

Memo



Date: May 2, 2014 (Updated May 21, 2014)

Re: 2015 Statewide Quality Reporting and Measurement System (SQRMS): MN Community Measurement's (MNCM) Preliminary Recommendations for Physician Clinic Quality Measures

Minnesota Statutes 62U.02 requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. A subset of the standardized set of quality measures will be used for public reporting purposes. To implement the collection of quality measurement data, the Minnesota Department of Health (MDH) has developed the Minnesota Statewide Quality Reporting and Measurement System (SQRMS), created through Minnesota Rules, Chapter 4654. This rule compels physician clinics and hospitals to submit data on a set of quality measures to be publicly reported and also establishes a broader standardized set of quality measures for health care providers across the state. MDH collects data on those measures to be publicly reported, while health plans may only require providers to submit data on those measures that are part of the standardized set.

The Commissioner of Health is required to evaluate the measures included in the set of quality measures to be publicly reported on an annual basis. MDH contracted with MN Community Measurement (MNCM) and other community partners to make recommendations for SQRMS about new and/or modified quality measures, and measure removals. Accordingly, MNCM submits preliminary quality measure recommendations to MDH. MNCM's preliminary recommendations for physician clinic quality measures for the 2015 reporting year for SQRMS are attached. These recommendations were reviewed and approved by MNCM's Measurement and Reporting Committee (MARC).

Key proposed changes include the following:

- The addition of four new measures in 2015: Spine Surgery – Lumbar Discectomy/Laminotomy, Spine Surgery – Lumbar Spinal Fusion, Pediatric Preventive Care – Adolescent Mental Health and/or Depression Screening, and Pediatric Preventive Care – Obesity/BMI & Counseling.
 - MDH first included the spine surgery measures in the SQRMS measure set for 2015 reporting in its 2012 update to the measure set.
 - MDH first included the pediatric preventive care measures in the SQRMS measures set for 2015 reporting in its 2013 update to the measure set.
 - MNCM listed the Total Knee Replacement measure as a new measure because 2014 is the first year of implementation; it would be a recurring measure in 2015.
- The removal of the cholesterol component from both the Optimal Diabetes Care and Optimal Vascular Care composite measures. MNCM recommends that clinics continue to submit LDL values in preparation for a potential cholesterol component redesign in 2015.
- MNCM removed the written asthma management plan component of the Optimal Asthma Care measure based on the MARC's recommendation and vote on March 12, 2014.

The Minnesota Department of Health invites interested stakeholders to review and comment on MNCM's preliminary recommendations for physician clinic quality measures for the 2015 Statewide Quality Reporting and Measurement System (SQRMS). Please send your comments to health.reform@state.mn.us by June 1.

MNCM will consider all public comments before submitting their final recommendations for physician clinic measures to MDH by June 15. The final recommendations will be presented at a public forum that MDH will hold on June 26, 2014. MDH will announce this public forum through its weekly [Health Reform update](#) which interested parties may subscribe to, and will post additional information for the forum to the [SQRMS website](#).

Enclosures:

- 1) 2015 Preliminary Slate of Measures for Physician Clinics Memo from MNMCM
- 2) Preliminary Slate of Proposed Measures for Physician Clinics 2015 Reporting Year
- 3) Optimal Diabetes Care Preliminary Ad-hoc Work Group Recommendations
- 4) Cholesterol High Level Guideline Landscape 2014
- 5) Optimal Asthma Care Cover Letter for March 2014 MARC
- 6) Optimal Asthma Care Workgroup Minutes January 2014
- 7) Optimal Asthma Workgroup Literature Review Abstracts
- 8) Total Knee Replacement Recommendation April 2014 MNMCM
- 9) Lumbar Spine Surgery Recommendation April 2014 MNMCM
- 10) Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening Recommendation April 2014 MNMCM
- 11) Pediatric Preventive Care: Obesity/BMI & Counseling Recommendation April 2014 MNMCM
- 12) Approved MARC meeting minutes September 11, 2013
- 13) Approved MARC meeting minutes November 13, 2013
- 14) Approved MARC meeting minutes March 12, 2014
- 15) Approved MARC meeting minutes April 9, 2014 (added May 21, 2014)
- 16) Measure Review Preliminary Rating Summary
- 17) MN Community Measurement (MNMCM) Measure Review and Maintenance Process and Structure



DATE: April 15, 2014

TO: Denise McCabe
Principal Planner, Health Economics Program
Minnesota Department of Health

FROM: Dina Wellbrock
Project Manager
MN Community Measurement

RE: 2015 Preliminary Slate of Measures for Physician Clinics

Please find attached the Preliminary Proposed Slate of Measures for Physician Clinics for the 2015 Statewide Quality Reporting and Measurement System (SQRMS). This preliminary slate was approved by MNMCM's Measurement and Reporting Committee (MARC) on April 10, 2014. MARC's approval was informed by the measure reviews described below.

Measure Maintenance Reviews

As you know, MNMCM strives to continually assess the value of quality measures utilized by the community and stakeholders. We rely heavily on empirical evidence and community input as we consider changes to measure specifications.

MNMCM has completed two such reviews this year, including formalizing this process into an annual measure maintenance review. This is done by the Measure Review Committee (MRC), a subcommittee of MARC. The MRC is charged with making recommendations to MARC for ongoing use of each publicly reported measure. These recommendations might include:

- 1) Continue a measure without change
- 2) Perform additional examination of a measure via a focused, ad-hoc review (generally recommended for a specific reason)
- 3) Transition a measure to monitoring
- 4) Retire a measure

The first measure review was approved in September 2013, when MARC approved an ad-hoc review of both the asthma and diabetes measures. The asthma workgroup convened in January 2014 and the diabetes workgroup convened in March 2014. The results of these workgroups are noted below.

Additionally, the newly-formed MRC met in April 2014 and reviewed the following SQRMS-related measures:

- Colorectal Cancer Screening
- Maternity Care, C-section Rate
- Depression Remission at 6 months



The MRC recommended continuing with all three measures. However, it's noteworthy that while the MRC confirmed the importance and strength of the depression measure set, it also acknowledged the complexity of the specifications. The MRC requested that a technical workgroup be convened to review the data submission process with the goal of reducing burden, if possible.

2015 Preliminary Proposed Slate of Measures for Physician Clinics

The 2015 preliminary proposed slate of measures is attached.

It includes the following changes based on the reviews described above:

- The cholesterol component of both the Optimal Diabetes Care and Optimal Vascular Care measures will not be included in the numerator calculation for 2015 report year; however, clinics will continue to submit LDL values in preparation for potential 2015 LDL component redesign. [Ad-hoc MRC recommendation, approved by MARC April 2014]
- The asthma action plan has been removed as a component of the Optimal Asthma Care measure based on MARC's approved recommendation on March 13, 2014.

Additionally, MNMCM reviewed the gap analysis that was completed in 2013 to identify potential areas for new measure recommendations. Due to four measures with initial implementation in 2015 (two in specialty care and two in pediatrics), our recommendation is not to add any other measures to the 2015 Proposed Slate at this time.

All measures in the Proposed Slate are recommended for public reporting.

Enclosures

The following items are attached:

- 2015 SQRMS Preliminary Slate of Measures for Physician Clinics
- MNMCM Measure Review and Maintenance Process and Structure
- Final reports from the asthma and diabetes ad-hoc MRCs. [This includes research completed on each measure in preparation for the reviews (listed in II.A.4 of the contract).]
- MRC summary report for the colorectal, maternity and depression measure reviews. [This provides the committee members' ratings of evidence, priority aspect of care, and observed performance gaps. The meeting minutes from this review will be forwarded as soon as they are completed.]
- Approved MARC meeting minutes September 11, 2013 (ad-hoc review diabetes & asthma)
- Approved MARC meeting minutes November 13, 2013 (MRC committee)
- Approved MARC meeting minutes March 12, 2014 (asthma recommendation)
- Approved MARC meeting minutes April 9, 2014 (diabetes recommendation)

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Preliminary Slate of Proposed Measures for Physician Clinics
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Existing Measures

Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Optimal Diabetes Care Composite: NQF# 0729</p> <p><i>Percent of patients with diabetes that are well-controlled</i></p> <ul style="list-style-type: none"> • 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 <p>*Cholesterol component will not be included in the numerator calculation for 2015 report year only; however, clinics will continue to submit LDL values in preparation for potential 2015 LDL component redesign.</p>	<ul style="list-style-type: none"> • Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Endocrinology 	<p>Collecting mid January 2015 to mid February 2015 on dates of service: January 1, 2014 through December 31, 2014.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator who meet all 4 components of HbA1c, blood pressure, daily aspirin use, tobacco free during dates of service.</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> • Insurance Product Type: <ul style="list-style-type: none"> ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age <ul style="list-style-type: none"> ○ 18-25 ○ 26-50 ○ 51-65 ○ 66-75 • Diabetes Type <ul style="list-style-type: none"> ○ Type 1 ○ Type 2

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Optimal Vascular Care Composite: NQF# 0076</p> <p><i>Percent of patients with vascular disease that are well controlled</i></p> <ul style="list-style-type: none"> • Blood pressure control (less than 140/90 mm Hg) • Daily aspirin use or valid contraindication to aspirin documented • Documented tobacco free <p>*Cholesterol component will not be included in the numerator calculation for 2015 report year only; however, clinics will continue to submit LDL values in preparation for potential 2015 LDL component redesign.</p>	<ul style="list-style-type: none"> • Family Medicine • General Practice • Internal Medicine • Geriatric Medicine • Cardiology 	<p>Collecting mid January 2015 to mid February 2015 on dates of service: January 1, 2014 through December 31, 2014.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator who meet 3 components of blood pressure, daily aspirin use, tobacco free during dates of service.</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> • Insurance Product Type: <ul style="list-style-type: none"> ○ Commercial ○ Medicare ○ MN Government Programs and Self-pay / Uninsured • Age <ul style="list-style-type: none"> ○ 18-25 ○ 26-50 ○ 51-65 ○ 66-75

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Depression Remission at 6 Months: NQF# 0711</p> <p><i>Percent of patients with depression that are in remission</i></p> <ul style="list-style-type: none"> Patients with major depression or dysthymia and an initial PHQ-9 score > nine whose PHQ-9 score at six months is less than 5. 	<ul style="list-style-type: none"> Family Medicine General Practice Internal Medicine Geriatric Medicine Psychiatry Licensed Behavioral Health (if physician on site) 	<p>Collecting February 2015 on index dates: July 1, 2013 through June 30, 2014, allowing for 6 month (+/- 30 days) follow-up contact.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator who have a PHQ-9 score less than 5 at 6 months (+/- 30 days).</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> Initial PHQ-9 severity bands <ul style="list-style-type: none"> Moderate (10-14) Moderately severe (15-19) Severe (20 and above) Insurance Product Type: <ul style="list-style-type: none"> Commercial Medicare MN Government Programs and Self-pay / Uninsured Age <ul style="list-style-type: none"> 18-25 26-50 51-65 66+

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Optimal Asthma Care Composite</p> <p><i>Percent of patients with asthma that are well controlled</i></p> <ul style="list-style-type: none"> • Asthma is well controlled (asthma control tool/test results indicate control) • Patient is not at risk for future exacerbations (patient reports less than two total emergency department visits and hospitalizations during previous 12 months) 	<ul style="list-style-type: none"> • Family Medicine • General Practice • Internal Medicine • Pediatrics • Allergy/Immunology • Pulmonology 	<p>Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients with asthma well controlled and not at risk for future exacerbations.</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> • Insurance Product Type: <ul style="list-style-type: none"> ○ 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
<p>Colorectal Cancer Screening</p> <p><i>Percent of patients current on colorectal cancer screening</i></p> <ul style="list-style-type: none"> Patients with colorectal cancer screening (allowable screens: colonoscopy within 10 years, sigmoidoscopy within 5 years, FOBT or FIT within the reporting period) 	<ul style="list-style-type: none"> Family Medicine General Practice Internal Medicine Geriatric Medicine Obstetrics /Gynecology 	<p>Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator with colorectal cancer screening.</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> Insurance Product Type: <ul style="list-style-type: none"> Commercial Medicare MN Government Programs and Self-pay / Uninsured Age <ul style="list-style-type: none"> 51-65 66-75

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Maternity Care- Primary C-Section Rate</p> <ul style="list-style-type: none"> Percentage of cesarean deliveries for first births <p><i>All clinics part of a medical group in which the medical group has providers who perform C-sections</i></p>	<ul style="list-style-type: none"> Family Medicine General Practice Obstetrics/Gyn Perinatology 	<p>Collecting mid July 2015 to mid August 2015 on dates of service: July 1, 2014 through June 30, 2015.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator who had a cesarean delivery. <u>Denominator:</u> All live, singleton, vertex, term (≥ 37 weeks gestation) deliveries to nulliparous women performed by a medical clinic site during measurement period.</p>	<ul style="list-style-type: none"> Insurance Product Type: <ul style="list-style-type: none"> Commercial Medicare MN Government Programs and Self-pay / Uninsured Age <ul style="list-style-type: none"> 17 and under 18-20 21-25 26-30 31-35 36 and older
<p>Patient Experience of Care</p> <p>Survey topics cover:</p> <ul style="list-style-type: none"> Getting care when needed / access to care Communication Helpfulness of office staff Providers with an exceptional rating <p>CG-CAHPS Clinician and Group 12-Month Survey</p> <p><i>*Measure is required every other year</i></p>	<ul style="list-style-type: none"> All specialties except Psychiatry 	<p>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.</p> <p>Data Source: MNMCM</p>	<p>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:</p> <ul style="list-style-type: none"> Physician specialty Reason for visit Duration of patient/physician relationship 	<p>Survey responses to:</p> <ul style="list-style-type: none"> Self-reported health status Age Education

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Health Information Technology Survey</p> <ul style="list-style-type: none"> Survey topics cover adoption of HIT, use of HIT, exchange of information, and on-line services <p>See attached MN Ambulatory Clinic HIT Survey for complete list of questions</p>	All Specialties	<p>Collecting February 15, 2015 to March 15, 2015 on current HIT status.</p> <p>Data Source: MNCM</p>	Question summary rollup into survey domains of adoption, utilization, and exchange EMR data.	Not applicable – data reported as descriptive statistics only

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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
<p>Total Knee Replacement:</p> <p><i>Average change of functional status and quality of life for total knee replacement patients</i></p> <ul style="list-style-type: none"> 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 EQ-5D tool. 	<ul style="list-style-type: none"> Orthopedic Surgery 	<p>Collecting mid April 2015 to mid May 2015 on dates of procedure: January 1, 2013 through December 31, 2013.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> functional status (or quality of life) score at one year of patients in denominator.</p> <p><u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> Insurance Product Type: <ul style="list-style-type: none"> Commercial Medicare MN Government Programs and Self-pay / Uninsured Body mass index (BMI) Tobacco Status

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Spine Surgery:</p> <ul style="list-style-type: none"> 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 EQ5D 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 EQ5D 	<ul style="list-style-type: none"> Orthopedic Surgery Neurosurgery 	<p>Collecting mid April 2015 to mid May 2015 on dates of procedure: January 1, 2013 through December 31, 2013.</p> <p>Data Source: MNCM</p>	<p>Discectomy/laminotomy: The average change in the the pre- to post-operative functional status, pain, and quality of life index for denominator patients at 3 months. <u>Denominator:</u> 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.</p> <p>Lumbar Spinal Fusion: The average change in the the pre- to post-operative functional status, pain, and quality of life index for denominator patients at one year. <u>Denominator:</u> 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.</p>	<ul style="list-style-type: none"> Insurance Product Type: <ul style="list-style-type: none"> Commercial Medicare MN Government Programs and Self-pay / Uninsured Body mass index (BMI) Tobacco Status <p><i>Tentative based on pilot testing results, expected to be collected in April 2013 and April 2014.</i></p>

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Measure	Eligible Specialties	Submission Date / Dates of Service	Numerator/Denominator	Risk Adjustment
<p>Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening</p> <ul style="list-style-type: none"> • Patient has a mental health and/or depression screening documented in medical record <p><i>Clinics that provide well-child visit services</i></p>	<ul style="list-style-type: none"> • Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine 	<p>Collecting mid April 2015 to mid May 2015 on dates of service: January 1, 2014 through December 31, 2014.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator with a mental health and/or depression screening documented.</p> <p><u>Denominator:</u> 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.</p>	<p>N/A</p>
<p>Pediatric Preventive Care: Obesity/BMI & Counseling</p> <ul style="list-style-type: none"> • Patient with a BMI percentile $\geq 85\%$ has documentation of both physical activity and nutrition discussion, counseling or referral documented in the medical record <p><i>Clinics that provide well-child visit services</i></p>	<ul style="list-style-type: none"> • Family Medicine • General Practice • Internal Medicine • Pediatric/Adolescent Medicine 	<p>Collecting mid April 2015 to mid May 2015 on dates of service: January 1, 2014 through December 31, 2014.</p> <p>Data Source: MNMCM</p>	<p><u>Numerator:</u> number of patients in denominator with physical activity and nutrition counseling documented.</p> <p><u>Denominator:</u> patients ages 3 to 17 with a BMI percentile $\geq 85\%$, 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.</p>	<p>N/A</p>



Date: April 3, 2014

From: Beth Averbeck, MD
Health Partners Medical Group
MNCM Diabetes Chair/ MNCM Board

Collette Pitzen, RN BSN CPHQ
Clinical Measure Developer
MN Community Measurement

Re: Optimal Diabetes Care- Ad-hoc Review Cholesterol Component
Measure Development Work Group Recommendations

Purpose of Ad-hoc Measure Review:

Address recent changes in guidelines¹ and evidence surrounding cholesterol management for diabetic patients. Current cholesterol target of LDL < 100 is no longer an appropriate intermediate outcome.

In September 2013, MARC requested an 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 guidelines² necessitated a more extensive consideration for revision of the cholesterol/ lipid target component.

The measure development work group met 3/13/2014 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.

High Level Summary of Recommendations:

- 2013 dates of service- report current measure without changes
 - 2014 dates of service- report a “D4” measure without cholesterol component (temporary)
 - 2015 dates of service- new cholesterol/ lipid component; focus on statin use
 - Diabetes Ad-hoc work group to reconvene in August 2014 following anticipated July 31st publication of updated ICSI Diabetes Guidelines. Plan to specify new cholesterol/ lipid component in more detail and align with the ICSI guideline work group’s recommendations where ever possible/ feasible with measurement
- ➔ Need direction on vascular measure; potential component to be transferrable for the ischemic vascular disease measure cholesterol component, which is less complicated than diabetes.

Detailed recommendations from measure development work group:

1. 2014 Public Reporting (2013 Dates of Service)

➤ **No changes to the current measure.**

For care provided 1/1/2013 to 12/31/2013 (dates of services in the measurement period) that are scheduled to be published on MNHealthScores in 2014, the work group recommends that the

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.



current measure (all five components inclusive of the component for LDL < 100) be reported without change, modification or suppression.

Rationale:

- For 11 months of the year, care was being provided according to guidelines that supported a risk reduction strategy that focused on an LDL target. New guidelines and evidence recommend strategies that no longer “treat to target” published 11/12/2013.
- Because these new guidelines came in at the end of the measurement period, it is reasonable to report the measure under the practice guidelines indicating treatment to LDL targets that were in place the majority of the year in which care was being provided to patients.
- Work group members recommend that the results be reported with a footnote or additional annotation explaining new guidelines/ goals for patients.

2. 2015 Public Reporting (2014 Dates of Service)

- **Temporarily move from a D5 to a D4 measure; no cholesterol component included in numerator calculation.**
- **Continue to collect LDL date and value, but suppress the cholesterol component from the numerator.**
- **Work group to reconvene in August 2014 following ICSI Diabetes guideline update to work on further measure refinements.**

For care provided 1/1/2014 to 12/31/2014 (dates of services in the measurement period) for reporting on MNHealthScores in 2015, the work group recommends that no new cholesterol component be incorporated into the numerator and that the numerator component LDL < 100 be suppressed.

Components of the diabetes measure for numerator calculation will be:

- HbA1c < 8.0
- Blood Pressure < 140/90
- Tobacco-free
- Daily Aspirin if cardiovascular disease and no contraindications

Rationale:

- Time for new cholesterol guideline to assimilate into practice/ work flows. Some controversy exists surrounding the cardiovascular risk estimation calculator and allow some time for the dust to settle for this paradigm shift in practice.
- ICSI Diabetes guidelines currently undergoing revision, due for publication 7/31/2014. Desire any new measure design to align with guideline.
- Planned measure changes cannot be implemented retrospectively (back to 1/1/2014) and groups need time to plan for and implement changes related to a new cholesterol component based on statin use.
- Continue to collect LDL values and date as part of the submission 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.

