

OVERVIEW

MN Community Measurement has served as a source of objective, comprehensive information to drive improvement in health care quality and affordability since 2005. This Spotlight Report presents initial data on health care quality measures in Minnesota for 2020. The measures included in this report are calculated using clinical data collected by MNCM directly from medical groups and clinics from January to April 2021.

2020 was a year like no other, with the COVID-19 pandemic having dramatic impacts on most aspects of life including how patients sought care and how health care providers delivered it. There is no doubt the pandemic had a significant impact on the quality measures included in this report. Please see page 3 for examples of factors that likely influenced quality measure performance for 2020.

This *Spotlight Report* presents statewide data for 2020, with comparison to 2019 as context for understanding the disruptions experienced in 2020. In many respects, however, 2020 should be considered a new baseline from which recovery should be measured. Although MNCM is also publishing 2020 quality measures for individual medical groups*, we urge caution in using this data or changes in rates for specific medical groups between 2019 and 2020 to draw general conclusions about quality of care. Organizations faced different types of challenges, that are likely reflected in the data in ways that are not typical of overall quality of care. However, MNCM stakeholders strongly supported continuing to make the data publicly transparent.

Several issue briefs that accompany this Spotlight Report delve deeper into the results for individual measures, looking at changes by age, sex, race/ethnicity, geography, and other factors. This analysis can help to answer important questions about quality of care and changes in the patient population that accessed care in 2020. In addition, these analyses can provide insight on population health strategies that will be needed to ensure all Minnesotans receive appropriate preventive and chronic care that supports the best health outcomes achievable.

Other quality measures that MNCM routinely collects and publishes are expected to be available in late 2021. These cover important topics like cancer screenings and immunizations and are calculated from data that MNCM gathers and combines from health plans based on both claims and clinical data.

2020 CHANGES TO MEASURES

Not surprisingly, the COVID-19 pandemic necessitated technical changes to some quality measures to reflect and accommodate changes in how care was delivered. For 2020 and future years, MNCM made two types of technical changes to the quality measures included in this report:

- Incorporating telehealth codes into measures that did not already include them, to ensure that patients receiving care via telehealth were included in quality measures as appropriate; and
- Allowing providers to use patient-reported blood pressures taken with a digital device in lieu of blood pressures taken in a health care setting.

Because national quality measurement organizations such as the National Committee for Quality Assurance (NCQA) made similar technical changes to quality measures for 2020, MNCM's changes help to ensure that MNCM remains aligned with national quality measurement practices.

*Quality measures for individual clinic locations will not be published for 2020

KEY TAKEAWAYS

Comparing the statewide data between 2019 and 2020, there are three key takeaways from this statewide analysis.

1

First, the numbers of children included in the quality measures declined by much more than the numbers of adults. Overall, it was expected that the number of people included in most measures would decline, since inclusion in many of the measures is triggered by having a health care visit during the year. Large declines in the number of children included in measures for asthma, adolescent mental health screening, and utilization of the PHQ-9 questionnaire with patients who have been diagnosed with depression likely reflect broader changes in use of health care services by children in 2020. As the health care system recovers from the disruptions of COVID-19, outreach to children who did not receive care in 2020 will be an essential strategy to ensuring population health.

2

Second, although the number of adults included in quality measures was more stable in 2020 than it was for children, the changes in statewide performance on quality measures were larger for adults than for children. Missing data for lab tests, blood pressure readings, and patient questionnaires were key drivers of declines in some measures. From a patient perspective, this means that their health care providers are missing key information that is normally used to manage their care. As the health care system returns to more normal operations, some of these gaps in information may resolve naturally as patients return to more in-person visits; however, to the extent that a substantial share of patients may continue to receive care via telehealth, it will be important to ensure that these gaps in essential information for managing care are filled.

3

Third, monitoring of patients who have been diagnosed with depression is an issue that warrants particular focus. During the pandemic, there has been a marked increase in patients experiencing depression and anxiety. For people who have been diagnosed with depression, the measure of PHQ-9 utilization assesses whether their condition is being reassessed and monitored during subsequent health care encounters. Comparing the last four months of 2020 to the same period in 2019, for adults the share of patients who were reassessed declined from 77.6% to 68.5%; for adolescents, performance declined from 79.3% to 71.8%. It is likely that difficulties in collecting this data remotely for telehealth visits were a contributing factor. If so, this is an issue that calls for continued attention to ensure that expectations for care quality and patient outcomes are similar for care delivered via telehealth compared to traditional methods.

