

The Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

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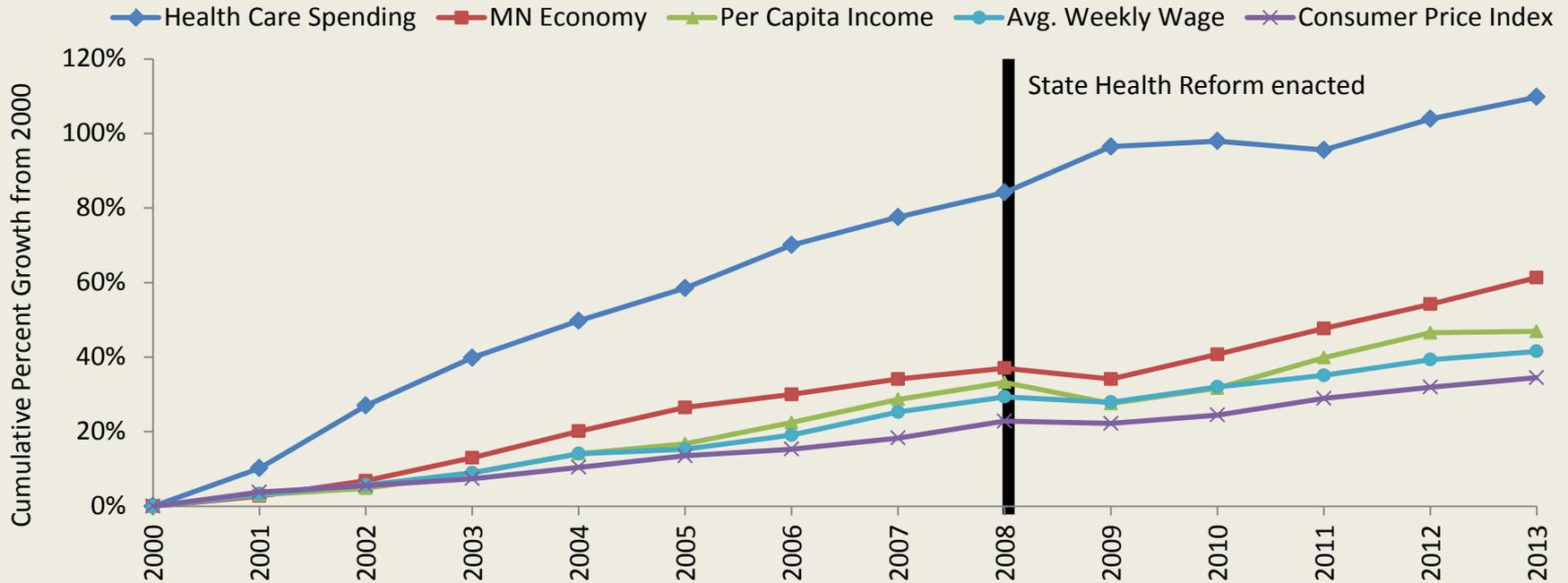
June 22, 2015

Overview

- Context
- Objectives and goals
- Alignment
- Organizational roles
- Rulemaking and opportunities for input
- Results over time
- Health equity

Health Care Growth Exceeds Growth in Income and Wages

Cumulative Change in Minnesota Health Care Spending and Key Economic Indicators



Note: "Health care spending" is Minnesota privately insured spending on health care services per person. It does not include enrollee out of pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

Sources: Health care cost data from Minnesota Department of Health, Health Economics Program; gross state product and per capita personal income data from U.S. Department of Commerce, Bureau of Economic Analysis; inflation data from U.S. Bureau of Labor Statistics (Consumer Price Index for Minnesota); average weekly wages from MN Department of Employment and Economic Development.

Context for State Health Reform

- High quality in Minnesota relative to other states
- Wide variation in costs and quality across different health care providers, with no evidence that higher cost or higher use of services is associated with better quality or better health outcomes for patients
- Health care costs are rising, placing greater share of health care costs on consumers
- Health plans, providers, and the State sought ways to increase health care accountability and transparency, and bring down costs

Statutory Requirements: Minnesota's 2008 Health Reform Law

- Establish standards for measuring quality of health care services offered by health care providers
- Establish a system for risk adjusting quality measures
- Physician clinics and hospitals are required to report
- Health plans use the standardized measures
- Issue annual public reports on provider quality

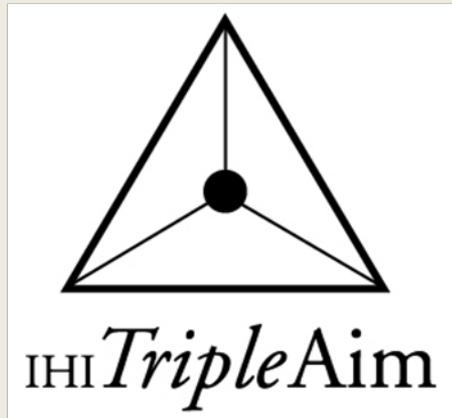
Minnesota Statutes, 62U.02

Objectives and Goals

- Enhance market transparency by creating a uniform approach to quality measurement
- Improve health / reduce acute care spending
- Quality measures must be based on medical evidence and be developed through a participatory process
- Public reporting quality goals:
 - Make more quality information broadly available
 - Use measures related to either high volume or high impact procedures and health issues
 - Report outcome measures or process measures that are linked to improved health outcomes
 - Not increase administrative burden on health care providers where possible

