

## Appendix F

### MNCM/Stratis Health Brief: Cross-Setting Ambulatory and Hospital, and Patient Safety Measurement



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#### **RE: Cross-Setting Ambulatory and Hospital, and Patient Safety Measurement**

MN Community Measurement (MNCM) and Stratis Health are pleased to provide follow-up to our conversation and e-mails on the topics of Cross-Setting Ambulatory and Hospital Measurement and a Composite or Index Patient Safety Measurement. MNCM and Stratis Health have a long history of working together. Together, we believe we can create measures that are impactful and meaningful. This letter provides information on the importance of these proposed new directions in measurement, as well as how the work would be accomplished through our continued partnership.

#### **Continued Coordinated Partnership**

MNCM and Stratis Health are unique organizations that leverage organizational expertise and stakeholder networks to maximize community participation and support. Specifically, MNCM's knowledge of the measure development process, measurement landscape, characteristics of strong measurement and potential barriers to community acceptance, are critical considerations in successful development and testing. Stratis Health's expertise in the area of quality improvement, patient safety, experience using measurement and evidence-based practices to develop improvement projects informs the feasibility and usability of any measure under consideration. Both organizations have oversight committees.

#### **Cross-Setting Measurement: Ambulatory and Hospital Measures**

##### **Why Measure?**

Quality measurement in health care initially developed over the past decade with setting-specific measures, such as measures specific to acute care or ambulatory care. However, measurement needs have evolved in recent years to accommodate new approaches to care delivery. Measures are needed today which are more comprehensive and patient-centered, extend across the continuum of care, and support new payment models that incorporate Total Cost of Care and Accountable Care contracts. The emerging care delivery and payment models are beginning to encompass population health and to help address health equity.

The State of Minnesota, through the Statewide Quality Reporting & Measurement System (SQRMS) program, reports on a portfolio of hospital and clinic measures, and should continue to do so to help support a culture of transparency and quality. In addition, there is an opportunity and need to add to SQRMS reporting joint or coordinated measures across the continuum of care (“cross-cutting measures”) in response to the changing care delivery and payment environment. Priorities identified by MNCM and Stratis Health, in their quality measurement work with multi-stakeholder groups, include cross-cutting measures in care transitions, advance care planning and time-critical care. These are areas prime for cross-cutting measurement in Minnesota, building on the RARE Campaign for care transitions, the work of Honoring Choices Minnesota and the Health Care Homes program for advance care planning and AHA Mission Lifeline and the MN Stroke Registry. These areas also reflect National Quality Strategy and CMS measurement priorities.

### **Patient Safety Composite or Index**

#### **Why Measure?**

Patient safety consistently emerges as a high priority for both health care delivery organizations and for patients and families. There are many hospital safety measures currently reported at a state and national level, yet they do not provide a comprehensive picture of how safe care is at a hospital or health system; nor do today’s clinical safety measures reflect the growing body of research related to organizational properties and systems which are essential for safety. Today’s measures tend to be condition-specific or harm-specific (e.g., surgical site infection, falls, sepsis), and do not include how reliable a hospital’s care is, or whether the culture is set up for reliability and learning.

To make patient safety hospital measurement meaningful and comprehensive, and more understandable to consumers, SQRMS could build upon the reporting individual hospital safety measures with reporting of a multi-faceted patient safety index or composite measure. The index or composite could include a balanced set of process, outcome, and structural measures and can be derived from existing measures and indices and put together in a combination to meet community needs. This aligns with the national measures from CMS and also aligns with suite, composite and/or outcomes measurement that MN Community Measurement has developed in the ambulatory setting.

#### **How We Partner**

MNCM and Stratis Health currently partner in a variety of ways. For the development of measures, we would collaborate utilizing Stratis Health’s extensive knowledge of hospital-based measurement and MNCM’s experience with successful measure development and implementation. This includes MNCM providing guidance regarding the important measure development factors for consideration and Stratis Health providing hospital-based priorities when developing a new measure concept. MNCM’s established measure development process would be utilized with Stratis Health and MNCM co-facilitating. Per the MNCM measure development process, an external chairperson with clinical expertise would be selected for the workgroups. Since attribution will be hospital, clinic or other provider based, both the Stratis Health Hospital Quality Reporting Steering Committee (HQRSC) and MNCM’s Measurement

and Reporting Committee (MARC) would be utilized to solicit stakeholder feedback and approval of the measures concepts. For both the Cross Setting and Safety Composite or Index Measure, a measure concept (which draws upon existing measures in developing a new composite or index) would be brought to the Committees, workgroups formed, methodology developed and agreed upon and then the measure tested. The entire measure development process would take approximately 18 to 24 months.

## **Feasibility**

In an environment of constrained resources, the measurement directions recommended above are feasible if some of the current reporting is simplified. Specifically, the Stratis Health team has suggested moving to a hospital reporting framework which reports two existing measure sets – the CMS Value-Based Purchasing (VBP Total Performance Score) for PPS hospitals and the HRSA Medicare Beneficiary Quality Improvement Project (MBQIP) set of measures for CAH hospital. By utilizing this pair of comprehensive national measures, time and resources are available to pursue the cross-setting and safety composite measures recommended.

This approach for hospitals would not have been possible even just a couple of years ago, but is today. The CMS VBP Total Performance Score is a single number reflective of a combination of process measures, outcome measures, patient experience of care measures, and efficiency/cost measures. The process and patient experience are both all payer measures, while the outcome and cost measures are Medicare-specific. There is wide variation in the Total Performance Score of Minnesota's 50 PPS hospitals, which indicates room for improvement and distinction between them.

For the Total Performance Score and the MBQIP measures, some up front design work would be required but no additional or separate data collection would be required since it is all already done by CMS or the State flex coordinator at MDH. SQRMS could add some additional analysis to the public report as well, showing the variation across hospitals and the comparison to both MN and national results. Similarly, MBQIP for critical access hospitals includes a balanced mix of measures relevant to rural small volume facilities.

In total, all this activity can occur and can continue in a coordinated way as we have for several years for MDH with Stratis as a subcontractor to MNCM through its Health Care Quality Measurement contract.

In conclusion, we believe that together we can create measures in these arenas that are meaningful and impactful. We look forward to your thoughts and future discussion.