FACTORS INFLUENCING RESULTS OF QUALITY MEASUREMENT FOR 2020

The following is a list of factors specific to COVID-19 that may have influenced quality measures in 2020. These factors are among those listed in response to MNCM consultation with stakeholders about the impact of COVID-19 on measurement. They may have contributed to changes in the number or characteristics of people included in the measures, changes in performance on measures, or both.



PATIENT BARRIERS:

- Patients' decisions to defer care - out of concern for safety, for financial reasons, or because other priorities were more important.
- Barriers to accessing care via telehealth: familiarity/ease with technology, access to devices and/or broadband, language barriers. On the flip side, telehealth *enhanced* access to care for some by removing transportation and distance barriers.



PROVIDER STAFFING/CAPACITY:

- Staff furloughs, burnout, turnover, and diversion to higher priority needs
- Some clinics repurposed/closed
- Some services restricted or shut down (e.g., colonoscopies, mammograms)
- Shortages of testing supplies and/or lab capacity
- Capacity restrictions in clinics for safety reasons



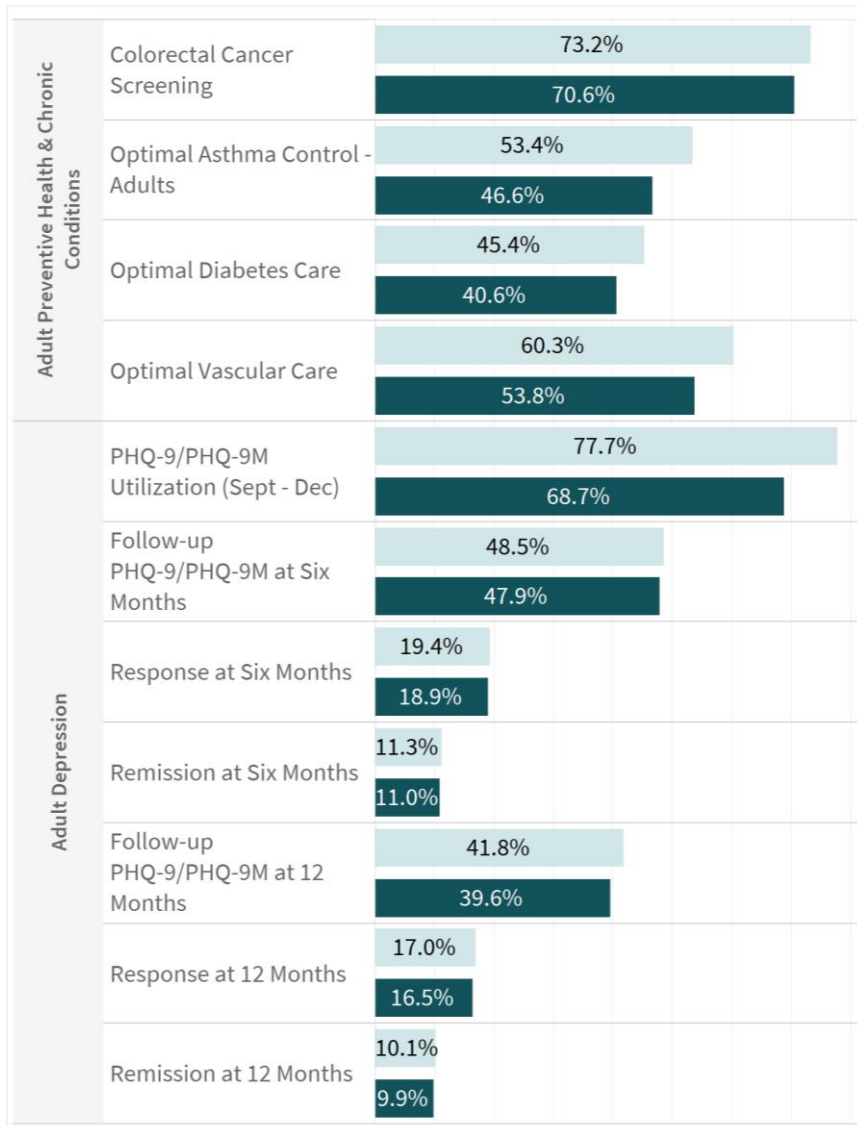
CARE DELIVERY:

- Decline in patient visits disrupted clinics' ability to deliver preventive services and manage chronic conditions.
- Transition to telehealth required workflows to be adjusted, including to gather patient-reported outcome (PRO) data used in some quality measures.
- Providers had more difficulty getting patients to complete PRO tools outside of the office setting.
- Care delivered via telehealth was more likely to be missing lab tests/blood pressures.

