MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC) /
Health Equity Advisory Council Meeting
Wednesday, June 12, 2019
Meeting Minutes

Members Present: Sue Knudson, Rahshana Price-Isuk, Dan Trajano, Barb Anderson, Lori Bethke, Joe Bianco, Cara Broich, Clarissa Cox, Karolina Craft, Roli Dwivedi, Matt Flory, Renee Frauendienst, Nancy Garrett, Sue Gentilli, Stefan Gildemeister, Bentley Graves, Greg Hanley, David Homans, Lynn Hassan Jones, Julia Joseph-DiCaprio, Jordan Kautz, Deb Krause, Chris Norton, Christopher Restad, Jonathan Rose, Patricia Ruiz de Somocurcio, Laura Saliterman, David Satin, Mark Sonneborn, Jess Wheeler,
Absent: Gaye Massey, Tesha Alston, Janet Avery, Jennifer DuPuis, Jamie Gulley, Andrea Hillerud, Theresa Kalugdan, Mariam Mohamed, Ekta Prakash, Alan Ross, Michelle Waste, Pahoua Yang, Marie Zimmerman
MNCM Staff: Jess Amo, Liz Cinqueonce, Collette Pitzen, Julie Sonier

Topic	Discussion
Welcome & Introductions	Sue Knudson called the meeting to order and introduced herself as MARC co-chair. Sue welcomed members of both the Measurement and Reporting Committee (MARC), members of the Health Equity Advisory Council (HEAC) and members of the Board of Directors. The purpose of this joint MARC/HEAC meeting was to have a community conversation about measurement gaps and to get input from a variety of stakeholders on what the most important topics/measures are to stakeholders. Members of MARC, HEAC and the Board of Directors introduced themselves. Sue also welcomed observers.
Opening Remarks – MARC/HEAC Co-chairs	Dan Trajano, HEAC co-chair, shared his support of the work of MNCM in terms of improving healthcare outcomes and convening multi-stakeholder groups to discuss the use of quality measurement to improve healthcare. For example, the Optimal Diabetes Care measure has improved significantly since its implementation. Dan supports the "Triple Aim" approach and highlighted the work MNCM has also done in reporting affordability of care as well as past work in patient experience. While Minnesota has some of the best healthcare in the nation, it also has some of the largest health care disparities, which are illustrated in the current health care disparities reports. Dan concluded by saying that with MNCM's ability to collect and analyze information on disparities, there is great opportunity to use that information to start decreasing those disparities. Rahshana Price-Isuk, MARC co-chair, shared that during multi-stakeholder discussions, she tries to consider the perspective of the consumer who may never have a seat at the table during these discussions. Given the diversity of the population in which the healthcare community serves, there are groups of people who may not have a voice. As a result, it is important that these perspectives are considered as well. Sue Knudson, MARC co-chair, added that while a lot of important work has been done already, there is still a lot to do, especially in health equity. Sue feels that given the amount of literature and press recently, there is a great opportunity to explore maternal and infant health inequity and how measurement can impact those areas.
Setting the Stage - Background and Context	Julie Sonier, President of MNCM, provided background on the purpose of convening a joint meeting. Since its inception, MN Community Measurement has played a key role as a convener of stakeholders to agree on priorities for where collaboration is most important and can have the most impact in driving improvement in health care and health outcomes. Through various conversations, MNCM frequently receives questions or suggestions about potential new measures. However, the last "big picture" conversation regarding future priorities for measurement was about five years ago. The field of measurement has been evolving in ways that may make it possible to measure high-priority concepts that have not been previously feasible (e.g., the ability to extract information from free text fields in clinical records). As a result, MNCM felt it was an appropriate time to have a conversation about identifying and prioritizing new measurement needs. The scope of identifying and prioritizing new measurement needs for this purpose of this meeting included: • Identifying measure concepts – either new or existing. Re-design of existing measures is out of the scope of conversation.

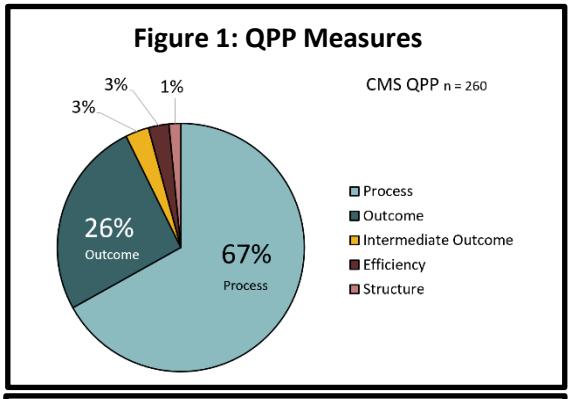
- May or may not include public reporting – MARC has a significantly role to play in making these decisions, but there may be measures that the community decides are useful for benchmarking and/or internal quality improvement purposes.
- Not related to what the state requires providers to report through its Statewide Quality Reporting and Measurement System (SQRMS)
- Ability to implement any changes will be contingent on future resource availability – especially if new measure development is needed.

