# Recommendations for 2018 SQRMS Hospital Measures Reporting April 1, 2017

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This material was prepared by Stratis Health under a contract with MN Community Measurement through funding from the Minnesota Department of Health.

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

# Statewide Quality Reporting and Measurement System (SQRMS) Hospital Measures: Recommendation Process and Recommendations

Minnesota's 2008 Health Reform Law requires the Minnesota Department of Health (MDH) to establish a standardized set of quality measures for hospitals and physician clinics across the state. The goal is to create a uniform approach to quality measurement in order to enhance market transparency. The Hospital Quality Reporting Steering Committee (Committee) serves in an advisory capacity to MDH regarding hospital measures to be used in SQRMS, and Stratis Health convenes and facilitates the Committee. Stratis Health conducts this work under contract with MN Community Measurement, which MDH has contracted with to lead a consortium of organizations that includes the Minnesota Hospital Association and Stratis Health, to assist in developing a standardized set of measures to assess the quality of health care services offered by health care providers.

This year, Stratis Health convened and facilitated the Committee for two meetings, via conference call, on March 1, 2017 and March 20, 2017, to consider and make recommendations for 2018 hospital SQRMS reporting. Six of the 17 state-approved Committee members were new in 2017, replacing members who retired or changed positions. The mix of returning and new members allows for both continuity and new perspectives and ideas. Fourteen Committee members participated in the March 1 meeting, and thirteen Committee members participated in the March 20 meeting.

## 2017 Hospital Measures Recommendations for 2018 Reporting

For the 2018 report year, the Committee recommended to maintain the measures that hospitals are reporting in 2017 under SQRMS. Specifically, the Committee continued to endorse the approach of measure alignment with federal programs for the 2018 hospital slate of measures, and to maintain several Minnesota-specific measures.

- For prospective payment system (PPS) hospitals, this alignment is achieved through reporting of the total performance and composite scores from the CMS Value-Based Purchasing (VBP) and Hospital Acquired Conditions (HAC) Programs, and the calculation of a composite score based on performance in the CMS Readmissions Reduction Program (RRP).
- For critical access hospitals (CAHs), measures align with those required for the federal Medicare Beneficiary Quality Improvement Program (MBQIP).

PPS Hospitals

The Committee voted to recommend continued alignment of the SQRMS hospital measures for PPS hospitals with composite scores derived from the three CMS pay for performance programs, thereby requiring hospital reporting on individual measures to align with the federal reporting requirements for these programs.

- VBP Total Performance Score
- Total HAC Score
- RRP composite calculated based on individual measure scores

CAHs

The Committee voted to recommend continued alignment of the SQRMS hospital measures for critical access hospitals with the measures required by the MBQIP, as well as to continue requiring a few additional MBQIP measures: CAUTI, ED-1, ED-2, OP-23, OP-25, PC-01, READM-30-HF, READM-30-PN, and READM-30-COPD. No measures were added or removed from the previous reporting year.

Minnesota-Specific Measures for All Hospitals

After some deliberation regarding the Agency for Healthcare Research and Quality (AHRQ) claims-based measures, PSI-04, PSI-90, and IQI-91, the Committee voted to recommend continuing the current slate of Minnesota-specific measures that are part of SQRMS for all hospitals. While the Committee questioned the utility in calculating these claims-based measures on behalf of CAHs (i.e., the measures are low volume and may not provide enough information to drive improvement efforts), in an effort to maintain alignment between PPS hospitals and CAHs, and recognizing that there is no increased reporting burden, the Committee voted to maintain these measures for all hospitals.

## Future Measure Considerations

In the spirit of aligning Hospital SQRMS requirements with federal programs, Stratis Health presented a few measures to the Committee for their consideration. The committee discussed the possibility of adding these measures to SQRMS this year, but in all cases opted instead to recommend future consideration when more information becomes available. Explanation of why the measures were presented and what the committee decided are provided below.

- Outpatient & Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) – This survey becomes a requirement for hospitals participating in the Outpatient Quality Reporting Program starting in January 2018. The committee wanted to wait until after the new requirement took effect and data becomes available to help inform a decision of whether or not to add this as a state required measure.
- *Clostridium difficile* and MRSA for CAHs – The Federal Office of Rural Health Policy (FORHP) is considering adding these two measure to those required through MBQIP, which could start as early as Fall 2017. The committee wanted to wait for formal changes from FORHP before adding either of these as new state required measures.