RATE CHANGES

The following charts illustrate the changes in performance rates among the quality measures for 2019 and 2020. The measures have been stratified by age group – adults and children.

ADULTS



Among the adult population, all quality measures showed a decrease in performance rates for care delivered in 2020 compared to 2019. However, the largest significant decreases in rates occurred in the following three measures:

- PHQ-9/PHQ-9M Utilization (-9.0 percentage points)
- Optimal Asthma Control (-6.8 percentage points)
- Optimal Vascular Care (-6.4 percentage points)

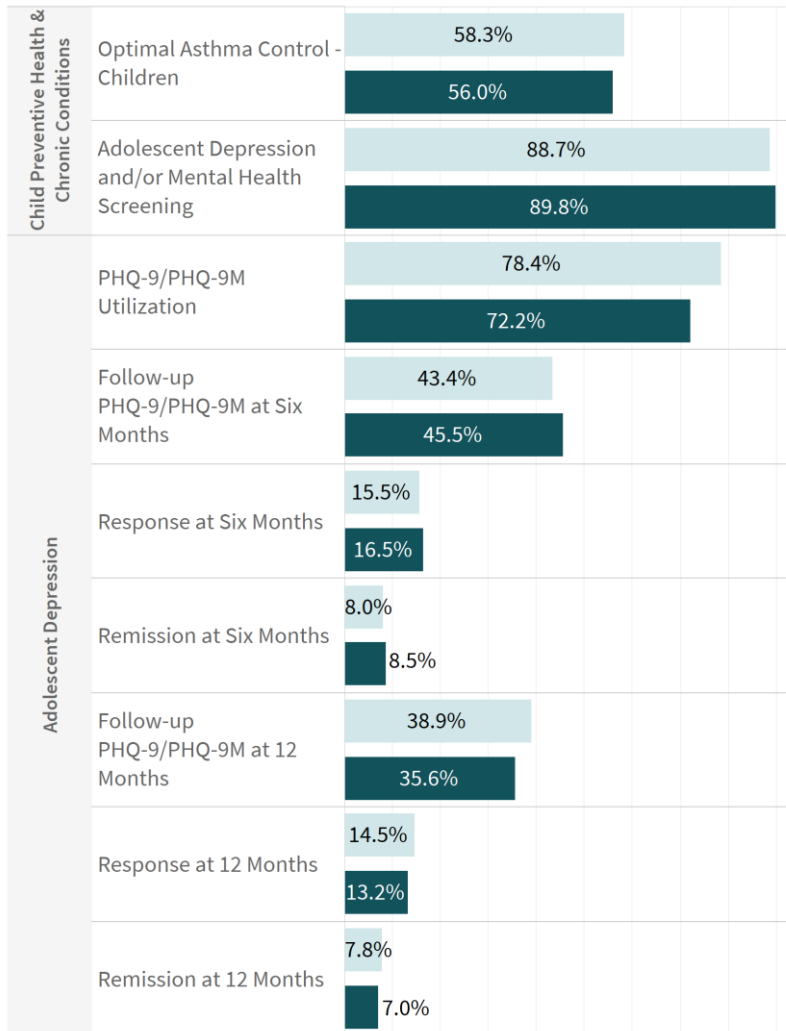
Note: The six-month depression measure rates reflect care primarily delivered in 2019. Please refer to the [Depression Care Issue Brief](#) for more detail about the measure.

■ 2019 ■ 2020

2019 = care delivered in 2019 and reported in 2020
 2020 = care delivered in 2020 and reported in 2021



CHILDREN



■ 2019 ■ 2020

Similar to the adult population, the largest decrease in rates occurred in PHQ-9/PHQ-9M Utilization measure (-6.2 percentage points) among the adolescent population.

The adolescent population also experienced a few significant rate increases among the following measures:

- Adolescent Depression and/or Mental Health Screening (+1.1 percentage points)
- Adolescent Depression: Follow-up PHQ-9/PHQ-9M at Six Months (+2.1 percentage points)
- Adolescent Depression: Response at Six Months (+1.0 percentage points)

Note: The six-month depression measure rates reflect care primarily delivered in 2019. Please refer to the [Depression Care Issue Brief](#) for more detail about the measure.