3. Plan for a new cholesterol component of the composite measure related to diabetic patients being prescribed (ordered) a moderate or high intensity statin.



Communicate to medical groups the intent to have a new, redesigned cholesterol component that will incorporate statin use for diabetics.

Planning by Medical Groups

What can medical groups plan for and anticipate for future data submission and measure calculation?

Suggestions based on preliminary measure plans below:

- Review EMR medication/ order system to identify the defined statin drug list; be prepared for the following data elements for submission:
 - Map your system's statins to a coded medication name. Current list below (ACC/AHA November 2013) includes the following:

▪ Atorvastatin	▪ Lovastatin	▪ Rosuvastatin
▪ Fluvastatin	▪ Pitavastatin	▪ Simvastatin
▪ Fluvastatin XL	▪ Pravastatin	

- Date of the most recent order (prescription) for statin
- Patient's daily prescribed dose in milligrams (in a separate field)
- 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 may 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.

MNCM Diabetes Measure Development Work Group Members

Name	Member Type	Organization
Beth Averbeck, MD	Chair, Internal Med, MNCM Board	HealthPartners
Mark Nyman, MD	Internal Med, MARC member	Mayo Clinic & Health System
Victor Montori, MD	Endocrinology	Mayo Clinic
JoAnn Sperl-Hillen, MD	Internal Med	HealthPartners
Courtney Baechler, MD	Cardiology	Allina Penny George Institute
Jonathon Ward Godsall, MD	Endocrinology	Allina Medical Group
Christopher Restad, DO	Family Medicine	Health East
Rebecca Moxness, MD	Endocrinology	Park Nicollet
Terry Murray, RN	Data Analyst	Allina Medical Group
Jeanine Rosner, RN	QI or Clinic Admin	Park Nicollet
Monica Simmer	Health Plan	Metropolitan Health Plan
Pam York	State Agency	MDH/ SQRMS
Kris Soegaard	Consumer/ Empl/ MARC Member	MN Health Action Group
Collette Pitzen	Facilitator/ Measure Dev	MNCM

Cholesterol Targets and Guidelines 2014

High Level Landscape

MNCM Optimal Care Measures for Diabetes and Ischemic Vascular Disease

	Cholesterol	Blood Pressure	Aspirin	Tobacco	HbA1c (diabetes only)
Targets 2013 DOS	LDL < 100	BP < 140/90	daily if CVD & no contra	tobacco free	< 8.0
ACC/AHA Nov 2013	Cholesterol Guidance Age \geq 21 Four statin benefit groups 1. Clinical ASCVD; high intensity age \leq 75 [A; strong] 2. Primary LDL > 190 [B; moderate] 3. Diabetes age 40 to 75 years with LDL 70 to 189 without clinical ASCVD a. Moderate intensity statin should be initiated or continued [A; strong] b. High intensity statin therapy is reasonable with estimated 10 year ASCVD risk \geq 7.5% [E] 4. Without clinical ASCVD or diabetes, LDL 70 to 189 and estimated 10 year ASCVD risk \geq 7.5% [A; strong]			Avoidance of all tobacco products	
ICSI Diabetes Apr 2012 Stable CAD May 2013	Cardiovascular disease ■ on statin with LDL < 70 [H] No cardiovascular disease ■ LDL < 100 <u>or</u> on a statin [H]	Systolic < 140 [H] Diastolic < 90 [H]	Aspirin/ anti-platelet if cardiovascular disease [H]	Tobacco cessation if indicated	Personalized goal to < 7.0 or < 8.0 based on risks and benefits. [H]
ADA Jan 2014 Note: Draft standards out for public comment in October (prior to ACC/ AHA)	Statin therapy regardless of baseline for diabetic patients: ■ with overt CVD [A] ■ without CVD who are > 40 yrs and have one or more CVD risk factors (family hx, htn, tobacco, dyslipidemia or albuminuria) [A]	Systolic < 140 [B] Diastolic < 80 [B]	Use aspirin therapy (75 to 162 mg per day as secondary prevention with CVD [A]	Advise all patients not to smoke or use tobacco products [A]	< 7.0 reasonable for many non-pregnant adults [B] < 8.0 hypoglycemia, comorbid, advanced micro/macrovascular complications [B]
JNC 8 Dec 2013		Age \geq 18 < 140/90 [E]			
ESH/ ESC		Systolic < 140 [A-I] Diastolic < 85 [A-I]			
ASH/ ISH		< 140/90			
Thoughts	Redesign or Remove Component	Stay with < 140/90	Current target still appropriate	Current target still	Current target still appropriate

Key for Guideline Groups		Evidence Grading Keys
ACC/AHA	American College of Cardiology/ American Heart Association Scientific Advisory: An effective approach to high blood pressure control 11/15/2013	National Heart Blood Lung Institute (used by ACC/AHA and JNC8) [A] Strong recommendation; high certainty based on evidence that net benefit is substantial [B] Moderate recommendation; moderate certainty based on evidence that net benefit is moderate to substantial or there is high certainty that net benefit is moderate [C] Weak recommendation; moderate certainty based on evidence that there is a small net benefit [D] Recommendation against; no net benefit or risks/ harms outweigh benefit [E] Expert opinion; net benefit is unclear, work group wanted to provide clinical guidance [N] No recommendation
ICSI	Institute for Clinical Systems Improvement Diabetes April 2012 Stable Coronary Artery Disease May 2013	
ADA	American Diabetes Association 2014 Standards of Care January 2014	
JNC8	Joint National Committee 2014 Evidence Based Guidelines for the Management of Hypertension in Adults 12/18/2014	
ESH/ESC	European Society of Hypertension/ European Society of Cardiology 2013 Guidelines Management of Arterial HTN	
ASH/ISH	American Society of Hypertension/ International Society of Hypertension Clinical Practice Guidelines for Management of Hypertension in the Community 12/19/2013 [Expert Opinion]	
Evidence Grading Keys American Diabetes Association Evidence: [A] Clear evidence from well-conducted, generalizable RCT's adequately powered [B] Supportive evidence from well-conducted cohort studies [C] Supportive evidence from poorly controlled or uncontrolled studies [E] Expert consensus or clinical experience		Institute for Clinical Systems Improvement (transitioning to GRADE) High Quality Evidence = Further research is very unlikely to change our confidence in the estimate of effect. Moderate Quality Evidence = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate. Low Quality Evidence = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate or any estimate of effect is very uncertain.
European Society of Hypertension/ European Society of Cardiology Level A Data derived from multiple RCTs or meta-analysis Level B Data derived from single RCT or large non-randomized studies Level C Consensus opinion of experts and/ or small retrospective studies, registries		
Class I Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective. Is recommended/ Is indicated Class II Conflicting evidence and/or a divergence of opinion about the usefulness/ efficacy of a given treatment or procedure Class IIa Weight of evidence/opinion is in favor of usefulness/efficacy. Should be considered. Class IIb Usefulness/efficacy is less well established by evidence/opinion. May be considered. Class III Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful. Is not recommended.		



Date: March 6, 2014

From: Peter Dehnel, MD,
Blue Cross & Blue Shield MN
Co-chair

William Nersesian, MD
Fairview Physician Associates
Co-Chair

Jasmine Larson, CPHQ
Manager, Health Care Measure Development MNMCM

Re: Optimal Asthma Care Measure
2014 Ad-hoc Measure Review Recommendations

Purpose:

Report measure development work group recommendations for the Optimal Asthma Care measure components:

1. Presence of written asthma action plan
2. Risk of exacerbation/ less than 2 ED visits and/or hospitalizations in the last 12 months

Enclosures:

- Optimal Asthma Care meeting minutes 1-30-2014

Greetings,

The Optimal Asthma Care measure was originally developed in 2009, and adopted into the Statewide Quality Reporting and Measurement System (SQRMS) in 2010. The measure development work group reconvened in 2011 to review first year results and did not recommend any changes to the measure.

As requested by the MARC, in response to feedback from the National Quality Forum and ongoing comment from providers, the measure development work group has recently completed its review of the measure components related to the written asthma action plan and risk of exacerbations.

Please see enclosed minutes for work group discussion.

After a review of the measure, evidence, data analysis and a thorough discussion of all potential issues surrounding the two components, the work group reached consensus in its decision to recommend no changes to the current measure.

Optimal Asthma Care Measure Development Work Group Roster
January 2014 Ad-Hoc Review

Name	Member Type	Organization
Peter Dehnel, MD	Health Plan; Co-Chair	Blue Cross Blue Shield
Bill Nersesian, MD	Pediatrics / MARC; Co-Chair	Fairview Physician's Associates
Richard Morris, MD	Allergy and Immunology	Allergy and Asthma Care PA



Name	Member Type	Organization
Randall Warren, MD	Pediatrics	HealthPartners
Tim Hernandez, MD	Family Medicine / MARC	Entira Family Clinics
Deborah McWilliams, MD	Pediatrics	Mayo Clinic, Ped & Adol Med
Gail Brottman, MD	Pulmonology	HCMC
Rina McManus	Public Health	St Paul/ Ramsey County Health
Angie Carlson	Pharmacy / Data Analyst	Data Intelligence Consultants
Wendy Markgraf	Clinic Admin	Advancements in Allergy & Asthma Care
Cara Broich	Health Plan	Medica
Kristi Van Riper	Quality Improvement	University of MN Physicians
Susan Ross	State Agency	MDH
Chris Norton	Consumer/ MARC Member	
Jasmine Larson	Facilitator/ Measure Development	MNCM



MNCM Optimal Asthma Care Workgroup Reconvene for Discussion of Two Measure Components; Written Asthma Management Plan and Risk of Exacerbation

Thursday, January 30, 2014
5:00 to 6:30 pm

Meeting Attendance:

Work Group		Work Group		Staff	
X	Bill Nersesian, MD, co-chair	X	Rina McManus, RN	X	Jasmine Larson, MNCM Facilitator
X	Peter Dehnel, MD, co-chair	X	Angie Carlson	X	Collette Pitzen, MNCM
X	Richard Morris, MD	X	Wendy Markgraf	X	Dina Wellbrock, MNCM
X	Randal Warren, MD	X	Cara Broich, RN	X	Anne Snowden, MNCM
X	Tim Hernandez, MD	X	Kristi Van Riper	Observers	
X	Gail Brottman, MD	X	Susan Ross, RN	X	Denise McCabe, MDH/ SQRMS
X	Deborah McWilliams, MD	X	Chris Norton	X	Vidya Ventkataraman, MDH/ SQRMS
				X	Pam York, RN, MDH Asthma Program

Minutes

Topic	Discussion	Action
Meeting Overview - Welcome, Agenda - Conflict of Interest (COI)	<p>Meeting is conducted by phone and WebEx, recorded for minute taking purposes.</p> <p>Materials distributed prior to the meeting included: agenda, roster, slides for meeting, research summary, full text articles, and practice guidelines.</p> <p>Members present in person and on the phone introduced themselves.</p> <p>Goals for the meeting today include:</p> <ul style="list-style-type: none"> ▪ Orientation for workgroup members ▪ Brief review of measure development process and measures ▪ Review Optimal Asthma Care measure ▪ Make recommendation for written asthma management plan component ▪ Make recommendation for risk of exacerbations component ▪ Planned presentation to the MNCM Measurement and Reporting Committee (MARC) in March 	None

Topic	Discussion	Action
	<p>MNCM is committed to disclosing all potential conflicts and competing interests and taking action when necessary to assure that all measure related activities are free from any real or perceived control or influence of commercial, proprietary or political interests. We all have the responsibility to recognize and clearly state any potential conflicts of interest that may arise during the course of workgroup discussions.</p> <p>Please also refer to the accompanying PowerPoint slides for meeting content.</p>	
<p>Workgroup Member Orientation</p>	<p><u>MNCM Background</u></p> <p>MNCM’s mission is to accelerate the improvement of health by publicly reporting health care information. It started as a project in 2000 to aggregate health plan HEDIS data and over time evolved to include clinical measure data collection from providers and subsequent public reporting.</p> <p>Public reporting and maintaining transparent processes encourages improvement above and beyond incentive programs and internal quality improvement efforts. For providers, reporting allows for comparison between practices, highlighting best practices and demonstrating variation. For consumers, reporting provides objective and neutral information for making decisions about health care.</p> <p><u>Measure Development Process</u></p> <p>There are definitive qualities that characterize a good measure. First, it should measure doing your best as opposed to meeting a minimum standard, passing the test or performing expected standards of care.</p> <p>It should focus on what the goal or desired outcome is for the patient. And it’s important that there exists variation in practice and performance with opportunity for improvement. There is little value in measuring something that everyone is accomplishing at a very high rate of success.</p> <p>The National Quality Forum, the national endorsement body for health care quality measurement, outlines specific measure evaluation criteria. There must be an importance to measure and report. This includes demonstration of the evidence to support the focus of measurement, that a performance gap exists and that there is impact on the populations. Scientific acceptability refers to the reliability and validity of the measure properties at all levels of testing. i.e. element validity (data elements accurately reflect the true source documentation) and measure validity (the measure construct accurately reflects the intended purpose of the measure). Usability and use is the extent to which potential audiences are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations. And finally, feasibility considers the availability of data and data capture without undue burden.</p> <p>The measure development process includes many decision points that are all considered and addressed very deliberately by the measure development workgroups. These decisions are reached with a consensus based approach where the acceptable solution can be supported by all even if it’s not the favorite choice or ideal solution for each individual. Hopefully these decisions can be made during the workgroup meetings, but occasions do arise where some follow up email communication is required. It is up to the workgroup chairperson to determine when enough input has been offered to formulate the recommendation to MARC. In</p>	<p>None</p>

Topic	Discussion	Action
	the event that consensus cannot be reached by a workgroup, the topic is submitted to MARC for discussion, direction and/or decision.	
Review of Optimal Asthma Care Measure	<p>This measure was originally developed and approved for implementation in 2009 and was subsequently included in the MN Rule for reporting in 2010. In 2011, the workgroup reconvened to review the first year of data as well as feedback received from providers during implementation. The eventual recommendation to MARC was for no changes to the measure. In 2012, MNMCM submitted the OAC measure to NQF for endorsement. The NQF steering committee did not recommend the measure for endorsement, and based on their feedback as well as continued feedback from the provider community, MARC has requested the current review by the workgroup for two of the three components: the written asthma management plan and the risk of exacerbations.</p> <p>The measure is reported by two populations, ages 5 – 17 and 18 – 50. It is an all or none composite, meaning that for any patient to be included in the numerator, they must hit all three targets.</p> <p>First is the control component. This component is an outcome measure and it demonstrates whether or not asthma is well controlled by reporting the score of the most recent patient reported outcome tool. The allowed tools are the Asthma Control Test, the Childhood Asthma Control Test, the Asthma Control Questionnaire and the Asthma Therapy Assessment Questionnaire.</p> <p>The second component is the risk of exacerbations component. It is an intermediate outcome and allows for numerator inclusion if the patient self-reports less than 2 ED visits or hospitalization due to asthma.</p> <p>The third component is the presence in the record, with creation, revision or review during the measurement year, of a written asthma management plan that has three required elements.</p> <p><u>MNCM Data Analysis</u></p> <p>NQF has a high standard regarding the evidence to support a process measure. There must be a high quality and consistent body of evidence that the measured process leads to a desired health outcome. Specifically, there must be empirical evidence where the specific focus of the evidence matches what is being measured.</p> <p>While there exists strong evidence that comprehensive education and self-management strategies inclusive of a written management plan impact asthma outcomes, the evidence supporting the independent influence of a written management plan are at best, mixed.</p> <p>In light of the mixed evidence regarding the written management plans, MNMCM conducted an analysis of the 2011, 2012 and 2013 data. We used the most appropriate test for this data set to evaluate association, which is the chi-square test. Separating the pediatric and adult data and excluding patients for whom there was no control score reported, we evaluated the association between the presence of a written plan to whether someone was in control or not. The chi-square test compares the expected frequency of each category due to random distribution with the observed frequency and determines if the difference between the two is different enough to be statistically significant, which indicates that the variation is not random but has other influences.</p>	None

Topic	Discussion	Action
	<p>The analysis demonstrated that there is a higher incidence of control when there is a plan, and non-control when there is not a plan, than we would expect due to random variation. Furthermore the degree of certainty regarding this variation being NOT due to random variation is represented by the very low p value of less than 0.0001.</p> <p>The pediatric population demonstrates similar results.</p>	
<p>Discussion of Written Asthma Management Plan Component</p>	<p>Workgroup discussion began with addressing the feedback received from the National Quality Forum. NQF feedback included: An asthma care plan is recommended by the NHBLI guideline, however the specification of the asthma management plan has a large degree of variability, and guideline recommendations alone (without empirical scientific evidence) do not constitute a strong enough evidence base for endorsement for process measures. Comments regarding the research: it is unclear whether the presence or absence of a management plan impacted outcome. Overall statement included: As long as control was achieved, the NQF committee questioned why the action plan was identified as the method that must be included for the provider to be successful. Also, during the same endorsement cycle, the Joint Commission process measure regarding asthma action plans for hospitalized patients was reviewed and had its endorsement removed due to lack of evidence of the process impacting outcomes.</p> <p><u>Work group member comments:</u></p> <ul style="list-style-type: none"> ▪ Much work in the community has been done in recent years regarding this component and if this component is no longer included, a concerted communication and education plan must be developed when the changes are implemented. Especially in light of the practice guidelines including written action plans. ▪ Written action plans are useful for many asthmatics, but should not be a criterion for every asthmatic without reference to severity of asthma and/or individual patient needs. ▪ If this component isn't included in the composite, it should still be measured for school-aged children. As it is, school nurses still struggle to get action plans and count on them to effectively help their students. ▪ Including this component in the measure has added some additional burden and a requirement to change some practices, but it has led to improvements in care. It has standardized this component of asthma care and has added tremendous value. ▪ The original workgroup spent considerable time discussing this measure and felt that the action plan was critical to comprehensive asthma care and should subsequently be included in measurement of that care. ▪ If this component is removed from the measure, providers may stop doing them because "they don't have to anymore." ▪ Any changes to this measure also impact health plan quality programs. ▪ Written action plans are beneficial and useful but quality measurement should be based on a strong body of evidence for impacting outcomes. The clinician should determine the need for an action plan and not be characterized as delivering poor quality care if it isn't beneficial. ▪ There is no perfect measure that will fit every patient. The 80/20 rule is a good rule of thumb for considering the value of a measure; does it benefit 80% of patients. ▪ Stratifying the measure or having hierarchal requirements is not feasible from a data collection perspective. 	

Topic	Discussion	Action
	<ul style="list-style-type: none"> ▪ Because EMR's have become so sophisticated, patient education isn't necessarily happening, but boxes are being checked, asthma plans are being printed, and patients are leaving with the plans to review on their own or being educated elsewhere. Providers have the ability to game the system. ▪ Evidence shows that people are much more satisfied with the care they receive when they receive an asthma action plan. ▪ While measurement should not be a check-box, this is the best we have available to evaluate this important component of asthma care. ▪ Measurement's intent is to improve individual care, population management of a disease and help us systematize our care delivery within health systems. This measure fulfills parts of each of these areas about as well as all of our other measures. ▪ If the intent of the measure is to evaluate how well a doctor is directly impacting individual patients then there is not enough evidence to say that doctors should be using an action plan with every single patient. If the goal of the measure is to provide structure, framework, support for those other than the patient that are supporting the patient (school nurses, family caregivers, etc.), then it is incredibly meaningful. <p><u>Work group members agreed on the following points:</u></p> <ul style="list-style-type: none"> ▪ The written asthma action plan is meaningful for the majority of asthma patients. ▪ Changes should be made to the language on MNHealthScores.org describing the asthma data. It currently states: "The bar charts and percentages below will tell you how successful MN physicians and other health care providers are in helping adults and children with asthma get all the care they need." The workgroup is uncomfortable with the oversimplification and would like to see a more detailed description of the measure components and caution equating that with the only way to deliver high quality care. <p>Consensus was reached to maintain the written asthma management plan component of the measure without changes.</p>	<p>Recommendation to MARC: Maintain written asthma management plan component as is.</p> <p>Revise language on mnhealthscores.org asthma page regarding the data and what it means.</p>
Discussion of Risk of Exacerbation Component	<p>NQF feedback questioned why a hospitalization and ED visit would receive equal weighting when the events themselves indicate very different levels of care required.</p> <p>Options considered were:</p> <ul style="list-style-type: none"> ▪ allow for zero hospitalizations or ED visits ▪ allow for one ED visit but zero hospitalizations ▪ allow for one ED visit or hospitalization (current measure construct) ▪ remove component completely <p><u>Work group member comments:</u></p> <ul style="list-style-type: none"> ▪ How can a physician be considered to be delivering optimal care if a patient is hospitalized due to asthma? Other factors can drive ED utilization, but if it is determined that the patient needs to be hospitalized, that patient is not in control. ▪ Risk adjustment should be applied to ED counts to account for higher risk populations that have access issues ▪ Some medical groups have been creative about how to better serve these patients to keep them out of the ED and have had success achieving higher performance scores in that regard 	

Topic	Discussion	Action
	<ul style="list-style-type: none"> ▪ If the measure changes to not allow any hospitalizations in a year, providers will feel penalized for patients that have historically been in good control and haven't been seen for some time, but end up coming in for follow up after a hospitalization. ▪ There will always be hospitalizations but the impact for unrelated, isolated events should be minimal. <p>Consensus was reached to maintain the risk of exacerbations component of the measure without changes.</p>	<p>Recommendation to MARC: Maintain risk of exacerbations component as is.</p>
Closing		

OPTIMAL ASTHMA CARE WORKGROUP

Written Management Plan Literature Review



Abstracts

January 2014

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

LITERATURE REGARDING WRITTEN MANAGEMENT PLANS

Abbreviation

Abstract

Bohgal (2006)

Background

While all asthma consensus statements recommend the use of written action plan (WAP) as a central part of asthma management, a recent systematic review of randomised trials highlighted the paucity of trials where the only difference between groups was the provision or not of a written action plan.