## Patient Safety Measurement

In 2016, the Hospital Quality Reporting Steering Committee chartered a Patient Safety Workgroup to explore the development and use of a patient safety composite measure in SQRMS. As defined by the National Quality Forum, a healthcare composite measure is "a combination of two or more individual measures in a single measure that results in a single score." Other terms for composite measures include composite index, composite indicator,

summary score, summary index, and scale. Combining measures of performance to convey a broader picture than can be done with single measures holds promise for improving understanding and stimulating improvement, and composite measures can reduce information burden and make provider assessments more comprehensive. However, composite measures also present challenges – detailed information can be lost, and they may not provide clinicians or policymakers with clear actionable information from which to target or prioritize specific quality-improvement efforts.

The workgroup was comprised of six members – Marie Dotseth (Minnesota Alliance for Patient Safety), Vickie Haverkamp (Meeker Memorial Hospital), Steve Meisel (Fairview), Carolyn Pare (MN Health Action Group), Britney Roseneau/Marsha Studer (Allina), and Mark Sonneborn (Minnesota Hospital Association). The workgroup was facilitated and supported by Stratis Health, and MDH staff attended the meetings as non-voting members. The workgroup met six times between June 2016 and February 2017, plus held a conference call with Leapfrog during that timeframe. An overview of the workgroup meeting activities, along with considerations and conditions in using Leapfrog's Value Based Purchasing Platform as Minnesota's publicly reported patient safety composite measure in SQRMS, is attached as Appendix A.

There was consensus among the workgroup that today's measurement of patient safety in Minnesota and nationally is unsatisfactory because the number of safety-related measures has grown substantially, to the point of not holding meaning or value The workgroup also agreed that the status quo is not serving hospitals or patients well – for patients, the large array of measures are not easily understandable or useable in making care decisions, and for hospitals, the wide range of measures disperses focus and priorities. Three options were developed by the workgroup, and the workgroup ultimately focused on exploring the use an existing measure (Leapfrog Value Based Purchasing Platform measure). At the end of the workgroup process, there was wide variation in workgroup member opinions, as noted below; in addition, the Minnesota Hospital Association articulated a stance against a composite measure generally and the Leapfrog measure specifically. As a result, the workgroup did not reach consensus on the best path forward in terms of a composite safety measure, and was not able to make a recommendation to the Hospital Quality Reporting Steering Committee.

Given the lack of consensus with regard to pursuit of a patient safety composite measure, further discussion or action by the Hospital Quality Reporting Steering Committee is tabled until MDH has completed its 2017 dialogue and engagement with a variety of stakeholders with regard to the future direction of measurement in Minnesota.

## Appendix A

**Summary of Patient Safety Workgroup Effort and Leapfrog Information**
**June 2016 through February 2017**

*Overview of workgroup meetings and activities*

<table>
<tr><th>Date</th><th>Primary purpose and outcome</th></tr>
<tr><td>June 13, 2016<br>Kick-off call</td><td>Orientation to workgroup charter. Clarified workgroup scope. Reviewed MDH measure criteria. Prepared for survey of workgroup regarding composite measures.</td></tr>
<tr><td>July 28, 2016<br>Two-hour in-person meeting</td><td>Synthesized workgroup survey results. Reviewed composite frameworks. Discussed and determined highest priority patient safety domains, topics, and subtopics for inclusion in composite measure.<br>Two important questions emerged:<ul><li>Is the group prioritizing a focus on a composite measure which has as its primary purpose to be meaningful to consumers? If so, it would focus exclusively on clinical care and patient harm (and not the organizational/system domain).</li><li>Is there an existing composite measure developed elsewhere that would meet our needs, given how rapidly changing the measurement environment is?</li></ul></td></tr>
<tr><td>September 1, 2016<br>Two-hour in-person meeting</td><td>Reviewed existing patient safety composite measures to see if any come close to meeting our purpose, including Leapfrog and PSI 90. Articulated four options for moving forward:<br>1) Develop or adapt, and publicly report, a comprehensive safety composite measure inclusive of clinical care and harm measures, as well as organizational and system characteristics<br>2) Develop or adapt, and publicly report, a patient safety composite measure focused on clinical care and harm<br>3) Do not develop or adapt, and publicly report, anything new, recognizing that there are already a number of safety measures and composites<br>Plus an Option 1.5: Develop or adapt, and publicly report, a patient safety composite measure focused on clinical care and harm plus require hospitals to report to the state their domain-level patient safety culture survey result.<br>Determined debate-style format for MAPS Conference breakout session.</td></tr>
<tr><td>October 27, 2016<br>Breakout session at MAPS Conference</td><td>Conducted debate, with a workgroup member each representing one of the three primary options. Gathered input and ideas from session participants (which were mostly hospital staff).</td></tr>
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| Nov. 3, 2016<br>Three hour in-person meeting | After intense and thoughtful deliberations about the options for a Minnesota hospital safety composite measure, the Patient Safety Workgroup agreed by consensus to:<br>• Explore using Leapfrog Hospital Safety Grade as a comprehensive measure of safety, but with conditions.<br>• If the conditions cannot be met, do not move forward at this time with a safety composite measure. |
| November 28, 2016<br>Workgroup call with Leapfrog | (See summary and synthesis of key issues and topics below.) |
| December 7, 2016<br>30-minute check-in call | De-briefed Leapfrog call. Although lacking consensus, workgroup agreed to pursue additional information gathering and discussion with Leapfrog. |
| December 20, 2016<br>Additional Questions to Leapfrog from Workgroup | (See summary and synthesis of key issues and topics below.) |
| February 27, 2017<br>One-hour final workgroup meeting | Called for vote by workgroup members on Option 1 or Option 3:<br>• Two votes which could support either option, but both leaning toward #3:<br>    o In one case, because the value to critical access hospitals isn't clear in option #1.<br>    o In one case, because the feasibility of Leapfrog isn't clear.<br>• One vote for #3.<br>    o But noting that the workgroup member would participate in the process if option #1 is selected.<br>• Two votes for #1.<br>    o In one case, because #1 seems low risk, and discomfort with option #3.<br>    o In one case, status quo of #3 is not acceptable; however, the feasibility of #1 is unclear. |