Collette Pitzen, clinical measure developer at MNCM, provided an overview of what makes a good measure and some measure history. There are five primary types of measures (hierarchical order; placed in lowest to highest order): structure (e.g., nursing staff ratios), experience of care (e.g., would highly recommend clinic), access (e.g., number of days to appointment), process and outcome measures. While each of these types of measures are important, some types of measures are better at improving the health of the population of interest.

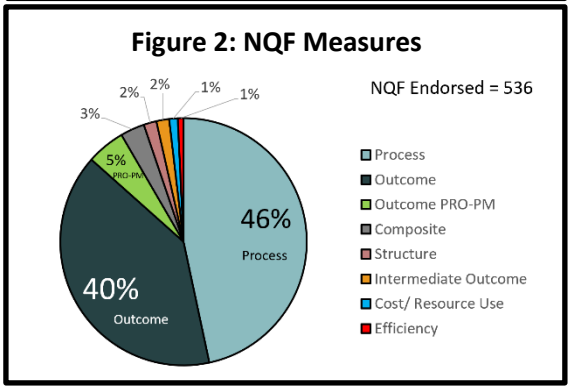
A process measure is a health service that is provided to a patient based on scientific evidence of efficacy or effectiveness. Examples include blood pressure recorded during the office visit, HbA1c obtained every six months and administering a patient-reported outcome tool. While process measures do not illustrate how a patient is doing, they have their place. For example, the adolescent mental health and/or depression screening measure is a process measure that started with a statewide rate of 40% and increase to 79% within four years. However, process measures have a tendency to "top out" and may not improve health outcomes.

An outcome measure is a health state of a patient resulting from care. Examples include end-result outcome measures (e.g., stroke or amputation), intermediate outcome measures (e.g., blood pressure < 140/90, A1c < 8.0) and patient-reported (e.g., depression symptoms, functional status). Outcome measures are highly desired, as they improve health outcomes and move the quality needle forward.

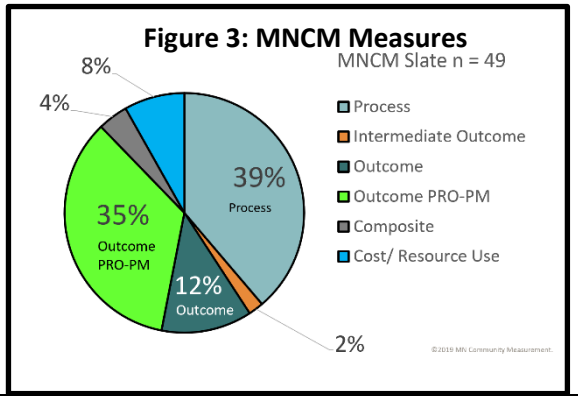
Currently, CMS' Quality Payment Program (QPP) has a large proportion of process measures compared to outcome measures – 67% and 26%, respectively (Fig 1).



The National Quality Forum (NQF) has more of a balance between process and outcome measures – 46% and 40%, respectively (Fig 2). Of note, NQF has decreased the number of endorsed process measures over the last 10 years. Over time, 391 process measures are no longer endorsed.



MNCM's Slate of Measures also has a good balance between process and outcome (patient-reported) measures – 39% and 35%, respectively (Fig 3). The slate of measures also has 12% outcome measures and 2% intermediate outcome measures.



There are five key components in making a good measure. First, the measure should be meaningful and impact a large number of people. While rare conditions are important to monitor, measurement is more successful when it impacts the health of an entire population. Second, measures should be evidence-based, particularly for process measures. Process measures require strong random control trial evidence in order for that process to be recommended for all patients. Third, there should be an opportunity for improvement – a known gap in care and variability in providers. Fourth, the measure should be actionable. That is, providers should be able to influence the outcome of interest. Lastly, the measure should be feasible for collection. Of these,