Objectives

The objectives of this review were firstly to evaluate the independent effect of providing versus not providing a written action plan in children and adolescents with asthma, and secondly to compare the effect of different written action plans.

Search methods

We searched the Cochrane Airways Group Specialised Register (November 2004), which is derived from searches of CENTRAL, MEDLINE, EMBASE, CINAHL, as well as handsearched respiratory journals, and meeting abstracts. We also searched bibliographies of included studies and identified review articles.

Selection criteria

Randomised controlled trials were included if they compared a written action plan with no written action plan, or different written action plans with each other.

Data collection and analysis

Two authors independently selected the trials, assessed trial quality and extracted the data. Study authors were contacted for additional information.

Main results

Four trials (three RCTs and one quasi-RCT) involving 355 children were included. Children using symptom-based WAPs had lower risk of exacerbations which required an acute care visit (N = 5; RR 0.73; 95% CI 0.55 to 0.99). The number needed to treat to prevent one acute care visit was 9 (95% CI 5 to 138). Symptom monitoring was preferred over peak flow monitoring by children (N = 2; RR 1.21; 95% CI 1.00 to 1.46), but parents showed no preference (N = 2; RR 0.96; 95% CI 0.18 to 2.11). Children assigned to peak flow-based action plans reduced by 1/2 day the number of symptomatic days per week (N = 2; mean difference: 0.45 days/week; 95% CI 0.04 to 0.26). There were no significant group differences in the rate of exacerbation requiring oral steroids or admission, school absenteeism, lung function, symptom score, quality of life, and withdrawals.

Authors' conclusions

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 conclude 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.

PLAIN LANGUAGE SUMMARY

This review examines the net impact of providing written action plans to children with asthma and their parents

We did not find any trial examining the benefit of providing versus not providing a written action plan to children with asthma. Four clinical trials with 355 children were identified which compared the effect of symptom-based versus to peak flow written action plans when all other co-interventions were similar. Children assigned to a symptom-based plan less frequently required an acute care visit for asthma compared to those who received a peak flow based plan. Most other outcomes were similar with the exception of more children intending to continue using the symptom-based compared to the peak-flow based written action plan.

Burrill (2009)	<p>Abstract unavailable; discussion section of article presented here.</p> <p>COMMENTARY</p> <p>The British Thoracic Society recommends that “patients with asthma be given written personalised action plans to reinforce self-management education”. In particular “prior to discharge in-patients should receive written personalised action plans from a clinician with expertise in asthma management”.¹ This sentiment is echoed in many national and international guidelines.² An example of a simple written management plan incorporating the key elements of current advice² is shown in fig 1. In adult patients with asthma, the health benefits of these self-management plans has been proven,^{3 4} but whether this can be applied to children at all remains controversial.⁵ Previous attempts to answer the vexed question of whether written asthma management plans are beneficial in children with asthma have identified a paucity of high-quality evidence on which to base this decision.^{5 11} Most of the studies included in their analyses (four out of five) merely compared different types of written action plan.</p> <p>By reviewing all the available data (and considering studies with imperfect design) we can make some cautious judgements about the impact of written management plans on hospitalisation rates. Not only do these seem to be ineffective, but in four out of five studies we saw increases in hospitalisation. Could written management plans be harmful and if so, how?</p> <p>One possible answer to this conundrum comes from looking at the impact of educational interventions on concordance in children with asthma. Paton has shown that education may actually reduce concordance.¹² Whilst this finding seems counterintuitive, it may explain how a combined education programme and written management plan might potentially do more harm than good. Reading through the studies another pattern emerges. This is one of reported benefit in symptom reduction and unscheduled healthcare attendances that fall short of hospital admission. Initially this seems at odds with an observed increased rate of hospitalisation, but written plans might discourage attendance at the general practitioner or emergency department until the child has deteriorated to a point where hospitalisation is inevitable.</p> <p>National guidelines continue to recommend the provision of written asthma management plans in adults and children with asthma. (Grade D) c Whilst there is good evidence for this practice in adults (grade A), evidence is lacking in children and worryingly hospitalisations may be increased in those receiving written management plans.</p>
Ducharme (2011)	<p>Rationale: An acute-care visit for asthma often signals a management failure. Although a written action plan is effective when combined with self-management education and regular medical review, its independent value remains controversial.</p> <p>Objectives: We examined the efficacy of providing a written action plan coupled with a prescription (WAP-P) to improve adherence to medications and other recommendations in a busy emergency department.</p> <p>Methods: We randomized 219 children aged 1–17 years to receive WAP-P (n 5 109) or unformatted prescription (UP) (n 5 110). All received fluticasone and albuterol inhalers, fitted with dose counters, to use at the discretion of the emergency physician. The main outcome was adherence to fluticasone (use/prescribed 3 100%) over 28 days. Secondary outcomes included pharmacy dispensation of oral corticosteroids, b2-agonist use, medical follow-up, asthma education, acute-care visits, and control.</p> <p>Measurements and Main Results: Although both groups showed a similar drop in adherence in the initial 14 days, adherence to fluticasone was significantly higher over Days 15–28 in children receiving WAP-P (mean group difference, 16.13% [2.09, 29.91]). More WAP-P than UP patients filled their oral corticosteroid prescription (relative risk, 1.31 [1.07, 1.60]) and were well-controlled at 28 days (1.39 [1.04, 1.86]). Compared with UP, use of WAP-P increased physicians’ prescription of maintenance fluticasone (2.47 [1.53, 3.99]) and recommendation for medical follow-up (1.87 [1.48, 2.35]), without group differences in other outcomes.</p> <p>Conclusions: 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.</p>

Fassl (2012)	<p>BACKGROUND AND OBJECTIVES: The Joint Commission introduced 3 Children’s Asthma Care (CAC 1–3) measures to improve the quality of pediatric inpatient asthma care. Validity of the commission’s measures has not yet been demonstrated. The objectives of this quality improvement study were to examine changes in provider compliance with CAC 1–3 and associated asthma hospitalization outcomes after full implementation of an asthma care process model (CPM).</p> <p>METHODS: The study included children aged 2 to 17 years who were admitted to a tertiary care children’s hospital for acute asthma between January 1, 2005, and December 31, 2010. The study was divided into 3 periods: preimplementation (January 1, 2005–December 31, 2007), implementation (January 1, 2008–March 31, 2009), and postimplementation (April 1, 2009–December 31, 2010) periods. Changes in provider compliance with CAC 1–3 and associated changes in hospitalization outcomes (length of stay, costs, PICU transfer, deaths, and asthma readmissions within 6 months) were measured. Logistic regression was used to control for age, gender, race, insurance type, and time.</p> <p>RESULTS: A total of 1865 children were included. Compliance with quality measures before and after the CPM implementation was as follows: 99% versus 100%, CAC-1; 100% versus 100%, CAC-2; and 0% versus 87%, CAC-3 (P , .01). Increased compliance with CAC-3 was associated with a sustained decrease in readmissions from an average of 17% to 12% (P = .01) postimplementation. No change in other outcomes was observed.</p> <p>CONCLUSIONS: Implementation of the asthma CPM 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.</p>
FitzGerald (2010)	<p>Patients with moderate asthma are symptomatic on an ongoing basis. They are usually treated initially with low-dose inhaled corticosteroids (ICSs) supplemented with a short-acting bronchodilator as a rescue medication. Most steroid-naïve patients will achieve good control with this strategy. For patients in whom adherence, inhaler technique, environmental control, and comorbidities have been addressed but who still have uncontrolled symptoms, the addition of a long-acting b-adrenergic agonist should be considered. Some patients might require a higher dose of ICS. Leukotriene receptor antagonists might be considered as alternate initial therapy or as an add-on to maintenance therapy with an ICS. 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. The most effective strategy in this situation has been shown to be the quadrupling of the maintenance dose of ICS.</p>

Gibson (2002)

Background

A key component of many asthma management guidelines is the recommendation for patient education and regular medical review. A number of controlled trials have been conducted to measure the effectiveness of asthma education programmes. These programmes improve patient knowledge, but their impact on health outcomes is less well established. This review was conducted to examine the strength of evidence supporting Step 6 of the Australian Asthma Management Plan: “Educate and Review Regularly”; to test whether health outcomes are influenced by education and self-management programmes.

Objectives

The objective of this review was to assess the effects of asthma self-management programmes, when coupled with regular health practitioner review, on health outcomes in adults with asthma.

Search methods

We searched the Cochrane Airways Group trials register and reference lists of articles.

Selection criteria

Randomised trials of self-management education in adults over 16 years of age with asthma.

Data collection and analysis

Two reviewers assessed trial quality and extracted data independently. We contacted study authors for confirmation.

Main results

We included thirty six trials, which compared self-management education with usual care. Self-management education reduced hospitalisations (relative risk (RR) 0.64, 95% confidence interval (CI) 0.50 to 0.82); emergency room visits (RR 0.82, 95% CI 0.73 to 0.94); unscheduled visits to the doctor (RR 0.68, 95% CI 0.56 to 0.81); days off work or school (RR 0.79, 95% CI 0.67 to 0.93); nocturnal asthma (RR 0.67, 95% CI 0.56 to 0.79); and quality of life (standard mean difference 0.29, CI 0.11 to 0.47). Measures of lung function were little changed.

Authors’ conclusions

Education in asthma self-management which involves self-monitoring by either peak expiratory flow or symptoms, coupled 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.

PLAIN LANGUAGE SUMMARY

Self-management education and regular practitioner review for adults with asthma

Guidelines for the treatment of asthma recommend that patients be educated about their condition, obtain regular medical review, monitor their condition at home with either peak flow or symptoms and use a written action plan. The results of trials comparing asthma self-management education to usual care were combined. These results showed that asthma sufferers who were educated about their asthma, visited the doctor regularly and who used a written action plan had fewer visits to the emergency room; less hospital admissions; better lung function; improvement in peak expiratory flow; fewer symptoms; and used less rescue medication.

Janson (2009)	<p>Background: Adherence to inhaled anti-inflammatory therapy and self-management skills are essential parts of the asthma treatment plan to improve asthma control and prevent exacerbations. Whether self-management education improves long-term medication adherence is less clear.</p> <p>Objective: A 24-week prospective, randomized controlled trial was performed to study the effect of self-management education on long-term adherence to inhaled corticosteroid (ICS) therapy and markers of asthma control.</p> <p>Methods: After stabilization on ICS medication during a run-in phase, 95 adults with moderate-to-severe asthma were recruited from a large metropolitan community, and 84 were randomized to individualized self-management education, including selfmonitoring of symptoms and peak flow or usual care with selfmonitoring alone. The key components of the 30-minute intervention were asthma information, assessment, and correction of inhaler technique; an individualized action plan based on self-monitoring data; and environmental control strategies for relevant allergen and irritant exposures. The intervention was personalized based on pulmonary function, allergen skin test reactivity, and inhaler technique and reinforced at 2-week intervals.</p> <p>Results: Participants randomized to the self-management intervention maintained consistently higher ICS adherence levels and showed a 9-fold greater odds of more than 60% adherence to the prescribed dose compared with control subjects at the end of the intervention (P 5.02) and maintained a 3-fold greater odds of higher than 60% adherence at the end of the study. Perceived control of asthma improved (P 5 .006), nighttime awakenings decreased (P 5 .03), and inhaled b-agonist use decreased (P 5 .01) in intervention participants compared with control subjects.</p> <p>Conclusion: Our results show that individualized asthma selfmanagement education attenuates the usual decrease in medication adherence and improves clinical markers of asthma control.</p>
Kaya (2009)	<p>Objective. To evaluate the impact of peak flow or symptom-based self-management plans on asthma control and patients' quality of life and to determine the main psychosocial factors that affect compliance with these plans.</p> <p>Methods. The study sample consisted of 63 patients with persistent asthma outpatients. Data collection included demographics, pulmonary functions, symptom scores, and asthma control parameters recorded over the previous 2 consecutive years. A standard asthma self-management education program including personal action plans was given to the patients who were randomly divided into peak flow meter (PFM) (n = 31) or symptom-based (n = 32) action plan groups. Patients were then assessed prospectively for various study outcomes including symptoms, drug compliance, psychiatric co-morbidities, quality of life, and asthma control over the next 12 months. Psychiatric co-morbidities were assessed using Rotter's Internal and External Locus of Control Scale (RIELCS), Beck Depression Inventory (BDI), Structured Clinical Interview for DSM-IV (SCID-I), Spielberger State-Trait-Anxiety Inventory (STAI), and Short Form-36 (SF-36).</p> <p>Results. Of the 63 patients (79% female; mean age 43), 85% of them had moderately or severely persistent asthma. Baseline demographics, clinical parameters, psychiatric diagnosis, and quality of life were not different between groups. Personal asthma plans increased optimal asthma control significantly. Emergency visits, antibiotic treatments, systemic corticosteroid treatments, and unscheduled visits were fewer than the previous year. Control parameters were better in the PFM group. After the self-management education, the quality of life dimensions, i.e., vitality, total mental and general scores of both groups increased. Frequency of psychiatric co-morbidities decreased from 61.9% to 49.2%. However, state anxiety levels were increased in both groups. These increases were statistically significant in the PFM group. Compliance with the action plans was better in the PFM group. Higher BDI scores were associated with worse compliance. No statistically significant association was found between demographic parameters and the compliance. Although the compliance had decreased in both groups after 6 months, this decrease was greater in the symptom group. Higher RIELCS and mental health scores were associated with better compliance.</p> <p>Conclusion. Introduction of self-management plans improved illness control and quality of life in asthma patients. Use of the PFM and the presence of higher RIELCS and lower BDI scores can be used to predict compliance with the action plans.</p>

Morse (2011)	<p>Context The Children’s Asthma Care (CAC) measure set evaluates whether children admitted to hospitals with asthma receive relievers (CAC-1) and systemic corticosteroids (CAC-2) and whether they are discharged with a home management plan of care (CAC-3). It is the only Joint Commission core measure applicable to evaluate the quality of care for hospitalized children.</p> <p>Objectives To evaluate longitudinal trends in CAC measure compliance and to determine if an association exists between compliance and outcomes.</p> <p>Design, Setting, and Patients Cross-sectional study using administrative data and CAC compliance data for 30 US children’s hospitals. A total of 37 267 children admitted with asthma between January 1, 2008, and September 30, 2010, with follow-up through December 31, 2010, accounted for 45 499 hospital admissions. Hospital-level CAC measure compliance data were obtained from the National Association of Children’s Hospitals and Related Institutions. Readmission and postdischarge emergency department (ED) utilization data were obtained from the Pediatric Health Information System.</p> <p>Main Outcome Measures Children’s Asthma Care measure compliance trends; postdischarge ED utilization and asthma-related readmission rates at 7, 30, and 90 days.</p> <p>Results The minimum quarterly CAC-1 and CAC-2 measure compliance rates reported by any hospital were 97.1% and 89.5%, respectively. Individual hospital CAC-2 compliance exceeded 95% for 97.9% of the quarters. Lack of variability in CAC-1 and CAC-2 compliance precluded examination of their association with the specified outcomes. Mean CAC-3 compliance was 40.6% (95% CI, 34.1%-47.1%) and 72.9% (95% CI, 68.8%-76.9%) for the initial and final 3 quarters of the study, respectively. The mean 7-, 30-, and 90-day postdischarge ED utilization rates were 1.5% (95% CI, 1.3%-1.6%), 4.3% (95% CI, 4.0%-4.5%), and 11.1% (95% CI, 10.5%-11.7%) and the mean quarterly 7-, 30-, and 90-day readmission rates were 1.4% (95% CI, 1.2%-1.6%), 3.1% (95% CI, 2.8%-3.3%), and 7.6% (95% CI, 7.2%-8.1%). There was no significant association between overall CAC-3 compliance (odds ratio [OR] for 5% improvement in compliance) and postdischarge ED utilization rates at 7 days (OR, 1.00; 95% CI, 0.98-1.02), 30 days (OR, 0.97; 95% CI, 0.90-1.04), and 90 days (OR, 0.96; 95% CI, 0.77-1.18). In addition, there was no significant association between overall CAC-3 compliance (OR for 5% improvement in compliance) and readmission rates at 7 days (OR, 1.00; 95% CI, 0.99-1.02), 30 days (OR, 0.99; 95% CI, 0.96-1.02), and 90 days (OR, 1.01; 95% CI, 0.90-1.12).</p> <p>Conclusion 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 the CAC-3 measure but no association between CAC-3 compliance and subsequent ED visits and asthma-related readmissions.</p>
Patel (2012)	<p>Background: Asthma action plans (AAPs) are a priority recommendation of the National Asthma Education and Prevention Program and have been shown to positively affect health outcomes. Patient satisfaction is an important clinical outcome, yet little is known about its association with receiving an AAP. This study examined the association between having an AAP and behaviors to keep asthma in control and patient satisfaction with care.</p> <p>Methods: The study design was a cross-sectional analysis of baseline data from a randomized trial evaluating a self-management program among 808 women with asthma. Participants reported demographic information, interactions with clinicians, whether they had an AAP and owned a peak flow meter, self-management behaviors, and symptoms.</p> <p>Results: The mean age of the participants was 48 ± 13.6 years, 84% (n = 670) were satisfied with their asthma care, and 48% (n = 383) had a written AAP from their physician. Women not having an AAP were less likely to take asthma medication as prescribed [OR, 2.15; 95% CI, 1.53-3.00, P = .001], to initiate a discussion about asthma with their physicians [OR, 2.35; 95% CI, 1.68-3.28, P = .001], and to own a peak flow meter [OR, 2.84; 95% CI, 2.07-3.94, P = .001]. Adjusting for asthma control, income, and medical specialty, women who did not have an AAP were more likely to report dissatisfaction with their asthma care (OR, 2.07; 95% CI, 1.35-3.17; P = .001).</p> <p>Conclusions: Women without an AAP were less likely to initiate discussions with their physicians, take medications 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.</p>

Sunshine (2011)

Background: Guidelines from the National Asthma Education and Prevention Program stipulate that multicomponent self-management interventions for asthma should include a written action plan (WAP). However the specific, independent effect of WAPs in improving outcomes remains unclear.

Objective: To measure the association between WAP use during the previous year and improved asthma outcomes.

Methods: We conducted a longitudinal quasi-experimental study using data from the Healthy Homes II (HH-II) randomized controlled trial in Seattle, WA. Action plan use during the previous year was measured at exit of HH-II. A participant was a WAP user if he used his action plan every day, almost every day, or once per week, and non-user if he did not meet these criteria. Sensitivity analyses explored less stringent criteria for WAP user designation. Prespecified outcomes were baseline-to-exit changes in asthma control in the previous 2 weeks, Pediatric Asthma Caregiver Quality of Life Scale score, and urgent health services utilization. We used robust linear and logistic regression to compare outcomes across groups.