*Considerations and Conditions in using Leapfrog as Minnesota's publicly reported patient safety composite measure in SQRMS (with salient points in* ***bold*** *text)*

Minnesota seeks to have a composite measure of hospital patient safety to be publicly reported as part of its state-mandated reporting program, SQRMS (State Quality Reporting and Measurement System). A workgroup of the Hospital Quality Reporting Steering Committee has been focused on this in 2016, determining whether to adopt or adapt an existing composite measure of safety, or to develop a new one.

After identifying and investigating options, reviewing data, gathering input from other stakeholders, and intense debate and discussion, the workgroup agreed by consensus to pursue Leapfrog Hospital Safety Grade as a comprehensive measure of safety, but with certain considerations and conditions.

The Leapfrog measure emerged as the preference because it is a comprehensive safety composite measure inclusive of clinical care and harm measures, as well as organizational and system characteristics. Patients are most interested and focused on outcomes, as represented by measures of clinical care and harm. At the same time, emerging research indicates the importance of the underlying organizational and system characteristics in assuring and improving safety, such as leadership, culture, and reliability. As a result, publicly reporting a composite measure which includes not only measures of clinical care and patient harm, but also of organizational and system characteristics, reflects important aspects of safety and can advance safety in Minnesota. The Leapfrog Hospital Safety Grade includes measures in 5 domains: Infections, Problems with Surgery, Practices to Prevent Errors, Safety Problems, and Doctors/Nurses/Hospitals Staff.

The overall Leapfrog program consists of an annual survey (which has been available since 2001) and two composite scores:

- A publicly reported Hospital Safety Grade, comprised of approximately half CMS measures and half survey-derived measures
- A Value-Based Purchasing Platform, derived entirely from survey responses, and not publicly reported

LF's philosophy is to utilize measures already in use to the extent possible, and fill in gaps as needed. For each set of measures, LF establishes a benchmark, accomplished through national expert panels. Hospital scores are available on each measure of the survey. More than 1800 hospitals are participating so far this year, and there has been a steady increase in recent years. **Currently, 36 of Minnesota's 140 hospitals have a Leapfrog grade and report. All of these are large or mid-sized PPS hospitals; none are small or critical access. Only 6 of the 36 hospitals participate in the Leapfrog survey,** which makes robust contributions to the composite measures; as a result, most of the data included in the Leapfrog composite for Minnesota's hospitals is from publicly available sources, for example, based on Medicare claims data, HCHAPS survey results, or NHSN infection data.