	the opportunity for improvement and the actionability are among the most important components. After sharing a review of the measures that MNCM has developed and re-designed, Collette shared the domains/important topics that CMS developed. See PowerPoint slides for this list. Julie reviewed the concepts that stakeholders have previously identified through conversations (text box on right). Some of these concepts are more specific than others, while others are broad. **Feedback from Stakeholders** • Behavioral • Anxiety • Healthy Days • Opioids • Shared decision-making • Advanced Care Planning • Overuse • Specialty care • Pediatric • Maternity • Multiple chronic conditions • Lung cancer screening • Hip Replacement • Heart failure • COPD
Discussion	**Medication adherence** Idea: Health plans are particularly interested in medication adherence among patients with chronic conditions. **Social determinants of health** Idea: Including information on access to healthy foods, housing security, etc. among a particular group of patients and not including elements already collected (i.e., race/ethnicity, language, country of origin). **Mammography screening** Idea: Mammography screening through direct data submission (DDS) to get enhanced data and improve gaps in care. Breast Cancer Screening measure is currently a HEDIS measure. **Improvements in health equity/inequity** Idea: Measurement highlights health care priorities and has been correlated with improvement in gaps within a particular topic. By having a general measure that assesses improvements in health equity, health equity can be highlighted as a priority. In the past, MNCM has looked at disparities by condition, but not at a global level. **A1C testing in patients with diabetes** Comment: A measure in Wisconsin measures the proportion of patients with diabetes who had at least two A1c tests in a year. **Well-child visits** Comment: A measure in Wisconsin measures the proportion of children who received six well-child visits before 15 months of age. From a disparities lens, transportation can be a barrier. Improved immunization rates have also been seen in conjunction with number of well-child visits. Patients who come in for their well-child visits have a better chance at receiving recommended immunizations. **Annual wellness visits** Idea: Annual wellness visits in those who are 65 years and older may help to prevent falls, improve quality of life, etc. **Anesthesia suite** Idea: A measure that assesses anesthesia overuse, cost and/or postoperative nurse experience. **Opioid stewardship** Comments: Opioid use is a large burden but is a general approach of pain management. The MN Health Collaborative at ICSI has been doing work related to acute prescribing, chronic prescribing and post-surgical prescribing. Opioid use is also related to child protection, which is valuable for county level health. Most health systems are already working on opioid use – developing best practices would be beneficial to determine who is doing well. **Pediatric measures** Idea: Adverse childhood events (ACEs) Idea: Improvement in immunization rates in populations with high refusal rates. **Pre-diabetes** Comment: The Minnesota Department of Health has done some work with pre-diabetes. Managing pre-diabetes may lessen the burden of diabetes.

	Lung cancer screening Comment: May be better coupled with shared decision-making **Coordination of care** Idea: A measure that considers how specialty care reports back to primary care providers, especially after patient referral to specialty care. There is a CAHPS measure that measures this. **Maternal/Infant Health** Idea: Breastfeeding as it relates to the health of the mother and the child – perhaps initiation at three months, six months, etc. Idea: Pre-natal care engagement, particularly for those who did not get regular pre-natal care with their first pregnancy. **Healthy Days** Comment: Particularly of national interest. Healthy Days has a strong potential for measuring quality of life. An example of quality of life collects data on how patients perceive their own health. **Shared decision-making** Idea: Shared decision-making may be a good balancing measure with other measures (e.g., risk-benefit of not getting a colorectal cancer screening). **Advanced care planning/End of life care** Idea: Advanced directives for patients under the age of 65 **Anxiety** Comment: MN Health Action Group has heard from employers that they are very interested in creating an anxiety measure. An anxiety measure would be meaningful in terms of the number of people impacted. Anxiety is also affecting productivity and performance of the organization and individual teams. There are no national measures related to anxiety so there is a gap in measurement, and it is a concept that is actionable. An anxiety measure would also align with national priorities in mental health. **Overuse** Comment: Significant issue in the payer/affordability side, especially with utilization of procedures such as total knee replacement **ACTIVITY** After the discussion, members of the committee were provided with three dots and were asked to place the dots next to topics that they believe are priority concepts. Members could place all three dots on one topic or were able to divide them among up to three topics. Members joining the meeting via telephone were able to submit their votes via the chat function in WebEx. Results of the vote are provided in the Measure Concept Discussion Summary.
Next Steps	Julie provided the next steps after this discussion. Over the summer, MNCM will summarize the conversation and plans to solicit broader community input through a survey on social media, MNCM newsletter, etc. The results of these survey will be brought back to the committee in the early Fall.
Meeting Adjournment	The next MARC meeting will be Wednesday, September 11, 2019. Sue adjourned the meeting.

Next Meeting: Wednesday, September 11, 2019

MN Community MEASUREMENT

Measurement & Reporting Committee (MARC)/Health Equity Advisory Council (HEAC) Meeting

Wednesday, June 12, 2019

MEASURE CONCEPT PRIORITIES

Members of both MARC and HEAC were given three dots and were asked to place the dots on the measure concepts that they felt are high priorities. Members could place all three dots on one concept, one dot on three different concepts, etc. Members joining the meeting by phone provided their response via the chat function on WebEx or voiced their priorities over the phone.

Measure Concept		# of votes
Behavioral		
Anxiety	●●●●●●●●●●●	11
Healthy Days	●●●●	4
Opioids	●●●	3
Shared decision-making	●●●●	4
Advanced care planning (e.g., end of life)	●●●●●●●	6
Overuse	●●●	3
Specialty care		
Pediatric	●	1
Well-child checks	●●	2
Adverse childhood events (ACEs)		
Improvement in vaccine rates among population with high refusal	●	1
Maternity	●	1
Breastfeeding		
Pre-natal care engagement	●●●●●●	6
Multiple chronic conditions	●●	2
Lung cancer screening		
Hip replacement		
Heart failure		
COPD		
Medication adherence	●●●	3
Other social determinants of health	●●	2
Mammography screening		
Improvements in health equity (inequity)	●●●●●●●●●●●●●●●●●●●●	17
A1C testing in patients with diabetes (2 tests in a year)		
Annual wellness visits	●●●	3
Anesthesia suite		
Pre-diabetes	●●	2
Coordination of care	●	1