Results: Two hundred fifty-one patients participated: 112 WAP users; 139 non-users. After adjustment, no significant differences in outcomes were observed between WAP users and non-users. Among a subgroup of participants with recent urgent health services utilization, WAP users had better asthma control than non-users. Changing WAP user criteria to include those who simply owned an action plan, irrespective of use, did not alter our results.

Conclusion: 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.

<p>Wolf (2002)</p>	<p>Background Self-management education programs have been developed for children with asthma, but it is unclear whether such programs improve outcomes.</p> <p>Objectives To determine the efficacy of asthma self-management education on health outcomes in children.</p> <p>Search methods Systematic search of the Cochrane Airways Group's Special Register of Controlled Trials and PSYCHLIT, and hand searches of the reference lists of relevant review articles.</p> <p>Selection criteria Randomized and controlled clinical trials of asthma self-management education programs in children and adolescents aged 2 to 18 years.</p> <p>Data collection and analysis All studies were assessed independently by two reviewers. Disagreements were settled by consensus. Study authors were contacted for missing data or to verify methods. Subgroup analyses examined the impact of type and intensity of educational intervention, selfmanagement strategy, trial type, asthma severity, adequacy of follow-up, and study quality.</p> <p>Main results Of 45 trials identified, 32 studies involving 3706 patients were eligible. Asthma education programs were associated with moderate improvement in measures of airflow (standardized mean difference [SMD] 0.50, 95% confidence interval [CI] 0.25 to 0.75) and selfefficacy scales (SMD 0.36, 95% CI 0.15 to 0.57). Education programs were associated with modest reductions in days of school absence (SMD -0.14, 95% CI -0.23 to -0.04), days of restricted activity (SMD -0.29, 95% CI -0.49 to -0.08), and emergency room visits (SMD -0.21, 95% CI -0.33 to -0.09). There was a reduction in nights disturbed by asthma when pooled using a fixed-effects but not a random-effects model. Effects of education were greater for most outcomes in moderate-severe, compared with mild-moderate asthma, and among studies employing peak flow versus symptom-based strategies. Effects were evident within the first six months, but for measures of morbidity and health care utilization, were more evident by 12 months.</p> <p>Authors' conclusions Asthma self-management education programs in children improve a wide range of measures of outcome. Self-management education directed to prevention and management of attacks should be incorporated into routine asthma care. Conclusions about the relative effectiveness of the various components are limited by the lack of direct comparisons. Future trials of asthma education programs should focus on morbidity and functional status outcomes, including quality of life, and involve direct comparisons of the various components of interventions.</p> <p>PLAIN LANGUAGE SUMMARY Educational interventions for asthma in children 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 health care utilization until 7 to 12 months following enrolment in an educational program.</p>
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Zemek (2008)

Objectives: To evaluate the independent effect of a written action plan vs no plan and to compare different plans to identify characteristics of effective plans in children with asthma.

Data Sources: We searched the Cochrane Airways Group Clinical Trials Register until March 2006, including MEDLINE, EMBASE, CINAHL, and the Cochrane Central Register of Controlled Trials, for randomized controlled trials that evaluated asthma action plans in the pediatric population.

Study Selection: Eligible studies were randomized or quasi-randomized controlled trials with participants aged 0 to 17 years diagnosed with asthma. Of 428 citations, 1 trial compared a peak flow-based plan with none and 4 parallel-group trials compared symptom-based plans with peak flow-based plans.

Intervention: Provision of a written action plan. Control groups received no action plan or another type of plan. All cointerventions (both medical and educational) were similar in both groups.

Main Outcome Measure: The number of children with at least 1 acute care asthma visit.

Results: Written action plan use significantly reduced acute care visits per child as compared with control subjects. Children using plans also missed less school, had less nocturnal awakening, and had improved symptom scores. As compared with peak flow-based plans, symptom-based plans significantly reduced the risk of a patient requiring an acute care visit.

Conclusions: Although there are limited data to firmly conclude that provision of an action plan is superior to none, there is clear evidence suggesting that symptombased plans are superior to peak flow-based plans in children and adolescents.



MN Community Measurement
 Total Knee Replacement Measures
 Recommendation for Inclusion in SQRMS- April 2014

<p>Degree of Impact</p>	<p>Annually there are over 500,000 total knee replacement (TKR) procedures performed in the US. It is projected that by 2030 the volume of this procedure will increase to over 3.48 million per year due to the aging baby-boomers, increased obesity and indications for TKR that extend to both younger as well as older patients.¹ From 2000 to 2006, the Medicare TKR rate overall in the United States increased 58%, from 5.5 to 8.7 per 1000² and TKR revisions currently represent 8.2% of all Medicare dollars spent.³ It is estimated that annual hospital charges for TKR will approach 40.8 billion dollars annually by 2015.⁴</p> <p>For the Minnesota Medicare population in 2006, 9,856 patients underwent a primary hip or knee replacement procedure (DRG 544) and 1,174 patients had a hip or knee revision (DRG 545). Nationally, for DRG 544 the average charge per hospitalization was \$38,447 with an average payment of \$11,916.⁵</p> <p>For consumers, there is a lack of publicly reported information that would provide patients with an understanding of potentially how well they will function after having total knee replacement surgery. These measures will provide outcome data for patients that currently does not exist.</p>
<p>Degree of improvability</p>	<p>Minnesota demonstrates an increased incidence of total knee replacement compared to the rest of the nation, with MN regional rates in the range of 10.8 to 12.9 per 1000 Medicare enrollees compared to the national average of 8.8.⁶ Volumes of procedures have increased, both in Minnesota and nationally, reflecting an aging and more active baby-boomer population and rates of total knee replacement are expected to increase exponentially.</p>
<p>Degree of inclusiveness</p>	<p>Approximately 12 percent of adults older than 60 have symptoms of knee osteoarthritis,⁷ and 94% of patients undergoing a primary TKR do so because of osteoarthritis.</p> <p>There are few absolute contra-indications to TKR other than active local or systemic infection and other medical conditions that substantially increase the risk of serious perioperative complications or death.⁸</p> <p>Because it is an elective procedure, patients have a lower Charlson Comorbidity Index (CCI), for primary TKR the score distribution was 64% at 0, 23% at 1 and 13% at 2 or greater.⁹ This procedure is not limited by age, gender or race; however it does occur more frequently for whites and females. Blacks and individuals with low income undergo this procedure less frequently and have higher rates of adverse outcomes. Obesity is not a contraindication to this procedure; however this comorbidity can lead to an increased risk of delayed wound healing or perioperative infection.</p> <p>A study by Mayo clinic (n = 4701) found moderate-severe activity limitation was reported by 20.7% at 2-years post TKR and identified risk factors to be BMI > 30, female gender and increased co-morbidity index.¹⁰</p>
<p>National consensus</p>	<p>This measure is currently not endorsed by the National Quality Forum.</p>
<p>Performance variation</p>	<p>Unknown at this time. More information regarding performance variation will be available in Fall 2014. It is important to note that administering PRO tools to patients pre and postoperatively is feasible and has been demonstrated by recent pilot results for patients undergoing lumbar spine</p>



MN Community Measurement
 Total Knee Replacement Measures
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	surgery.
Degree of validity/reliability	Pilot participants successfully completed standard validation audits, concluded that pilot data was acceptable for analysis and rate calculation. Reliability statistics (measuring the degree of variability between practices) requires at least one full cycle of data collection. More information will be available in the fall of 2014.
Degree of alignment	There are currently no other measures that calculate outcomes based on functional status for this population of patients.
Degree of burden	Pilot participants were surveyed utilizing MNCM's standard survey format for assessing feasibility and burden during the pilot testing of a measure. Surprisingly, groups rated administering PRO tools to their patients as more challenging than doing the EMR builds necessary to store and then later extract the data. Pilot testing reiterates the need to allow time to implement PRO tools into practice prior to the start of a measurement period. The data used is generated by and used by healthcare personnel during the provision of care and may be stored in structured fields in an EHR.

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.

¹ American Association of Orthopedic Surgeons 2006 Annual Meeting Presentation Future Caseload Kurtz SM

² Racial Disparities in Total Knee Replacement Among Medicare Enrollees 2000—2006 MMWR 2/20/2009

³ Economic Burden of Total Hip and Knee Arthroplasty in Medicare Enrollees Ong et al 2006



MN Community Measurement
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⁴ Kaiser-Permanente March 2007, Future Clinical & Economic Impact of Revision Total Hip & Knee Revision Kurtz, Ong JBJS 2007

⁵ Inpatient Hospital Payment Information for Value-Driven Health Care Top 31 DRGs Aug 2008 www.cms.gov

⁶ Trends and Regional Variation in Hip, Knee and Shoulder Replacement: The Dartmouth Institute for Health Policy and Clinical Practice April 2010

⁷ Total Knee Replacement Appears Cost-Effective In Older Adults Arch Internal Med June 2009

⁸ NIH Consensus Development Program Conference on Total Knee Replacement- 2003

⁹ Epidemiology of Total Knee Replacement in the United States Medicare Population JBJS 2005

¹⁰ Predictors of moderate-severe functional limitation after primary TKA at 2 and 5 Yrs Mayo Clinic AORSI May 2009



MN Community Measurement
Lumbar Spine Surgery Measures
Recommendation for Inclusion in SQRMS- April 2014

<p>Degree of Impact</p>	<p>Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point in their lifetime. For individuals younger than 45 years, LBP represents the most common cause of disability and is generally associated with a work-related injury. It is the third most common reason for disability for individuals older than 45 years. The prevalence of serious mechanical LBP (persisting > 2 weeks) is 14%, while the prevalence of true sciatica is approximately 2%. Of all cases of mechanical LBP, 70% are due to lumbar strain or sprain, 10% are due to age-related degenerative changes, 4% are due to herniated disks, 4% are due to osteoporotic compression fractures and 3% are due to spinal stenosis.¹ According to the National Ambulatory Medical Care Survey in 2002, visits to a physician in the last past three months for low back pain were reported by 26.4% of the respondents.²</p> <p>In 2005, Americans spent an estimated \$85.9 billion for back and neck pain related treatment (medications, office visits, physical therapy and surgery). Age, sex and inflation adjusted health care expenditures increased 65% between 1997 and 2005 without evidence of improvement in health status.^{3,4}</p> <p>Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex spinal fusion procedures has increased 15-fold, from 1.3 to 19.9 per 100,000 Medicare beneficiaries. Complications increased with increasing surgical invasiveness, from 2.3% among patients having decompression alone to 5.6% among those having complex spinal fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex spinal fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50-3.49).⁵</p> <p>For consumers, there is a lack of publicly reported information that would provide patients with an understanding of potentially how well they will function after having lumbar spinal surgery. These measures are cutting edge and will provide outcome data for patients that currently do not exist.</p>
<p>Degree of improvability</p>	<p>Minnesota, as compared to national Medicare statistics⁶, demonstrates a lumbar spinal fusion rate that is four times the national average [0.84 per 1000 enrollees as compared to 0.2 per 1000]. Spinal fusion has become one of medicine's most controversial procedures. Some surgeons argue that spinal fusion is appropriate only for a small number of conditions, such as spinal instability, spinal fracture or severe curvature of the spine and that the financial incentives have caused the procedure to become overused. Others say that it is a useful tool to treat patients who have debilitating back pain and have tried other options, like physical therapy, to no avail.⁷</p>
<p>Degree of inclusiveness</p>	<p>Low back pain is a leading cause of disability. It occurs in similar proportions in all cultures, interferes with quality of life and work performance, and is the most common reason for medical consultations. Few cases of back pain are due to specific causes; most cases are non-specific. Acute back pain is the most common presentation and is usually self-limiting, lasting less than three months regardless of treatment. Chronic back pain is a more difficult problem, which often has strong psychological overlay: work dissatisfaction, boredom, and a generous compensation system contribute to it.⁸</p> <p>Low back pain is often triggered by some combination of overuse, muscle strain, or injury to the muscles and ligaments that support the spine. Less commonly, low back pain is caused by illness or</p>



MN Community Measurement
Lumbar Spine Surgery Measures
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	<p>spinal deformity. Risk factors include: middle age (risk decreases after age 65), male, family history of back pain, previous back injury or surgery, lack of regular exercise, job related activities that include long periods of sitting, lifting heavy objects, tobacco users, being overweight, having poor posture, stress, depression and long-term use of corticosteroids. ⁹</p> <p>The proportion of physician visits attributed to LBP has changed very little in the past decade and accounts for approximately 2% of all office visits. ¹⁰</p>
<p>National consensus</p>	<p>This measure is currently not endorsed by the National Quality Forum.</p>
<p>Performance variation</p>	<p>Pilot results demonstrate 1) the ability of orthopedic and neurosurgery practices to incorporate patient reported outcome tools into their practice and clinical work flows, 2) the ability to capture and extract needed data elements and 3) variation in outcome rates.</p> <p>Phase I pilot results (discectomy/ laminotomy patients assessed at three months post-op) demonstrate the following: 50.2% average percent change in low back functional status scores (Oswestry Disability Index- ODI) 26.3 average change in points on the ODI scale 43.7% average percent change in low back pain 57.0% average percent change in leg pain 19.4 average points change in self-perceived health status</p> <p>Phase II pilot results (spinal fusion assessed at one year post-op) will be available in the Fall 2014.</p>
<p>Degree of validity/ reliability</p>	<p>Pilot participants successfully completed standard validation audits, concluded that pilot data was acceptable for analysis and rate calculation. Reliability statistics (measuring the degree of variability between practices) requires at least one full cycle of data collection. More information will be available in the Fall 2015.</p>
<p>Degree of alignment</p>	<p>There is currently no other functional status/ patient reported outcome measure assessing the pre and postoperative change for patients undergoing discectomy/laminotomy or lumbar spinal fusion .</p>
<p>Degree of burden</p>	<p>Pilot participants were surveyed utilizing MNCM's standard survey format for assessing feasibility and burden during the pilot testing of a measure.</p> <p>Respondents indicated some difficulty in implementing patient reported outcome (PRO) assessment tools into their clinical work flows; however were very successful in administering tools to their patients. Rates of administration approached what the measure development group considered to be an acceptable standard for administration. Pilot testing reiterates the need to allow time to implement PRO tools into practice prior to the start of a measurement period.</p> <p>No group spent more than 60 hours to program and abstract the data. Many of the measure specific fields were rated as "very easy" or "easy", but some groups had more difficulty than others. The data used is generated by and used by healthcare personnel during the provision of care and may be stored in structured fields in an EHR.</p>



MN Community Measurement
Lumbar Spine Surgery Measures
Recommendation for Inclusion in SQRMS- April 2014

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.

¹ eMedicine Mechanical Low Back Pain Hills, Everett C. MD Penn State Hershey Rehabilitation Hospital Nov 2009
<http://emedicine.medscape.com/article/310353-overview>

² Back Pain Prevalence and visit rates: estimates from US national surveys, 2002 Deyo, RA Spine Nov 2006

³ Expenditures and Health Status Among Adults with Back and Neck Problems Brook, Martin et al JAMA Feb 2008

⁴ The Price of Pain Newsweek Feb 2008

⁵ Trends, Major Medical Complications and Charges Associated with Surgery for Lumbar Spinal Stenosis in Older Adults Deyo.

⁶ Dartmouth Atlas of Health Care: Studies of Surgical Variation- Spine Surgery

⁷ Top Spine Surgeons Reap Royalties, Medicare Bounty- Wall Street Journal December 2010

⁸ Low Back Pain Erlich, George Bulletin of the World Health Organization 2003

⁹ ICSI Adult Low Back Pain Guidelines 13th Revision www.icsi.org/guidelines_and_more/gl_os_prot/musculo-skeletal/low_back_pain/low_back_pain__adult_5.html

¹⁰ Back Pain Prevalence and Visit Rates; from US National Surveys 2002 Deyo, RA Spine Nov 2006



MN Community Measurement
 Pediatric Preventive Adolescent Mental Health/ Depression Screening Measure
 Recommendation for Inclusion in SQRMS- April 2014

<p>Degree of Impact</p>	<p>2.0 million US adolescents ages 12-17 had a major depressive episode in 2008.¹ According to the Institute of Medicine’s report on mental and emotional health in children, the annual estimate for the percentage of children and adolescents with mental, emotional and behavioral disorders is between 14 and 20% and the use of prevention and early intervention can effectively delay or prevent emotional, mental or developmental disorders.² National mental health treatment expenditures were estimated at more than \$11 billion in 1998.³</p> <p>US Preventive Services Task Force conducted a study in April 2009 assessing the health effects of routine primary care screening for Major Depressive Disorder (MDD) among children and adolescents ages 7 to 18 years, including evaluating the accuracy of screening tests. The study concluded primary care feasible screening tools may be accurate in identifying depressed adolescents.</p>
<p>Degree of improbability</p>	<p>The American Academy of Pediatrics’ Bright Futures guidelines report:</p> <ul style="list-style-type: none"> • Half of all the lifetime cases of mental illness begin by the age of 14 years, which means that mental disorders are chronic diseases of the young. • An estimated 21% of U.S. children and adolescents ages 9 to 17 years have a diagnosable mental health disorder that causes at least some impairment. The under-detection of mental health problems in pediatric practice has been well documented and recognized. • One of the most efficient ways for health care professionals to improve the recognition and treatment of psychosocial problems in children and adolescents is by using a mental health screening tool.
<p>Degree of inclusiveness</p>	<p>The intent of this measure is to increase screening rates for potential mental health and/or depression conditions in the adolescent population and the measure is specified broadly to include all adolescents age 12 to 17.</p>
<p>National consensus</p>	<p>There is currently no NQF endorsed measures for screening for either mental health conditions or depression in the adolescent population.</p>
<p>Performance variation</p>	<p>Pilot results demonstrate variability and opportunity for improvement for providing screening for mental health and/or depression. Overall average rate for screening with an acceptable patient reported outcome assessment tool, one of eleven with reliable psychometric properties, is 46.3% with significant variability of rates between clinic sites.</p>
<p>Degree of validity/ reliability</p>	<p>Pilot participants successfully completed standard validation audits with rates of concurrence > 90%, and concluded that pilot data was acceptable for analysis. Reliability statistics (measuring the degree of variability between practices) requires at least one full cycle of data collection. More information will be available in the Fall of 2015.</p>
<p>Degree of alignment</p>	<p>There is currently no NQF endorsed measures for screening for either mental health conditions or depression in the adolescent population. Recently, an NQF endorsed measure “Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan” (CMS/ NQF # 0418/ CMS2v2), was</p>



MN Community Measurement
 Pediatric Preventive Adolescent Mental Health/ Depression Screening Measure
 Recommendation for Inclusion in SQRMS- April 2014

	modified from an adult depression screening measure to include adolescents (age 12 and older).
Degree of burden	Pilot participants were surveyed utilizing MNMCM's standard survey format for assessing feasibility and burden during the pilot testing of a measure. 42% of the groups participating in the pilot were able to extract all information from their EMR system without additional manual abstraction and an additional 33% used a hybrid method (EMR with some manual extraction. 82% spend less than 60 hours creating the new extract programs for data retrieval. The majority of groups rated the difficulty for measure specific fields as very easy, including providing the result of the tool. The data used is generated by and used by healthcare personnel during the provision of care and may be stored in structured fields in an EHR.

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.

¹ Agency for Healthcare Quality and Research (AHRQ)'s National Healthcare Quality Report, 2010. <http://www.ahrq.gov/qual/nhqr10/Chap2b.htm#xviii> . Accessed April 30, 2011.

² Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. National Academies Press, Washington, D.C.; 2009.

³ Ringel JS, Sturm R. National estimates of mental health utilization and expenditures for children in 1998. [J Behav Health Serv Res.](#) 2001 Aug;28(3):319-33.