Alignment with the Triple Aim and National Quality Strategy

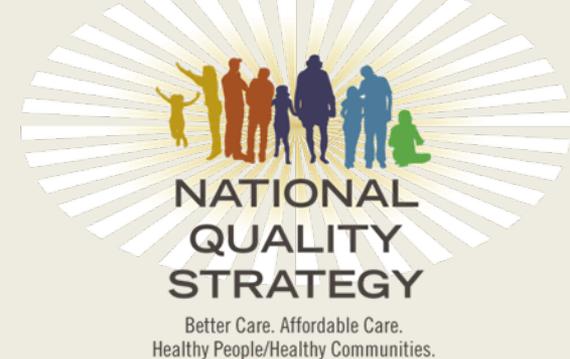
Improving the patient experience of care
(including quality and satisfaction)



Improving the health of populations

Reducing the per capita cost of health care

Better Care: Improve overall quality, by making health care more patient-centered, reliable, accessible, and safe.



Healthy People/Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health.

Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

Alignment with Quality Improvement Programs

State	Federal
<ul style="list-style-type: none">• Health Care Homes• Integrated Health Partnerships Demonstration• Quality Incentive Payment System and Bridges to Excellence• Accountable Communities for Health• Office of Health Information Technology• Community Wellness Grant• Minnesota Stroke Registry• Minnesota Asthma Program• Health Promotion & Chronic Disease programs	<ul style="list-style-type: none">• Hospital Inpatient and Outpatient Quality Reporting Programs• Hospital Value-Based Purchasing• Hospital-Acquired Condition Reduction Program• Medicare Beneficiary Quality Improvement Project (MBQIP)• Meaningful Use• Physician Quality Reporting System (PQRS)

SQRMS Characteristics

- Critical aspect of health care reform
 - Measures inform patients of the value of provider care in Minnesota
 - Component of assessing overall value for the first time
- Intentional and transparent
 - Community input and engagement informs MDH's development of quality measurement and reporting for the state of MN
- Evolving
 - Quality measurement and reporting continually evolves based on changes in measurement science, community buy-in and community priorities

Organizational Roles and Responsibilities

MDH	MN Community Measurement	Stratis Health	Minnesota Hospital Association
<ul style="list-style-type: none"> • Annually promulgates rules that define the uniform set of measures • Obtains input from the public at multiple steps of rulemaking • Publicly reports summary data • Develops vision for further evolution of SQRMS 	<ul style="list-style-type: none"> • Facilitates data collection and validation with physician clinics and data management • Submits data collected to MDH • Develops recommendations for the uniform set of quality measures and the Quality Incentive Payment System for the State's consideration • Works with groups of stakeholders to review and maintain measures • Develops and implements educational activities and resources 	<ul style="list-style-type: none"> • Develops recommendations for the uniform set of quality measures for the State's consideration • Facilitates the Hospital Quality Reporting Steering Committee and subcommittees • Develops and implements educational activities and resources 	<ul style="list-style-type: none"> • Facilitates data collection from hospitals and data management • Submits data collected to MDH • Develops recommendations for the Quality Incentive Payment System for the State's consideration