2019 = care delivered in 2019 and reported in 2020
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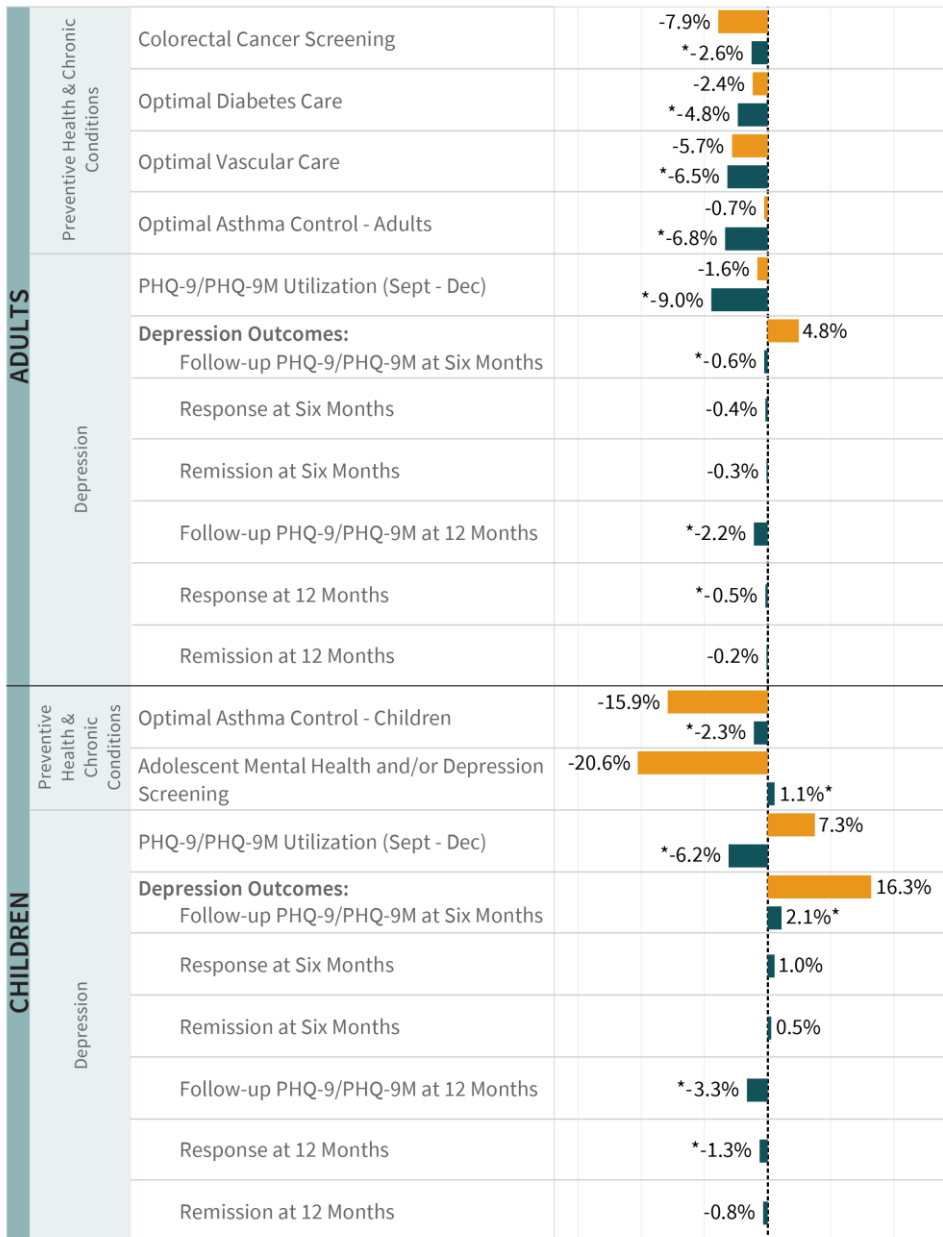


SPOTLIGHT REPORT

Summary of Health Care Quality Measures for 2020



POPULATION & RATE CHANGES



*Significant rate change from 2019

- Patients (Percent change)
- Rate (Percentage point change)

Along with performance rate changes, there were notable changes in the denominators for the measures, reflecting dramatic shifts in health care utilization patterns in 2020.