MN Community Measurement
 Pediatric Preventive Overweight Counseling Measure
 Recommendation for Inclusion in SQRMS- April 2014

<p>Degree of Impact</p>	<p>As a society, obesity has been labeled a growing and emerging epidemic. Related to children and adolescents, the numbers of overweight and obese children are on the rise. Recommendations to screen, assess, counsel and refer exist from a variety of organizations. According to the 2007-2008 National Health and Nutrition Examination Survey, nearly 17% of children ages 2 to 19 are obese and almost 32% are overweight or obese.¹ The percentage of overweight and obese children and adolescents aged 10-17 in Minnesota was 23.1% in 2007 and the US average was 31.6%.²</p> <p>Pilot testing of this measure, which included over 42,900 children from 13 medical groups representing 116 clinics, demonstrated the following distribution: 27.4% of children ages 3 to 17 had a BMI percentile \geq 85; 14.8% were overweight and 12.6% obese.</p> <p>Bright Futures guidelines³ report that although a child’s weight status is the result of a number of factors (genes, metabolism, height, behavior and environment) working together, two of the most important determinants of weight status are nutrition and physical activity. Children older than two years who are between the 85th and 95th percentile of BMI need a second-level assessment and screening, and treatment which includes interventions focused on dietary changes/nutrition and physical activity.</p>
<p>Degree of improvability</p>	<p>In 2012, the BMI percentile documentation rate reported by the National Committee for Quality Assurance (NCQA) was 51% for commercial HMO patients and 52% for Medicaid patients. Rates of nutrition counseling were 54.3 % commercial HMO, 55.0% Medicaid while physical activity counseling were 50.4% commercial HMO, 44.2% Medicaid.⁴</p>
<p>Degree of inclusiveness</p>	<p>Obesity does affect all groups, but specific subgroups, including African Americans, Hispanics, and American Indians, do show greater a share of burden.⁵ The measure development work group reaffirms that this is an important issue and a first step towards addressing the obesity epidemic. A recent study demonstrates that 80% of children that were overweight between the ages of 10 – 15, were obese adults.⁶</p>
<p>National consensus</p>	<p>This measure is modeled after an existing NQF endorsed measure “Weight Assessment and Counseling for Children and Adolescents (NCQA/ NQF# 0024).</p>
<p>Performance variation</p>	<p>Pilot results demonstrate variability and opportunity for improvement for the provision of nutrition and physical activity counseling for overweight children (BMI percentile \geq 85). Overall average rate for providing counseling for both nutrition and physical activity for overweight children was 68.3% with rates ranging between 11.3% and 100%.</p>
<p>Degree of validity/ reliability</p>	<p>Pilot participants successfully completed standard validation audits with rates of concurrence > 90%, and concluded that pilot data was acceptable for analysis. Reliability statistics (measuring the degree of variability between practices) requires at least one full cycle of data collection. More information will be available in the Fall of 2015.</p>
<p>Degree of alignment</p>	<p>This measure is modeled after an existing NQF endorsed measure “Weight Assessment and Counseling for Children and Adolescents (NCQA/ NQF# 0024/ CMS155). Definitions of counseling</p>



MN Community Measurement
 Pediatric Preventive Overweight Counseling Measure
 Recommendation for Inclusion in SQRMS- April 2014

	and physical activity documentation were obtained from and align with this measure.
Degree of burden	<p>Pilot participants were surveyed utilizing MNMCM’s standard survey format for assessing feasibility and burden during the pilot testing of a measure. 50% of the groups participating in the pilot were able to extract all information from their EMR system without additional manual abstraction and 70% spend less than 60 hours creating the new extract programs for data retrieval. Ratings for measure specific fields were distributed equally among the categories of difficulty. The data used is generated by and used by healthcare personnel during the provision of care and may be stored in structured fields in an EHR.</p> <p>Pilot testing demonstrated difficulty in submitting a calculated BMI value that matched the floating displayed BMI percentile in the electronic medical record. The work group proposed many technical steps to reduce the burden associated with this measure 1) MNMCM data portal calculate the BMI percentile to accurately identify the denominator for overweight counseling, 2) reduce the number of fields that attempt to capture type of counseling and move to a binary (yes/no) field and 3) maintain current HEDIS/ NCQA definitions of counseling, but adherence to the definition of counseling to be validated on audit.</p>

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.

¹ Bridging the Gap in Obesity Prevention: A Framework to Inform Decision Making. Committee on an Evidence Framework for Obesity Prevention Decision Making. Food and Nutrition Board, Institute of Medicine, 2010

² Kaiser Family Foundation 2007 National Survey of Children’s Health at www.statehealthfacts.org

³ Bright Futures Guidelines American Academy of Pediatrics

⁴ National Committee Quality Assurance 2013 State of Health Care Quality Report.



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Pediatric Preventive Overweight Counseling Measure
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⁵ Preventing Childhood Obesity: Health in the Balance. Committee on Prevention of Obesity in Children and Youth. Food and Nutrition Board. Board on Health Promotion and Disease Prevention. The National Academies Press, Washington, D.C.; 2005.

⁶ Bellows. L. Colorado State University Childhood Obesity March 2013

**MN Community Measurement
Measurement and Reporting Committee**
September 11, 2013
Meeting Minutes

Members Present: Tim Hernandez (co-chair) Howard Epstein (co-chair), Craig Christianson, Caryn McGeary, Chris Norton, Darin Smith, David Homans, Ernest Valente, Jeffrey Rank, John Frederick, Kris Soegaard, Laura Saliterman, Linda Walling, Mark Sonneborn, Mark Nyman, Matt Flory, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson, Terry Cahill

MNCM Staff: Alison Helm, Anne Snowden, Collette Pitzen, Erika Vetta, Tina Frontera

Members Absent: Ann Robinow, David Satin

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed the committee. Committee members introduced themselves.
Approval of Minutes	<p>The committee reviewed the minutes from August 2013. Sue Knudson noted that there was another important difference between the PPG and MNMCM Total Cost of Care program. She asked for the following addition to be reflected in the August minutes: Another difference is that MNMCM will be able to conduct provider verification of attribution. Rahshana Price-Isuk also noted that her name was not on the list of present members. These additions will be included in the August 2013 meeting minutes.</p> <p>Mark Sonneborn made a motion to accept the minutes with the suggested additions. Sue Knudson seconded. Motion passed.</p>
Review of MNMCM's Measurement Strategies and Activities	<p>Tina Frontera provided an overview of MNMCM's measurement strategies. Last year, the Board of Director's strategic planning sessions included a discussion about the value chain of health care improvement – which begins with identifying improvement needs and ends with executing on improvement processes. They identified that MNMCM's role in the community was in the middle portion of the value chain which encompasses measurement – measure development, collection, validation, analysis and reporting. This year's strategic planning meeting of the MNMCM Board, held in August 2013, focused on the creation of a 3-5 year strategic plan for measurement with consideration for the local and national landscape in order to stay relevant; and the creation of measures that are meaningful, useful, and not redundant.</p> <p>MNMCM has sought feedback on a 3-5 year strategic plan for measurement in a variety of ways. Tina reviewed feedback provided by participants at the MNMCM April 2013 seminar regarding framework development which included:</p> <ul style="list-style-type: none"> • High priority for measure development: overuse, specialty care, total cost of care, care effectiveness, provider burden reduction and EMR data extraction efficiency. • Low priority for measure development: prevention, technology, health behaviors, population quality of life, process measures. • Strong support for measuring other care types such as chiropractic, dental, home care and specialists. • Support for aligning local and national initiatives without regressing. • Pay close attention to alleviating provider burden in measure collection. • 23% used measures in pay for performance programs. <p>MNMCM researched local and national initiatives from organizations such as the Health Affairs Framework for Accountable Care Measures, the Institute of Medicine Framework, the National Quality Forum's Measure Applications Partnership (MAP) and others. Analysis of these frameworks, although ultimately different, showed general alignment.</p> <p>Measurement strategies discussed at the 2013 Board of Director's strategic planning meeting were similar to feedback received from seminar participants in many key areas. Framework ideas discussed included concepts under the Triple Aim: Health Care Quality, Cost, Patient Experience and Individual and Community Health. One key concept discussed was how to remain a leader while maintaining balance. Other areas discussed included alignment of measures to MNMCM's vision and framework, development of priorities, barriers, provider burden, use of data, and public reporting and engagement.</p> <p>Tina also shared guiding principles to be used in the development of a measurement framework:</p> <ol style="list-style-type: none"> 1. Focus on outcome measures and align with national efforts without regressing. 2. Measure across populations using patient-reported outcomes with less focus on disease-specific measures. 3. Increase efforts to measure specialty care and other settings such as post-acute or home care measures in order to measure across the continuum of care. 4. Balance measure development with burden. 5. Consider measure retirement when appropriate. 6. Focus on wise use of resources such as overuse, underuse, appropriate use of imaging and treatment, patient selection, appropriateness procedure and available data sources. <p>The next steps in developing a measurement framework will include reviewing and synthesizing the feedback as well as balancing concepts of alignment, burden, funding, and usability of measures. The Board of Directors will review the information received from the strategic planning session at their next meet and more information will be brought back to MARC in the future.</p>

Questions/Comments/Discussion:

Sue Knudson shared that the value of transparency should be considered when developing the measurement framework. This is especially important because organizations are using current MNMCM measures and MNMCM is considered the preferred source of data and measures in the community. Sue also stated that as our measures begin to be adopted nationally, Minnesota will be able to be compared on a national level. She also noted that measures are valuable even if there is little variation within the measure. She indicated consumers have different values and preferences from others which is important to take into consideration when retiring or changing measures. Sue expressed that she understands the need to assess burden, but feels that if there is not significant burden in collecting data for a measure, it may be valuable to continue data collection. John Fredrickson stated measures should be reviewed to determine if enough benefit has been received from a measure prior to retirement.

Craig Christianson stated that moving beyond process measures introduces many social and socio-economic factors that are outside a physician's or clinic's influence. He feels this is something that MNMCM needs to consider when moving toward outcome measures. Craig also expressed caution about measuring other settings such as chiropractic or home care. These services may not be covered by insurance for all patients and this may have implications for measurement.

Terry Cahill shared that he feels that measurement needs be broadened to other specialties. He shared that internal evaluation differs from public reporting and that it is frustrating when the cost of screening used for measurement is more than the cost of reimbursement from insurance. Tim Hernandez also agreed that primary care has been responsible for submitting data on many measures. He shared that burden is part of the consideration of needing to balance priorities especially given that many measures are used by multiple programs and in a variety of ways.

Stefan Gildemeister asked if certain specialties stand out for consideration of measurement and if those specialties are prepared for measurement. Tina shared that measures are currently in the pilot phase for Total Knee Replacement and Spine Surgery to measure orthopedic clinics. Beyond orthopedics, there are no specialties currently under consideration for measurement. Stefan communicated that public comments and the gap analysis did not reveal any apparent patterns for which specialties should be measured next. Tina conveyed that the 3-5 year measurement plan framework is intended to serve as a conceptual roadmap which may provide guidance on future measures for specialties. Tim Hernandez wondered if issues highlighted by the Choosing Wisely program may be helpful to consider when identifying specialties for measurement.

Jeff Rank shared that many specialties do have ways of being measured and that data is often collected in a national database. He feels that specialties would find it helpful to have their data used to compare themselves against others. He further noted that many specialty groups often wonder why they are not being measured. Jeff expressed that specialties understand the burden of data collection because many are already doing it for internal purposes. Howard Epstein shared that measure development often works best when those who will be measured assist in the measure development process. He reflected that one of the challenges with specialty care measures is that the data is typically reported to national organizations and that many currently available measures focus on process. Tina communicated that MNMCM has been approached by a few specialties for measurement development purposes. It is hoped that future specialty measures will not only be transparent for all but also helpful for consumers. Developing outcome-based measures, will not only be more useful, but will be better positioned for national endorsement.

MNMC Slate of Measures for Reporting in 2014 – For approval

Anne Snowden reviewed the MNMCM Slate of Measures for 2014 Public Reporting and the processes for reviewing and updating measures. MNMCM regularly reviews measures to ensure that they continue to be aligned with guidelines, the most recent evidence, national measures, and to ensure codes are up-to-date. The measure review process is categorized into three levels:

- A routine annual review
- An ad hoc review, and
- An extensive measure review every three years

The first level of review is a routine annual review. This means that measures have received industry code updates and have been compared against the most recent guidelines. It also includes a review of rates to determine if variation or disparities continue to exist, if there is still room for improvement, and if the measure is still being utilized in the community. All of the measures included on the slate underwent a routine annual review in 2013. The second level is an ad hoc review and includes a focused work group review of measures based on substantial changes in evidence, guidelines, or comments received. The third level of review is an extensive measure review that is conducted every three years. This process is similar to the NQF process for maintenance of measures. MNMCM is the steward for five NQF-endorsed measures.

Anne also reviewed an important distinction between the MNMCM slate and the Statewide Quality Reporting and Measurement System (SQRMS) slate. "Reporting" on the MNMCM slate refers to the "public reporting" of results while "reporting" on the SQRMS slate refers to "data submission". Anne will update the MNMCM slate so that the header in the last column on the right says: "Recommend for Public Reporting?"

Anne reviewed each row and column in the MNMCM Slate of Measures for 2014 Public Reporting. The document contained information about each measure title, data source, data collection method and key changes. A section was also added to indicate if a measure was endorsed, aligned or used by other organizations.

Cervical Cancer Screening measure:

Anne reviewed key changes made for the Cervical Cancer Screening measure. The current measure focuses on cervical cytology performance every three years for women aged 21-64 only. Starting in the 2014 report year, NCQA will add cervical cytology/HPV co-testing performed every 5 years for women ages 30-64 which means that a patient would meet numerator criteria if they had either test.

Another key change for this measure is the data collection method. Currently, health plans submit data for this measure using the administrative claims method. For 2014, NCQA has made it possible to use the hybrid method (claims plus chart review) as an option for the commercial population (The hybrid method is already an option for the Medicaid population). In general, rates that are calculated using the hybrid method tend to be more precise; however, chart reviews can increase burden on clinics. Anne also noted that the hybrid method usually requires sampling which could substantially reduce the number of reportable entities for this measure. Since there are significant changes to this measure and NCQA has a policy to not publicly report first-year measures, NCQA will not publicly reporting results for this measure in 2014.

Anne outlined three choices for MARC regarding this measure:

1. Publicly report the measure in 2014 using the new measure specification but continue to use the claims-based method.
2. Follow NCQA's lead and do not publicly report the measure in 2014.
3. Do not publicly report the measure in 2014, but complete testing of the new measure and the various data collection methods to determination next steps for 2015.

Questions/Comments/Discussion regarding Cervical Cancer Screening Measure:

Terry Cahill shared his concern of the increased burden and decreased comparability caused by retiring the measure for one year and then introducing a similar measure. Rahshana Price-Isuk stated her concern that clinic's EMRs are unable to keep up with measure changes and that public programs are not aligned with recommendations. For example, SAGE, which is a public program for uninsured Minnesota residents to receive breast and cervical cancer screening, does not cover HPV testing and only provides coverage for cytology. John Fredrickson felt it would not be harmful to not report a measure for a year given that the measure is undergoing changes.

Jeff Rank asked if using the hybrid data collection method would be mandatory. Anne shared that it would be an option for health plans. Sue Knudson conveyed that these rates will be used for health plan rankings and there is an incentive for health plans to use the hybrid method. Sue also stated that continuing to use the claims-based only method as outlined in the first option may be challenging when the hybrid option is now available. Sue Knudson clarified that the third option would allow our reporting to be in sync with NCQA. Sue also stated that data collection would still occur regardless of our decision because health plans still need to report this measure to NCQA.

Anne also reiterated that while the hybrid method would increase preciseness, it usually requires sampling which would likely lead to a decrease in the number of reportable medical groups. Sue added that sticking with a consistent definition would be beneficial for national comparison.

Tim Hernandez asked where the burden would lie for the hybrid method. Anne stated that it is a shared burden in that health plans would hire staff to complete the chart reviews, but that the staff would be going into clinics to complete the reviews.

Mark Nyman reminded MARC that this is a process measure, but that much of the discussion has focused around increasing outcome measures as a value metric for consumers. Mark stated that he feels a review needs to be completed in order to determine next steps for the measure. Sue Knudson agreed that a thoughtful process needs to take place in order to review other evidence and to make a determination of next steps for public reporting purposes.

Mark Nyman made a motion to retire the current Cervical Cancer Screening measure and table a decision about next steps until further testing and review of the new measure can be completed. Sue Knudson seconded motion. Motion passed.

All Other Measures in Slate of Measures for Public Reporting in 2014:

Anne reviewed all other measures in the slate for public reporting in 2014 and key changes to measures. One key change occurred for the Breast Cancer Screening measure – the age range will be changed to 50-74 in 2014. Anne shared that MARC has previously approved a variation on the NCQA measure to report Breast Cancer Screening for women ages 50-69 (NCQA's measure had an age range of 40-69). For the new, 2014 Breast Cancer Screening measure, NCQA not only eliminated the 40-49 age range but also raised the upper age limit to 74 to be consistent with guidelines.

Anne clarified that MNMCM will not publicly report results for the Maternity Care: Primary C-Section in 2014, but noted that clinics will still need to submit data under the SQRMS mandate. Anne also shared that MNMCM will make this recommendation to MDH. Another key change was that the CG-CAHPS survey was moved from a visit-specific CG-CAHPS survey to a 12-month CG-CAHPS survey. Anne also reviewed the list of previously retired measures as requested by MARC.

Questions/Comments/Discussion regarding All Other Measures in Slate of Measures for Public Reporting:
 Mark Nyman mentioned that the Optimal Diabetes Care measure was adopted by PQRS's web interface Group Practice Reporting Option (GPRO). Anne stated that she will confirm this with Collette Pitzen and make this change on the slate of measures as appropriate.

Stefan Gildemeister asked if there had been discussion regarding a 6-month CG-CAHPS survey. Anne shared that the 6-month CG-CAHPS survey is currently going through the approval process at AHRQ and it is anticipated that it will be released in early 2014. Anne conveyed that MNMCM and MDH are working to revise wording in the SQRMS Rule to possibly state "12-month CG-CAHPS Survey or more recent survey if available." MNMCM and MDH will continue to communicate with the CAHPS Consortium about the availability of the 6-month tool to assess the possibility of including it as part of SQRMS.

Terry Cahill shared that the increased use of electronic communication with patients should be considered in measure specifications. Jeff Rank agreed.

Chris Norton made a motion to accept the MNMCM Slate of Measures for 2014 Public Reporting as presented excluding the Cervical Cancer Screening measure. Jeff Rank seconded motion. Motion passed. Terry Cahill opposed the motion.

Recommendation for an Ad Hoc review of Optimal Diabetes Care and Optimal Asthma Care measures – For approval

Anne Snowden reviewed recommendations to conduct ad hoc reviews of specific components of the Optimal Diabetes Care and Optimal Asthma Care measures. Ad hoc measure reviews have been completed in the past. For example, the ACCORD study revealed evidence that supported the need for MNMCM to relax numerator targets for the Optimal Diabetes Care measure due to patient safety concerns. A work group completed an ad hoc review and brought forth a recommendation for MARC approval. Anne noted that MNMCM measures follow the evidence; they do not precede the evidence. Anne invited MARC members to consider serving on one of the ad hoc review committees. She noted that the aim is to complete these ad hoc reviews by February 2014.

Optimal Diabetes Care measure - Ad Hoc Review Recommendation:
 The first recommendation was for an ad hoc review of the LDL component of the Optimal Diabetes Care measure. Several comments have been submitted to MNMCM from community stakeholders about the LDL component and guidelines are now suggesting a target LDL level of less than 100 or on a statin. Terry Cahill requested that the workgroup also consider an HbA1c of less than 8; however, Collette Pitzen stated that this was previously reviewed and discussed by the work group.

Kris Soegaard made a motion to approve the recommendation to complete an ad hoc review of the LDL component of the ODC measure. David Homans seconded the motion. Motion passed.

Optimal Asthma Care measure - Ad Hoc Review Recommendation:
 The second recommendation was for an ad hoc review of two components of the Optimal Asthma Care measure - the asthma action plan and the risk of exacerbation. Anne noted that MNMCM continues to receive comments and feedback about the asthma action plan. The concerns center primarily on the strength of the evidence of the ability of the asthma action plan to impact the outcome of asthma. In addition, we've received feedback about the component that assesses a patient's risk of exacerbation based on the number of hospitalizations and emergency department visits. Anne noted that a workgroup would discuss the details of the measure specifications and potential changes. She also noted that workgroup recommendations would be brought to MARC for approval.

Questions/Comments/Discussion regarding Optimal Asthma Care Ad Hoc Review:
 Laura Saliterman asked if the pediatric and adult populations will be reviewed separately. Anne shared that each component will be reviewed separately for each population.

Mark Nyman made a motion to approve the recommendation to complete an ad hoc review of the asthma action plan and the component that assesses a patient's risk of exacerbation. Chris Norton seconded the motion. Motion passed.