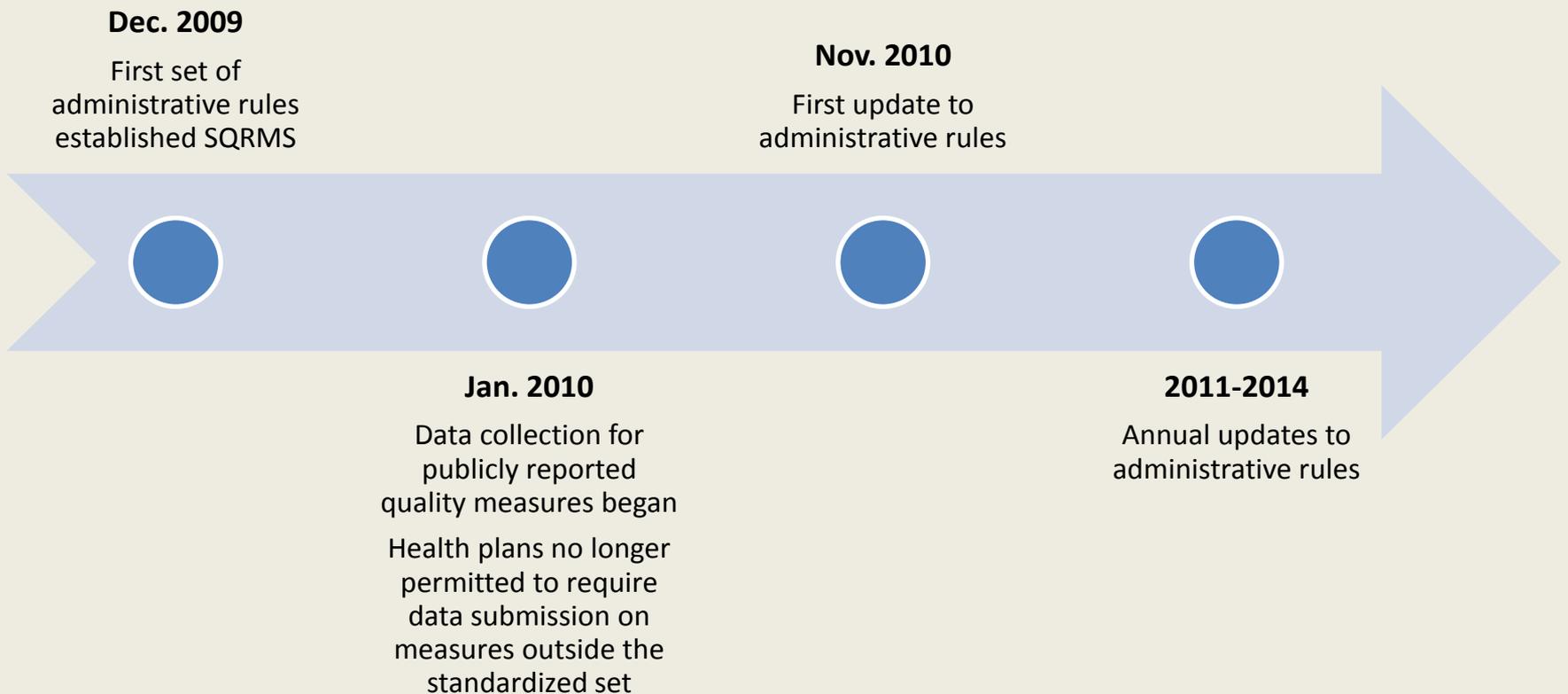
Rulemaking and Opportunities for Input

Jan	Feb	Mar	Apr ①	May ① ②	Jun ③ ④	Jul	Aug ⑤	Sep	Oct	Nov	Dec ⑥
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1. MNCM and Stratis Health submit preliminary recommendations to MDH by mid-April; MDH opens public comment period – *Closed June 5*
2. MDH invites interested stakeholders to submit recommendations for standardized measures to MDH by June 1 – *Closed June 5*
3. MNCM and Stratis Health submit final recommendations to MDH by mid-June; MDH opens public comment period – ***Closes July 6***
4. MNCM’s and Stratis Health’s measure recommendations are presented at a public forum toward the end of June – ***June 22***
5. MDH publishes a proposed rule by mid-August with a 30-day public comment period
6. Final rule adopted by the end of the year

*Orange spaces denote when public comment periods begin

Historical Timeline



Measure Criteria

Recommendations must address how addition, removal, or modification of a quality measure relates to one or more of the following criteria:

- Social and individual impact of the clinical condition
- Gap between current practices and evidence-based practices for the clinical condition
- Relevance of the quality measure to a broad population
- The measure has been developed, accepted, or approved through a national consensus effort
- Likelihood to demonstrate a wide degree of variation across providers
- The measure is valid and reliable

