MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, March 11, 2020
Meeting Minutes

Members Present: Sue Knudson (Co-chair), Rahshana Price-Isuk (Co-chair), Barb Anderson, Janet Avery, Joe Bianco, Cara Broich, Clarissa Cox, Karolina Craft, Matt Flory, Sue Gentilli, Stefan Gildemeister, Greg Hanley, Steve Inman, Jordan Kautz, Deb Krause, Sue Mitchell, Asif Mujahid, Christine Norton, Christopher Restad, Jonathan Rose, Mark Sonneborn
Absent: Cristina Baker, Lori Bethke, Jennifer Lamprecht, David Satin
MNCM Staff: Liz Cinqueonce, Collette Cole, Jess Donovan, Will Muenchow, Julie Sonier

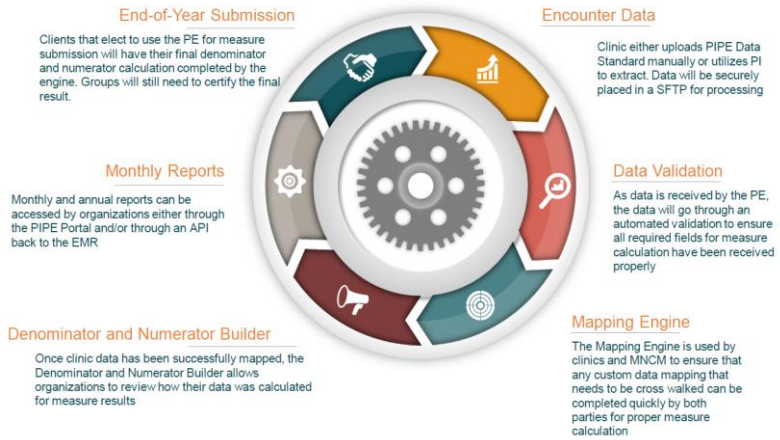
Topic	Discussion
Welcome & Introductions	Rahshana Price-Isuk called the meeting to order and introduced herself as MARC co-chair. Rahshana introduced three new MARC members that were present at the meeting: Asif Mujahid, Steve Inman and Sue Mitchell. Two additional members, Jennifer Lamprecht and Cristina Baker, were unable to attend the meeting and will be introduced to the committee in June. MARC members, MNCM staff, Board members and observers also introduced themselves. Rahshana provided an overview of the committee charter, the conflict of interest policy and MARC member competencies and expectations (included in meeting packet). Rahshana also reviewed the new process for meeting minutes. Meeting minutes will be sent out to committee members the Monday after the MARC meeting for review. Committee members will have until Friday of that week to submit any corrections or edits. If changes are needed, they will be incorporated and sent out to the committee the following week. The goal of this new process is to ensure the Board of Directors receives the minutes in a timely manner.
Overview of 2020	Sue Knudson provided an overview of the year. She reminded committee members that meetings will now be held on a quarterly basis and Outlook calendar invites have been sent out to committee members for those meetings. The Measure Review Committee (MRC), a subcommittee of the MARC, will be condensing their schedule from two meetings (spring for DDS measure review and fall for HEDIS measure review) to one meeting in the fall. This will make the review process more efficient and timelier for the slate of measures review in December. Additionally, there are two openings for the MRC. Interested committee members are encouraged to contact Jess Donovan if they have an interest in participating on this subcommittee.
Process Intelligence Performance Engine (PIPE)	Will Muenchow, MNCM's director of technology and data integrity, presented on MNCM's new Process Intelligence Performance Engine, or PIPE. **OVERVIEW OF PRESENTATION:** • Goal of PIPE is to address key challenges often referenced by providers: 1) Data collection burden – takes time, resources and investment 2) Timeliness of results – annual submission limits opportunity to identify quality issues as they happen 3) Complexity of systems – collecting data from multiple sources requires manual interventions and integrations for measurement • Differences between DDS and PIPE methods:

	DIRECT DATA SUBMISSION (DDS) METHOD	PIPE METHOD
Measure specifications	Multiple – one for each measure	One specification (PIPE data standard)
Eligible populations	Eligible population for each measure identified by submitter	Eligible populations for all measures identified centrally by the performance engine (PE)
Feedback timing	Annually	Monthly, quarterly and/or annually (or as often as desired)
Burden	High	Low

• Multiple components to PIPE *(see slide 6 from presentation for more detailed information)*:
  ○ **PIPE Data Standard:** One specification for all measures

- **Process Intelligence (PI) Extraction (optional):** Clinics can use their own extraction methodologies to submit the PIPE data standard OR they can opt to use MNCM's Softbot technology to implement intelligent automation to retrieve data needed for submission
- **PIPE secure delivery:** Data is submitted to MNCM via secure file transfer protocol (sFTP)
- **PE Data Calculation:** MNCM'S Performance Engine (PE) analyzes data in real time to calculate both the clinic's numerator and denominator for all measures
- **Timely Data Feedback:** Data can be submitted for calculation as often as a clinic needs or requires. Reports can be reported via the PIPE Portal or through a secure API back to the organization

- Softbot technology is not a physical robot but a configurable software. It will pull data, perform algorithms, creates reports, etc. – similar tasks that a human would complete but can be automated
- For the PIPE data standard, there are nine files that are submitted: demographic file, encounter/CPT file, problem list file, blood pressure file, medication file, allergy file, lab/procedure file, PRO assessment file and exclusions files. Patients are linked across these files through a unique patient ID.
- Performance Engine analytics *(slide 10 from presentation):*



- Pilot groups have submitted via prior method (DDS) for 2020, but will receive results from PIPE once a month in 2020 and will submit via PIPE in 2021
- MNCM will use 2019 report year data to compare results for PIPE onboarding

QUESTIONS/DISCUSSION

- **Financial implications for medical groups to participate in this program:** No financial cost to clinics to use this technology, unless if the clinic does not have an API (application program interface – how two programs are bridged together) already built into their system.
- **Supplemental data for health plans:** NCQA has said that they will be coming out with a form later this year to clearly define what is considered supplemental data. Once that form is released, MNCM will look at it and see how it can be worked into PIPE so that it aligns correctly.
- **Handling "messy" data:** The robotics side of PIPE is simply mimicking what a human would do in terms of running reports, etc. If there is data that is coming in that is not clean (e.g., extra columns being added), it will be flagged for the MNCM team to review to determine if that data is pertinent to the measure. However, during the onboarding process for pilot groups, MNCM works with each group to make sure the data is coming in as expected. If there is any change to the reports, MNCM and the medical group will receive notification of a change. However, the PE side of PIPE will not be prevented from running during this situation.
- **Data security:** PIPE employs a state-of-the-art security system that many health care organizations use to protect their data. Additionally, MNCM conducts quarterly security assessments as well as blind security assessments.
- **Challenges with legal departments within organizations**: Medical groups that are onboarded must sign an updated Data Use Agreement (DUA) and Business Associate Agreement (BAA), which is taking about 4-6 weeks on average to complete. A member added that from their own experience, understanding the differences between a DUA and BAA has been the most challenging piece.
- **Measure development:** PIPE will also enable the measure development process for building the measure into the system to happen much quicker.

	• **Timeline of transition from DDS to PIPE:** More information on that decision will be available once more groups are onboarded onto the system and so that MNCM can understand implementation needs for small- and medium-sized groups.

Guiding Principles for Measure Changes	Collette Cole, MNCM's clinical measure developer, presented on guiding principles for measure changes for MNCM-stewarded measures.
	