Next Meeting: Wednesday, October 9, 2013 at 7:30 – 9:00 am

**MN Community Measurement
Measurement and Reporting Committee**

Wednesday, November 13, 2013

Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Ann Robinow, Caryn McGeary, Chris Norton, Darin Smith, Ernie Valente, John Frederick, Kris Soegaard, Linda Walling, Mark Nyman, Mark Sonneborn, Matt Flory, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson,

MNCM Staff: Alison Helm, Anne Snowden, Gunnar Nelson, Jasmine Larson, Tina Frontera

Members Absent: Terry Cahill, Craig Christianson, Jeff Rank, Laura Saliterman, David Homans, David Satin

Guests: Kris Kopski (Alternate for David Homans)

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed the committee members and everyone introduced themselves. Tim also introduced Kris Kopski, a physician from Park Nicollet, who attended the meeting as David Homans' alternate. Tim reminded MARC members that they have the option of appointing an alternate to attend the MARC meeting if they are unable to attend. Tim also noted that alternates do not have the authority to vote. He encouraged members to contact Anne if they would like to designate an alternate so she can include them on the email distribution list and prepare tent cards. Members with a designated alternate who is planning to attend a MARC meeting are asked to give notice to the chairs, via staff, prior to the meeting.
Approval of Minutes	Chris Norton made a motion to accept the September 2013 meeting minutes. Mark Sonneborn seconded. Motion passed.
Update from Nominating Committee meeting	<p>Anne Snowden provided an update from the Nominating Committee meeting. She noted that the MARC has openings for five members at the end of 2013 because terms are ending. Anne mentioned that MNMCM received approximately 2-3 applicants for each opening. Selections were made based on established criteria. New MARC members will start their terms in February 2014, but were invited to attend the December meeting to become familiar with the committee process ahead of time. Anne reviewed the names of the newly selected MARC members:</p> <p><u>New MARC member/Type of representation</u></p> <p>Bill Nersesian, MD – Fairview Physician Associates (FPA)/Large, metro medical group</p> <p>Dan Walczak – UCare/Health Plan</p> <p>Allan Ross, MD – Ortonville Area Health Services/Small, non-metro medical group</p> <p>Ann Robinow/Consumer</p> <p>Julie Krenik, MD – Hutchinson Health Clinic/Medium, non-metro medical group</p> <p>She noted that this slate of new members was approved by the MNMCM Board chair and all new members have been notified and sent orientation materials. In 2014, there will be four openings on the MARC and we will follow a similar process for notifying the community about these opportunities.</p>
REL Reporting Plan for Hospitals	<p>Mark Sonneborn provided his annual update regarding Race, Ethnicity and Language (REL) data collection and reporting by hospitals in Minnesota. The Minnesota Hospital Association (MHA) collects administrative claims data from most Minnesota hospitals. As part of the Aligning Forces for Quality (AF4Q) grant from the Robert Wood Johnson Foundation, there was an expectation to stratify publicly reported measures by Race, Ethnicity, and Language (REL) by 2013, beginning with readmissions measures. The dates for key milestones were noted.</p> <p>In addition to REL data being useful for quality measurement activities and accurately assessing disparities, various stakeholders (DHS, MDH, grant foundations, academic researchers) have also expressed a need for REL data. With the recent rapid adoption of Electronic Health Records (EHRs), primarily fueled by Meaningful Use requirements, the administrative costs in collecting and transmitting REL information has been significantly reduced to the point where collection may be fiscally feasible for hospitals.</p> <p>One current use of data reported to MHA is calculating quality measures such as readmissions and mortality rates at both institutional and aggregate levels. This method of data collection differs from the methods employed by MN Community Measurement, which gathers numerator/denominator numbers on specific conditions such as diabetes. Hospitals that</p>

	<p>want to qualify as “meaningful users” of EHRs must collect REL data as part of each patient’s demographic profile. The CMS Medicare and Medicaid EHR Incentive Programs began registration in January 2011 and 2016 is the final year hospitals may initiate participation and receive any payment (incentive payments are reduced over time providing motivation to start early). Further, hospitals that have not demonstrated meaningful use by 2015 will experience payment adjustments in their Medicare reimbursement.</p> <p>The administrative claim form has designated REL fields, but these fields are currently labeled as “not used” when submitting claims for payment. At the end of 2011, virtually no hospital in Minnesota was populating these fields on the form. MHA has engaged select hospitals in using these fields as a means of REL data collection, and is working with this select group in mapping these elements to standard OMB categories within the administrative claims database.</p> <p>MHA has found that the ideal way to collect Minnesota hospital REL data is to have it submitted on the claim form, where feasible. However, with continuing research and implementation, an alternative method may be more viable for hospitals. Further, a “mixed mode” method (i.e., some hospitals submit REL data via claims and others submit REL data separately from claims) may yield the largest participation.</p> <p>Mark provided a summary of the progress of MHA’s efforts in REL data collection. MHA conducted a survey regarding REL data collection, quality, usage, and extraction capabilities. The survey was similar to the National Public Health and Hospital Institute survey used to conduct research for the report “Race, Ethnicity, and Language of Patients” (2006). Responses from 122 of the 135 hospitals in the state were received meaning there was a 91% response rate, providing valuable insight into the current status of REL data collection, frameworks and policies used by hospitals, current usage of REL information at hospitals collecting it, and their ability to extract and send REL data to MHA. Among affiliated hospitals which are part of a system, Epic was the most commonly used EHR vendor. For non-affiliated hospitals, Epic was the third most commonly used with Meditech and Healthland being the first and second most used, respectively. Other findings were also shared. Hospitals identified the top three barriers to REL data collection as 1) Reluctance of patients to provide the information, 2) Reluctance of staff to ask, and 3) Confusion about race and ethnicity categories.</p> <p>In addition to the survey, a pilot group of hospitals have been engaged to submit REL data to MHA over the past year. Currently, 49 hospitals are submitting at least some REL information on their billing records, which is slightly short of the 40% participation target. Initially, this target seemed attainable as 55 hospitals were submitting REL information in 2012 or 2013; however, but some hospitals dropped REL submission due to software changes that occurred when they became acquired by a larger system. A successful strategy in recruiting hospitals to participate has been to request the inclusion of REL information during their conversions of the new electronic claims format. Work is currently underway with some hospitals to map REL codes to OMB categories in the administrative claims database. At present, 53 hospitals have supplied REL master lists.</p> <p>Initial steps have also been taken to analyze completeness of the REL data. As anticipated, the completeness of the data varies from hospital to hospital. Next steps will determine whether this is due to transmission issues or the REL data collection issues. Mark wrapped up his report with a review of future plans.</p> <p><u>Questions/Comments/Discussion:</u></p> <p>Tim Hernandez asked why some health plans seem to require REL data and others do not. Mark shared that the health plans are not requiring the REL data.</p> <p>Kris Soegaard asked why claims would be rejected if they contained REL information. Mark explained that the REL data components are in a “not used” category and some, but not all, health plans are set up to reject claims when there is information entered into the “not used” category. Kris then asked if there will be penalties for not collecting this information. Mark shared the requirement that REL information is to be collected in the EHR for Meaningful Use; the penalties for not collecting REL data via EHRs starts in 2015. Mark clarified that the REL data he had been referencing was collected on the claims form which is separate from the EHR; thus, there are no penalties associated with not collecting REL information using the claims form.</p>
<p>Interim Progress Report on Total Cost of Care measure development process – Results of Phase 1 data test</p>	<p>Gunnar Nelson provided an interim report on the Total Cost of Care measure focusing primarily on results of the Phase 1 data test. He recognized the MARC members who serve on the Total Cost of Care technical advisory group: Ernie Valente, Howard Epstein, Kris Soegaard, Mark Sonneborn, Stefan Gildemiester, and Sue Knudson.</p> <p>Gunnar shared that Total Cost of Care (TCOC) is a NQF endorsed measure of a provider’s cost effectiveness at managing a specific population of patients. This is an attributed population and includes all costs associated with treating patients including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. The interim objective is to have commercial insurance plans report TCOC to MNMCM and to eventually report a Total Resource Use measure using all claims-based data. Since cost, defined for this measure as allowed payment available in</p>

administrative claims, is a continuous variable and is greatly impacted by health risk of each patient, outlier rules and risk adjustment is required.

Gunnar provided a history and background on the measure development process for the TCOC measure that occurred between April 2012 and July 2013. The remainder of his report highlighted results from the Phase 1 data test that occurred between August and November 2013. Blue Cross and Blue Shield of Minnesota and HealthPartners participated in the data test and MNMCM tested a distributed data model. This data was analyzed, overall results were reviewed, blinded medical group results were analyzed, and findings were reported to MARC and Board of Directors.

One health plan used their established protocol and software for the risk adjustment software and the other health plan used MNMCM's limited license from the Johns Hopkins ACG. The results were comparable and the data was produced in a reasonable amount of time. MNMCM then aggregated the results and successfully merged medical group level risk adjusted total cost of care files between the two plans with reliable output and without concerns of sharing PHI or confidential business intelligence. The TCOC results per medical group showed a normal distribution range.

The patient level attribution test is currently being completed by a small set of medical groups and final results were not yet available. The distributed data model is unique in that it allows medical groups to receive attributed patient lists directly from the health plans and this allowed for a true test of attribution. The NQF Methodology for this measure requires a minimum of 600 patients per medical group before public reporting. Typically, a single plan can report on an average of 85 medical groups; two plans can merge results and report about 112 medical groups, and four health plans can report on an estimated 130 medical groups. Therefore, there is a 53% increase (compared to a single health plan) in the number of reportable medical groups by combining results across health plans.

Pharmacy costs per patient were estimated separately from medical costs and distribution was found to be stable across medical groups. The TCOC methodology also has an "outlier rule" which states that the cost per patient is limited to \$100,000 per year. When this rule was used during this test, we found that 8% of dollars were removed and the impact varied by medical group.

The attribution methodology has a two-step attribution process: 1) Patients were first attributed based on their primary care activity in the measurement year 2) Patients who were unable to be attributed based on their primary care activity in the 12 months of the measurement year, were attributed using the 12 months prior to the measurement year and only if the patient had activity in the 4th quarter of the prior measurement year. The second step of attribution added 6% more attributed patients to the denominator and this was distributed almost equally among medical groups. There was also evidence that those patients had a lower average cost per patient but had a higher percentage of outlier dollars.

Public comments were collected between August and November 2013 using MNMCM's standard process. Gunnar reviewed the comments and MNMCM's response for each comment.

Questions/Comments/Discussion:

John Frederickson asked how specialty care was attributed using the TCOC attribution method. Gunnar shared that specialty care was attributed to a primary care provider and their tax ID number.

Kris Kopski asked if data was sent back to medical group/clinic with patient names attached and their total cost of care. She feels this may be helpful to medical groups/clinics in order to address patients who incur higher costs. Gunnar shared that medical groups/clinics receive patient names in order to correctly attribute patients, but they do not receive the costs each patient incurs. He shared that this is out of scope for the TCOC measure.

Howard Epstein asked if health plans have the option of calculating total cost of care using their own methods for their own purposes. Gunnar confirmed that this is correct. He also noted that the MNMCM TCOC measure is an attempt to standardize the method of calculating the costs for public reporting purposes. Howard then asked for the key takeaways from the Phase I data test. Gunnar shared that the data flow occurred as expected although some items will have to be fine-tuned, but that there are no major issues. He also shared it is a work in progress and communication about the measure needs to be developed to clarify the scope of the project to a variety of stakeholders. Tim Hernandez asked if part of the work was to standardized methodology to provide common language to medical groups and consumers. Gunnar shared that the intent was to develop a common, standard methodology for health plans to use without imposing on other current methods.

Sue Knudson shared that as a representative from a health plan, she feels that TCOC differs from quality measures and was developed using a different model than health plans have used in the past. She shared that it would take time for health plans to be able to evaluate and report data using the new method. She also shared that the current methods health plans are using are involved in current contracts. She feels provider and health plan contracts may affect the

	<p>timeline of adopting the new TCOC method. Ernie Valente agreed. Gunnar also shared that the aggregation and attribution model is similar to the one that MNMCM uses for HEDIS measures and that it is the least expensive way to calculate results for this measure.</p> <p>Howard Epstein asked for context on how Minnesota compares to other states in terms of TCOC reporting from a national perspective. Gunnar shared that there is national interest in the TCOC methodology. Tina Frontera shared that other organizations and states are reviewing this methodology, but that Minnesota is unique in using the distributed data model.</p>
<p>Measure Review Process and Structure and Formation of Measure Review subcommittee – For approval</p>	<p>Jasmine Larson shared MNMCM’s measure review process and structure. Jasmine sought approval for the formation of a Measure Review subcommittee of the MARC.</p> <p>MNMCM’s strategic planning for 2013 included an overall measurement framework and the recommendations approved by the Board included a general process to update and/or retire measures. The purpose of this agenda item was to:</p> <ul style="list-style-type: none"> • Educate MARC about MNMCM’s measure review process and the criteria used to determine the appropriate level/depth of review • Obtain approval from MARC on the formation of a Measure Review subcommittee of MARC, to be involved in the Level I review process and to make recommendations to MARC • Initiate recruitment of MARC members to serve on the Measure Review subcommittee <p>To date, a review of existing measures has been conducted by MNMCM staff. However, there is opportunity to formalize the review process, increase stakeholder participation and influence, and increase the transparency/awareness of the process through a more formal structure. Jasmine reviewed handouts of the measure review process as well as a flow chart which outlined the various levels of review.</p> <p>Jasmine reviewed the Measure Review Committee structure and composition. This committee would consist of 8 – 10 MARC members including a chairperson and would have a similar composition as the MARC with representation from medical groups, health plans and consumers. The MARC co-chairs would approve the roster and the committee would meet twice per year - February and August. The first meeting would occur in February 2014. This committee would be involved in Level I – the Annual Measure Maintenance process. At the February meeting, there would be a review of the DDS/ASC/Patient Experience of care measures and recommendations would be brought to MARC in April. At the August meeting, there would be a review of the HEDIS measures and recommendations would be brought to MARC in September. A consensus based decision making process for recommendations would be used by the committee.</p> <p>Jasmine also reviewed the Measure Evaluation Criteria anticipated to be used to determine a measure’s value. The criteria are consistent with NQF criteria for measure endorsement. Jasmine then reviewed each review level separately:</p> <p>Level I review is an annual review of our measures. MNMCM personnel conduct a scan of the environment and review any changes in a measure’s alignment with the evaluation criteria. A report of the findings for each measure will be prepared for the Measure Review Committee. Only minor changes in CPT, ICD9, ICD10 codes, or modifications for alignment/harmonization with national measures or guidelines would be considered for a Level I review.</p> <p>The Measure Review Committee would evaluate the measures based on information provided by staff and make measure-specific recommendations to MARC, which may include:</p> <ul style="list-style-type: none"> • Continuation of the measure, as-is or with minor modification as described • Recommend for further review and/or redesign • Remove from public reporting, but continue to monitor (collect and report privately) • Retirement using the following criteria: <ul style="list-style-type: none"> ○ Loss of measure validity ○ Loss of opportunity for improvement ○ Evidence of undesirable consequences of implementation ○ Replacement by a superior measure <p>Level II review is a focused review performed on an ad-hoc basis. It is meant to evaluate the impact of technical measure changes or changes in evidence that may affect alignment with the measure evaluation criteria. For example, the ACCORD study resulted in a change or update to practice guidelines that required a Level II review of our Optimal Diabetes Care measure. Reconvening the measure development work group may occur during a Level II review.</p> <p>Level III review is applied to NQF endorsed measures only and includes a systematic literature review and submission of the NQF endorsement maintenance application.</p>

Level IV review is needed to review major changes to a measure which may include redesign. This level mirrors the measure development process and would include a systematic literature review, reconvening of the measure development work group for in-depth discussion and measure redesign of numerator, denominator and/or exclusions. Possible recommendations include recommending no changes; redesign of measure with revised specifications; replacement of measure with specifications; or retirement of measure.

Questions/Comments/Discussion:

Tim Hernandez asked about the level of involvement of the subcommittee in Levels II, III and IV. Jasmine shared that as a part of a Level I review, the subcommittee may recommend a Level II or IV review but doesn't actively participate in Level II, III or IV reviews.

Sue Knudson asked if the Measure Review Committee would consist only of MARC members or if there would be other representation. Jasmine stated that it would only be comprised of MARC members which would ensure that members have a level of familiarity with the measures. Howard supported the value in having MARC members on the subcommittee given that they are involved in the in-depth discussions about our measures and could represent the issues when recommendations are brought to MARC for approval. Sue shared she feels it would be beneficial to have an additional 'representation type' on the subcommittee – someone with clinical and technical expertise who has an understanding of operational workflows and could provide feedback on the feasibility and burden of any proposed changes specifically in regards to EMR functionality, reportability, and burden.

Sue also shared that she feels it is still valuable to the consumer to report on measures that otherwise would be retired. Chris Norton agreed and shared she feels that consumers would appreciate information and that a balance of burden and reporting should be reached.

Sue also noted that she would like other factors (i.e., community need) should be reviewed when considering retiring a measure rather than only looking at criteria outlined during the presentation and asked for a reasonability check regarding retirement of measures. In response, Anne Snowden shared that MNCM has received feedback from some medical groups that appreciate having their high rates publicly reported because it is a reflection of their good work. In other words, achieving high rates with little room for improvement might not be an automatic reason to retire a measure. John Fredrickson asked what is to be gained by continuing to publicly report a measure with high rates. Kris Kopski shared that continuing to publicly report a measure may offer the ability for other states and organizations to compare their rates to rates of clinics in Minnesota.

Ernie Valente asked what is the value to the consumer to continue to report a measure and shared he feels the ability for consumers to compare results is important, but that should not occur at the risk of regressing a measure or rates. He feels that a value to the consumer is allowing a consumer to act and comparing allows consumers to act. Ernie shared that he feels this might be a reporting issue such as how are results displayed or what results are displayed. Sue Knudson shared that she agrees with Ernie and that decisions must be based on variation with everything else being equal especially when considering future steps in terms of the Triple Aim.

Ernie Valente made a motion to accept the recommendation for the formation of a Measure Review subcommittee of the MARC. Chris Norton seconded the motion. Motion approved.

Next Meeting: Wednesday, December 11, 2013
7:30-9:00 am

**MN Community Measurement
Measurement and Reporting Committee**
Wednesday, March 12, 2014
Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Caryn McGeary, Chris Norton, David Satin, David Homans, Ernie Valente, Jeff Rank, John Frederick, Julie Krenik, Kris Soegaard, Laura Saliterman, Mark Nyman, Mark Sonneborn, Matt Flory, Robert Lloyd, Stefan Gildemeister, Sue Knudson

MNCM Staff: Alison Helm, Anne Snowden, Collette Pitzen, Jasmine Larson, Tina Frontera

Alternates: Anne Herzog (alternate for Dan Walczak); Jinny Johnson (alternate for Rahshana Price-Isuk)

Members Absent: Dan Walczak, Darin Smith, Rahshana Price-Isuk

Topic	Discussion
Welcome & Introductions	<p>Tim Hernandez welcomed committee members and everyone introduced themselves. Tim introduced new committee members: Allen Ross, physician from Ortonville Area Health Services; Julie Krenik, Medical Director at Hutchinson Health Clinic; Bill Nersesian, Chief Medical Officer of Fairview Physician Associates (FPA); and Dan Walczak, Assistant Director of Health Economics at UCare. Tim also reviewed the MARC charter and the policy for alternates.</p> <p>Tim reminded MARC members of MNMCM's Conflict of Interest policy for committees and work groups. He shared that the joint MNMCM/ICSI COI review committee reviewed the COI forms from MARC members and all members were approved for full participation; a list of MARC member COI declarations was distributed to the committee. Howard reminded members that if circumstances do change during the year, please inform MNMCM staff of those changes.</p>
Approval of Minutes	<p>The committee reviewed the minutes from December 2013. Chris Norton made a motion to accept the minutes, Laura Saliterman seconded the motion. Motion passed.</p>
Optimal Asthma Care (OAC) Measure Review Work Group Recommendation– For approval	<p>Tim Hernandez introduced this agenda item by sharing his perspectives both as a MARC member and as a measure development work group member participating in this ad-hoc measure review process. Members of the MARC committee who also served on this group included Bill Nersesian (co-chair) and Chris Norton. Tim reminded MARC members that measure development work groups are convened to bring together community experts representing a balance of stakeholders for discussion and measure development activities. A great deal of time and effort was expended in this measure review process.</p> <p>Collette Pitzen reviewed the Optimal Asthma Care (OAC) measure work group recommendations and presented the information on behalf of Jasmine Larson, lead staff for the asthma measure, who joined the meeting by phone. This measure is an all-or-none composite measure originally developed and approved for implementation in 2009. The components include: 1) Asthma symptoms are in control based on most recent patient reported outcome tool; 2) Risk of exacerbations – Less than two ED visits and/or hospitalizations due to asthma in the last twelve months; 3) Documentation of a written asthma action plan containing information about medications, triggers and what to do during an exacerbation.</p> <p>In September 2013, MARC recommended an ad-hoc review of the Optimal Asthma Care measure due to feedback received from the National Quality Forum's (NQFs) review of MNMCM's 2012 application for measure endorsement as well as ongoing comments received from the community.</p> <p>The work group was tasked with reviewing two components of the composite: 1) documentation of a written asthma action plan and 2) ED visits and/or hospitalizations. Prior to the meeting, a complete literature review was conducted and distributed to work group members who also had the opportunity to contribute additional relevant literature. The work group convened in January 2014, and detailed minutes of this meeting were included in the MARC meeting packet. The first component discussed by the work group was the written asthma action plan. When MNMCM sought NQF endorsement of the overall Optimal Asthma Care measure, NQF provided feedback that although several guidelines recommend written action plans, there was not strong evidence linking the process of written action plans to the desired outcome of asthma control. The evidence criteria for NQF endorsement of a process measure/component require direct, empirical evidence of a strong relationship to the desired outcome.</p> <p>The work group acknowledged that while there is strong evidence that comprehensive education and self-management strategies lead to better outcomes, the evidence supporting the influence of a written action plan is mixed. After a thorough discussion, inclusive of all work group members, the work group agreed that the asthma action plan was meaningful for the majority of patients and consensus was reached to recommend continued inclusion of the written asthma action plan in the OAC measure.</p> <p>The second component reviewed was the use of the number of ED visits and/or hospitalizations in the previous 12 months, as</p>

reported by the patient, to serve as a proxy for risk of exacerbation. The current measure allows either one ED visit or one hospitalization to count as numerator compliant for that component. During the NQF endorsement process, NQF questioned the rationale for treating a hospitalization event equally to an ED visit. MNMCM's work group discussed several options for revising the component, but ultimately determined that it should remain as originally specified.