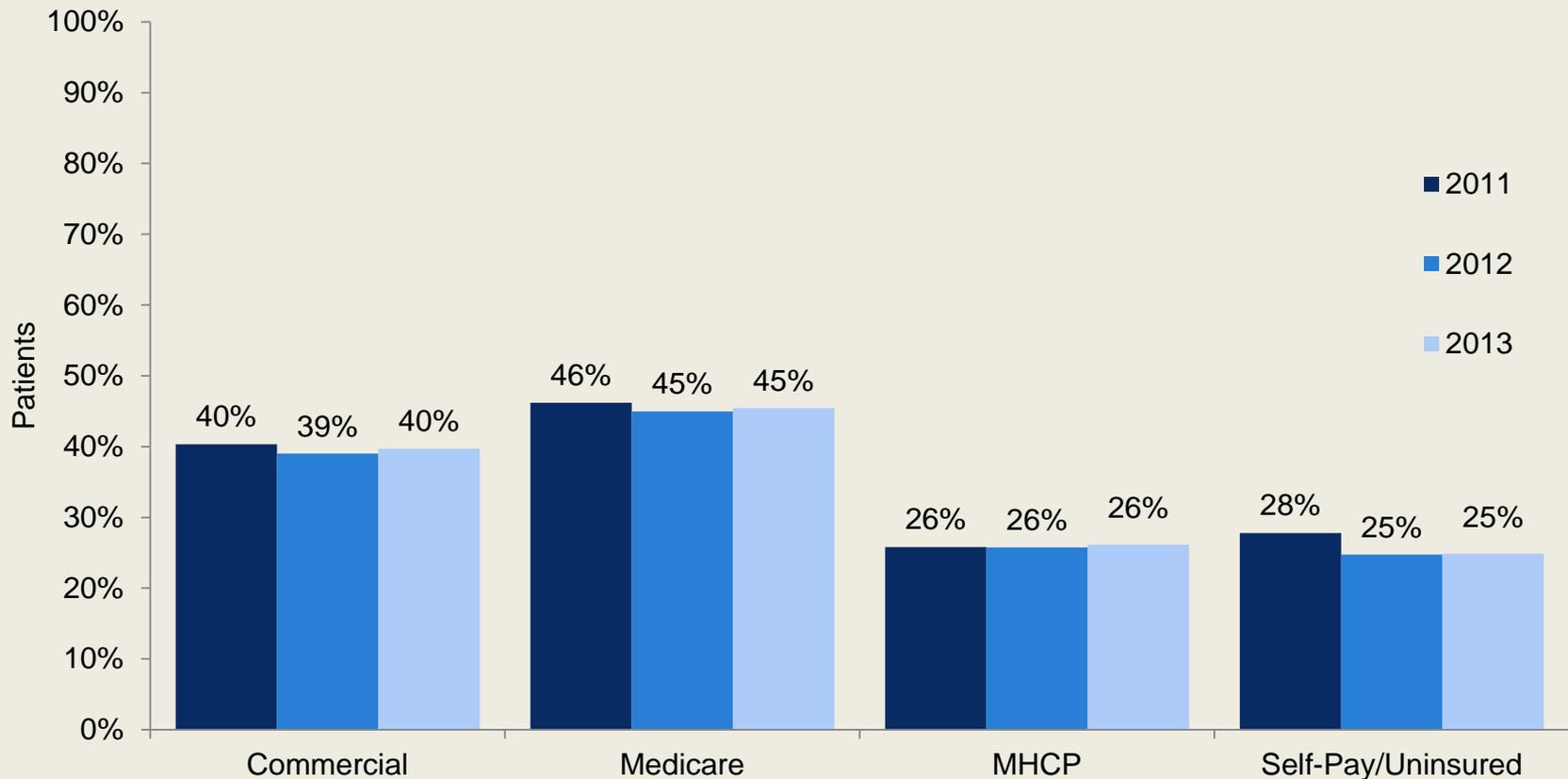
Physician Clinic Measures

- Optimal Diabetes Care
- Optimal Vascular Care
- Depression Remission at 6 Months
- Total Knee Replacement
- Spine Surgery
 - Lumbar Discectomy/Laminotomy
 - Lumbar Spinal Fusion
- Pediatric Preventive Care
 - Adolescent Mental Health and/or Depression Screening
 - Overweight Counseling
- Asthma
 - Optimal Asthma Control
 - Asthma Education and Self-Management
- Colorectal Cancer Screening
- Primary C-Section Rate
- Patient Experience of Care Survey (every-other year)
- Health Information Technology Survey
- HEDIS Measures

Hospital Measures

- CMS and Joint Commission Hospital Compare Measures
- Agency for Healthcare Research and Quality (AHRQ) Indicators
- Patient Experience of Care Survey (HCAHPS)
- Minnesota Stroke Registry Indicators
- Emergency Department Transfer Communication
- Vermont Oxford Network (VON)
- CDC National Healthcare Safety Network-Based Healthcare-Associated Infection Measures
- Health Information Technology Survey

Optimal Diabetes Care by Payer



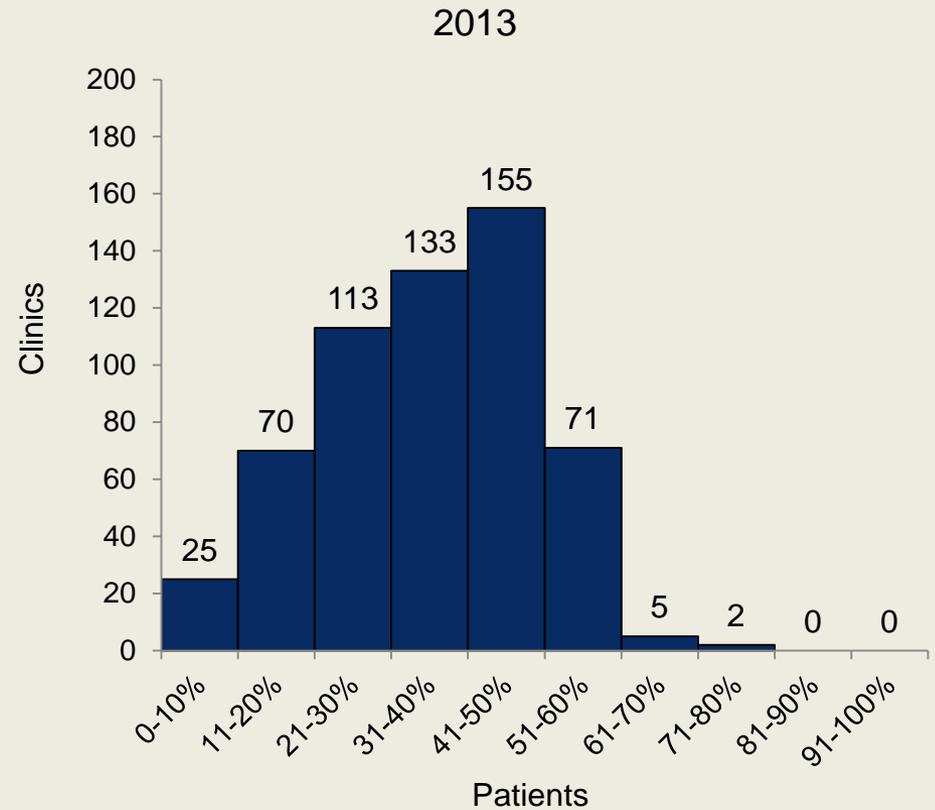
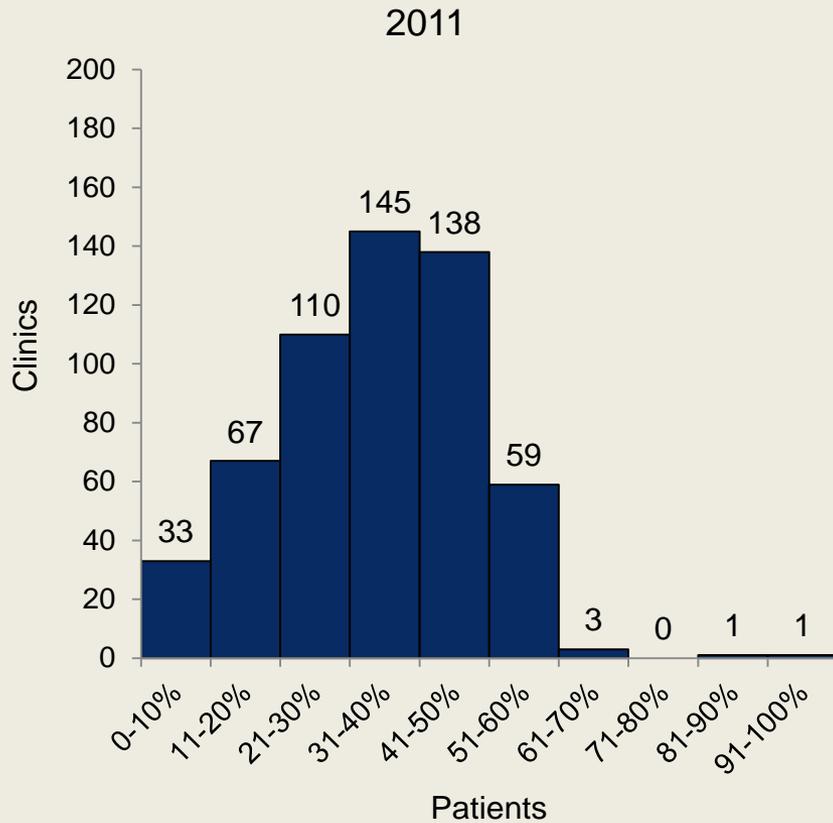
The overall optimal rate remained consistent at 40% in 2011, 38% in 2012 and 39% in 2013.

MHCP is Minnesota Health Care Programs, which includes: Medical Assistance (MA), MinnesotaCare, Minnesota Family Planning Program, home and community-based waiver programs, and Medicare Savings Programs.

Service year: January 1 through December 31.

Source: MDH Health Economics Program analysis of SQRMS data.

Optimal Diabetes Care



There were 557 reporting clinics in 2011, and 574 in 2013.
 Source: MDH Health Economics Program analysis of SQRMS data.

Performance for Health Care Homes and Non-Health Care Homes by Year

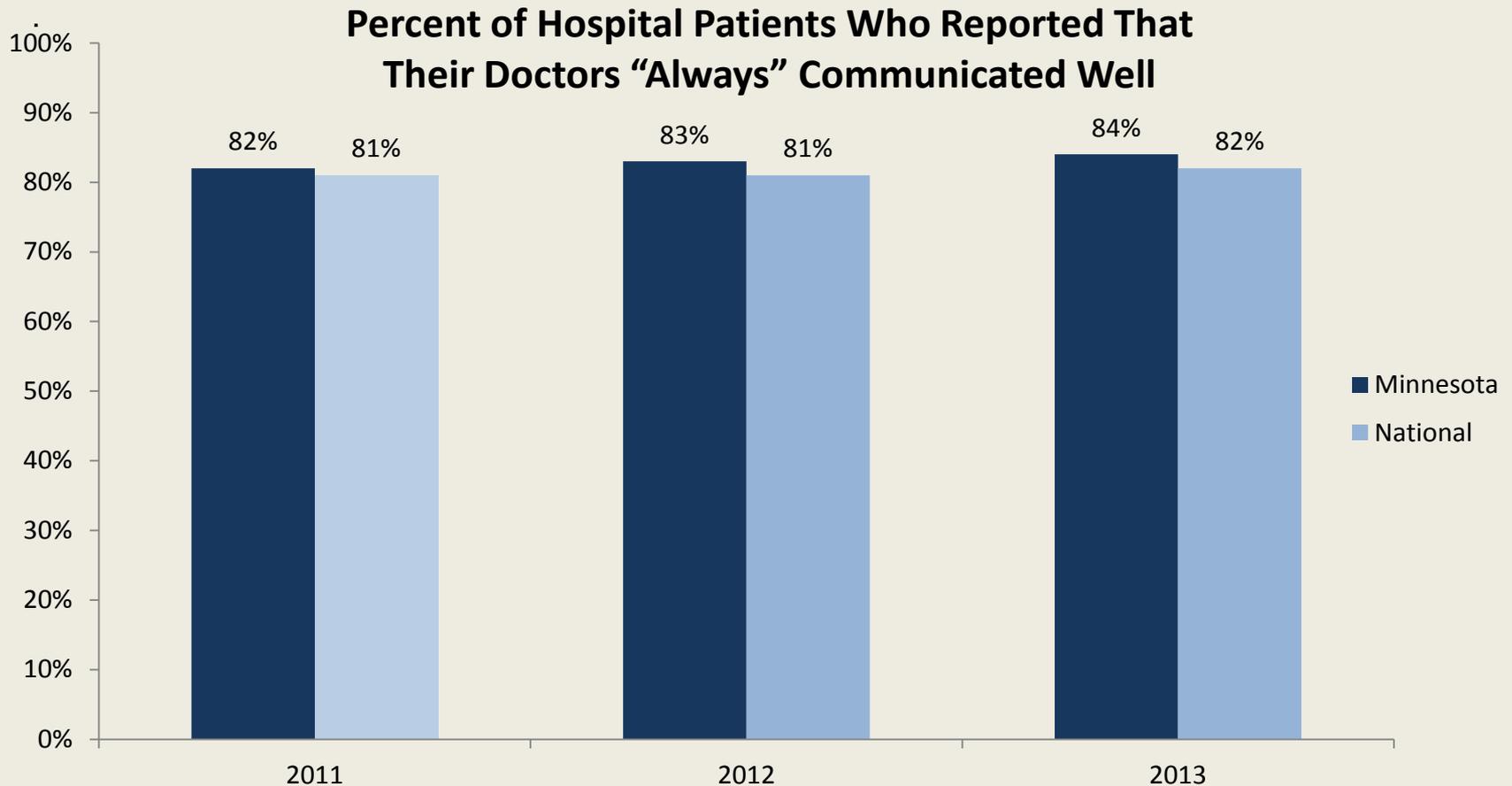
	Year	HCH	Non-HCH	Percentage Point Difference [^]	p-value*
Colorectal Cancer Screening	2011	71.6%	66.3%	5.3	<0.0001
Depression Remission at 6 Months	2012	26.7%	26.7%	0	0.9217
Optimal Asthma Care	2011	42.3%	23.2%	19.1	<0.0001
Optimal Diabetes Care	2012	40.9%	37.5%	3.4	<0.0001
Optimal Vascular Care	2012	53.6%	48.0%	5.6	<0.0001

[^]Difference in percentage points calculated by subtracting the non-HCH performance percentage from the HCH performance percentage.

*P-values of <0.0001 indicate statistically significant annual comparisons between HCH and non-HCH clinics (there is less than 1 chance in 10,000 that these results would have occurred randomly).

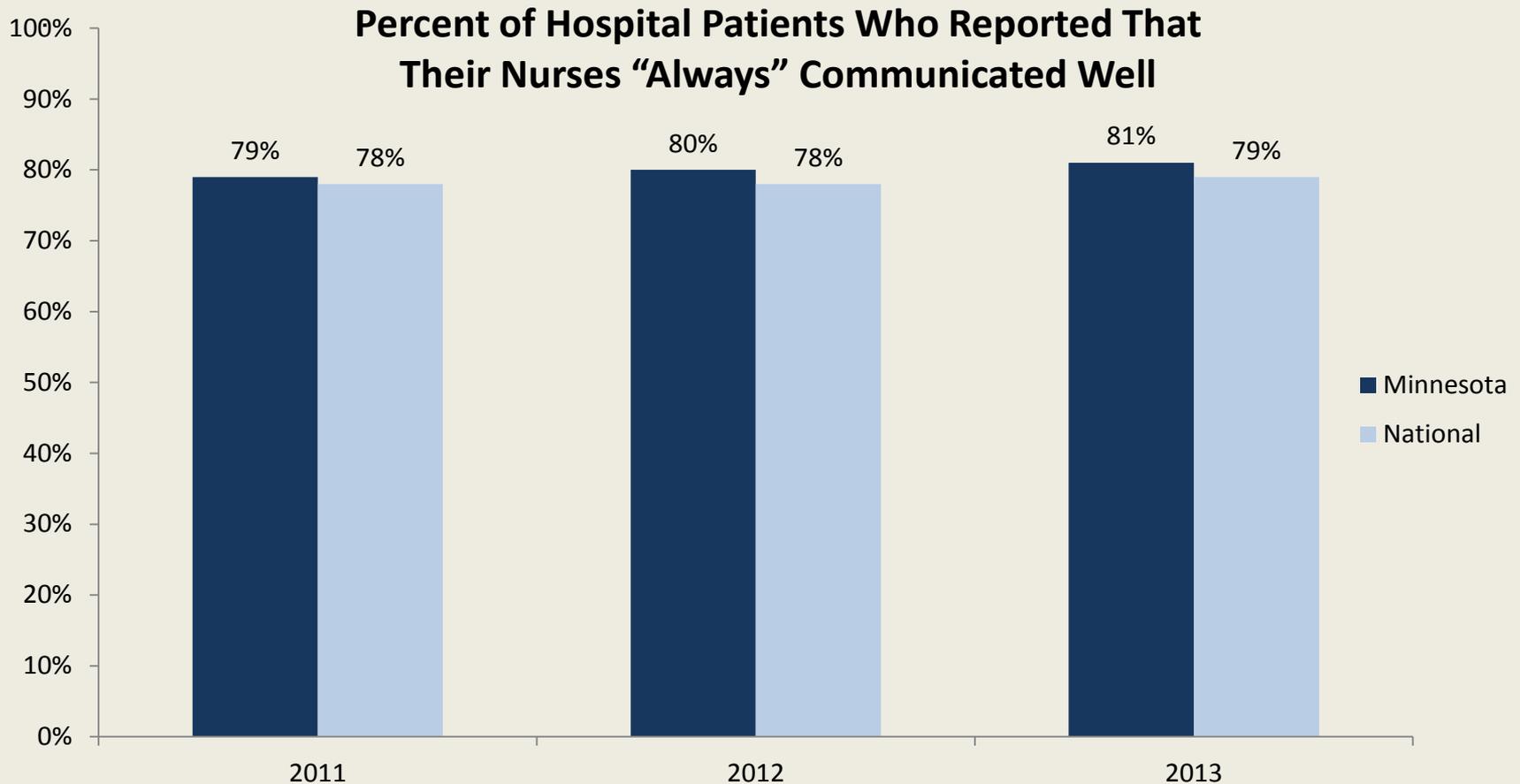
Source: [Evaluation of Health Care Homes: 2010-2012](#), Minnesota Department of Health, Minnesota Department of Human Services, University of Minnesota, Report to the Minnesota Legislature, January 2014.

HCAHPS Survey: Doctor Communication



Source: MDH Health Economics Program analysis of SQRMS data.

HCAHPS Survey: Nurse Communication

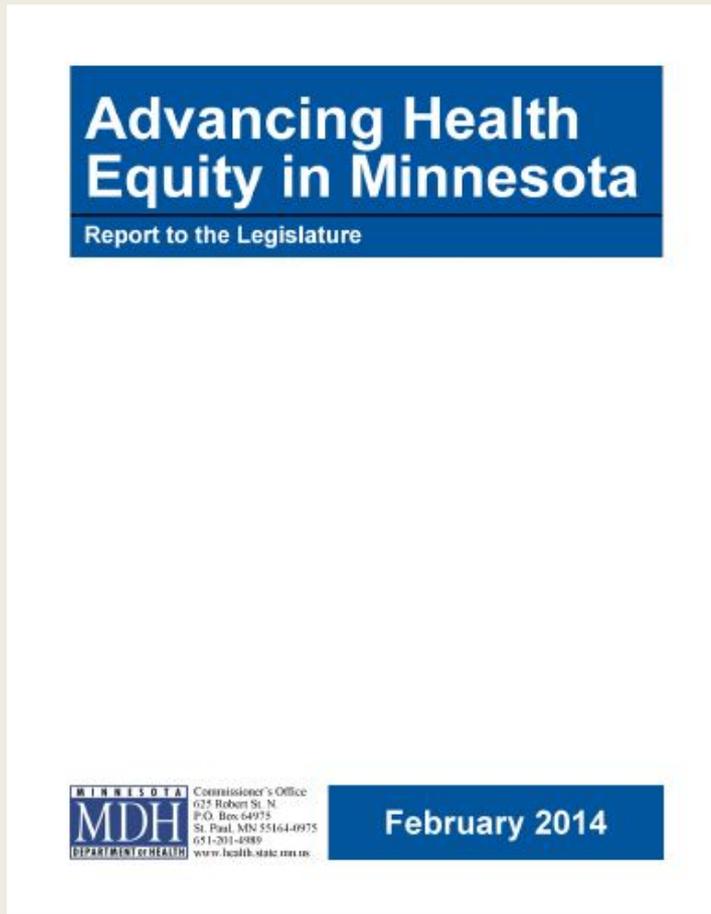


Source: MDH Health Economics Program analysis of SQRMS data.

Health Equity

Recommendation #7. Strengthen the collection, analysis, and use of data to advance health equity

- MDH must strengthen coordination of data activities related to health equity across all divisions and programs, and develop a long-term plan for improving the collection, analysis, reporting, dissemination and use of health equity data



2014 Legislation

2014 Minnesota Laws, Chapter 312, Article 23, Section 10

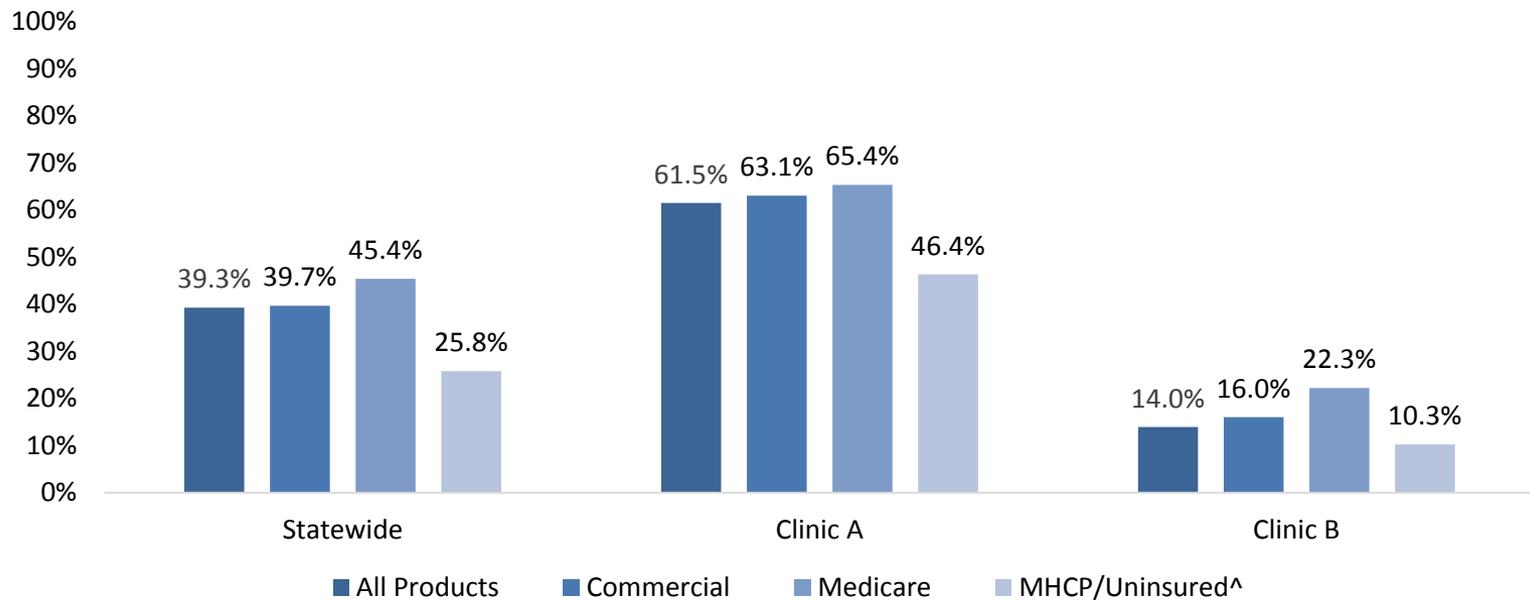
- **Develop an implementation plan for stratifying measures** based on disability, race, ethnicity, language, and other socio-demographic factors
- By January 2016, **assess the risk adjustment methodology** to identify changes that may be needed to alleviate potential harm and unintended consequences of the existing methodology for patient populations who experience health disparities and the providers who serve them