	OVERVIEW OF PRESENTATION
	Evolution of Measurement
	• Started with a data source based in chart abstraction of paper records and moved to administrative claims-based measures (less resource intensive)
	• Claims-based measures are appropriate for screening and procedural measures because they can be tracked by billing codes
	  ○ However, lack clinical data needed for understanding outcomes
	• Evolution of electronic health records makes clinical data more readily available for extraction (automation)
	
	Guiding Principles Overview
	• As MNCM moves forward to reduce burden and increase automation, there is a need to evaluate existing measures, especially in terms of exclusions/exceptions, and future measure development
	• Guiding principles recommended for measure changes are:
	  ○ For existing measures, consider retaining components that are codable (e.g., ICD, RxNorm, SNOMED, etc) and remove those without a standardized code set
	  ○ For future measures, components must be able to be identified by reliable (and used) code and exceptions/exclusions must affect at least five percent of the population or have a strong contraindication
	  ○ MNCM staff will use these guiding principles and clinical judgment to make decisions before communicating to medical groups
	
	Illustration of Guiding Principles
	• The statin component of the Optimal Diabetes Care Measure was used as an example to illustrate these guiding principles for measure changes:
	  ○ Statin use was added as a component of the measure in 2014 (to replace LDL <100 as a component) due to strong evidence for statin use in patients with diabetes
	  ○ Multi-stakeholder group convened to redesign measure – discussed black box warning for statin use during pregnancy, which led to adding child-bearing potential and breastfeeding as exceptions for statin use; however, these exceptions are difficult to collect/extract
	  ○ The National Quality Forum (NQF) recommends that exclusions/exceptions are supported by clinical evidence and are of "sufficient frequency" that may "distort" the measure
	  ○ Currently, the measure has nine exceptions for taking a statin. Some of the exceptions are black box or have strong contraindications.
	  ▪ The most frequently used exceptions are allergies to statin, active liver disease and documented intolerance (common, but not distinctly codable)
	• The following slide illustrates the guiding principles based on code set availability including extensive review of SNOMED-CT *(slide 11 from presentation):*

Exception	Code Set	% of Diabetes	Difficult	Notes
Retain				
Documented allergy to statin	-	1.6%	moderate	structure exists; no standard
Active liver disease	✓	1.2%	easy	strong contra; drug metabolized
Heart failure	✓	0.5%	easy	not absolute contra; some can take
Pregnancy	✓	0.3%	easy	strong contra; birth defects
Documented drug interaction	✓	0.3%	easy	strong contra; short list of drugs
End stage renal disease	✓	0.1%	easy	moderate contra; no benefit
Rhabdomyolysis	✓	0.02%	easy	rare, but strong contra
Remove but Continue to Evaluate				
Documented intolerance	✓↓	1.0%	difficult	Common (15%); use of T46.6X5A?
Breastfeeding	-/snm	0.01%	very hard	Perception; related pregnancy SNOMED
Remove				
Women of childbearing years	-	0.1%	very hard	perception related to pregnancy

	QUESTIONS/DISCUSSION • **5% rule:** Clinics with small populations should be kept in mind when assessing if an exclusion meets the 5% rule. There can be large variation in prevalence across clinics for certain exclusions. • **Using eCQM:** Referencing value sets from national eCQM measures could help support alignment and reduce burden as well
Brief Update on Recent MNCM Publications	Jess Donovan, MNCM'S measure development specialist, provided an overview of MNCM's recent publications. The 2019 Health Care Quality report was published in February 2020 and features MNCM's new chartbook style for reports. This new style cuts down on lengthy text and lets the charts created stand out on their own. Additionally, Jess has been working on co-authoring a blog post with Matt Flory at the American Cancer Society for Colorectal Cancer Awareness month (March). MNCM created an infographic to accompany the blog post that highlights county-level achievements as well as opportunities for improvement in communities across Minnesota. The blog was published on LinkedIn on March 11th.
Meeting Adjournment	The next meeting will be Wednesday, June 10, 2020. Sue adjourned the meeting.

Next Meeting: Wednesday, June 10, 2020