The work group reached consensus to recommend that no changes be made to the Optimal Asthma Care measure. Additionally, the work group recommended changes to language on the MNHealthScores website describing the measure.

Questions/Comments/Discussion:

Laura Saliterman asked how numerator compliance was calculated for the ED visits/hospitalization component. Collette clarified that a patient could have one ED visit or a hospitalization within 12 months and be numerator compliant if their asthma is under control based on their Asthma Control Test score. If the patient had one ED visit and a hospitalization the patient would not be numerator compliant.

Bill Nersesian noted that one ER visit or hospitalization may not necessarily indicate that a patient has a loss of control and that some ED visits or hospitalizations cannot be prevented no matter how good the care provided. Jeff Rank shared that he would argue that a patient should not have any ED visits or hospitalizations to be numerator compliant for that component.

Ernie Valente asked about the workgroup's rationale for keeping the asthma action plan as a component of the measure given the weak evidence. Bill Nersesian stated that while there is not strong evidence the action plan lowers morbidity and mortality; some studies support it and some studies do not. He shared that the action plan is a means to provide patient education. He further noted testimony from non-medical individuals who interact with individuals who have asthma (i.e., school nurses), for whom the asthma action plan is very useful and helpful.

Stefan Gildemeister asked if there is evidence in support of using the action plan for adult patients who have asthma. Bill Nersesian shared there is stronger evidence in support of using the action plan for adult patients and that action plan use is more controversial in pediatric patients. He noted that literature shows it prevents hospitalizations and deaths in adult patients. David Homans asserted, based on his organization's data and experience, action plan use for adults is controversial.

David Satin stated that PQRS does not include a measure for asthma action plan usage. Collette shared that there was a stand-alone process measure for a written asthma action plan that was previously endorsed by NQF, and endorsement was removed in 2012 due to failure to meet the evidence criteria.

Tim Hernandez shared that there was a significant amount of time devoted to the discussion of this component and that the work group acknowledged that evidence is not always the driver of a measure. He felt that not all measures need to be outcome-based and used for comparison; some are meant to measure the quality improvement of care delivered. He shared that for primary care providers who take care of many different types of patients, having the structure of an action plan is beneficial and helps systematize care.

Allan Ross noted that education is good, but a lot of money and resources are expended on implementation of the action plan when there is weak evidence supporting its benefit. David Satin agreed and stated he is not convinced that social reasons are enough to use the action plan when evidence is low and entities like PQRS and NQF are dropping measures that focus on the use of the action plan.

Ann Robinow expressed concerned about having a process measure in what should be an outcome measure, as she felt the action plans are a way to achieve an outcome of having zero ED visits or hospitalizations. She asked how prescriptive the directions for the action plans were. Collette shared that there are certain components an action plan must contain such as medications, triggers and plans for exacerbation; but the mode/method of obtaining the plan is not prescriptive.

Bill Nersesian stated he feels all patients should have an asthma action plan, but that some patients may have exercise induced asthma and may not need asthma action plans. He wondered if it was possible to have a two component measure rather than a three component measure.

Laura Saliterman shared she has spent time with parents who do not retain the information about instructions related to their child's asthma and wondered if it would be worse if there was no action plan to document the discussion with patients. She also pointed out parents need to get the plan and an inhaler to the school and the school needs permission to administer an inhaler. She noted the plan itself is useful for communication but does not solve all of the potential issues for schools to manage the child's asthma.

Stefan Gildemeister asked if analysis from data submitted to MNMCM was completed and if it added support or evidence.

	<p>Collette shared analysis was completed and showed a highly statistically significant difference in support of using the action plan, but the magnitude was not large. Jasmine Larson also shared that a chi square test was initially completed and looked at as related to the presence or absence of a written management plan. The analysis demonstrated with statistical significance that there were factors beyond random variation influencing the relationship between the two components. Further analysis could be completed to contribute to the evidence base. Ernie Valente stated chi square tests are extremely sensitive to sample size. Jasmine clarified that the sample of patients was very large as many groups submit full population, and that the threshold for significance with this size population was a p value < 0.05. This threshold was exceeded with a p value of < 0.0001. David Homans asked if there was analysis completed to determine the number needed to treat in order to prevent an exacerbation. Bill Nersesian replied that such an analysis was not completed.</p> <p>David Homans stated given the additional implications that occur because of using the measure in pay-for-performance programs and publicly reporting, he is uncomfortable including the action plan given the low evidence. David felt MNMCM is supposed to be the trusted source of information per its mission. David and Jeff Rank shared that MNMCM measures drive resources allocated at clinics and they are uncomfortable including the action plan in the measure given the lack of evidence. David Satin stated he feels it hurts MNMCM to have measures with low evidence rather than measures with strong evidence.</p> <p>Howard Epstein asked if past data could be recast if the action plan was removed from the measure in order to have comparable data. Anne stated that may be possible. Collette shared nationally there is interest in the patient reported outcomes component of this measure.</p> <p>Chris Norton noted that part of the work group's discussion was concern whether providers would still complete patient education and action plans if the plans were not a part of a measure. She shared children may be at school for up to 12 hours a day and it is important for them to have an asthma action plan in place. Ernie Valente stated that that was a valid worry, but not having the action plan as part of the measure should not prevent a provider from completing a plan with a patient.</p> <p>Chris Norton made a motion to accept the recommendation from the work group. Mark Nyman seconded the motion. Votes for motion (4); votes against motion (7). Motion did not pass.</p> <p>David Satin made a motion to accept the recommendations, but with the removal of the asthma action plan. Ernie Valente seconded the motion. Votes for motion (11); votes against motion (3). Motion passed.</p>
<p>Pediatric Preventive Care Measures Development Work Group recommendations for Mental Health/Depression Screening and Obesity Screening – For approval</p>	<p>Collette Pitzen reviewed the Pediatric Preventive care measure pilot results and work group recommendations. Collette introduced work group members present at MARC: Laura Saliterman (MARC Member) who chaired the work group; Terri Lloyd, Children's Physician Network; Glenace Edwall, MDH Children's Mental Health Division; Katy Schalla Lesiak, MDH Child and Teen Checkups; Tim Stratton, U of M Duluth College of Pharmacy; and Marie Reisdorfer, Mayo Health System.</p> <p>These measures were developed with the intention to be included in the Statewide Quality Measurement and Reporting System (SQRMS), under a contractual agreement with the MN Department of Health. In 2011, one of the measure concepts approved by MARC for measure development activities was Pediatric Preventive Care. The measure development work group spent a significant amount of time evaluating potential areas of measurement, reviewing the fifteen preventive services recommended by ICSI and the USPTF as services that were level I (must do) or level II (should do). Mental health/depression and overweight/obesity were chosen as topics for measure development and MARC approved pilot testing for each measure set in 2013. Each measure was discussed by the committee separately.</p> <p><u>Adolescent Mental Health and/or Depression Screening Review</u></p> <p>The Adolescent Mental Health and/or Depression Screening measure is intended to measure and increase mental health and depression screening rates in the adolescent population. It is estimated approximately 21% have a diagnosable mental health disorder between the ages of 9 and 17 and in 2011 about 8% of the U.S. adolescent population had a major depressive episode.</p> <p>Collette reviewed the numerator, denominator and exclusions for this measure. The numerator includes patients who received a screening with a valid assessment tool. The denominator includes patients ages 12 to 17 who had a well-child visit during measurement period. The work group confirmed their decision to focus on the well-child visit, determining that although there might be opportunities to screen more adolescents if all visits were included; it would be impractical and not necessarily appropriate to provide screening at all acute care visits. Exclusions for this measure include bipolar disorder, major depression, dysthymia, depression NOS, personality disorders, schizophrenia, and specified intellectual disabilities (moderate, severe and profound). Exclusions are necessary as it is not practical to administer screening tools when a mental health condition is present.</p> <p>This measure had excellent pilot participation; 17 medical groups participated (123 clinics) and submitted data on over 20,000</p>

patients and the average screening rate was 46.3%. Rates by medical group and individual clinics demonstrated variability and opportunity for improvement. Medical groups gave feedback that there was some burden in programming and work flow changes, but many of the fields were easy to collect. Collette shared that with any new measure there will be some burden associated with creating new work flows, mechanisms to collect and extract data, but burden can lessen over time as measures are implemented and supportive structures are implemented.

During the pilot, eleven tools were included for screening including a mix of public and proprietary tools, and they were evaluated by a team of DHS/MDH experts. As recommended by MARC in 2011, a reference table of all tools was created for users and incorporated into the data collection guide. The assessment tools used in the pilot were either in the Pediatric Symptom Checklist (PSC) group of tools including the PSC-17, PSC-35 or the PSC Youth Self-Report or the Patient Health Questionnaire (PHQ) group of tools including the PHQ-9, PHQ-9 Modified for Teens/Adolescents or the PHQ-2. For patients submitted in the pilot, 58% of patients were screened using PSC tools and 42% using PHQ tools. No proprietary tools were used by medical groups during pilot. The ability to capture the result of the tool administered was tested as part of the pilot process; however, submitting the value was optional for the pilot. Of the 54.7% of patients who were screened AND had a result submitted, 9.4% had a positive screening of mental health/depression.

Collette also shared the work group made minor modifications to the definitions and specifications for this measure after pilot. There was confusion among medical groups about the PHQ-9M and PHQ-A tools. The PHQ-A is an 83 item yes/no questionnaire that also contains depression questions; the intent was to use a modified PHQ-9 depression assessment tool which is sometimes referred to incorrectly as the PHQ-A. The specifications will be modified to add clarifying language about the two screening tools. Based on pilot results and the ease of collecting the screening tool score, it was determined that the value/score of the tool will be required for data submission rather than remaining optional. The measure development work group wanted to better understand the patient population, incidence of positive screens and support the evolution of future measure development around adolescent mental health conditions.

Collette also shared that the work group discussed the possibility of reducing the number of approved tools since no proprietary tools were used during the pilot, but as the measure is implemented more broadly there may be some use of these tools and the work group wanted to offer providers a choice; therefore, the list of tools was not reduced as a result of the pilot. All tools meet the intent of the measure, have strong psychometric properties and result in a score. After full implementation, tool use will be evaluated before the decision to reduce the list of tools is made.

Recommendation from the work group was as follows: the pilot results demonstrate opportunity for improvement in the screening of adolescents for mental health and/or depression, conditions with an increasing prevalence, and variability in rates between practices. The measure development work group recommended this measure be considered for wider implementation and use in Minnesota.

Adolescent Mental Health and/or Depression Screening Questions/Comments/Discussion:

Laura Saliterman summarized the work group's discussion of this measure and shared there is no doubt that mental health issues represent a significant problem needing to be addressed. In terms of the potential burden for medical groups to screen and report, it was felt that the amount of burden was reasonable and the measure feasible. She also noted an additional concern was raised by the work group in terms of assessing and identifying adolescents with depression or mental health issues who then would require intervention, but resources may be difficult to obtain. The work group felt that focusing on screening was a good first step and future measure evolution may include consideration of outcomes, but having resources in place for intervention is key to improving outcomes.

David Satin asked for clarification about the "Teen Screen" validation. Laura Saliterman replied that all acceptable tools are validated tools. She also shared that the PHQ-A (83 questions) is very cumbersome and difficult to administer. Collette clarified that the PHQ-A and PHQ-9M are often thought of as the same tool, but they are two separate tools. She also mentioned that the PHQ-2 is accepted, and is included in the Meaningful Use depression screening measure, but was not listed as a highly recommended tool. Mark Nyman shared information about scoring the PHQ-2 and different cut points that can affect the sensitivity of the tool. Collette stated that the PHQ-2 can be used; it was not highly recommended as compared to some of the other tools but still accepted. Mark asked how the experts formulated their recommendations. Collette shared that the MDH/DHS team created a table which contained the following: purpose of screening tool, age range, description of tool, languages available, psychometric properties including reliability, validity, sensitivity and sensitivity, administration time, and cost/availability for each tool. Mark shared that the cut point used will affect the sensitivity of a tool.

Jeff Rank asked if this was only depression screening. Collette shared that the Pediatric Symptom Checklist also screens for mental health issues as well as depression. Caryn McGeary asked if there will be a summary provided back to the medical groups of what tools were used for screening and the rate of positive screens. Collette shared that it would be possible to analyze this when data is submitted; however, there are no current measures/structure to report this. It could be a future

enhancement provided to medical groups as an internal tool for use.

Chris Norton made a motion to accept the recommendations from the work group. Ernie Valente seconded the motion. Motion passed.

Obesity/BMI Assessment and Overweight Counseling Review

The Obesity/BMI Assessment and Overweight Counseling measure is intended to assess overweight/obese patients in the pediatric population and to assess if counseling was provided for children who have a BMI percentile greater than 85. The measure set included two measures. The first measure assesses the ability to calculate and measure a child's BMI. The numerator includes patients who had documentation of a BMI screening. The denominator includes all patients ages 3 to 17 who had a well-child visit during measurement period. Information from this measure was used by medical groups to determine the denominator for the second measure.

The second measure is to assess if counseling was provided to patients whose BMI percentile greater than 85. The numerator for the second measure includes patients who had documentation of counseling for both physical activity and nutrition. The denominator for the second measure was all patients ages 3 to 17 who had a well-child visit during measurement period and a BMI percentile greater than 85. The acceptable documentation for counseling activities was aligned with the NCQA/HEDIS Meaningful Use measure. Activities include discussion of current behavior, checklist, counseling/anticipatory guidance, providing educational materials and/or a referral. Exclusions included patients who were pregnant.

This measure also had excellent pilot participation; 16 Medical groups with 116 clinics participated and submitted data for over 42,000 patients. The average Obesity/BMI Assessment rate was 98.2% and the prevalence BMI Percentile greater or equal to the 85th percentile was 27.4%. There were 14.8% children who were overweight with a BMI percentile of 85 to 94.9 and 12.6% of children who were obese with a BMI percentile of 95 to 100. The average overweight counseling rate was 68.3% and types of documentation included anticipatory guidance (58%), discussion of behaviors (29%), providing educational materials (11%), checklist (2%), and referral (<0.5%).

Obtaining the BMI percentile was difficult for medical groups. For the pediatric and adolescent populations, the BMI percentile is the only way to determine overweight or obesity. A BMI value does not work for children and if this method is used it would over represent children and adolescents in the underweight and normal weight categories. Thus, using the BMI percentile to define overweight and obesity in children is more accurate.

During the development process, it was known that the BMI percentile is not a stored reportable field in the medical record. EMR vendors have built a floating field to display the BMI percentile based on the child's gender, height, weight, and age at the time of the visit. One solution work group members worked through to enable medical groups to submit the BMI percentile was to calculate the BMI percentile using a CDC calculator with the intent to receive data that was an exact match to the patient's record. During the pilot testing, some medical groups experienced significant difficulty in calculating the percentile on historical data or found their vendor's calculations did not match the CDC calculations. Given these issues, the work group recommended that the MNCM data portal calculate the BMI percentile using data elements to aid in correct identification of the denominator for the overweight counseling measure and reduce the burden for the medical groups.

Collette shared that the work group decided to make modifications to the measure based on the pilot. The collection, programming and submission of types of counseling provided were burdensome and activities are of relatively equal weight for medical groups. Data burden reduction would be accomplished by moving to a binary yes/no field to determine if counseling was offered rather than asking medical groups to submit the type of counseling. These changes resulted in the removal of ten fields from the submission file.

Since the pilot for the Obesity/BMI Assessment Measure demonstrated no opportunity for the measure of assessment; the work group recommended a modified assessment measure that would capture the date of birth, gender, height, weight and metric system to support and quantify the success in capturing the data elements needed to for the calculation of BMI percentile and can be used by medical groups for internal quality improvement if needed. This recommendation was made because there is concern that there may be some selection bias in pilot participation of only those groups who were ready to submit data and in part could be driving high rates.

The pilot for the Overweight Counseling Measure demonstrated some opportunity and some variability among medical groups for this measure. The work group felt that the variation could be greater with a wider implementation, but may have limited longevity and could "top-out" in the next 2-3 years. The work group confirmed that this is an important issue and a first step towards addressing the obesity epidemic, with a recent study demonstrating that 80% of children that were overweight between the ages of 10 – 15, were obese adults.

Work group recommended the following: 1) reduce burden related to providing BMI percentile by having the MNMCM data portal calculate the BMI percentile to accurately identify the denominator for overweight counseling, 2) reduce burden surrounding the types of counseling offered by moving to a binary or yes/no field and not require medical groups to submit type/s offered, and 3) recommended the modified measure be considered for implementation in Minnesota.

Obesity/BMI Assessment and Overweight Counseling Questions/Comments/Discussion:

Laura Saliterman shared the technical issues of obtaining a BMI percentile were the most difficult issues for medical groups and that it required many hours to create it as a reportable field in the EMR. Laura felt the modifications recommended are a reasonable solution to reduce burden for medical groups.

Jeff Rank stated this is a process measure and asked if an outcome measure had been considered. Laura Saliterman shared that more conversation is needed before an outcome measure can be considered, but feels this measure would be a first step towards an outcome measure. If the measure is implemented, this issue will be discussed when the work group reconvenes.

Ann Robinow asked about the strength of evidence of counseling's effect on BMI. Collette replied that there is strong evidence from the USPTF. She also noted that the counseling activities used in the measure were based on a Meaningful Use measure which also has strong evidence in addition to support from the American Academy of Pediatrics. David Homans shared that his organization has found that counseling is helpful, but not sufficient. He hopes that future measures incorporate additional effective counter measures because the battle of obesity is being lost.

David Satin asked if MNMCM can work with the medical groups in order to calculate if a patient's BMI is greater than the 85th percentile given that is the most difficult aspect of the measure. Collette shared that that is possible and MNMCM will explore ways to do this. She mentioned that medical groups could possibly upload their patient file to the MNMCM data portal; the data portal would then complete the calculation and then provide a file back to the medical groups that contained patients whose BMI was greater than the 85th percentile. Tim Hernandez verified this would be during a well-child visit and the provider can usually visually see that a patient's BMI is greater than the 85th percentile via the medical chart, but that field is difficult to abstract.

Howard Epstein shared that he feels there is a positive impression from medical groups regarding this and he is comfortable recommending this measure with the recommended modifications for wide spread implementation.

Stefan Gildemeister asked what the "top out" potential is for the measure and how much of a selection bias there was within the pilot measure. Collette stated this is unknown, but it was the largest pilot MNMCM has completed and medical groups participated in the pilot with a variety of medical charts including EMR, paper, and hybrid which is a combination of electronic plus some manual abstraction. Laura Saliterman shared the measure would mean a provider would provide counseling to patients whose BMI is greater than the 85th percentile and a provider could not do that without knowing who those patients are. Thus, it is assumed that if a provider is compliant in the second measure, they are compliant in the first measure.

