Objectives

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

• Describe 2014 changes to the hospital measures and deadlines for quality data reporting
Objectives

- Understand the hospital quality measures recommendation process
- Understand the specifications for the new stroke measures
- Discuss options for data collection and submission of stroke measures
Minnesota Statewide Quality Reporting and Measurement System (SQRMS)

January 8, 2014

Denise McCabe
Quality Reform Implementation Supervisor
Overview

• State health reform
• Objectives and goals
• Annual measures update
• 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

Source: MDH analysis of annual health plan reports.
Quality Measures: Statutory Requirements

• Minnesota Statutes, § 62U.02, Subd. 1 and 3

• The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers...

• The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and 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
Annual Update of Quality Reporting 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 contractors and subcontractors mid-April; MDH opens public comment periods
3. MDH receives final recommendations 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 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
November 2013
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

• November 2011, 2012, 2013
  – Annual updates to administrative rules
Health Care Quality Measures

Minnesota’s 2008 Health Reform Law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state. The goal is to create a uniform approach to quality measurement in order to enhance market transparency. The Minnesota Department of Health seeks to build on community standards and input in developing the measures.

After January 1, 2010, health plans may not require providers to submit data on any measure outside this standardized set. Physician clinics and hospitals must begin to submit data on those measures to be publicly reported starting January 1, 2010.

The quality measures must be based on medical evidence, must be developed through a process in which health care providers participate, and must be reviewed on at least an annual basis. In addition, the measures must:
Resources

• Subscribe to MDH’s Health Reform ListServ to receive weekly email updates
  – http://www.health.state.mn.us/healthreform/announce/index.html

• SQRMS website
  – http://www.health.state.mn.us/healthreform/measurement/index.html

• For questions about SQRMS, contact:
  – Denise McCabe, Denise.McCabe@state.mn.us, 651.201.3569
  – David Hesse, David.Hesse@state.mn.us, 651.201.3556
2013 Hospital Measures Recommendation Process
Recommendations Process

1. MDH focus
2. Identify potential measures
3. Convene team
4. Team rate measures
5. Request feedback from expert groups
6. Additional analysis of AHRQ measures
7. Final Slate of Measures
8. Team discussion

[Diagram showing the flow of the process]
Recommendations Process

1. Future measures previously identified in past years were shared with steering committee.

2. Steering committee brainstormed additional areas for feedback.

3. Steering committee approved expert group input process.

- MDH focus
- Identify potential measures
- Convene team
- Final Slate of Measures
- Team discussion

Request feedback from expert groups
Hospital Quality Reporting Structure
With Clinical Expert Groups

Input

MDH Groups
- Stroke Registry Advisory Committee
- Heart Disease and Stroke Prevention Committee
- Adverse Events Committee
- MN Trauma Advisory Council

MHA Groups
- Perinatal Advisory Committee
- Neonatal Group
- Pediatric Group
- Falls Advisory
- Pressure Ulcer Advisory
- Infection Advisory
- Small Rural Advisory

Stratis Health Groups
- QuRI Steering Committee
- Core Measures Group
- NHSN Users Group
- RARE Readmissions Committee

Request
Recommendations Process

1. NQF endorsed
2. CMS required measure
3. AHRQ determination of suitability for comparison reporting
4. Number of hospitals impacted
5. Patient volume
6. Additional considerations
2014 Hospital Measures
2014 Added Measures

- PC-1 - Elective delivery prior to 39 completed weeks gestation
  - July 1, 2013 discharges for PPS hospitals
  - Jan 1, 2014 discharges for CAH hospitals

- Time to intravenous thrombolytic therapy for stroke patients
  - Jan 1, 2014 discharges
2014 Measure Removed
July 1, 2013 Discharges

Removed May 2013 by technical bulletin:

• SCIP-VTE-1 Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered

• OP-16 Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients
2014 Measures Removed

• Children’s Asthma Care (CAC-3 Home Management Plan of Care document given to patient/caregiver)
  – July 1, 2014 discharges
2014 Measures Removed to Align with CMS Changes

- AMI-2 Aspirin prescribed at discharge
- AMI-10 Statin prescribed at discharge
- HF-1 Discharge instructions
- HF-3 ACEI or ARB for LVSD
- PN-3b Blood culture performed in ED prior to initial antibiotic
- SCIP-Inf-10 Surgery patients with perioperative temperature management
- IMM-1 Pneumococcal Immunization
2014 Measures Removed

• Appropriate Care Measures (ACM)
  – Acute myocardial infarction
  – Heart Failure
  – Pneumonia
AHRQ Measures to Remove

- PSI 3 Pressure ulcer
- PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis (DVT)
- IQI 4 Abdominal aortic aneurysm (AAA) repair volume
- IQI 5 Coronary artery bypass graft (CABG) volume
- IQI 6 Percutaneous transluminal coronary angioplasty (PTCA) volume
- IQI 11 Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)
- IQI 12 Coronary artery bypass graft (CABG) mortality rate
- IQI 19 Hip fracture mortality rate
- IQI 30 Percutaneous transluminal coronary angioplasty (PTCA) mortality rate
2014 Change to Voluntary Data Collection for CAH

- Inpatient Emergency Department Throughput (ED1a through 2c)
2014 Specification Changes

- Emergency Department Transfer Communication:
  - Increase scope to include all transfers
  - Put sampling plan in place to reduce data burden
  - Changed specifications format to align with CMS
  - Offer excel tool to facilitate data collection/calculation
  - Will review specs/excel tool at CAH core measure meeting on January 29, 2014.
Future Discussion

• Stroke
• VTE
• Readmissions
• Behavioral/mental health
• Nurse sensitive conditions
• Safety culture/patient safety measures
• Infections
Resources

• SQRMS Timeline
  http://www.stratishealth.org/documents/2014_SQRMS_timeline.docx

• 2014 Hospital Measures Summary
Resources

• Data Collection Guide for ED Transfer Communication Measures
Questions?

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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.
TIME TO IV THROMBOLYTIC THERAPY

Minnesota Statewide Quality Reporting and Measurement System
2013-2014 Emergency Stroke Measures
Stroke Measures

- Required for discharges July 1, 2013 (Q3 2013) through June 30, 2014 (Q2 2014)

- Door to Imaging <25 min (same as in 2012-2013)
- NEW: Time to IV Thrombolytic Therapy
  - Time to IV tPA
  - Door-to-Needle

- NIHSS at evaluation: dropped in 2011-2012
Time to IV tPA: Goal

- Door to Needle < 60 minutes
  - American Heart Association Target: Stroke
  - Recommendation from Brain Attack Coalition
  - Goal for Minnesota Stroke System
    - Will be used for monitoring system success
- Will be reported as a percentage (%<60 minutes)
Inclusions: Time to IV tPA

- Ischemic stroke, TIA or Stroke Not Otherwise Specified
- OR
- ICD-9 discharge from Table 1

AND

- Received IV tPA at your hospital
Exclusions: Time to IV tPA

- Age <18
- Admitted solely for elective carotid endarterectomy
- Enrolled in clinical trial related to stroke
- In-hospital stroke
- Date or time of arrival missing or unknown
- Date or time last known well missing or unknown
- Date or time of tPA administration missing or unknown
- Received tPA > 4.5 hours after last known well
- Documented eligibility or medical reason for a delay in treatment (more than 60 minutes after arrival)
Additional Exclusions from Door-to-Imaging <25 minutes:

- Expire in ED
- Received comfort care while in ED
- Last known well >3.5 hours to arrival time
- Symptoms resolved
- Transferred to your facility
Data Submission

• Log into the Minnesota Stroke Registry Tool at
  https://www.health.state.mn.us/divs/hpcd/mnstrokeregistry/login.cfm

• New address, Coming Soon: http://stroke.mn.gov/
  (“Minnesota Stroke Central”)
Welcome!
If you are looking to do any of the following, you're in the right place:

- Submit data for the Minnesota Stroke Registry Program ("Coverdell")
- Submit stroke measures for the Minnesota Statewide Quality Reporting and Measurement System (SQRMS)
- Submit an application to be designated as a stroke hospital in the Minnesota Stroke System

Account Login Help: health.stroke@state.mn.us or (651) 201-5477
Data Submission

• MSRT (MSR-Coverdell, MSR-ESC) or Patient Management Tool (GWTG-Stroke): No change

• MSRT-Quality: Added three data elements:
  • Was IV tPA initiated at this hospital?
  • Date/time IV tPA was administered
  • If Door-to-Needle>60 minutes, were eligibility or medical reasons documented as cause for delay?
<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Identifier</td>
<td>54234</td>
</tr>
<tr>
<td>Arrival Date/Time</td>
<td>Date 12/11/2013, Time 11:11</td>
</tr>
<tr>
<td>Discharge / Transfer Date</td>
<td>Date 12/18/2013</td>
</tr>
<tr>
<td>Principal ICD-9</td>
<td></td>
</tr>
<tr>
<td>Clinical diagnosis</td>
<td>□ Intracerebral hemorrhage</td>
</tr>
<tr>
<td></td>
<td>□ Subarachnoid hemorrhage</td>
</tr>
<tr>
<td></td>
<td>□ Ischemic stroke</td>
</tr>
<tr>
<td></td>
<td>□ Transient ischemic attack</td>
</tr>
<tr>
<td></td>
<td>□ Stroke not otherwise specified</td>
</tr>
<tr>
<td></td>
<td>□ No stroke related diagnosis</td>
</tr>
<tr>
<td>Age/Gender</td>
<td>Age 77, Gender: Male</td>
</tr>
<tr>
<td>Last known well</td>
<td>Date: Unknown / ND / UTD</td>
</tr>
<tr>
<td></td>
<td>Time: Unknown / ND / UTD</td>
</tr>
<tr>
<td>Brain imaging performed</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td>Imaging Date:</td>
</tr>
<tr>
<td></td>
<td>Imaging Time:</td>
</tr>
<tr>
<td>IV-tPA Initiated at this hospital</td>
<td>Administered Date:</td>
</tr>
<tr>
<td></td>
<td>Administered Time:</td>
</tr>
<tr>
<td>If Door-to-Needle &gt; 60 min, were eligibility or medical reasons documented as cause for delay?</td>
<td>□ Yes, □ No</td>
</tr>
</tbody>
</table>
Data Submission (2)

- MSRT-Summary: Data fields (numerator and denominator) added
  - “DTN (N)” = Door-to-Needle (Numerator)
  - “DTN (D)” = Door-to-Needle (Denominator)
## MSRT-SUMMARY

### Summary Period

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>Dates</th>
<th>Numerator</th>
<th>Denominator</th>
<th>%</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>3</td>
<td>2013 Q3 (July 1 - Sept 30)</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Door-to-Imaging Performed Time (% imaged in 25 minutes or less)

- **Discharge Dates**: Quarter 3, 2013: 7/1-9/30
- **Numerator**: 2
- **Denominator**: 2
- **%**: 100
- **Submission Deadline**: February 15, 2014

### Time to IV Thrombolytic Therapy (% received IV tPA<60 minutes)

- **Discharge Dates**: Quarter 3, 2013: 7/1-9/30
- **Numerator**: 1
- **Denominator**: 2
- **%**: 50
- **Submission Deadline**: February 15, 2014

**Hospitals are required to submit data on “NIHSS Performed in Initial Evaluation” through Q2 2012. Beginning with Q3 2012, data on “NIHSS Performed in Initial Evaluation” are no longer required to be reported.**

### NIHSS Performed in Initial Evaluation

- **Discharge Dates**: Quarter 3, 2013: 7/1-9/30
- **Numerator**: 
- **Denominator**: 
- **%**: n/a
- **Submission Deadline**: February 15, 2014

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[Save] [Reset]
Questions?

- Download the data submission guide from the Resources section in the MSRT

- Albert W. Tsai, PhD, MPH
  Minnesota Department of Health
  (651) 201-5413
  albert.tsai@state.mn.us

- Web Application (MSRT) Problems:
  health.stroke@state.mn.us