For the adult population, the Colorectal Cancer Screening and Optimal Vascular Care measures had some of the largest decreases (-6.7% and -5.7%, respectively).

Children had more dramatic declines in measure denominators for 2020 than adults. The Optimal Asthma Control (-15.9%), Adolescent Mental Health and/or Depression Screening (-20.6%) and the PHQ-9/PHQ-9M Utilization (-27.1%) measures all had large decreases in their respective denominators.

Note: The depression measure denominators are determined by diagnosis prior to 2020. For more information on the population increases in the depression populations, see the [Depression Care Issue Brief](#).



ISSUE BRIEF SERIES

This spotlight report summarizes the statewide findings for care delivered in 2020. As a supplement to this report, MNCM has also released a series of issue briefs that further analyzes the impact of COVID-19 by demographic characteristics for each of the measures. The measures featured in this report and in the issue briefs are measures collected by MNCM directly from medical groups and clinics. Below are links to each of the individual measure issue briefs as well as a description of each measure for reference.

MEASURE	DESCRIPTION
<u>Colorectal Cancer Screening</u>	<p>Denominator: Patients between the ages of 50-75 who had at least one eligible visit with an eligible provider during the measurement period</p> <p>Numerator: Patients in the denominator who had an up-to-date colorectal cancer screening</p>
<u>Optimal Diabetes Care</u>	<p>Denominator: Patients between the ages of 18-75 who had a diagnosis of diabetes and who had at least one eligible office visit with an eligible provider during the measurement period</p> <p>Numerator: Patients in the denominator who met all of the following during the measurement period: most recent HbA1c less than 8.0, most recent blood pressure < 140/90, on a statin medication (unless contraindicated), tobacco-free and if diagnosed with ischemic vascular disease, on daily aspirin (unless contraindicated)</p>
<u>Optimal Vascular Care</u>	<p>Denominator: Patients between the ages of 18-75 who had a diagnosis of ischemic vascular disease and who had at least one eligible office visit with an eligible provider during the measurement period</p> <p>Numerator: Patients in the denominator who met all of the following during the measurement period: most recent blood pressure < 140/90, on a statin medication (unless contraindicated), tobacco-free and on daily aspirin (unless contraindicated)</p>
<u>Optimal Asthma Control Adults & Children</u>	<p>Denominator: Patients between the ages of 5-17 (children) and 18-50 (adults) who had a diagnosis of asthma and who had at least one eligible office visit with an eligible provider during the measurement period</p> <p>Numerator: Patients in the denominator who met the following during the measurement period: well-controlled asthma based on most recent asthma control tool result and not at elevated risk of exacerbation (less than two patient-reported emergency department visits and/or hospitalizations due to asthma in the last 12 months)</p>



ISSUE BRIEF SERIES CONTINUED

MEASURE	DESCRIPTION
<u>Adolescent Mental Health and/or Depression Screening</u>	<p>Denominator: Patients between the ages of 12-17 who had at least one office or telehealth well-child visit with an eligible provider during the measurement period</p> <p>Numerator: Patients in the denominator who were screened for mental health and/or depression</p>
PHQ-9 Utilization <i>Adults & Adolescents</i>	<p>Denominator: Patients aged 12 years and older who had an encounter (includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter) coded with Major Depression/Dysthymia between 9/1/2020 and 12/31/2020</p> <p>Numerator: Patients in the denominator who had a PHQ-9/PHQ-9M tool administered and completed between 9/1/2020 and 12/31/2020</p>
<u>Depression Care Outcome Measures</u> <i>Adults & Adolescents</i> (Note: The following measures have the same denominator)	<p>Denominator: Patients aged 12-17 (adolescents) and 18 and older (adults) with depression who indexed (identified as eligible) between 11/1/2018 and 10/31/2019</p>
Follow-up PHQ-9/PHQ-9M at Six and 12 Months	<p>Numerator: Patients in the denominator who had a completed PHQ-9/PHQ-9M six months (+/- 60 days) or 12 months (+/- 60 days) after an index event</p>
Response at Six and 12 Months	<p>Numerator: Patients in the denominator who demonstrated a response to treatment with a PHQ-9/PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result six months (+/- 60 days) or 12 months (+/- 60 days) after index event</p>
Remission at Six and 12 Months	<p>Numerator: Patients in the denominator who reached remission with a PHQ-9/PHQ-9M result less than five six months (+/- 60 days) or 12 months (+/- 60 days) after index event</p>

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