Jeff Rank made a motion to accept the work group recommendations, Chris Norton seconded the motion. Motion passed.

Next Meeting: Wednesday, April 9, 2014

**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	<p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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 <p>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.</p> <p>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.</p>

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 MNMCM 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.

Existing measures:

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.

New measures:

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 MNMCM 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 MNMCM 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 MNMCM 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

<p>Coordination Measures (2): Measure Development Work Group Recommendations</p>	<p>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.</p> <p>Nathan Hunkins informed MARC that the workgroup settled on two measures for quality improvement purposes: Advance Care Planning and Follow-up After Hospital Discharge.</p> <p><u>Advance Care Planning</u></p> <p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 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. <p>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.</p> <p>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.</p> <p><u>Follow-up After Hospital Discharge</u></p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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</p>
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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



Ambulatory Surgery Center Timing of Prophylactic IV Antibiotics

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients with an order for a prophylactic IV antibiotic for prevention of surgical site infections who receive the prophylactic antibiotic on time.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
3	0	0	2

Comments:

- Need n size for reliability. High use potential for ASCs to be used in lieu of hospital setting
- Having surgery center leadership review

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
No comments					

High priority aspect of healthcare:	5	0	0	0	0
No comments					

Performance gap:	1	0	3	0	1
Are ASCs all doing well now? Is there really still a significant gap warranting continuation?					

Reliability and validity:	4	0	0	1	0
Need n size; not clear on how measure validity is checked with summary data. Validity findings not included.					

Feasibility and burden:	3	1	0	0	1
Unsure					

Use and usability:	3	0	2	0	0
<ul style="list-style-type: none"> • Even though this is high performing, usability could be high if available for public reporting as ASCs are affordable and great alternatives to expensive hospital settings. • How is the data publicly reported? Does it translate into terms that the “consumer” would understand, like center with the lowest infection rates? 					

Harmonization:	1	0	1	0	3
No comments					



Ambulatory Surgery Center Surgical Site Hair Removal

Measure Review Preliminary Rating Summary

Measure description/intent

The percentage of patients who have appropriate surgical site hair removal (with a razor or clippers from the scrotal area or with clippers or depilatory cream from all other surgical sites).

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
2	1	1	1

Comments:

- Good for transparency as a viable alternative to costly hospital venue.
- Interesting that measure is suspended by SQRMS. A question I have has is does it make sense to retire a measure or transition to monitoring if it has now become a standard of care embedded into routine practice?
- Suggest removing use of a razor because of increase in surgical site infections vs hair removal with clippers or depilatory cream.
- Having surgery center leadership review.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	3	2	0	0	0
<ul style="list-style-type: none"> • Evidence is confusing; randomized is high but more recent observational contradicts. • More research is needed on evidence of surgical site hair removal and section sites, most recent research shows hair removal should not be performed. 					

High priority aspect of healthcare:	2	3	0	0	0
No comments					

Performance gap:	2	0	3	0	0
High performing but would be great for transparency to promote ASC as viable alternative to more expensive hospital venues for care.					

Reliability and validity:	4	0	0	1	0
Need n size; how is validity determined with summary data. Validity findings not included.					

Feasibility and burden:	4	0	0	0	1
No comments					

Use and usability:	2	0	1	1	1
<ul style="list-style-type: none"> • Very usable if transparently reported to promote ASC as an affordable alternative to expensive hospital venue. 					

Harmonization:	5	0	0	0	0
No comments					



Ambulatory Surgery Center Hospital Transfer or Admission

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients who are transferred or admitted to a hospital upon discharge from the ASC. Lower percentage indicated higher (better) performance.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
2	0	1	2

Comments:

- General question: What is the usefulness of transition to monitoring without public reporting – is it for internal quality improvement at center/clinic level?
- Having surgery center leadership review

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
No comments					

High priority aspect of healthcare:	5	0	0	0	0
No comments					

Performance gap:	2	0	3	0	0
Low variation but good for transparency as ASCs are affordable options compared to more expensive hospital venue.					

Reliability and validity:	4	0	0	1	0
Need n size; not clear on how measure validity is checked with summary data. Validity findings not included.					

Feasibility and burden:	4	0	0	0	1
No comments					

Use and usability:	3	0	2	0	0
<ul style="list-style-type: none"> • Even though this is high performing, usability could be high if available for public reporting as ASCs are affordable and great alternatives to expensive hospital settings. 					

Harmonization:	3	0	1	1	0
Appears to be the same as NQF 0265: all-cause hospital transfer/admission, which CMS uses.					



Colorectal Cancer Screening

Measure Review Preliminary Rating Summary

Measure description/intent

The percentage of patients who are up to date with appropriate colorectal cancer screening exams. This is a HEDIS measure adapted for Direct Data Submission. MNCM is not the measure developer or measure steward. Patients aged 51 – 75 who have had a colonoscopy in the last 10 years OR sigmoidoscopy in the last 5 years OR stool blood test in the last year.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
5	0	0	0

Comments:

- Please add n size for reliability and validity. Please correct validity section.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
No comments					

High priority aspect of healthcare:	5	0	0	0	0
No comments					

Performance gap:	4	1	0	0	0
No comments					

Reliability and validity:	4	1	0	0	0
No mention of the n size needed to reach this level of reliability. I assume it is correct but this should be added, please add the n size and I may be able to rate it high. Validity info didn't line up (it is on maternity care) so is this a cut/paste issue?					

Feasibility and burden:	3	2	0	0	0
No comments					

Use and usability:	4	1	0	0	0
No comments					

Harmonization:	5	0	0	0	0
No comments					



Maternity Care, C-Section Rate

Measure Review Preliminary Rating Summary

Measure description/intent

Primary Cesarean-section rate (percentage of nulliparous, term, singleton, vertex positioned cesarean deliveries). This measure is reported at the medical group level.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
4	1	0	0

Comments:

- Reliability at medical group level needs to be checked.
- If we are focusing on an outpatient measure, I wonder if we should really be looking at elective inductions which may lead to unnecessary C-sections. I really think the measure should be retired, completely redeveloped or transitioned to monitoring. There was also a lot of info on disparities. I do not think this measure addresses disparities in entry to prenatal care at all.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	4	0	0	1	0
Where is the background evidence that C-section leads to more poor outcomes? What are they?					

High priority aspect of healthcare:	3	2	0	0	0
Small denominators that most other measures					

Performance gap:	4	1	0	0	0
Some patients lost in measurement due to attribution model					

Reliability and validity:	2	1	2	0	0
Due to reliability = 0.584 0.584 low reliability, need n size. Is the reliability at the medical group level available?					

Feasibility and burden:	1	1	1	1	1
<ul style="list-style-type: none"> • I can't tell based on the information provided how feasible this is and what the burden actually is. • High burden for groups. • Not sure how to rate this one, but it appears as it could prove fairly burdensome. • Largely a manual audit process for this measure. 					

Use and usability:	2	2	1	0	0
<ul style="list-style-type: none"> • Potentially high of reliability proves out and results are publicly reported. • In the meeting, it was concluded that the focus of this measure was to allow the consumer to better choose a provider for their prenatal care – does this graph represent consumer use of data/measure elements? Have concern that the majority of consumers are not considering C-section rates when choosing their outpatient provider, they do look at “hospital” however. 					

Harmonization:	3	1	0	1	0
Outpatient evaluation of c-section rates and hospital may be different in collection and other ways?					



Depression, Remission at 6 months

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate remission six months after index with a PHQ-9 score less than 5.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
2	2	1	0

Comments:

- Due to concerns about burden and measure construct
- Continue but we should really better understand reliability of the measure itself in addition to the survey
- Maybe monitoring can help prepare for improving the 12 month remission rates? How does evaluating PHQ9 for remission at 6 months account for those who may need multiple medication changes, referral for therapy or other interventions from the time of the index PHQ9? It seems like a difficult task to get complete remission in 6 months. I like % change in PHQ9 score better.

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
Question on appropriateness of using the 300.4 dysthymia disorder as physicians would like to see only major depression utilized. Physicians suggest involving psychiatry in code selection for the depression measure. Also question if patients should get re-indexed as these are chronic patients. Suggestion potentially separating new diagnosis and chronic diagnosis if needing to include re-indexed patients.					

High priority aspect of healthcare:	5	0	0	0	0
No comments					

Performance gap:	4	1	0	0	0
See other comments with concerns using the 300.4 code					

Reliability and validity:	4	1	0	0	0
Reliability appears to be of the survey instrument, not of the measures. The instrument reliability is important but we also need to look at the measure.					

Feasibility and burden:	0	3	2	0	0
<ul style="list-style-type: none"> • MNMCM feedback received on burden; don't feel survey results about data submission process addresses what the burden is with these measures. • Do we really need the 6 and 12 month measures? Can we choose one set? • Difficult to internally track due to MNMCM selection of re-indexing patients. 					

Use and usability:	3	2	0	0	0
No comments					

Harmonization:	4	1	0	0	0
Is this referring to the PHQ9 Utilization measure?					



Depression, Remission at 12 months

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate remission twelve months after index with a PHQ-9 score less than 5.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
3	2	0	0

Comments:

- Due to concerns about burden and measure construct
- Need measure reliability results.
- Noticed that to be included in the category of “Remission” the patient must have an index PHQ9 and this would be greater than 9. Can those patients with a dx of MDD already on meds at initiation of care with index of PHQ9<5 be included? This would indicate remission on treatment with dx?

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
Question on appropriateness of using the 300.4 dysthymia disorder as physicians would like to see only major depression utilized. Physicians suggest involving psychiatry in code selection for the depression measure. Also question if patients should get re-indexed as these are chronic patients. Suggestion potentially separating new diagnosis and chronic diagnosis if needing to include re-indexed patients.					

High priority aspect of healthcare:	5	0	0	0	0
No comments					

Performance gap:	4	1	0	0	0
No comments					

Reliability and validity:	3	1	1	0	0
Need measure reliability in addition to survey reliability.					

Feasibility and burden:	0	3	2	0	0
<ul style="list-style-type: none"> • MNMCM feedback received on burden; don't feel survey results about data submission process addresses what the burden is with these measures. • Do we really need the 6 and 12 month measures? Can we choose one set? • Difficult to internally track due to MNMCM selection of re-indexing patients. 					

Use and usability:	4	1	0	0	0
No comments					

Harmonization:	4	1	0	0	0
Is this referring to the PHQ9 Utilization measure?					



Depression, Response at 6 months

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate a response to treatment six months after index, as defined by a PHQ-9 score that is reduced by 50% or greater from the index value.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
3	2	0	0

Comments:

- Due to concerns about burden and measure construct
- n size needed; also need measure reliability in addition to survey instrument. Do we really need both 6 and 12 month measures from a burden perspective?

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
Question on appropriateness of using the 300.4 dysthymia disorder as physicians would like to see only major depression utilized. Physicians suggest involving psychiatry in code selection for the depression measure. Also question if patients should get re-indexed as these are chronic patients. Suggestion potentially separating new diagnosis and chronic diagnosis if needing to include re-indexed patients.					
High priority aspect of healthcare:	5	0	0	0	0
No comments					
Performance gap:	3	1	0	0	0
No comments					
Reliability and validity:	1	2	1	0	0
Need measure reliability in addition to survey reliability.					
Feasibility and burden:	0	3	2	0	0
<ul style="list-style-type: none"> • MNMCM feedback received on burden; don't feel survey results about data submission process addresses what the burden is with these measures. • Do we really need the 6 and 12 month measures? Can we choose one set? • Difficult to internally track due to MNMCM selection of re-indexing patients. 					
Use and usability:	3	1	0	0	0
No comments					
Harmonization:	4	1	0	0	0
Is this referring to the PHQ9 Utilization measure?					



Depression, Response at 12 months

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients aged 18 years and older with major depression or dysthymia AND an index PHQ-9 score greater than 9 who demonstrate a response to treatment twelve months after index, as defined by a PHQ-9 score that is reduced by 50% or greater from the index value.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
2	2	0	0

Comments:

- Due to concerns about burden and measure construct
- n size needed; also need measure reliability in addition to survey instrument.
- Unsure

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
Question on appropriateness of using the 300.4 dysthymia disorder as physicians would like to see only major depression utilized. Physicians suggest involving psychiatry in code selection for the depression measure. Also question if patients should get re-indexed as these are chronic patients. Suggestion potentially separating new diagnosis and chronic diagnosis if needing to include re-indexed patients.					
High priority aspect of healthcare:	5	0	0	0	0
No comments					
Performance gap:	3	1	0	0	0
No comments					
Reliability and validity:	1	2	0	1	0
Need measure reliability in addition to survey reliability.					
Feasibility and burden:	0	3	2	0	0
<ul style="list-style-type: none"> • MNMCM feedback received on burden; don't feel survey results about data submission process addresses what the burden is with these measures. • Do we really need the 6 and 12 month measures? Can we choose one set? • Difficult to internally track due to MNMCM selection of re-indexing patients. 					
Use and usability:	2	2	0	0	0
No comments					
Harmonization:	4	1	0	0	0
Is this referring to the PHQ9 Utilization measure?					



Depression, PHQ-9 Utilization

Measure Review Preliminary Rating Summary

Measure description/intent

Percentage of patients aged 18 years and older with major depression or dysthymia who had a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.

Recommendation summary

Continue without changes	Refer for higher level review	Transition to monitoring	Retire
4	1	0	0

Comments:

- Due to concerns about burden and measure construct of the other depression care measures

Rating	High	Moderate	Low	Insufficient	N/A
Evidence:	5	0	0	0	0
Question on appropriateness of using the 300.4 dysthymia disorder as physicians would like to see only major depression utilized. Physicians suggest involving psychiatry in code selection for the depression measure. Also question if patients should get re-indexed as these are chronic patients. Suggestion potentially separating new diagnosis and chronic diagnosis if needing to include re-indexed patients.					
High priority aspect of healthcare:	5	0	0	0	0
No comments					
Performance gap:	5	0	0	0	0
No comments					
Reliability and validity:	5	0	0	0	0
No comments					
Feasibility and burden:	0	3	2	0	0
<ul style="list-style-type: none"> • MNMCM feedback received on burden; don't feel survey results about data submission process addresses what the burden is with these measures. • Do we really need the 6 and 12 month measures? Can we choose one set? • Difficult to internally track due to MNMCM selection of re-indexing patients. 					
Use and usability:	5	0	0	0	0
No comments					
Harmonization:	4	1	0	0	0
Is this referring to the PHQ9 Utilization measure?					



MN Community Measurement (MNCM) Measure Review and Maintenance Process and Structure

OVERVIEW:

MN Community Measurement has been successful in working with the community as a neutral convener to develop and report measures that are aligned across the state and drive improvement in health. As our measures and their uses have expanded, there is a need to increase the transparency of our measure review, maintenance and retirement decision making processes, and to ensure an appropriate, balanced representation of stakeholders are involved in this process in order to maintain broad support.

The purpose of this document is to provide 1) guidance for the composition of a Measure Review Committee and 2) clarity regarding the measure review process; specifically the timing, considerations and decision making.

Measure Review Committee

The Measure Review Committee is a sub-committee of the Measurement and Reporting Committee (MARC) and is comprised of MARC members. The Measure Review Committee meets two times per year (February & August).

Size: In order to be efficient and effective, the ideal work group size is 8-10 members.

Chair: The Measure Review Committee will have a chair who is appointed by the MARC co-chairs. The chair works with MNCM staff to support measure review activities and processes, and serves as the spokesperson of the committee to MARC.

Composition: The Measure Review Committee is comprised of MARC members and has balanced stakeholder representation.

The MARC co-chairs are responsible for reviewing and approving the subcommittee roster.

Representation Type	Ideal #
Medical Group (with specialist and/or ASC representation)	2-3
Health Plan	2
State Agency	1-2
Consumer	1-2
Employer	1-2



MN Community Measurement (MNCM) Measure Review and Maintenance Process and Structure

Measure Review and Maintenance Process

Ongoing evaluation of existing measures is necessary to ensure continued value to the community. The principles of measure evaluation criteria that are applicable during measure development hold through the review and maintenance of a measure as well. Criteria for determining the value of a measure must include (i.e., all four criteria must be met):

1. Consistent with evidence-based standards of care and guidelines,
2. Address a high-priority aspect of healthcare; (i.e., high disease burden, high resource use, severity of illness)
3. Demonstrate gap in performance, and
4. Reliability and validity

Additional criteria for consideration include:

5. Feasibility and burden
6. Current use of the measure in accountability programs and/or quality improvement activities, and
7. Harmonization with existing local and national measures and/or programs.

The measure review process includes four levels of increasingly intensive review, research, assessment and redesign.

Level I: Annual Measure Maintenance

Level II: Focused Measure Review (on an ad hoc basis as needed)

Level III: Extensive Measure Review (MNCM-developed measures only that are endorsed by NQF)

Level IV: Measure Redesign

The Measure Review Committee has responsibilities for the Level I review only and makes recommendations (using a consensus based decision making process) to MARC regarding next steps.

Work products from Level II – IV reviews are addressed by MARC directly.

Level I: Annual Measure Maintenance includes:

1. Coding changes that do not impact the reliability, validity or intent of the measure
 - a. If coding changes will likely impact reliability or validity, Level II review is indicated
2. Assessment of measure evaluation criteria:
 - a. Scan of environment to ascertain the presence (or absence) of change in each measure's alignment with the evaluation criteria
 - b. If substantial change is identified, higher level review is indicated



MN Community Measurement (MNCM) Measure Review and Maintenance Process and Structure

3. Recommendation to MARC for ongoing use of each publicly reported measure. Potential recommendations:
 - a. Continue without changes
 - b. Elevate to Level II, III or IV review
 - c. Transition to Monitoring (Collect without public reporting)
 - d. Retirement, criteria for considering measure retirement include:
 - i. Loss of measure or element validity
 - ii. Loss of opportunity for improvement
 - iii. Evidence of undesirable consequences of measure implementation, such as manipulation or gaming by providers
 - iv. Replacement by a superior measure

Level II: Focused Measure Review (performed on an ad-hoc basis), includes:

1. In depth, focused review to evaluate the impact of technical changes or changes in evidence that may affect the measure's alignment with the evaluation criteria
2. Development of proposed changes to numerator, denominator or exclusions that do not change the validity or intent of the measure.
 - a. The measure development work group may be reconvened for discussion and determination of proposed changes.
 - b. If major changes in evidence result in a need for measure redesign, Level IV review is indicated.
3. Recommendation to MARC of proposed changes and with stated rationale.

Level III: Extensive Measure Review (MNCM-developed measures only that are NQF endorsed; 3-year cycle), includes:

1. Assessment of all measure evaluation criteria, supported by a systematic literature review, including published guidelines
2. Submission of NQF Endorsement Maintenance application
3. If a substantial change in alignment with measure evaluation criteria is identified, Level II or IV review is indicated.

Level IV: Measure Redesign (measure development process), includes:

1. Reconvening of measure development work group for in-depth discussion on major changes in evidence, significant coding changes and/or other need for measure redesign

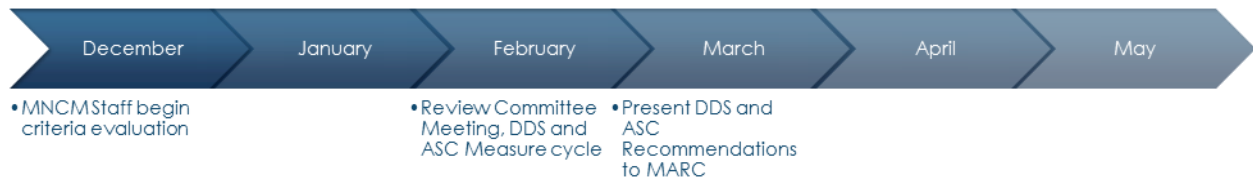


MN Community Measurement (MNCM) Measure Review and Maintenance Process and Structure

2. Systematic literature review, including published guidelines, for identification and evaluation of proposed measure changes
3. Recommendation to MARC of proposed changes with stated rationale. Potential recommendations include:
 - a. Continuation of existing measure as-is
 - b. Redesign of existing measure, draft specifications and proposed timeline
 - c. Replacement of existing measure with a new or existing measure, draft specifications and proposed timeline
 - d. Retirement, criteria for considering retirement include
 - i. Loss of measure or element validity
 - ii. Loss of opportunity for improvement
 - iii. Evidence of undesirable consequences of measure implementation, such as manipulation or gaming by providers

LEVEL I TIMELINE

DDS, ASC, CAHPS MEASURE REVIEW CYCLE:



HEDIS MEASURE REVIEW CYCLE:

