2015 Hospital Measures

Vicki Tang Olson, Stratis Health
David Hesse, Minnesota Department of Health

Statewide Quality Reporting and Measurement System (SQRMS) Annual Update
January 14, 2015
Objectives

• Review quality measurement statutory requirements and development of the Statewide Quality Reporting and Measurement System

• Describe 2015 changes to the hospital measures and deadlines for quality data reporting

• Understand the hospital quality measures recommendation process
Agenda

12:00 Welcome and introductions
12:05 Overview of the Statewide Quality Reporting and Measurement System
12:15 Hospital Measures recommendations process and changes in the hospital slate of measures for 2015
12:30 Q & A, future measures under consideration
Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

January 14, 2015

David Hesse, Planner Principal
Quality Reform Implementation Unit
Health Economics Program
Overview

• State health reform
• Objectives and goals
• Annual measures update
• Use of data
• Resources
Context for State Health Reform

• High quality in Minnesota relative to other states
• Wide variation in costs and quality across different health care providers, with no evidence that higher cost or higher use of services is associated with better quality or better health outcomes for patients
• Health care costs are rising, placing greater share of health care costs on consumers
• What tools do consumers have to choose how to spend their health care dollars?
Health Care Growth Exceeds Growth in Income and Wages

Cumulative Percent Change in Key Minnesota Health Care Costs and Economic Indicators

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

Source: MDH analysis of annual health plan reports.
Statutory Requirements: Minnesota’s 2008 Health Reform Law

- Statewide Quality Reporting and Measurement System, Minnesota Statutes 62U.02
  - Establish standards for measuring quality of health care services offered by health care providers, and a standardized set of measures
  - Establish a system for risk adjusting quality measures
  - Physician clinics and hospitals are required to report
  - Health plans use the standardized measure set
  - Issue annual public reports on provider quality
Objectives and Goals

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

• SQRMS is a critical aspect of heath care reform
  – Measures inform patients of the value of provider care in Minnesota
  – They are a component of assessing overall value for the first time

• SQRMS processes are intentional and transparent
  – Community input and engagement informs MDH’s development of quality measurement and reporting for the state of MN

• SQRMS is an evolving process
  – Quality measurement and reporting continually evolves based on changes in measurement science, community buy-in and community priorities
Partnership

- MDH conducted two competitive procurements in the fall of 2008 and again in 2013, and subsequently entered into contracts with MN Community Measurement (MNCM).

- Currently, MDH has a 21-month, $1.5 million contract with MNCM as lead member of consortium that includes Stratis Health and the Minnesota Hospital Association (MHA) to carry out key activities.
## MDH, Stratis Health & MHA Roles and Responsibilities

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| • Annually promulgates rules that define the uniform set of measures  
• Obtains input from the public at multiple steps of rulemaking  
• Publicly reports summary data  
• Develops vision for further evolution of SQRMS | • Develops recommendations for the uniform set of quality measures for the State’s consideration  
• Facilitates the Hospital Quality Reporting Steering Committee and subcommittees  
• Develops and implements educational activities and resources | • Facilitates data collection from hospitals and data management  
• Develops recommendations for the Quality Incentive Payment System for the State’s consideration |
Historical Timeline

• December 2009
  – First set of administrative rules established SQRMS

• January 2010
  – Data collection for publicly reported quality measures began
  – Health plans no longer permitted to require data submission on measures outside the standardized set

• November 2010
  – MDH issued its first public report with data on the standardized measures to be publicly reported
  – First update to administrative rules

  – Annual updates to administrative rules
1. MDH invites interested stakeholders to submit recommendations on the addition, removal, or modification of standardized quality measures to MDH by June 1
2. MDH receives preliminary recommendations from Stratis Health mid-April; MDH opens public comment periods
3. MDH receives final recommendations from Stratis Health by June 1; MDH opens public comment period
4. Measure recommendations are presented at a public forum toward the end of June
5. MDH publishes a new proposed rule, typically by mid-August with a 30-day public comment period
6. Final rule adopted by the end of the year
Reporting Requirements

Minnesota Statewide Quality Reporting and Measurement System:
Appendices to Minnesota Administrative Rules, Chapter 4654

Minnesota Department of Health

December 2014
Quality Measure Changes

• Emergency Department Transfer Communication composite measure – NEW, aligns with Medicare Beneficiary Quality Improvement Project (MBQIP)

• Stroke Door to Imaging Performed Time – Revised measure name to Door to Imaging Initiated Time

• Removal of 11 measures to align with Centers for Medicare & Medicaid Services’ (CMS) Hospital Inpatient and Outpatient Quality Reporting Programs
Percent of Patients Who Reported That Staff “Always” Explained About Medicines Before Giving It to Them, 2009-2013

Service year: January 1 through December 31.
Source: MDH Health Economics Program analysis of SQRMS data, HCAHPS Survey
Percent of Health Care Consumers Who Feel Like They Were Treated as a Whole Person

Health Care Consumers Ratings of Hospital Care

- **Nurse-Patient Communication**: 80%
- **Doctor-Patient Communication**: 83%
- **Receiving Help When Wanted**: 73%
- **Patient’s Overall Rating of Hospital**: 73%

Source: MDH Health Economics Program analysis of SQRMS data. HCAHPS Survey for discharge dates 01/01/2013-12/31/2013. **Nurse-Patient Communication**: Percent of patients who reported “always” to a question about how often nurses explained things clearly, listened carefully to the patient, and treated the patient with courtesy and respect. **Doctor-Patient Communication**: Percent of patients who reported “always” to a question about how often doctors explained things clearly, listened carefully to the patient, and treated the patient with courtesy and respect. **Receiving Help When Wanted**: Percent of patients who reported “always” to a question about how often they were helped quickly when they used the call button or needed help in getting to the bathroom or using a bedpan. **Patient’s Overall Rating of Hospital**: Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
Alignment

**State**
- Office of Health Information Technology
- Minnesota Stroke Registry
- Quality Incentive Payment System
- Accountable Communities for Health
- DHS Integrated Health Partnerships Demonstration

**Federal**
- Centers for Medicare & Medicaid Services (CMS)
  - Hospital Inpatient and Outpatient Quality Reporting Programs
  - Hospital Readmission Reduction Program (RRP)
  - Hospital Value-Based Purchasing (VBP)
  - Hospital Acquired Conditions (HAC) Reduction Program
- The National Healthcare Safety Network (NHSN)
- Health Information Technology Meaningful Use
Resources

• Subscribe to MDH’s Health Reform ListServ to receive updates: [www.health.state.mn.us/healthreform/announce/index.html](http://www.health.state.mn.us/healthreform/announce/index.html)

• SQRMS website: [www.health.state.mn.us/healthreform/measurement/index.html](http://www.health.state.mn.us/healthreform/measurement/index.html)

• Stratis Health: [www.stratishealth.org/index.html](http://www.stratishealth.org/index.html)

• Minnesota Hospital Association (MHA): [www.mnhospitals.org](http://www.mnhospitals.org)

• Minnesota Hospital Quality Reports: [www.mnhospitalquality.org](http://www.mnhospitalquality.org)

• Minnesota HealthScores: [www.mnhealthscores.org](http://www.mnhealthscores.org)

• For questions about SQRMS, contact:
  – Denise McCabe, Supervisor Quality Reform Implementation Unit [Denise.McCabe@state.mn.us](mailto:Denise.McCabe@state.mn.us), 651.201.3569
  – David Hesse, Planner Principal [David.Hesse@state.mn.us](mailto:David.Hesse@state.mn.us), 651.201.3556
2015 Hospital Measures Recommendation Process
Recommendations Process

- Aid consumers, employers and other health care purchasers in decision-making
- Use measurement criteria to recommend measures for public reporting and improvement
- Preference for outcome, patient reported outcome or functional status, and electronic measures
Recommendations Process

- **MDH focus**
- **Identify potential measures**
- **Convene team**
- **Team discussion**
- **Request feedback from expert groups**
- **Final Slate of Measures**

Compiled suggestions from previous discussions but did not consider for this year since there was not adequate time to prioritize and solicit feedback from expert groups.
Recommendations Process

- MDH focus
- Identify potential measures
- Convene team
- Request feedback from expert groups
- Team discussion
- Final Slate of Measures

Added roles:
- Hospitalist
- Minnesota Alliance for Patient Safety (MAPS) leadership
- Consumer
- Employer
- Health plan
- MD
- Nursing
- Pharmacy
- Rural
- Hospital Systems
- Pt Safety/Risk Management
Recommendations Process

Only feedback was: questioning value of collecting low volume measures for critical access hospitals
Recommendations Process

1. Discussed feedback on measures with low volume.
2. Voted on proposal to remove AMI 7a and AMI 8a for CAH
Recommendations Process

Additions/Removals/Modifications

1. MDH focus
2. Identify potential measures
3. Convene team
4. Request feedback from expert groups
5. Team discussion
6. Final Slate of Measures
Process after Recommendations

- Final Recommendations
- Public Forum
- Formal Comment Period
- Final Rule
2015 Hospital Slate of Measure Changes
Measures Changed to Voluntary

CAH only

• **AMI 7a** Fibrinolytic therapy received within 30 minutes of hospital arrival
Measures Removed

- **AMI-8a** Timing of Receipt of Primary Percutaneous Coronary Intervention
- **HF-2** Evaluation of LVS Function
- **PN-6** Initial Antibiotic Selection for CAP in Immunocompetent Patient
Measures Removed - SCIP

- **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
Measures Removed - SCIP

• **SCIP-Inf-9** Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being 0
Measures Removed - SCIP

• **SCIP-Card-2** Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker during the Perioperative Period

• **SCIP-VTE-2** Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours after Surgery
Measures Removed - Outpatient

- **OP-6** Timing of Antibiotic Prophylaxis
- **OP-7** Prophylactic Antibiotic Selection for Surgical Patients
Measures Added

• CAH only (CCN numbers beginning in 241xxx)
  – **All or none** composite of ED Transfer Communication 7 sub measures

• PPS hospitals (CCN numbers beginning in 240xxx)
  – None
2016 Hospital Measures Process
Changes to Process

- Steering committee will convene throughout the year and will consider feedback from expert groups.
- Preliminary slate of measures will be developed by April 15 each year to match the clinic measures recommendation process.
Recommendations Process

1. MDH focus
2. Identify potential measures
3. Convene team
4. Request feedback from expert groups
5. Team discussion
6. Preliminary slate of measures
7. Added step
8. Final slate of measures

Enhanced step

Enhanced step

Enhanced step
Topic areas for potential new/added measures

• Patient Safety
• Readmissions
• Mental/Behavioral Health
• End of Life
• Cost/Spending
• Federal alignment – CMS and HRSA
Questions?

Vicki Olson, Program Manager
952-853-8554 or 877-787-2847
volson@stratishealth.org

www.stratishealth.org
Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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