- For the Hospital Safety Grade, a letter grade is assigned A-F, based on 30 safety measures. Half of the weighing is from process/structure measures (15), and half of the weighing is from outcome measures (15). Each individual measure has its own weight, based on potential for harm and opportunity for improvement, and the methodology is fully transparent. Hospitals are not eligible for a Safety Grade if they are missing scores for more than nine process measures or more than five outcome measures, which typically means that low volume hospitals are not eligible.
- For the Value-Based Purchasing Platform, a numeric score is assigned 1-100 (with 100 being the best), based on 24 survey-derived measures in five domains. For the VBP composite, scores are available by domain and the Platform then calculates an overall composite score, the Value Score. The domains are:
    - Medication Safety (15%)

- Inpatient Care Management (20%)
- High-Risk Surgeries (15%)
- Maternity Care (15%)
- Infections & Injuries (35%)

The patient Safety Workgroup initially approached Leapfrog with interest in the hospital safety grade, conveying that one criteria for use of LF would be that all Minnesota hospitals have the opportunity to earn a grade and report, including the 78 critical access hospitals and the smaller PPS hospitals in the state. We learned, however, that hospitals with low volumes in certain measures would be missing scores needed to make up the "grade" and as such it would make the hospital safety grade not an option for Minnesota's patient safety composite measure interests. The workgroup then turned its attention to Leapfrog's Value-Based Purchasing Platform.

**Value-Based Purchasing Platform –** Because this program is based solely on measures from the Leapfrog Hospital Survey, Leapfrog treats missing data similarly to the survey program where hospitals are not penalized for measures in which they are scored as 'does not apply' (e.g., they don't have an ICU) or 'unable to calculate score' (i.e., volume was too low to calculate a score)

a. **Declined to Respond –** If a hospital is scored as 'declined to respond' on a measure from the survey, they are assigned a score of 'zero' for that measure and the measure score of 'zero' is multiplied by the measure weight. Because this is used as a pay for performance program by health plans, it's important that hospitals receive some penalty for not reporting
b. **Does Not Apply –** If a hospital is scored as 'does not apply' on a measure from the survey, they are assigned 'n/a' for that measure and the measure weight is re-apportioned to other measures within the domain. Hospitals are not penalized for measures that do not apply to them.
c. **Unable to calculate score –** If a hospital did not have enough cases to meet Leapfrog's minimum reporting requirements, they are scored as 'unable to calculate score' and this is treated in the exact same way as a score of 'does not apply.' The hospital is assigned 'n/a' for that measure and the measure weight is re-apportioned to other measures within the domain. Hospitals are not penalized.

- **As noted above, hospitals are not penalized for measures in which they are scored as 'does not apply' (e.g., they don't have an ICU) or 'unable to calculate score' (e.g., volume was too low to calculate a score).** However, if a hospital is scored as 'declined to respond' on a measure from the survey, they are assigned a score of 'zero' for that measure and the measure score of 'zero' is multiplied by the measure weight. LF has indicated that Minnesota could choose to have Minnesota hospitals respond on selected measures only on the survey, rather than the entire survey. However if this option to use some sections of the survey and not others as a means to achieve a patient safety composite was pursued, it will be important to understand how the sections not completed will be scored and compared, and what the public report would reflect.

- The range for time for hospitals to complete the survey is dependent on whether a hospital is able to complete all the measures. **The estimated time to complete the full**

**survey is up to 40 hours for a large academic medical center, and 10-20 hours for a small hospital, depending on if they are doing maternity care and surgeries.** Where possible, LF uses data the hospital is reporting to other entities and asks the hospital to send the same data to LF, or in the case of infections, allow the hospital to join the LF NHSN group so that LF can pull the data for the hospital.

**LF cannot abbreviate the survey for our purposes, but our program could focus on certain measures for which MN hospitals would report on selected sections of the survey and not others. Hospitals can submit a partially completed survey.** There are nine sections to the survey. If a section is skipped, the hospital will be scored on the sections that are completed. While LF doesn't generally encourage this, it is an option and the survey will allow a hospital to submit a survey on which some sections are incomplete. LF has done this with other states or coalitions, especially if they want to incrementally bring the survey into use. LF could work with MN to understand the specific measures of interest and the weighting of those measures.

- The LF hospital survey needs to be completed annually for the results to be comparable and reflect current performance. It also ensures the survey results align with any changes of the measure owner (e.g., CMS measure changes). **There is no cost for a hospital to complete a survey.**

- There are states which are prioritizing certain aspects of safety, and are then selecting which measures they want to focus on for their state. The Maine Health Management Coalition is an example of this approach, which includes critical access hospitals: http://www.getbettermaine.org/search-hospitals

- LF uses technical expert panels that meet at regular intervals, as well as coordinates alignment with measure stewards for specific measures to ensure the patient safety measures remain meaningful. LF also tracks on upcoming areas of interest and mentioned diagnostic error and antibiotic stewardship as two areas of future interest.

**Leapfrog resources for reference:**

- Leapfrog Hospital Survey Scoring Algorithms - http://www.leapfroggroup.org/survey-materials/scoring-and-results (with individual measure cut-points used in scoring)
- National Measures Crosswalk - http://www.leapfroggroup.org/survey-materials/survey-overview