



Statewide Quality Reporting and Incentive Payment Program Physician & Hospital Measure Development Update

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BACKGROUND

In February of 2009, Minnesota Community Measurement (MNCM), under contract with the Minnesota Department of Health, provided a list of recommended quality measures for initial reporting under the Statewide Quality Measurement and Reporting initiative. Due to continuing changes in science and measurement methodologies, MNCM agreed to update this list of quality measures annually through 2012.

The ongoing development of new quality measures will target Primary Care providers, Specialty Care groups, Hospitals and, potentially, Ambulatory Surgery Centers. Section 1 of the following report summarizes MNCM's ambulatory measurement development plans for 2009 and 2010, and includes preliminary ideas for 2011. In Section 2, prospective Hospital and Ambulatory Surgery Center measures are discussed and summarized for 2011 and beyond.

Section 1

AMBULATORY QUALITY MEASURE DEVELOPMENT

Process

Minnesota Community Measurement has a well-defined process for identifying and developing new ambulatory quality measures of care. Extensive research is conducted, involving literature review and interviews with community stakeholders, including physicians, quality improvement experts, and payers. A general impact document which summarizes research findings is written for each proposed clinical topic area for which a measure could be developed. This document is presented to MNCM's Reporting Advisory Committee (RAC) for review and discussion. The RAC is made up of clinicians, consumers, technical specialists and health plans. The group also considers and reviews nationally endorsed and/or developed measures and consults with the Institute for Clinical Systems Improvement (ISCI) for recent guidelines of care. If a proposed clinical topic area is approved by the RAC, MNCM staff moves forward to more fully develop a proposal for the MNCM measure. At this stage, a measurement work group is formed (for each individual measure), which is comprised of relevant clinicians and stakeholders who are considered experts in the field of the proposed measure. This workgroup has the responsibility to more thoroughly develop the measure to prepare it for public reporting.

For externally developed measures (typically the NCQA HEDIS measures) –MNCM may pull together a special, ad hoc, workgroup. Other process steps may include taking the measures to the Data Planning workgroup for technical review and then to RAC for approval; or taking a MNCM staff-prepared recommendation directly to RAC or the MNCM Board of Directors for approval. Regardless of the process taken, the MNCM Board of Directors has ultimate approval.

for the reporting of performance measurement results on the MNCM website. Please see the flow chart in Appendix A for detailed steps in the measure development process.

The MNCM process resulted in the recommendation to begin development of several priority measures for Primary Care Physicians (PCP) and Specialty Care physicians during 2009 and 2010. The recommended measures for development are summarized in Table 1. Most of these measures will be collected using MNCM's preferred Direct Data Submission (DDS) process, in which providers directly submit data from patient charts. In addition to the DDS measures, MNCM continues to add measures via the health plan aggregated claims process. Most suggested measures will move through the table from development (year 1) to voluntary reporting (year 2), and finally to inclusion in the Standardized Quality Measurement Set for required reporting (year 3). However, health plan claims measures may move from approval by RAC and the Board of Directors directly to public reporting, upon passing all data quality checks.

Table 1. Measure Development for Ambulatory Care

Year	Develop new measures Select future priorities	Data collection begins Voluntary data submission and public reporting	Public reporting state-wide
2009	<p><u>Develop New Measures:</u> One Primary Care: 1) Asthma One Specialty: 2) High Tech Diagnostic Imaging (HTDI) – Primary Care and All Specialties 3) Asthma - Pulmonologist & Allergists</p>	<ul style="list-style-type: none"> • Depression – Primary Care • Depression – Specialty • HIT – Primary Care and Specialty • Patient Experience – Primary Care 	<ul style="list-style-type: none"> • Existing MNCM Measures • New Health Plan measure 1) Avoidance of Antibiotic use for Acute (Adult) Bronchitis
2010	<p><u>Develop New Measures:</u> One Primary Care: 1) Colorectal Cancer Screen Two Specialty: 2) Colorectal Cancer Screen 3) Quality of Colonoscopy 4) Overuse of Colonoscopy - Gastroenterology; Surgeons</p>	<ul style="list-style-type: none"> • Asthma – Primary Care and Specialty • HTDI – Primary Care and all Specialties 	<ul style="list-style-type: none"> • Depression – Primary Care • Depression – Specialty • HIT – Primary Care and Specialty • Patient Experience – Primary Care
2011	<p><u>Develop New Measures:</u> Two Specialty: (exploration stages – not yet presented or approved by RAC) 1) Low back pain (overuse of procedures) 2) Overuse of cardiovascular procedures 3) Hospital readmissions</p>	<ul style="list-style-type: none"> • Colorectal Cancer Screen – Primary Care and Specialty • Quality of Colonoscopy - Specialty • Overuse of Colonoscopy - Specialty 	<ul style="list-style-type: none"> • Asthma – Primary Care and Specialty • HTDI – Primary Care and all Specialties
Jan 2012- July 2012		Two Specialty Measures (developed in 2011)	<ul style="list-style-type: none"> • Colorectal Cancer Screen – Primary Care and Specialty • Quality of Colonoscopy - Specialty • Overuse of Colonoscopy - Specialty

Ambulatory Measure Criteria

The new measures listed in Table 1 for 2009 and 2010 were approved the MNCM's Report Advisory Committee in early 2009, using the established measure criteria presented in previous reports (the degree of impact, improvability, inclusiveness, national consensus, and performance variation). A condensed summary of the criteria for each measure follows.

Asthma Measure:

- Impact:** The *Asthma in Minnesota 2008 Epidemiology Report* published by the Minnesota Department of Health noted that in 2007:
- 10.9% of adults in MN reported that they had been told sometime in their lifetime that they had asthma; 7.7% reported that they still had asthma.
 - That translates to an estimated 429,000 Minnesota adults who have a history of asthma and an estimated 303,000 who currently have asthma.
- In 2006, the MN Behavioral Risk Surveillance System (BRFSS) reported that
- 9.5% of children (age 0-17) in Minnesota have been diagnosed with asthma, and 7% were reported to currently have asthma.
 - That translates to an estimated 116,000 Minnesota children with a history of asthma and an estimated 85,000 who currently have asthma. The prevalence of asthma among children has remained stable since 2003.
- According to AHRQ data, the total costs for asthma in Minnesota for 2003 have been estimated at \$363.9 million, including \$208.6 million in direct costs of office visits, ED visits, hospitalizations and medication, and \$155.3 in indirect costs of missed school and work days.
- Improvability:** Asthma is a chronic disease associated with familial, infectious, allergenic, socioeconomic, psychosocial and environmental factors. It is not curable, but asthma morbidity and mortality are largely preventable. Despite improvements in diagnosis and management, and an increased understanding of the disease, asthma prevalence, morbidity, and mortality have progressively increased over the past 15 years.
- Inclusiveness:** Asthma is a chronic condition that affects every demographic of the population, however it disproportionately affects children, minorities, and persons of lower socioeconomic status. According to the BRFSS, in 2007, 13.9% of black Minnesotans reported that they currently have asthma, compared to 7.3% for whites. MDH data also indicates women in MN are affected more than men.

National Consensus:	The National Heart Lung and Blood Institute, National Institute of Health, Institute for Clinical Systems Improvement and the Minnesota Department of Health agree that asthma morbidity and mortality are largely preventable if patients and providers follow clinical guidelines for asthma care.
Performance Variation:	In 2004, the MNMCM reported medical group average was 74%; in the 2006 Quality Report the medical group average was 91%, an increase of 17 percentage points. For the past three years (2006-2008) the medical group average has remained steady at 92%.

High-Technology Diagnostic Imaging Measure:

Impact: Recent studies show that a range of 20-50% of high-tech diagnostic imaging (HTDI) for a variety of conditions fail to provide information that improves patient diagnosis and treatment and may be considered redundant or unnecessary. The cost of imaging studies is approximately \$100 billion annually for health plans. Information from the Health Care Financing Administration show that a significant portion – as much as \$30 billion annually – is due to inappropriate utilization of imaging or duplication of studies.

ICSI information indicates that the use of HTDI procedures is increasing at 15-20% annually, twice the rate of prescription drugs and far greater than the 10% annual increase in overall healthcare spending. From 2000 to 2006, Medicare expenditures for such services (CT, MRI, nuclear medicine including PET) rose from \$3.6 billion to \$7.6 billion (17% a year on average). This rate of growth was more rapid than that of any other service for which physicians billed Medicare during this period.

Improvability: Recently, several Minnesota health plans established prior notification (PN) programs – where the provider needed to contact a radiology business management vendor (RBM) to obtain approval before ordering an MRI, CT, PET or Nuclear Cardiology test. These PN programs reduced the number of HTDI tests ordered in Minnesota, but it was not clear if PN resulted in more *appropriate* use of HTDI tests.

ICSI has conducted a pilot program studying an alternative approach to PN with 5 medical groups, 3 insurance companies and Minnesota Department of Human Services. The goal of the pilot was to test a model that addressed 90% of the ordered CT, MRI, PET and Nuclear Cardiology tests by using appropriateness criteria at the point of service. Results to date indicate the HTDI utilization has decreased (nearly leveling the utilization rate). HealthPartners utilization data suggest that this decision support reduced unnecessary tests by more than \$5.8 million an 80% savings increase over last year.

- Inclusiveness:** A measurement and transparency effort developed around the appropriate use of HTDI tests of MRI, CT, PET and Nuclear Cardiology would affect virtually all specialty providers, primary care providers as well as rendering radiologists. The measure would also affect patients across all demographic groups.
- National Consensus:** The American College of Radiology (ACR) has developed appropriateness guidelines/criteria for imaging use. The guidelines are developed by expert panels in diagnostic imaging, interventional radiology, and radiation oncology. Major scientific societies representing specialties outside of radiology also participate in the development of the criteria. Members from over 15 non-radiology specialty organizations are currently participating. Over 200 physician representatives are involved in the criteria development process.
- Performance Variation:** Specific findings from the ICSI Pilot Study:
- Combined data from the five pilot medical groups showed 63% of all images ordered met high-utility appropriateness criteria, 7% moderate utility, 4% low utility and 26% fell into the “other” category.
 - A chart study on three HTDI procedures showed a 10% improvement in appropriate scans ordered when using the EMR decision-support criteria versus physicians ordering scans without the decision support.
 - It is estimated that the ICSI pilot contributed to roughly half of the decrease in the number of claims filed for HTDI tests (prior notification contributed to the other half) among Minnesota’s major health plans. Combined, these two options reduced the number of HTDI tests in 2007 in Minnesota by 8%.

Colorectal Cancer Measures:

- Impact:** National Cancer Institute data indicate:
- 2,430 new colorectal cancer cases in Minnesota in 2008
 - 760 deaths due to colorectal cancer in Minnesota in 2008
 - National spending on direct medical costs for colorectal cancer in 2004 was \$8.4 billion
 - Colorectal cancer screening is cost effective compared to the absence of screening (\$10,000 to \$25,000 per life year saved)
- Improvability:** Minnesota Community Measurement reports that 63% of insured Minnesotans aged 50-80 had appropriate colorectal cancer screening in 2008 (based on claims

data only). The use of colonoscopy for screening and surveillance of colorectal cancer is recommended as the preferred method for preventing the illness and monitoring colorectal health.

- Colorectal cancer has a defined progression of an adenoma developing into a cancerous lesion over time and the detection and removal of adenomas is the most important tool in the prevention of colorectal cancer.
- Increased cecal intubation rates and withdrawal times of 6 minutes or more are both associated with increased adenoma and polyp detection rates.

Inclusiveness: According to the National Cancer Institute, over 75% of all deaths due to colorectal cancer occur in adults over the age of 65. Based on data from the MDH:

- Rates of colorectal cancer are 34% higher for men than women
- Outstate Minnesotans have higher incidence rates than metro area residents
- American Indian men show a far greater incidence (86.8%) than other populations
- Mortality rates are significantly higher for African Americans and American Indians

National Consensus: A number of national guidelines center on the need for screening and the quality of screening procedures, including:

- American Cancer Society
- American Society for Gastrointestinal Endoscopy (ASGE)
- Institute for Clinical Systems Improvement
- Physician Consortium for Performance Improvement (with ASGE, American Gastroenterological Association (AGA), American Medical Association, National Committee for Quality Assurance)
- U.S. Preventative Services Task Force

Performance Variation:

Screening and Surveillance

- MNCM reports a colorectal screening rate of 63% for insured adults in MN aged 50-80
- A 2007 study showed endoscopists recommended colonoscopies too frequently, following the guidelines only 36.7% of the time

Colonoscopy Quality

- The rate at which endoscopists reach the cecum should be $\geq 90\%$ of all patients ($\geq 95\%$ in healthy/screening patients), but variation exists with rates dipping to 76% after performing multiple colonoscopies in one observational study
- Withdrawal times vary, but times of 6 minutes or more have been shown to be associated with greater detection of adenomas and polyps
- Adenoma detection rates vary by physician but recommended levels are

≥25% in men and ≥15% in women

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis Measure:

The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were *not* dispensed an antibiotic prescription.

- Impact:** According to the National Committee for Quality Assurance’s (NCQA) *The State of Health Care Quality Report 2008* antibiotics are not recommended in clinical guidelines for the treatment of acute bronchitis for adults who do not have a co-morbidity or other infection. Only one in 10 cases of acute bronchitis is bacterial which strongly suggests that antibiotic treatment is neither necessary nor effective for the majority of cases. Yet, antibiotics are commonly used to treat acute bronchitis in adults. NCQA states that between 65- 80 percent of patients with acute bronchitis receive a course of antibiotics despite evidence that they are largely ineffective. This overuse can cause general resistance to antibiotics in patients, and may also lead to adverse side effects.
- Improvability:** *Antibiotic Resistance:* The CDC states that antimicrobial resistance has become a common clinical problem. The Institute of Medicine (IOM) has indicated that antibiotic resistance is “one of the key microbial threats to health in the United States” and that decreasing the inappropriate use of antibiotics is a primary solution to antibiotic resistance.
- Overuse:* In addition, the CDC states that more than 10 million courses of antibiotics are prescribed each year for viral conditions that are not improved with this course of treatment – pointing to a critical area of resources overuse.
- Inclusiveness:** According to the NCQA, about 5% of adults report an episode of acute bronchitis each year and 90% of those adults seek treatment. Research has shown that elderly patients are particularly likely to receive an antibiotic to treat a viral illness.
- National Consensus:** This measure is NQF endorsed and is also supported by The Evidence-Based Clinical Practice Guidelines developed by the American College of Chest Physicians (2006). This measure is also aligned with the goal of the ICSI guideline on the Diagnosis and Treatment of Respiratory Illness in Children and Adults.
- Performance Variation:** The NCQA’s *The State of Health Care Quality Report 2008* shows declining trends in this measure in commercial populations from 33.9% avoiding antibiotic treatment for acute bronchitis in 2005 to 25.4% in 2007. In the Medicaid

population, results also declined and varied from 30.6% in 2005 to 25.9%. In Minnesota, recent 2008 HEDIS measures from three Minnesota health plans show variation from 16.97% to 19.35% in the commercial population. Rates in the Medicaid population from two health plans range from 14.65% to 18.73%.

Additional Measure Development

In addition to the DDS measures that are under formal development in Table 1, development and collection of measures by MNCM is ongoing in 2009 and 2010:

- Data will be collected and reported on several measures which were identified in the initial set (February, 09 report). MNCM recently reported results from the new Patient Experience measure for Primary Care providers. MNCM will be reporting the new Depression measure (for both Primary Care and Behavioral Health) in 2010.
- The Health Information Technology (HIT) survey, which was first administered in 2008, is being revised and condensed for a second collection in July, 2009. In addition, MNCM is drafting a new HIT survey, with input from the MHA, Stratis Health, and other community stakeholders, for administration by the end of 2009.
- Every year, new health plan administrative measures are reviewed and may be added to the set for public reporting

Looking ahead to 2011, initial exploration is underway on ambulatory measures that will focus on the overuse of procedures for screening and treatment of low back pain, as well as overuse of cardiovascular procedures. MNCM is also in the initial stages of exploring a measure to track hospital readmissions. Finally, due to strong interest voiced by both the physician and hospital community, MNCM and Stratis Health will convene a joint workgroup later in 2009, to explore measures that cross clinic and hospitals settings, to better capture the full range of patient care.

Section 2

HOSPITAL QUALITY MEASURE DEVELOPMENT

Background

Stratis Health, under subcontract with MNCM, and in collaboration with the Minnesota Hospital Association, convened and facilitated the Hospital Quality Reporting Steering Committee to make recommendations to MDH regarding measures to be used for hospitals in a statewide quality reporting and incentive payment system. This work group served in an advisory capacity to MNCM. The group's charge was in two phases:

- Phase I: The group will conduct a high-level review and discussion of the University of Minnesota's recommendations for designing an incentive program, recommend changes as appropriate with a rationale for their recommended changes, and submit feedback through a formal feedback process. (The group will not discuss or recommend changes to the University of Minnesota's recommendations on payment amount to avoid issues of anti-trust.) *(Completed March 2009)*
- Phase II: The group will make recommendations for additional new measures for future public reporting and/or incentive payment. *(May and June 2009)*

Process- Phase II

The group met three times in May and June 2009, with the goal of submitting a report and recommendations regarding additional hospital measures for public reporting starting in the second year of the program, or 2011, and additional hospital measures on which payment incentive should be based.

- Meeting #1 (May 7): Clarified the overall goals of the public reporting and incentive payment program and continued the incentive payment design work begun in March to recommend year 2 (and beyond) incentive measures.
- Meeting #2 (May 19): Reviewed and recommended new hospital measures for public reporting for year 2 and beyond.
- Meeting #3 (June 2): Finalized the set of recommendations for public reporting and incentive payment for year 2 and beyond.

The measure sets discussed and evaluated in this phase of the work included:

- Inpatient Surgical Care Measures
- Ambulatory Surgery Center Measures
- AHRQ Prevention Indicators

- Hospital Outpatient/Emergency Department Measures
- Pediatric Measures
- Obstetrical/Perinatal Care Measures
- Hospital Acquired Infection Measures
- Readmission Measures
- Patient Experience of Care Measures
- AHRQ Quality and Patient Safety Indicators

The Steering Committee used the same criteria as the ambulatory measures, as an informal guide in their discussions regarding measures for public reporting and incentive payment: degree of impact; degree of improvability; degree of inclusiveness; national consensus; and degree of performance variation. The committee added additional criteria of validity, reliability, and accuracy of data.

As part of the process, an on-line survey was used to gather committee member level of support for the measure sets that had been discussed, and asked specifically whether committee members supported each measure set for public reporting and for incentive payment, making the distinction between recommendations for large and medium hospitals (i.e., PPS, or Prospective Payment System hospitals) and small, rural hospitals (i.e., CAH, or Critical Access Hospitals). The survey also requested narrative comment and/or alternate recommendations to the proposed measures. The results of the survey, completed by 14 of 17 committee members, are included as Appendix B. Appendix C is a summary table that was developed by Stratis Health and provided to the committee as background information about each of the measure sets. Appendix D contains a list of community used abbreviations.

The committee was comprised of hospital representatives from both large and small, and rural and urban hospitals; health plans; and employer, purchaser, and consumer representatives.

Recommendations

Summary

For **Minnesota's Prospective Payment System (PPS) hospitals**, the large and medium hospitals in the state, the committee recommends the following measures be publicly reported (in addition to those already recommended for the first year of reporting):

- Inpatient Surgical Care Improvement Project (SCIP) Appropriate Care Measure (ACM): A new all-or-none measure based on four individual indicators
- Hospital Emergency Department Care Measures: 5 measures of timeliness for patients with heart attack/chest pain
- Hospital Outpatient Surgery Measures: 2 antibiotic measures

- Obstetrical/Perinatal Care Measures: 2 measures
- All Domains of the Patient Experience of Care Survey: 10 domains measured

For **Minnesota’s Critical Access Hospitals (CAH)**, the 79 small rural hospitals in the state, the committee recommends the following measures be publicly reported (in addition to those already recommended for the first year of reporting):

- Inpatient Surgical Care Improvement Project (SCIP) Appropriate Care Measure (ACM): A new all-or-none measure based on four individual indicators
- Hospital Emergency Department Care Measures: 5 measures of timeliness for patients with heart attack/chest pain
- Hospital Outpatient Surgery Measures: 2 antibiotic measures
- Obstetrical/Perinatal Care Measures: 2 measures
- For all CAHs that are voluntarily reporting Patient Experience of Care results to Hospital Compare, the committee recommends reporting All Domains of the Patient Experience of Care Measure: 10 domains measured

Note that the PPS and CAH recommendations are nearly identical. The only exception is the committee does not recommend mandating that CAHs collect and report patient satisfaction measures using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Instead, the committee recommends for any CAHs that are voluntarily collecting and reporting HCAHPS data, these results be reported as part of the Minnesota effort.

In addition, for **Minnesota’s Ambulatory Surgery Centers**, the committee recommends the following measures be publicly reported:

- Ambulatory Surgery Center Measures: 8 measures

The committee does not recommend the addition of any new measures for incentive payment at this time, feeling transparency is currently a stronger tool for hospital improvement.

Details of the Hospital Quality Reporting Steering Committee’s deliberations and final recommendations are provided in the following section, including comments from committee members regarding individual measure sets.

Methodology and Implementation Comments, Issues, and Recommendations

As part the committee’s deliberations, a number of methodology and implementation comments, issues, and recommendations arose.

First, the committee is aware there are a number of national public reporting and incentive payment initiatives underway or planned. The Minnesota program should align with these efforts

whenever possible to maximize efficiency for both the state and Minnesota hospitals, and to support consumer understanding and use of publicly reported data.

Second, the committee felt strongly that in instances where the Minnesota public reporting program is drawing on measures being reported elsewhere, the same data specifications and methodology should be used. This includes measure definitions and specifications, sampling methodologies, and case volume thresholds. Specific attention should be paid to the minimum number of cases/patients needed to report for Critical Access Hospitals; for the national Hospital Compare website, data are collected and submitted quarterly, and the minimum threshold for publicly reporting a hospital-specific measure is 25 cases over a rolling four quarters.

Finally, the committee notes the importance of the timing of when national programs will have data available to draw on, and recommends the Minnesota program not mandate data collection for Minnesota hospitals prior to when a national organization (i.e., typically CMS and Joint Commission) is launching its program. This is not to say the Minnesota program should not include measures above and beyond those that are part of national programs (in fact, the committee encourages innovation and being on the leading edge of public reporting); but, rather, if and when a national program is designed and slated for implementation, to align data collection and reporting timeframes for the Minnesota program and the national program. For the measures recommended in this report, these dates are included whenever possible.

Inpatient Surgical Care Measures:

Recommendations:

Public Reporting – Report a new all-or-none Appropriate Care Measure (ACM) for the following SCIP measures for PPS and CAH:

- SCIP-Inf-1 Prophylactic antibiotic received within one hour prior to surgical incision
- SCIP-Inf-2 Prophylactic antibiotic selection for surgical patients
- SCIP-Inf-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time
- SCIP-Inf-6 Surgery patients with appropriate hair removal

Rationale for and Committee Discussion of Recommendation:

The committee strongly supported having a surgical ACM similar to the ACM reported for pneumonia, heart failure, and heart attack (AMI). Use of an ACM, an all-or-none measure, was preferred over a composite measure, since the all-or-none is a measure of whether everything that should have been done was in fact completed (i.e., no “partial credit.”). The committee also recommended a definition of the measure and the rationale for its use be provided whenever a measure is publicly reported as an ACM or a composite measure. This will be a new measure reported about hospitals, although it will be derived from data already reported by many hospitals. Specifically, the individual SCIP measures are currently collected and publicly reported by all PPS hospitals for Centers for Medicare & Medicaid

Services (CMS) and Joint Commission purposes. The majority of CAHs are collecting and reporting some SCIP measures, typically SCIP-Inf-6, which was mandated for hospital acquired infection reporting for all Minnesota hospitals effective January 1, 2009. The committee acknowledged that CAHs will have smaller patient volumes for this measure because CAHs often do not perform some or all of the types of surgeries included in the measure.

For purposes of incentive payment, the committee recommended re-evaluating when adequate data has been collected through public reporting of the measures.

Implementation Notes:

Although individual measure data are already collected by many Minnesota hospitals, publicly reporting the ACM surgical care measure will require development of additional processes and infrastructure. Following are the two options for pursuing this development:

1. The SCIP data that are currently collected by hospitals through a chart abstraction process are submitted to the CMS data warehouse (either directly by the hospital, or by the hospital's data vendor). Access to the data warehouse is only available to the Minnesota Medicare QIO (Stratis Health). For the other Appropriate Care Measures being reported in Minnesota (in heart failure, pneumonia, and heart attack), Stratis Health has a Data Use Agreement with the Minnesota Hospital Association and hospital consent forms from hospitals that enable the data to be shared. Stratis Health downloads the data from the data warehouse, analyzes it to calculate the ACMs, and submits the ACM rates to MHA for public reporting. A similar process could be used for SCIP ACM reporting.
2. Hospitals could be mandated to submit their SCIP data directly to a Minnesota entity that MDH designates and contracts with to analyze and calculate the SCIP ACM, and then submit it for public reporting. Appropriate data use and confidentiality agreements would need to be in place, since the data needed to calculate ACM rates are at the patient level.

Written Comments Received from Committee Members:

“Prefer an all or none measure over a composite for the three antibiotic measures as it aligns with the AMI, HF, and PN measurement metrics chosen for year one reporting. Hospitals have had more experience with the antibiotic measures than VTE, thus would hold on reporting an incentive payment for VTE measures.”

“Partial credit doesn't count for incentive payment.”

“CAH should be required to report same measures as PPS hospitals.”

“Does not apply for CAH: the inclusion populations for the three Antibiotic Measures are not typically done at CAH and so would not be an appropriate measurement tool for surgical quality of care at any given CAH.”

“I believe the reporting/incentives should be based on all or none measures only.”

“Consider incentive after at least one year reporting. Perhaps start with average and move to all or nothing.”

Ambulatory Surgery Center (ASC) Measures:

Recommendation:

Public Reporting – Recommend publicly reporting ASC Measures when available. The ASC measures include:

- Patient burns
- Antibiotic selection, use, timing, and discontinuation
- Transfer/admission to hospital
- Patient falls
- Wrong site surgery

Rationale for and Committee Discussion of Recommendation:

Although perhaps outside of the scope of the committee charter (i.e., to recommend measures about the care delivered in *hospitals*), the committee felt strongly public reporting of quality measures should not be limited based on where the surgery occurs, whether inpatient hospital, outpatient hospital, or ambulatory surgery center. It is important to include these measures for purposes of transparency and to have a well informed consumer of health care, regardless of where the surgery takes place. As a result, the committee recommended publicly reporting ASC measures.

For purposes of incentive payment, the committee recommended re-evaluating when adequate data has been collected through public reporting of the measures.

Implementation Notes:

A date for release of these data has not been published. The data are part of the ASC Quality Collaboration.

Written Comments Received From Committee Members:

“Hospitals report a lot of data, do ambulatory surgery centers report any?”

“I would support the adoption of the CMS outpatient SCIP measures to be applied to PPS, CAH and ASC for public reporting and incentive payment.”

AHRQ Prevention Indicators:

Recommendation:

Public Reporting – No public reporting for AHRQ Prevention Indicators in year two of the program.

Rationale for and Committee Discussion of Recommendation:

Committee members concluded that the AHRQ prevention indicators may be more appropriate as a community measure or a transition of care measure, rather than a measure of hospital-specific care.

Written Comments Received From Committee Members:

“These are area-level measures, so no differentiation between PPS and CAH.”

“Hospitals are currently not collecting data on these measures—no experience with what these measures look like at the individual hospital level.”

“I support this only if there is a way to justify admissions of patients with co-morbid conditions and/or advanced age.”

“These ought to be reported somewhere, but because they are not provider-specific, it seems outside the purpose of this engagement.”

Hospital Outpatient/Emergency Department Measures:

Recommendation:

Public Reporting – Two measure sets were recommended by the committee for public reporting, one specific to hospital emergency department care, and the other specific to hospital outpatient surgery.

Report Emergency Department Measures for acute myocardial infarction (AMI)/ chest pain for PPS and CAH. This is a 5 measure set that includes:

- Median time to fibrinolysis
- Fibrinolytic therapy within 30 minutes
- Transfer to another facility
- Aspirin at arrival
- Median time to ECG

Report Hospital Outpatient Surgery Measures for antibiotic timing and antibiotic selection for PPS and CAH. This is a 2 measure set that includes:

- Antibiotic timing
- Antibiotic selection

Rationale for and Committee Discussion of Recommendation:

A growing amount of care is delivered by hospital outpatient units, such as the emergency department and hospital-based outpatient surgery centers. Reporting of AMI/chest pain Emergency Department Measures for CAH and PPS received strong support from committee members. The committee also strongly supported reporting of antibiotic use for Hospital Outpatient surgery. All of these measures are particularly relevant for CAH.

For purposes of incentive payment, the committee recommended re-evaluating when adequate data have been collected through public reporting of the measures.

Implementation Notes:

Public reporting for all required outpatient measures (OP 1-11), which includes those measures recommended by the committee above, is expected to occur in 2010. CMS has not made a decision about which data will be reported, or where the data will be publicly reported.

Written Comments Received from Committee Members:

“These are the rural-relevant measures, but the third set is not currently reported by a majority of CAHs and would impose a significant additional burden. However, I would support voluntary collection and reporting of these measures.”

“Would need to know more about the other ED measures to make a determination to include for reporting. They seem to be measures of documentation.”

“We already report some of this ED data (AMI). The data sounds like great data to collect, but who is going to pay for the people power to collect it?”

“I believe Emergency Department measures are some of the most important areas to report, and they apply to most hospitals.”

Pediatric Measures:

Recommendation:

Public Reporting – Although the committee agrees pediatric measures are extremely important to include in public reporting, the committee did not feel it could recommend public reporting of the current measures. Therefore, the committee recommends development of a workgroup,

which would include representatives from children’s hospitals, to review, develop, and recommend pediatric measures for public reporting.

Rationale for and Committee Discussion of Recommendation:

Of the Pediatric Measures reviewed by the committee, only two asthma measures are currently publicly reported (via Hospital Compare). Committee members moderately support public reporting of pediatric asthma and outcome measures. Considerable discussion took place among committee members about the need for publicly reported pediatric measures by children’s hospitals.

For purposes of incentive payment, the committee recommended re-evaluating when adequate data has been collected through public reporting of the measures.

Written Comments Received from Committee Members:

“The admission rates are area-level. The asthma measures are meant for the children’s hospitals, which are really a different category than PPS or CAH.”

“Very small volume in most hospitals.”

“Too similar to NQF never events, which are already reported.”

“We have very few pediatric admissions, so I have little or no experience to base my opinion on.”

Obstetrical/Perinatal Care Measures:

Recommendation:

Public Reporting – Report Obstetrical/Perinatal Measures for PPS and CAH. This 2 measure set includes:

- 3rd and 4th degree laceration
- Inpatient neonatal mortality

Rationale for and Committee Discussion of Recommendation:

Neonatal mortality and 3rd and 4th degree laceration were thought to be applicable measures for PPS and CAH. A comment was made that neonatal mortality may need to be adjusted for hospitals with a Neonatal Intensive Care Unit (NICU). Data for these measures are not currently publicly reported, as these are Joint Commission measures.

For purposes of incentive payment, the committee recommended re-evaluating when adequate data have been collected through public reporting of the measures.

Implementation Notes:

A date for release of the data has not been published. The data currently are collected for the Joint Commission.

Written Comments Received From Committee Members:

“3rd & 4th degree laceration is already in the recommended measure list. The other two measures are problematic—VBAC because there is disagreement on whether they are preferred anymore and neonatal mortality because it is relatively rare.”

“Many CAH do not perform OB. Many PPS hospitals don't know what their experience is in these measures as they are not collecting the Joint Commission pregnancy related core measures.”

“We already collect these, so no additional manpower is needed. I would support if applied to both PPS and CAH hospitals.”

“These measures are changing—this should reflect what is being proposed by the Joint Commission.”

“Would be especially applicable to the MA population. Might need to be adjusted, however, for those patients who got little or no prenatal care prior to admission.”

Hospital Acquired Infection Measures:

Recommendation:

Public Reporting – Although the committee supported public reporting of the hospital acquired infection measures, it expressed concern about adding new measures when the recently mandated Minnesota hospital infection reporting measures have not yet been published (public reporting is slated for later in 2009). The committee agreed further evaluation of hospital infection measures for public reporting was warranted.

Rationale for and Committee Discussion of Recommendation:

Minnesota’s hospital infection reporting was mandated to begin for care delivered starting January 1, 2009. The measures were developed to be in line with National Quality Forum (NQF) recommendations for hospital acquired infections. Hospital infection reporting for Minnesota will be available publicly in late 2009. The committee suggested the current process for publicly reporting Minnesota hospital infection data be allowed to move forward as mandated, with no additional changes. Measures previously mandated by the legislature for 2009 public reporting include:

- SCIP Inf-4 – Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
- SCIP Inf-6 – Surgery patients with appropriate hair removal

- Central line bundle
- Ventilator bundle
- Surgical site infections (total knee and vaginal hysterectomy)

Written Comments Received from Committee Members:

“Again, need to split these out. I support the NQF recommended set for HAIs which includes the central line and ventilator bundles and SSI.”

“Hospitals are struggling to collect the current IC measures, let alone adding additional measures. There are limited ICP resources in hospitals to do this work.”

“I think we need to start with a process like we had with the 27 never events and develop state wide workgroups before we go public reporting these.”

“Too broad - need to be concrete, specific, and better defined.”

“HAI reporting should also be a priority.”

“On the other hand, I could support public reporting of VAP because we can track them much more easily.”

Readmission Measures (30-Day):

Recommendation:

Public Reporting – No public reporting of Readmission Measures in year two of the program.

Rationale for and Committee Discussion of Recommendation:

The committee offered little support for public reporting of Readmission (30-Day) Measures for PPS or CAH. It acknowledged that readmission rates for pneumonia, heart failure, and heart attack/AMI for Medicare patients will be publicly reported on Hospital Compare in June 2009. However, due to the narrow scope of the measures (i.e., Medicare only discharges, readmission to any hospital, and inability to control variables), the committee did not support use of these measures for public reporting or incentive for the Minnesota Health Reform Initiative.

Written Comments Received from Committee Members:

“Too many uncontrolled variables in this measure.”

“These will be reported by CMS for Medicare-only. It will be difficult for us to capture all-payer data on these measures.”

“These are all cause measures—not a good reflection of the care for these clinical topics. Can't control what happens at home with a patient, whether follow advice, etc. This seems to be a community measure, not a hospital measure.”

“With the Mass General report earlier in the week, this does not seem to measure hospital performance. If there is a way to limit to areas where hospital controls or "is at fault," then I would support.”

“I do not support this unless the measure is refined to pick up only those readmissions for same diagnosis in patients who are not end-stage disease.”

“Need to explore ‘potentially preventable’ readmissions.”

Patient Experience of Care Measures:

Recommendation:

Public Reporting – Report all domains of the Patient Experience of Care Measures for PPS hospitals. For all CAHs that voluntarily report patient experience of care results to Hospital Compare, report all domains. The domains of the HCAHPS survey tool are:

- Nurses communicate well with patients
- Doctors communicate well with patients
- Patients receive help quickly from hospital staff
- Patients' pain well controlled
- Staff explain about medicines before giving them to patients
- Patients given information about what to do during their recovery at home
- Patients' rooms and bathrooms kept clean
- Area around patients' rooms quiet at night

Two overall patient experience measures:

- Patients rating of hospital
- Patients recommend the hospital to friends and family

Rationale for and Committee Discussion of Recommendation:

The committee offered moderate to strong support for public reporting on patient experience of care domains. It expressed concern that not all hospitals submit HCAHPS data; PPS are required to submit HCAHPS while CAH submit voluntarily. In addition, it may be difficult to account for small numbers of surveys from hospitals. Therefore, incentive payment was not recommended at this time.

The committee also noted the cost of conducting the HCAHPS is a barrier for smaller hospitals. It suggested that MDH consider developing an alternative to HCAHPS for Minnesota hospitals that would ensure uniformity and use by all providers, or MDH could develop a buying group to contract with a certified HCAHPS vendor to lower survey implementation costs for hospitals.

Implementation Notes:

These data are currently collected and reported by PPS hospitals on Hospital Compare, as part of the CMS reporting and payment program. PPS hospitals use a validated and standardized patient survey, HCAHPS, and a standardized data collection methodology. The use of HCAHPS is currently voluntary for CAH for the CMS program.

Written Comments Received from Committee Members:

Quality Reporting

“Recently, CMS issued a statement that hospitals should not be prepping patients for the HCAHPS survey. This data can be easily skewed.”

“I marked no for public reporting of all measures for CAHs, but only on a mandatory basis—I think they should have to publicly report in order to qualify for the incentive.”

“I would support public reporting these measures, I think incentive payment would be difficult. These are hard measures to move as they are based on patient perception rather than on evidence base.

It is well known that very small hospitals in small communities get better rankings. Does that mean better care is given or received? No, it probably means you know one other.”

“Already part of the publicly reported data.”

“I think all the measures should be reported. There are real differences between facilities and this data is actually acted on by many facilities. I feel less strong on P4P.”

“I strongly support those questions that get at patient safety issues. The others are too subjective.”

“I think the last three are the ones that lend themselves to the incentive best.”

“One of the most important questions isn't on the list? Do your physicians and nurses talk to each other?”

AHRQ Quality and Patient Safety Indicators:

Recommendation:

Public Reporting – No public reporting of AHRQ Quality and Patient Safety Indicators in year two of the program; re-evaluate in the future.

Rationale for and Committee Discussion of Recommendation:

The claims-based AHRQ quality and patient safety indicators have generated considerable controversy regarding how the composite measures are currently collected. Only one of the quality and safety indicators is currently publicly reported. The committee recommended public reporting and incentive payment for these measures be postponed until the measures are further developed and tested. Specifically, when AHRQ completes its current process of re-defining a composite measure based on the AHRQ Quality and Patient Safety Indicators, the committee recommended the new composite measure be considered for public reporting in Minnesota.

Written Comments Received from Committee Members:

“Mortality is ok for reporting, but because this is based on claims data, I feel it would not be wise to put incentives on it—too much variation in coding and the risk adjustment for medical conditions is not robust enough. Composites are candidates for P4P, but AHRQ needs to clean up the methodology before I can say ok—I marked I don't know.”

“I do not support the PSI for public reporting or incentive. Hospitals have little experience with these measures. Many of the procedures included are specific to large hospitals.”

“Safety indicators are best used as an aggregate picture. Because they are so claims dependent they have their weaknesses for payment.”

“I support the "27" never events we already report—these have provider buy-in and have resulted in statewide workgroups to improve care.”

“None of these rates are risk adjusted—O/E rates would be preferred vs. a raw number.”

“My concerns for those I marked no are related to risk adjustment and population differences, as well as size variations of hospitals. Rates and percentages mean different things in different settings.”

“Area-level measures do not differentiate PPS or CAH. We already have a number of these measures in our recommendations.”

“Where would the incentive dollars come from? We are still on a journey figuring out what is evidence-based safety. Is the fact our community serves an older population put us at a disadvantage and inaccurately represent the care we deliver (by simple data reporting)?”

“Until reporting mechanisms are tested, validated and organizations understand P4P implications, no P4P immediately. This should be a planned timeline to move toward P4P.”

“We do not know if it makes sense to have an incentive payment when one does not know the risk adjustment factors that are present. Volume is not necessarily an indicator of better care.”

Adding Clinical Lab Data to Administrative Data:

Recommendation:

Although lab data-enhanced AHRQ quality indicator measures were not discussed by the committee, the state contract calls for their development and implementation in later years. In order to expand the AHRQ project statewide and keep on the contract’s schedule, it may be helpful to include these measures in the recommendations.

Rationale for Recommendation:

One of the primary criticisms of the current AHRQ Quality Indicators has been because they are based exclusively on administrative (i.e., claims) data, the available risk adjustment methodologies cannot account for some key clinical factors. Previous studies conducted by AHRQ have shown that certain lab data, coupled with present on admission coding, add significant predictive power for severity adjustment of hospital performance results.

The Minnesota Hospital Association is currently engaged with AHRQ in a project to merge clinical data commonly found in hospital laboratory information systems with the administrative data that is already collected here in Minnesota. The experience from this project has been promising. Both large and small hospitals have been able to submit their lab data electronically, and merge it successfully with the administrative data.

Future Considerations for Hospital Public Reporting and Incentive Payment

The committee offered comments and recommendations on public reporting, incentive payment, and an overall summary comment for the state and any future multi-stakeholder committees to consider.

Public Reporting

The committee made recommendations for consideration by future multi-stakeholder committees charged with recommending hospital measures for public reporting and/or incentive payment.

When AHRQ completes its current process of re-defining composite measures based on AHRQ Quality and Patient Safety Indicators, the committee recommends the new composite measures be considered for public reporting in Minnesota.

- The committee recommends three measurement areas be considered in the future, each of which is currently being considered for other reporting initiatives at the state or national level, and are areas of interest and value from the committee’s perspective:
 - imaging efficiency measures
 - stroke measures
 - emergency department throughput measures
- The committee indicated a preference for the use of risk adjusted data.

Incentive Payment

The committee does not recommend the addition of any new measures for incentive payment at this time, feeling transparency is currently a stronger tool for hospital improvement. Lengthy discussions were conducted about needing clarity of purpose for incentive payments—for example, would the program target areas most in need of improvement across the state, or would this be a step toward payment reform? Concerns were expressed about the potential unintended consequences of incentive payment programs, such as incenting all hospitals to work on the same clinical areas and measures, when in fact, each hospital has different areas where they need improvement based on patient population, scope of services, and current systems and processes. The committee called for a longer timeframe to be able to design an incentive payment program based on clarity of purpose and goals, an understanding of current research and literature, and more detailed data about current hospital performance available.

However, as part of the committee’s deliberations, innovative approaches to incentive payment in the area of patient experience measures were discussed and were included as part of the survey of committee members. Although the committee is recommending no additional measures for incentive payment at this time, when incentive payment is deliberated in the future, it strongly supports designing an incentive payment program where hospitals must attain a minimum threshold of patient satisfaction to be eligible for any payment incentive. Moderate support existed for incentive payment based on a patient experience composite measure (to be developed) or focused on the two overall measures of patient experience (rating of hospital/recommend hospital). Further detail is available in the survey results in Appendix B, and some of the comments are excerpted below:

“Any of these could work—remember that CMS adjusts the raw results for both mode of survey (telephone vs. mail) and type of patient. I would favor a qualify-for-eligibility approach rather than doing a straight benchmarking-type incentive—the range of scores are fairly tight in some of these domains where one or two patients marking a 4 instead of a 5

can put you down several percentile ranks. I would also point out that the domains listed are already a composite of multiple questions from the survey, so the 4th option needs explanation.”

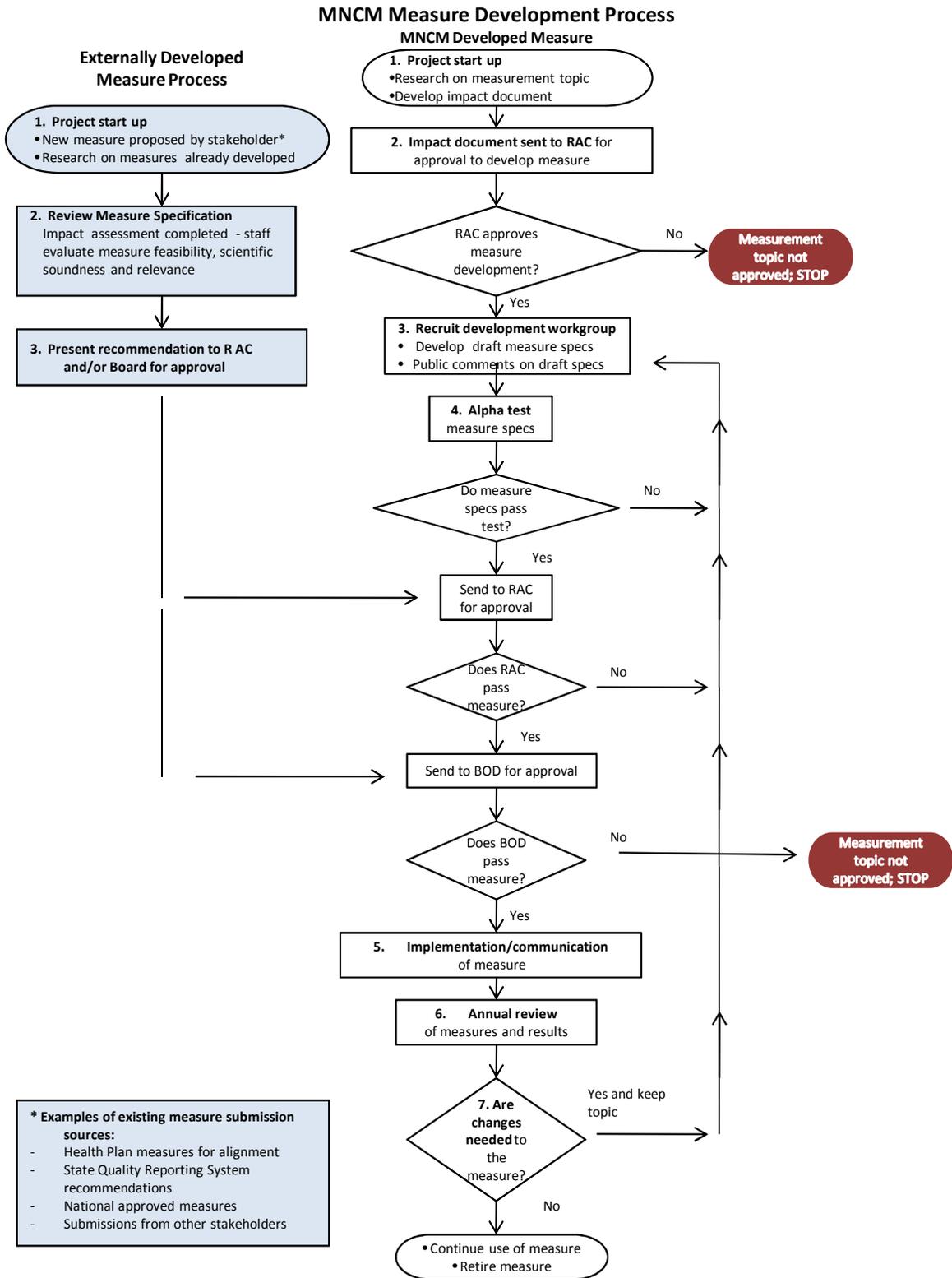
“I think this is one where we want to tie money to a subset—for example, doc and nurse communication and pain management.”

“I would recommend a safety composite as indicated above.”

Summary Comment

Finally, as an overall summary comment, the committee voiced strong support that the measure designation process for public reporting be an iterative process, re-visited annually, taking into account new clinical advances, as well as research about the use of public reports of quality measures as a tool to drive improvement and/or consumer and patient engagement. As the field of measurement advances, so should Minnesota’s quality measurement system.

Appendix A
MNCM Measure Development Process



Annotated Flow Chart for MNCM Measure Development –
MNCM developed measures

1. Select/Identify Topic Area for Measurement

- Drivers for selection/identification of the measurement topic area would be that data is available (for example national registries exist, data is collected via health plan HEDIS process), the topic fits our strategic plan.
- Literature search exploring topic and potential opportunities for improvement
- If measure is to be developed by MNCM staff, the following criteria will be used to prepare an impact document for the Reporting Advisory Committee:
 - **Degree of Impact** – the magnitude of the individual and societal burden imposed by a clinical condition, including disability, mortality, economic costs, presenteeism. Includes what we know at a statewide level or nationally on prevalence and costs – including productivity.
 - **Degree of Improvability** – the extent of the gap between current and evidence-based practices (variation) and the likelihood that the gap can be closed through changes made in the clinical process - what has worked to improve care (need clear evidence base/guidelines developed); opportunity to achieve improvement in the 6 IOM aims (safe, effective, efficient, equity, patient-centered, timely).
 - **Degree of Inclusiveness** – the relevance of a condition to a broad range of individuals with regards to age, gender, race/ethnicity, SES, and the generalizability of associated QI strategies across the spectrum of healthcare conditions and the capacity for change across a range of healthcare settings and providers.
 - **National Consensus** – a measure has been developed or accepted/ approved through a national consensus effort; national/ local guidelines, standard of care , white papers have been developed based upon scientifically accepted process, research studies have been conducted, etc.
 - **Performance Variation** – is there any local or national data to show degree of gap in care (via a measure)

2. Present Impact Document at Reporting Advisory Committee

- Contact Anne Snowden for scheduling of attendance at RAC meeting; upon approval to move forward proceed to next step.

3. Recruit Workgroup and Engage Consensus Process for Measure Recommendation

- Involve multiple health care stakeholders (stakeholders to consider, depending on the measure include all eligible professions to be measured, health plans, consumers, employers).
- Sources for Physician recruitment: ICSI members, MMA recommendations, phone book, DDS participation, measure comments. Could survey about interest and current data around the topic.
- Model measures of national organizations and specialty societies, if applicable (NQF, PCPI, NCQA, JCAHO, PQRI, specialty societies).

Annotated Flow Chart for MNCM Measure Development –
MNCM developed measures

3. Recruit Workgroup and Engage Consensus Process for Measure Recommendation (continued)

- For technical construction of measures reflect evidence-based medicine; define the eligible population as denominator (age, gender, diagnosis, exclusions); define the desired event as the numerator (process, structure, outcome, time windows); define data elements (codes, diagnoses, clinical procedures/tests, medications); define the unit of measurement (individual, group, clinic) and to whom the measure applies (specialties, professionals).
- Identify audit/data validation specifications and how results could be collected and reported.
- Before first draft specification is complete, send out for public comment period to provide additional perspectives; with workgroup – integrate comments as relevant.

4. Alpha Test Measurement Specification

- Field test to refine validity and reliability of measures. Test potential measures against a repository. Need access to database/repository – WCHQ, medical group, other database/repository.
- Consider a baseline data collection for a small pilot to determine “workability” of the specification.
- If measurement specifications pass test, send to RAC for approval.
- If measurement specs to not pass test, send back to development workgroup for revisions and refinement.

Approvals Needed:

- Reporting Advisory Committee.
- Board of Directors - can move forward with implementation planning before goes to BOD. Must be approved by BOD before execution of implementation.

5. Implementation and Communication

- Write detailed specifications.
- Write Direct Data Submission Guide, if applicable.
- Conduct eligible professional trainings (webinars) on the measure specifications and data submission process (if new to DDS).
- Plan DDS - submission cycle given business needs (BTE, P4P programs).
- Work with AncillaPartners on portal updates, think about budget cycles and impacts.
- Prepare audit plan; conduct first audit before handing off to Director of Performance Measurement and Reporting.
- Prepare web-site public reporting plan with Project Director.

Annotated Flow Chart for MNCM Measure Development –
MNCM developed measures

6-7. Annual (or Ad-hoc) Review of Measures (and Results)

- Ad-hoc review is taking action when ground-breaking evidence emerges; otherwise annually review evidence-base for potential changes in measures.
- Determine the need for revision or refinement based upon how measure is performing - Is measure continuing to demonstrate opportunities exist for improvement? Is there variation (and how much) in the performance results between groups? Integrate changes if applicable from research of the evidence base (updating codes, clinical logic), integrate public comments.
- As needed, engage workgroup as per step 3 and test new measure specifications as per step 4.
- Take revised measure to RAC for approval.
- Based upon changes, rewrite specifications, conduct re-training, change data collection tools and portal, change DDS guide instructions, change audit plan, change data trending/reporting display on website.

Retirement of a Measure - criteria

- When performance differences are no longer statistically and clinically meaningful.
- When evidence changes.
- A new and better measure has been developed.
- Cost and burden of measurement is too high.
- Measure is found to not be reliable (stable results/reproducible) or valid (accurately representing the concept).

Annotated Flow Chart for Externally Developed Measures

1. Project Start Up

- Drivers for review of an existing measures would be that a stakeholder has proposed a measure for public reporting or that a new measure has been developed by NCQA through the HEDIS development process.
- 2. MNCM staff review proposed measure** against criteria of measure feasibility, scientific soundness, room for improvement/variation of results, tested/valid/reliable measures, data collection costs are reasonable, relevance to consumers. This step may include review by and advise from a MNCM facilitated workgroup.
- 3. Impact statement and recommendation prepared and presented for approval** to RAC and/or Board of Directors.

Appendix B

Phase II Hospital Survey Results

Survey designed, implemented, analyzed, and reported by Stratis Health

14 of 17 (82.4%) committee members responded

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Appropriate Care Measure (ACM): All or none 3 antibiotic measures	100%	0%	0%	57%	29%	14%	86%	7%	7%	43%	29%	29%
Composite: Average 3 antibiotic measures	43%	50%	7%	14%	71%	14%	43%	43%	14%	14%	64%	21%
Composite: Average 3 antibiotic measures and hair removal	50%	36%	14%	7%	79%	14%	50%	36%	14%	7%	71%	21%
Composite: Average 2 VTE measures	57%	29%	14%	29%	50%	21%	50%	29%	21%	21%	50%	29%

Inpatient Surgical Care (Surgical Care Improvement Project-SCIP) Measures

Rationale:

- This should be a choice between an ACM or composite for the antibiotic measures; doing both would be confusing.
- Prefer an all or none measure over a composite for the 3 antibiotic measures as it aligns with the AMI, HF, and PN measurement metrics chosen for year one reporting. Hospitals have had more experience with the antibiotic measures than VTE, thus would hold on reporting and incentive payment for VTE measures.
- Partial credit doesn't count for incentive payment.
- CAH should be required to report same measures as PPS hospitals.
- Does not apply for CAH: the inclusion populations for the three Antibiotic Measures are not typically done at CAH and so would not be an appropriate measurement tool for of surgical quality of care at any given CAH.
- I believe the reporting/incentives should be based on all or none measures only.

Additional Comments:

- Why not ACM for VTE measures? Why not add hair removal to ACM for antibiotics?
- Consider incentive after at least one year reporting. Perhaps start with average and move to all or nothing.

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	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Mortality Rates for Medical Conditions: acute myocardial infarction, AMI without transfer cases, congestive heart failure, stroke, gastrointestinal hemorrhage, hip fracture, pneumonia	57%	43%	0%	14%	71%	14%	57%	36%	7%	21%	50%	29%
Composite Mortality for Medical Conditions	29%	57%	14%	0%	71%	29%	29%	50%	21%	0%	64%	36%
Mortality Rates for Surgical Procedures: esophageal resection, pancreatic resection, abdominal aortic aneurysm repair, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, carotid endarterectomy, craniotomy, hip replacement	57%	43%	0%	14%	71%	14%	36%	57%	7%	7%	79%	14%
Composite Mortality for Surgical Procedures	36%	50%	14%	0%	71%	29%	36%	43%	21%	0%	64%	36%
Patient Safety Indicators-Area level: foreign body left in during procedure, iatrogenic pneumothorax, selected infections due to medical care, postoperative wound dehiscence in abdominopelvic surgical patients, accidental puncture and laceration, transfusion reaction, post-operative hemorrhage or hematoma	57%	36%	7%	14%	79%	7%	57%	29%	14%	14%	71%	14%

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	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Composite Patient Safety Indicators	57%	29%	14%	36%	43%	21%	50%	29%	21%	36%	36%	29%
Procedure Utilization Rates-Hospital level: cesarean section delivery, primary cesarean delivery, vaginal birth after cesarean, VBAC-all, laparoscopic cholecystectomy, incidental appendectomy in the elderly, bi-lateral cardiac cauterization	43%	57%	0%	0%	93%	7%	36%	57%	7%	0%	86%	14%
Utilization Rates-Area level: coronary artery bypass graft, percutaneous transluminal coronary angioplasty, hysterectomy, laminectomy or spinal fusion	36%	50%	14%	0%	86%	14%	14%	57%	29%	0%	79%	21%
Volume of Procedures: esophageal resection, pancreatic resection, abdominal aortic aneurysm repair, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, carotid endarterectomy	64%	36%	0%	0%	100%	0%	43%	43%	14%	0%	79%	21%

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AHRQ Quality and Patient Safety Indicators

Rationale:

- Mortality is ok for reporting, but because this is based on claims data, I feel it would not be wise to put incentives on it—too much variation in coding and the risk adjustment for medical conditions is not robust enough. Composites are candidates for P4P, but AHRQ needs to clean up the methodology before I can say ok—I marked I don't know.
- I do not support the PSI for public reporting or incentive. Hospitals have little experience with these measures. Many of the procedures included are specific to large hospitals.
- Safety indicators are best used as an aggregate picture. Because they are so claims dependent they have their weaknesses for payment.
- I support the "27" never events we already report—these have provider buy-in and have resulted in statewide workgroups to improve care.
- None of these rates are risk adjusted—O/E rates would be preferred vs. a raw number.
- My concerns for those I marked no are related to risk adjustment and population differences, as well as size variations of hospitals. Rates and percentages mean different things in different settings.

Additional Comments:

- Area-level measures do not differentiate PPS or CAH. We already have a number of these measures in our recommendations.
- Where would the incentive dollars come from? We are still on a journey figuring out what is evidence-based safety. Is the fact our community serves an older population put us at a disadvantage and inaccurately represent the care we deliver (by simple data reporting)?
- Until reporting mechanisms are tested, validated and organizations understand P4P implications, no P4P immediately. This should be a planned timeline to move toward P4P.
- We do not know if it makes sense to have an incentive payment when one does not know the risk adjustment factors that are present. Volume is not necessarily an indicator of better care.

Ambulatory Surgery Center Measures

	Public Reporting			Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know
Ambulatory Surgery Center Measures: burns, IV antibiotic, transfer, admission, falls, wrong site, hair removal, appropriate antibiotics and timing	71%	7%	21%	43%	36%	21%

Rationale:

- These measures do not apply to hospitals. Would require infrastructure development to collect the data.
- Hospitals report a lot of data, do ambulatory surgery centers report any?
- I would support the adoption of the CMS outpatient SCIP measures to be applied to PPS, CAH and ASC for public reporting and incentive payment.

Additional Comments:

- No clue about the infrastructure for obtaining these data.

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AHRQ Prevention Indicators

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Admission Rates For Ambulatory Care Sensitive Conditions: diabetes, appendicitis, COPD, hypertension, CHF, low birth weight, dehydration, pneumonia, UTI, angina, asthma, amputations	43%	43%	14%	21%	64%	14%	43%	36%	21%	14%	64%	21%

Rationale:

- These are area-level measures, so no differentiation between PPS & CAH.
- Hospitals are currently not collecting data on these measures—no experience with what these measures look like at the individual hospital level.
- I like the idea of ambulatory care failure measures, but how do you account for the patient that doesn't follow the physician's advice?
- I support this only if there is a way to justify admissions of patients with co-morbid conditions and/or advanced age.

Additional Comments:

- These ought to be reported somewhere, but because they are not provider-specific, it seems outside the purpose of this engagement.
- This is a health of community issue and should be handled by MDH or Wilder.

Hospital Outpatient/Emergency Department Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Emergency Department Acute Myocardial Infarction (AMI) and Chest Pain: median time to fibrinolysis, fibrinolytic therapy received within 30 min, median time to transfer to another facility, aspirin at arrival, median time to ECG	93%	7%	0%	64%	21%	14%	93%	0%	7%	64%	14%	21%
Outpatient Surgery: antibiotic timing, antibiotic selection	79%	14%	7%	57%	21%	21%	79%	14%	7%	57%	21%	21%

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	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Other Emergency Department Measures: ED vital signs, transfer time, arrived by ambulance, discharge status, sepsis and shock, pregnancy test, endotracheal tube placement, anticoagulation for acute pulmonary embolus, pediatric weight, time in ED	36%	50%	14%	7%	64%	29%	36%	50%	14%	7%	64%	29%

Rationale:

- These are the rural-relevant measures, but the 3rd set are not currently reported by a majority of CAHs and would impose a significant additional burden. However, I would support voluntary collection and reporting of these measures.
- Would need to know more about the other ED measures to make a determination to include for reporting. They seem to be measures of documentation.
- We already report some of this ED data (AMI). The data sounds like great data to collect, but who is going to pay for the people power to collect it?
- Unaware of the literature supporting these as indicators of quality.
- I believe Emergency Department measures are some of the most important areas to report, and they apply to most hospitals.

Additional Comments:

- I don't buy the theory that CAH hospitals should be excluded from most measures. They should.

Pediatric Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Admission Rates: asthma, diabetes complication, gastroenteritis, perforated appendix and UTI	21%	57%	21%	7%	79%	14%	21%	50%	29%	7%	71%	21%
Outcome Measures: accidental puncture or laceration, decubitus ulcer, foreign body, pneumothorax, heart surgery mortality and volume, post-op hemorrhage, respiratory failure, sepsis and wound dehiscence, select infection rates, transfusion reaction	64%	29%	7%	7%	64%	29%	57%	29%	14%	14%	50%	36%
Asthma Measures: 3 measures during inpatient stay (relievers, corticosteroids, admissions)	50%	36%	14%	21%	64%	14%	43%	36%	21%	21%	50%	29%

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Rationale:

- The admission rates are area-level. The asthma measures are meant for the children's hospitals, which are really a different category than PPS or CAH.
- Very small volume in most hospitals.
- Too similar to NQF never events, which are already reported.
- We have very few pediatric admissions, so I have little or no experience to base my opinion on.

Additional Comments:

- Some of the second set is already in our recommendations.

Obstetrical Care Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Prenatal Care Measures: VBAC, inpatient neonatal mortality, 3rd or 4th degree laceration	71%	29%	0%	21%	64%	14%	71%	29%	0%	21%	64%	14%

Rationale:

- 3rd & 4th degree laceration is already in the recommended measure list. The other two measures are problematic—VBAC because there is disagreement on whether they are preferred any more and neonatal mortality because it is relatively rare.
- Many CAH do not perform OB. Many PPS hospitals don't know what their experience is in these measures as they are not collecting the Joint Commission pregnancy related core measures.
- We already collect these, so no additional manpower is needed. I would support if applied to both PPS and CAH hospitals.
- These measures are changing—this should reflect what is being proposed by TJC.
- Would be especially applicable to the MA population. Might need to be adjusted, however, for those patients who got little or no prenatal care prior to admission.

Additional Comments: None

Appendix B

Phase II Hospital Survey Results

Survey designed, implemented, analyzed, and reported by Stratis Health

Hospital Acquired Infection Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Hospital Acquired Infections: central line-associated bloodstream infection (CLABSI), central line insertion practices adherence (CLIP), ventilator-associated pneumonia (VAP), catheter-associated urinary tract infection (CAUTI), dialysis incident (DI), surgical site infection (SSI), post-procedure pneumonia (PPP), antimicrobial use and resistance option (AUR)	64%	36%	0%	29%	71%	0%	64%	36%	0%	36%	64%	0%

Rationale:

- Again, need to split these out. I support the NQF recommended set for HAIs which includes the central line and ventilator bundles and SSI.
- Hospitals are struggling to collect the current IC measures let alone adding additional measures. There is limited ICP resources in hospitals to do this work.
- I think we need to start with a process like we had with the 27 never events and develop state wide workgroups before we go public reporting these.
- Too broad—need to be concrete, specific and better defined.
- HAI reporting should also be a priority.

Additional Comments:

- On the other hand, I could support public reporting of VAP because we can track them much more easily.

30-Day Readmission Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
30-Day Readmission: heart failure, pneumonia, AMI	36%	50%	14%	21%	64%	14%	29%	50%	21%	21%	57%	21%

Rationale:

- Too many uncontrolled variables in this measure.
- These will be reported by CMS for Medicare-only. It will be difficult for us to capture all-payer data on these measures.
- These are all cause measures—not a good reflection of the care for these clinical topics.
- Can't control what happens at home with a patient, whether follow advice, etc. This seems to be a community measure, not a hospital measure.
- Core Measures sets.

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- With the Mass General report earlier in week, this does not seem to measure hospital performance. If there is a way to limit to areas where hospital controls or "is at fault," then I would support.
- I do not support this unless the measure is refined to pick up only those readmissions for same diagnosis in patients who are not end-stage disease.

Additional Comments:

- Need to explore "potentially preventable" readmissions.

Patient Experience Measures

	PPS Public Reporting			PPS Incentive Payment			CAH Public Reporting			CAH Incentive Payment		
	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know	Yes	No	I don't know
Nurses communicate well with patients	86%	14%	0%	14%	64%	21%	71%	21%	7%	14%	57%	29%
Doctors communicate well with patients	86%	14%	0%	14%	64%	21%	71%	21%	7%	14%	57%	29%
Patients receive help quickly from hospital staff	71%	29%	0%	14%	71%	14%	64%	29%	7%	14%	64%	21%
Patients' pain well controlled	86%	14%	0%	14%	71%	14%	71%	21%	7%	14%	64%	21%
Staff explain about medicines before giving them to patients	86%	14%	0%	7%	79%	14%	71%	21%	7%	14%	64%	21%
Patients' rooms and bathrooms kept clean	64%	29%	7%	0%	86%	14%	50%	36%	14%	0%	79%	21%
Area around patients' rooms quiet at night	57%	36%	7%	7%	79%	14%	43%	43%	14%	7%	71%	21%
Patients given information about what to do during their recovery at home	93%	7%	0%	21%	57%	21%	79%	14%	7%	21%	50%	29%
Patients rating of hospital	79%	21%	0%	14%	64%	21%	64%	29%	7%	14%	57%	29%
Patients recommend the hospital to friends and family	79%	21%	0%	14%	71%	14%	64%	29%	7%	14%	64%	21%

Rationale:

- Recently, CMS issued a statement that hospitals should not be prepping patients for the HCAHPS survey. This data can be easily skewed.
- I marked no for public reporting of all measures for CAHs, but only on a mandatory basis—I think they should have to publicly report in order to qualify for the incentive.
- I would support public reporting these measures, I think incentive payment would be difficult. These are hard measures to move as they are based on patient perception rather than on evidence base.
- It is well known that very small hospitals in small communities get better rankings. Does that mean better care is given or received? No, it probably means you know one other.
- Already part of the publicly reported data.

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Phase II Hospital Survey Results

Survey designed, implemented, analyzed, and reported by Stratis Health

- I think all the measures should be reported. There are real differences between facilities and this data is actually acted on by many facilities. I feel less strong on P4P.
- I strongly support those questions that get at patient safety issues. The others are too subjective.

Additional Comments:

- I think the last three are the ones that lend themselves to the incentive best.
- One of the most important questions isn't on the list? Do your physicians and nurses talk to each other?

If the steering committee recommends patient experience measures for payment incentive, please indicate whether you support the following:

	Yes	No	I don't know
Hospitals must reach a minimum threshold of patient satisfaction to be eligible for payment incentive	71%	21%	7%
Hospitals will receive payment incentive if a minimum level of patient experience is achieved for one or more patient experience domains	21%	64%	14%
Hospitals will receive payment incentive based on overall patient experience	50%	29%	21%
Hospitals will receive payment incentive based on a new composite created for select questions or domains	43%	29%	29%

Comments:

- Any of these could work—remember that CMS adjusts the raw results for both mode of survey (telephone vs. mail) and type of patient. I would favor a qualify-for-eligibility approach rather than doing a straight benchmarking-type incentive—the range of scores are fairly tight in some of these domains where one or two patients marking a 4 instead of a 5 can put you down several percentile ranks. I would also point out that the domains listed are already a composite of multiple questions from the survey, so the 4th option needs explanation.
- I would not commit to a composite without knowing what it is.
- It all depends on which measures are selected. Not all the questions used in the survey are ranked as being very important to the patient.
- I think this is one where we want to tie money to a subset—for example, doc and nurse communication and pain management.
- I would recommend a safety composite as indicated above.

Additional Suggested Measures

- Imaging efficiency measures.
- Stroke core measures.
- ED throughput measures.
- Risk adjusted data would be preferred.

Appendix C
Hospital Measure Set Background

Measure Set/Description	Data Source	Currently Publicly Reported Anywhere?	For Which Hospitals?	Readily Available Data?	Rural Relevant?	Patient Population	Types of Measures In This Set	Current Performance
Ambulatory Surgery Center Measures								
This set of measures is limited to Ambulatory Surgery Centers: burns, IV antibiotic, transfer, admission, falls, wrong site, hair removal and appropriate antibiotics and timing	Administrative + Medical Record	Unknown - part of the Ambulatory Surgery Center (ASC) Quality Collaboration	Ambulatory Surgery Centers	Unknown	Unknown	Limited to Ambulatory Surgeries	Process and Outcome	Note: The Medicare Outpatient Prospective Payment System (OPPS) requires hospitals to submit data to CMS on measures for the hospital outpatient setting in CY 2008 in order to get their full payment update in CY 2009. Ambulatory Surgical Centers (ASCs) will be added for data collection in the future.
AHRQ Prevention Indicators: Hospital Admission Rates for ambulatory care sensitive conditions								
Admission Rates for Ambulatory Care Sensitive Conditions: diabetes, appendicitis, COPD, hypertension, CHF, low birth weight, dehydration, pneumonia, UTI, angina, asthma, amputations	Administrative	No	Collected from inpatient claims but is a community indicator	Yes, hospital claims	Yes	Admissions diagnoses cover all age groups including peds and young adults	Outcome	Unknown
Hospital Outpatient/Emergency Department Measures								
Emergency Department Acute Myocardial Infarction (AMI) and Chest Pain: median time to fibrinolysis, fibrinolytic therapy received within 30 minutes, median time to transfer to another facility, aspirin at arrival, median time to ECG	Administrative + Medical Record	No, but may be available on Hospital Compare HOP QDRP (Hospital Outpatient Quality Data Reporting) in 2010	Hospital Emergency Department	TBD	Yes	All populations with some specific to special populations	Process	Note: The Medicare Outpatient Prospective Payment System (OPPS) requires hospitals to submit data to CMS on measures for the hospital outpatient setting in CY 2008 in order to get their full payment update in CY 2009. The seven (7) outpatient department measures adopted by CMS for data collection beginning in April of 2008 and payment in CY 2009, focus on the following topic areas: Emergency Department (ED) Transfers - Acute Myocardial Infarction (AMI) Care and Surgical Care Infection Prevention (SCIP)

Appendix C
Hospital Measure Set Background

2008 Rural Measures Project: 19 Hospitals participated: 1) Aspirin at Arrival or prior to transfer: Hospitals generally did well: 92.1% giving aspirin according to the guideline 2) Median Time to ECG (target is 10 minutes): range 0 to 220. Only half of the patients (55.5%) received an ECG within 10 minutes. Another 33.6% received the first ECG between 11 minutes and 30 minutes of arrival. 3 and 4) Chest Pain (fibrinolytic therapy given within 30 minutes): For the majority, fibrinolytics are never administered. Ten patients (7.2%) in the study received fibrinolytics. The mean time ranged from 28 to 208 with a median of 68. 5) Median time to transfer (recommendation 90 minutes or less): 75 patients (54.4%) were transferred for acute coronary intervention, 41.3% were transferred for another reason or no documentation of transfer reason. 4.4% were admitted to observation status prior to the transfer. Of the 137 with a documented discharge time, transfer time ranged from 23 minutes to 23 hours. 16.1% had transfer times of 90 minutes or less. Five of the six patients admitted to observation account for the transfer time of 240 minutes or more. None of the five received thrombolytics.

Outpatient Surgery: antibiotic timing and selection

Hospital
Outpatient
Surgeries

TBD

Yes

All populations

Process

Other Emergency Department Measures: ED vital signs, transfer time, arrived by ambulance, discharge status, sepsis and shock, pregnancy test, endotracheal tube placement, anticoagulation for acute pulmonary embolis, pediatric weight and other measures regarding time in the ED

Administrative +
Medical Record

No. Some measures are NQF, some are HQA outpatient and many were used for Flex Monitoring (i.e. rural, Oct '09) and some for Joint Commission

Hospital
Emergency
Department

No

Yes

All populations
with some
specific to
special
populations

Process

Pediatric Measures

Admission Rates: asthma, diabetes complication, gastroenteritis, perforated appendix and UTI

Administrative

No

All hospitals but most are only applicable to Children's Hospitals, unknown if other hospitals have data - some large hospitals not reporting

If reported, yes, through Hospital Compare

Possibly some, but may have low volume

Pediatric

Utilization

Appendix C Hospital Measure Set Background

<p>Outcome Measures: accidental puncture or laceration; decubitus ulcer; foreign body; pneumothorax; heart surgery mortality and volume; post-op hemorrhage, respiratory failure, sepsis and wound dehiscence; select infection rates and transfusion reaction</p>	Administrative + Medical Record	No				Pediatric	Outcome	
<p>Asthma Measures: three measures for asthma in children during inpatient stay (relievers, corticosteroids, admissions) - overall rate and breakdowns by age available</p>	Administrative + Medical Record					Pediatric	Process	
Obstetrical Care Measures								
<p>Prenatal Care Measures: VBAC, Inpatient Neonatal Mortality and Third or Fourth Degree Laceration</p>	Administrative	No, Joint Commission	Inpatient	?	May have low volume	Prenatal	Process and Outcome	
Hospital Acquired Infections								
<p>Measures include central line-associated bloodstream infection (CLABSI), central line insertion practices (CLIP) adherence, ventilator-associated pneumonia (VAP), catheter-associated urinary tract infection (CAUTI), dialysis incident (DI), antimicrobial use and resistance (AUR), surgical site infection (SSI) and post-procedure pneumonia (PPP)</p>	Administrative + Medical Record	Minnesota mandate tied to NQF HAI recommendations	Inpatient	MN Hospital Infection Reporting	Some are rural relevant but many may have low volume	Specific to Certain Surgeries and treatments	Process and Outcome	
30-Day Readmission Measures								
<p>30-Day Readmission for heart failure (HF), pneumonia (PNE) and acute myocardial infarction (AMI)</p>	Medicare claims	Hospital Compare 6/2009	Inpatient	Hospital Compare	Yes	M/C Only	Outcome	<p>1) AMI: 127 hospitals, US Rate = 19.9%, 0 better, 34 no different, 1 worse, 92 too small (fewer than 25 cases). 2) HF: 131 hospitals, US Rate = 24.5%, 3 better, 105 no different, 1 worse, 22 too small. 3) PNE: 131 hospitals, US Rate = 18.2%, 4 better, 117 no different, 1 worse, 10 too small</p>
Patient Experience Measures								
<p>HCAHPS Survey domains include:</p>	Survey	Hospital Compare (required for PPS Hospitals but not CAH)	Inpatient hospital stays	Hospital Compare	Yes, although a measure of hospital outpatient services experience would capture more of the rural patient experience	All populations	Satisfaction	HCAHPS results for MN on Hospital Compare are at or above the nation for all domains.
								Nurses Communication: MN=76% Nation=74%

Appendix C Hospital Measure Set Background

Doctors communicate well with patients
 Patients receive help quickly from hospital staff
 Patients' pain well controlled
 Staff explain about medicines before giving them to patients

Patients' rooms and bathrooms kept clean

Area around patients' rooms quiet at night

Patients given information about what to do during their recovery at home
 Patients rating of hospital
 Patients recommend the hospital to friends and family

Patient experience methodology:

Hospitals must reach a minimum threshold of patient satisfaction to be eligible for payment incentive
 Hospitals will receive payment incentive if a minimum level of patient experience is achieved for one or more patient experience domains
 Hospitals will receive payment incentive based on overall patient experience
 Hospitals will receive payment incentive based on a new composite created for select questions or domains

AHRQ Measures Quality and Patient Safety Indicators: (Note that 12 of these measures were recommended for Public Reporting)

Mortality rates for Medical Conditions: AMI, CHF, stroke, GI hemorrhage, hip fracture and pneumonia

Administrative

AMI, CHF and PNE on Hospital Compare

Inpatient PPS

Many measures only relevant to hospitals that perform certain surgeries. Many may not be relevant for small CAH hospitals.

Various populations

Outcome

Composite Mortality Rate for all Medical Conditions

Mortality rates for Surgical Conditions: esophageal resection, pancreatic resection, AAA repair, CABG, and PTCA, carotid endarterectomy, craniotomy, hip replacement

Administrative

Inpatient PPS

Various populations

Outcome

Composite Mortality Rate for all Surgical

Doctors Communication: MN=80% Nation=80%
 Patients receive help quickly: MN=68% Nation=62%
 Patients' pain well controlled: MN=67% Nation=68%
 Staff explain about medicines before giving them to patients: MN=60% Nation=59%
 Patients' rooms and bathrooms kept clean: MN=74% Nation=69%
 Area around patients' rooms quiet at night: MN=59% Nation=56%
 Patients given information about what to do during their recovery at home: MN=82% Nation=80%
 Patients rating of hospital: MN=67% Nation=64%
 Patients recommend the hospital to friends and family: MN=70% Nation=68%

Appendix C

Hospital Measure Set Background

Conditions

Patient Safety Indicators-Area level: foreign body left in during procedure, iatrogenic pneumothorax, selected infections due to medical care, postoperative wound dehiscence in abdominopelvic surgical patients, accidental puncture and laceration, transfusion reaction, post-operative hemorrhage or hematoma

Administrative

Inpatient PPS

Various populations

Outcome

Patient Safety Indicators-Hospital level: complications of anesthesia, death in low mortality DRGs, decubitus ulcer, failure to rescue, foreign body left in during procedure, iatrogenic pneumothorax, selected infections due to medical care, postoperative hip fracture, postoperative hemorrhage or hematoma, postoperative physiologic and metabolic derangements, postoperative respiratory failure, postoperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, postoperative wound dehiscence in abdominopelvic surgical patients, accidental puncture and laceration, transfusional reaction, birth trauma-injury to neonate, obstetric trauma-vaginal delivery with/without instrument or cesarean delivery

Administrative

Inpatient PPS

Various populations

Outcome

Composite of all Patient Safety Indicators

Procedure Utilization Rates-Hospital level: cesarean section delivery, primary cesarean delivery, vaginal birth after cesarean, VBAC-all, laparoscopic cholecystectomy, incidental appendectomy in the elderly, bi-lateral cardiac catheterization

Administrative

Inpatient PPS

Various populations

Utilization

Utilization Rates-Area level: CABG, PTCA, hysterectomy, laminectomy

Administrative

Inpatient PPS

Various populations

Utilization

Volume of Procedures: esophageal resection, pancreatic resection, abdominal aortic aneurysm repair, coronary artery bypass graft, percutaneous transluminal coronary angioplasty, carotid endarterectomy

Administrative

Inpatient PPS

Various populations

Utilization

Inpatient Surgical Care Measures - Surgical Care Improvement Project (SCIP) Measures: (Note that the individual measures have been recommended public reporting)

SCIP measures include appropriate antibiotic and timing, serum glucose, hair removal, beta blocker and VTE

Administrative + Medical Record

Hospital Compare

SCIP required for PPS by CMS, voluntary for CAH

Hospital Compare

Most are, some smaller hospitals have small numbers. Serum glucose, Beta-blocker and VTE measures less

Collected for all but most relevant for 65+

Process

One year of data available: 1) **SCIP 1,2,3 ACM** currently at 84.8% for Q3 2008: PPS performing better than CAH (85.5% vs. 73.1%) 2) **SCIP VTE ACM** currently at 90.8% for Q3 2008: PPS and CAH performance is relatively the same over the past year with some variation (currently CAH is 88.2% compared to 91.0%) Performance for VTE measures is similar when looked at separately. 3) **SCIP Inf-6** currently at

Appendix C

Hospital Measure Set Background

relevant to CAH

94.4% for Q3 2008: CAH performing better than PPS (97.9% compared to 94.2%) AHRQ report shows MN is above average for antibiotic timing measure. AHRQ report estimate for the nation in 2006 (for timing only) is 80.9%.

Proposed SCIP Measure Methodology

Appropriate Care Measure (ACM): All or none 3 antibiotic measures

Composite: Average 3 antibiotic measures

Composite: Average 3 antibiotic measures + hair removal

Composite: Average 2 VTE measures

Pneumonia Measures: (Note that the individual measures have been recommended public reporting, and the ACM measure for payment incentive)

Set Includes inpatient measures for pneumonia and influenza vaccinations, cultures, smoking cessation and antibiotic timing

Administrative + Medical Record

Most are reported on Hospital Compare. PNE ACM is reported on MN Hospital Compare

PNE required for PPS by CMS, voluntary for CAH

Hospital Compare + ACM reported for consenting hospitals on MN Hospital Quality Report

Most measures are, some smaller hospitals have small numbers

Collected for all but most relevant for 65+

Process

Pneumonia ACM currently 83.1% for MN for Q3 2008. Performance for MN has been improving since 2004. PPS hospitals performing better than CAH (83.1% compared to 70.2%).

AMI Measures: (Note that the individual measures have been recommended public reporting, and the ACM measure for payment incentive)

Set Includes inpatient measures for AMI patients including aspirin, ACEI/ARBs, Beta-Blockers, smoking cessation, Fibrinolysis, PCI

Administrative + Medical Record

Most are reported on Hospital Compare. AMI ACM is reported on MN Hospital Compare

AMI required for PPS by CMS, voluntary for CAH

Hospital Compare + ACM reported for consenting hospitals on MN Hospital Quality Report

Most measures are, some smaller hospitals have small numbers

Collected for all but most relevant for 65+

Process

AMI ACM currently 95.5% for MN for Q3 2008. Performance relatively stable since 2004 with a slight increase. CAH hospitals have more variation and are performing worse than PPS (70.2% compared to 83.1%). AHRQ report estimate for nation in 2006 is 95.2%

Heart Failure Measures: (Note that the individual measures have been recommended public reporting, and the ACM measure for payment incentive)

Appendix C Hospital Measure Set Background

Set includes inpatient measures for HF patients including discharge instructions, evaluation of LVS function, ACEI/ARB and smoking cessation	Administrative + Medical Record	Most are reported on Hospital Compare. HF ACM is reported on MN Hospital Compare	HF measures are required for PPS by CMS, voluntary for CAH	Hospital Compare + ACM reported for consenting hospitals on MN Hospital Quality Report	Most measures are, some smaller hospitals have small numbers	Collected for all but most relevant for 65+	Process	HF ACM currently 84.5% for MN for Q3 2008. Performance for MN has been improving since 2004. PPS hospitals performing much better than CAH (84.5% vs. 59.0%). AHRQ report shows MN is average for HF patients receiving the recommended care. AHRQ report estimate for nation in 2006 is 89.2%
Mortality Measures								
Mortality Rates for HF, PNE and AMI	Medicare claims	Hospital Compare	Inpatient	Hospital Compare	Yes, but smaller hospitals may have small numbers	Medicare claims so Medicare population only	Outcome	1) AMI: 126 hospitals, US Rate = 16.6%, 5 better, 41 no different, 0 worse, 80 too small (fewer than 25 cases). 2) HF: 131 hospitals, US Rate = 11.1%, 5 better, 101 no different, 1 worse, 24 too small. 3) PNE: 131 hospitals, US Rate = 18.2%, 0 better, 120 no different, 1 worse, 10 too small

Appendix D
Relevant Terms

Term	Definition
ACM	Appropriate Care Measure, an all-or-none measure
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction, sometimes referred to as a heart attack
CAH	Critical Access Hospital, frequently a small or rural hospital
CMS	Centers for Medicare & Medicaid Services
ED/ER	Emergency Department/Emergency Room
HAI	Hospital Acquired Infection
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems, patient experience of care survey
JAMA	Journal of the American Medical Association
LOS	Length of Stay
MDH	Minnesota Department of Health
MHA	Minnesota Hospital Association
MNCM	Minnesota Community Measurement
PPS	Prospective Payment System, frequently larger, metropolitan hospitals
SCIP	Surgical Care Improvement Project
SIP	Surgical Infection Prevention
VTE	Venous Thromboembolism
HF	Heart Failure
PN	Pneumonia