMS	QualityNet	Secure Qualitynet site by vendor or CART tool	Removal for CAH	Evidence'based practice
litynet.org/dcs/Co ıge&pagename=Q e%2FQnetTier4&c 73564870	CMS	QualityNet	Secure Qualitynet site by vendor or CART tool	Removal for CAH	Evidence'based practice
litynet.org/dcs/Co ıge&pagename=Q e%2FQnetTier4&c 73564870	CMS	QualityNet	Secure Qualitynet site by vendor or CART tool	Removal for PPS	Evidence'based practice
litynet.org/dcs/Co ıge&pagename=Q e%2FQnetTier4&c 73564870	CMS	QualityNet	Secure Qualitynet site by vendor or CART tool	Removal for PPS	Evidence'based practice

Degree of improvability. The extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in the clinical processes.	**Degree of inclusiveness.** The relevance of a measure to a broad range of individuals with regard to: age, gender, socioeconomic status, and race/ethnicity; the generalizability of quality improvement strategies across the spectrum of health care conditions; and the capacity for change across a range of health care settings and providers.	**National consensus.** The measure has either been developed or accepted/approved through a national consensus effort (e.g., the National Quality Forum). *Identify NQF # if exists*	**Degree of performance variation**. The measure performance rates show a wide degree of variation across the health care system.
No cases apply to CAH	No cases apply to CAH	NQF #164	No cases apply to CAH
No cases apply to CAH	No cases apply to CAH	NQF #0163	No cases apply to CAH
Very low volume of cases apply to PPS	Very low volume of cases apply to PPS	NQF #164	Very low volume of cases apply to PPS
16 of 52 hospitals had cases to report on April 2014 hospital compare release	17 of 52 hospitals had cases to report on April 2014 hospital compare release	NQF #0163	85-100%

Degree of validity and reliability. The extent to which the measure is valid and reliable.	**Degree of alignment.** The measure is aligned with other state and national quality measurement, improvement, and reporting initiatives, and does not duplicate existing efforts.	**Degree of reporting burden.** The reporting l	Final: Recommended or not recommended?
Tested as part of NQF process and measure is validated by inpatient reporting program for PPS hospitals	Not included in MBQIP	Requires pulling population and answering criteria when no cases qualify	Recommend to remove from CAH slate of measures
Tested as part of NQF process and measure is validated by inpatient reporting program for PPS hospitals	Not included in MBQIP	Requires pulling population and answering criteria when no cases qualify	Recommend to remove from CAH slate of measures
Tested as part of NQF process and measure is validated by inpatient reporting program for PPS hospitals	Part of CMS inpatient quality reporting program	Requires pulling population and answering criteria when no cases qualify	No change recommended
Tested as part of NQF process and measure is validated by inpatient reporting program for PPS hospitals	Part of CMS inpatient quality reporting program, but proposed to transition to a voluntary electronic measure with Jan 1, 2015 discharges	If voluntary proposal is finalized, then would add measurement burden if a hospital did not report as part of the 16 e-measures they are required to report	No change recommended ; recommend to reassess all voluntary e-measures after IPPS rule is finalized

Describe stakeholder input employed recommendation process.	include a summary of any concerns or objections that stakeholders raised during the recommendation process.
Low volume issue was raised by a critical access hospital. Steering committee members discussed and recommended removal. Recommendations will be presented at June public forum	
Low volume issue was raised by a critical access hospital. Steering committee members discussed and recommended removal. Recommendations will be presented at June public forum	
Discussed alignment with CMS in steering committee	
Discussed alignment with CMS in steering committee	