Stratification

- Calculating health care performance scores separately for different patient groups based on some characteristic
- Can unmask healthcare disparities by examining performance for groups who have been historically disadvantaged compared to groups who have not been disadvantaged

Example

Optimal Diabetes Care, 2013



Source: MDH Health Economics Program analysis of SQRMS data

^MHCP are Minnesota Health Care Programs, which include Medicaid and MinnesotaCare

Stratification Report



Stratifying Health Care Quality Measures Using Socio-demographic Factors

Minnesota Department of Health
Report to the Minnesota Legislature 2015

March 2015

Research Questions

- 1) What is the perspective of members from diverse communities about sharing socio-demographic factors with health care providers and seeing the information used?
- 2) What socio-demographic factors do Minnesota clinics and hospitals collect for state and federal quality measurement and reporting initiatives?
- 3) What other socio-demographic factors and data sources could be used to stratify Quality Reporting System measures, and what are the associated benefits and challenges?
- 4) What options should Minnesota consider in stratifying quality measures using socio-demographic factors, and what are the associated benefits, challenges, costs, and timelines?

Study Approach

- Analysis of quality measure data
- Literature review
- Stakeholder input
 - Voices for Racial Justice interviewed community representatives using culturally appropriate methods, and partnered with the Minnesota Association of Community Health Centers to interview representatives of safety net clinics
 - MDH consulted with the Minnesota Administrative Uniformity Committee and the Minnesota e-Health Initiative Advisory Committee and Standards and Operability Workgroup, and conducted interviews with representatives of MN Community Measurement, Minnesota Council of Health Plans, Minnesota Hospital Association, Minnesota Medical Association, and Stratis Health

Key Findings

- **Community results**
 - **Build trusting relationships** between patients and health care system
 - **Increase community understanding** of the collection and use of socio-demographic data
 - **Provide health equity data to communities**
- **Socio-demographic factors that clinics and hospitals currently collect**
 - Most Minnesota clinics and hospitals currently collect and store basic socio-demographic information including: patient age, gender, residential zip code, health insurance primary payer, race, ethnicity, language, and country of origin to participate in various state and federal quality measurement and improvement initiatives
- **Other patient socio-demographic factors**
 - Disability, sexual orientation, and gender identity could be used to stratify health care quality measures in the future, but lack of a uniform disability definition, patient privacy and discrimination concerns, and perceived limited clinical usefulness of some of these factors impede standardized and statewide data collection and use at this time

2015 Legislation

2015 Minnesota Laws, Chapter 71, Article 9, Sections 4-7

July 1, 2016

- Stratify five quality measures by race, ethnicity, preferred language, and country of origin

July 1, 2017

- Risk adjust quality measures using patient socio-demographic factors

January 1,
2018

- Quality measures may be stratified by other socio-demographic factors

SQRMS Website

MDH Minnesota Department of Health

HOME TOPICS ABOUT US

Health Care Quality Measures

- Home
- 2010 Report
- Adopted Rule - December 2014**
- Recommendations
- Measurement and Reporting Committee
- Hospital Quality Reporting Steering Committee
- Quality Incentive Payment System
- Incentive Payment Work Group
- About

Minnesota's Health Reform Initiative

- Home
- MNsure provider networks
- Quality, cost and payment reform
- News, events and announcements
- 2008 health reform law

health reform
MINNESOTA
A Better State of Health

Update

Report Stratifying Quality Measures

MDH issued a report which presents findings from its study of stratifying Quality Reporting System measures based on disability, race, ethnicity, language, and other socio-demographic factors that are correlated with health disparities and impact performance on quality measures as required by 2014 Minnesota Laws, Chapter 312 Article 23, Section 10. Eliminating health disparities and creating a culture of health equity in which all individuals have the opportunity to be healthy is among MDH's highest priorities. This report lays out a series of recommendations that offer multiple pathways to stratification that acknowledge both the differing sources of data that make up the Quality Reporting System and the current state of the evidence.

[Stratifying Health Care Quality Measures Using Socio-demographic Factors \(PDF: 1MB/60 pages\)](#)

Resources

MDH's Health Reform list-serv: Sign-up for SQRMS email updates

- www.health.state.mn.us/healthreform

Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

- www.health.state.mn.us/healthreform/measurement

MN Community Measurement

- www.mncm.org

Stratis Health

- www.stratishealth.org

Recommendations from the Public

- Comments from representatives of two provider organizations
 - Concerned about reporting burden, reporting processes, and related resource expenditures

Questions and Discussion



*Reminder: Submit written comments on final measure recommendations to MDH at health.reform@state.mn.us by 4:30 p.m., July 6, 2015.