Minnesota Statewide Quality Reporting and Measurement System

Annual Public Forum
June 29, 2016

Denise McCabe
Quality Reform Implementation Supervisor
Overview

- Context and background
- Measure set update steps, timeline, and opportunities for input
- Measure results
- Health equity and legislative requirements
- Resources
Background

- Minnesota clinics, hospitals and health plans have a rich history of health care quality measurement

Prior to 2005
- Health insurers used quality measures to assess provider performance
- Measurement was burdensome and inconsistent

2005
- MN Community Measurement established
- Better coordinate quality measurement activities, develop new measures with community support, and publicly report results

2008
- MN Health Reform Law

MDH Minnesota Department of Health
Minnesota’s 2008 Health Reform Law and Quality Measurement

- Establish **standards** for measuring quality of health care services offered by health care providers
- Establish a system for **risk adjusting** quality measures
- **Physician clinics** and **hospitals** are required to report
- **Health plans** may use the standardized measures; may **not** require reporting on measures outside the official set

Minnesota Statutes 62U.02
## Organizational Roles

<table>
<thead>
<tr>
<th>MDH</th>
<th>MN Community Measurement</th>
<th>Stratis Health</th>
<th>Minnesota Hospital Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Annually updates the Quality Rule that defines the measure set</td>
<td>• Facilitates data collection and validation with physician clinics and data management</td>
<td>• Develops recommendations for the uniform set of quality measures for MDH’s consideration</td>
<td>• Facilitates data collection from hospitals and data management</td>
</tr>
<tr>
<td>• Obtains input from the public at multiple stages of rulemaking</td>
<td>• Submits collected data to MDH</td>
<td>• Facilitates the Hospital Quality Reporting Steering Committee and subcommittees</td>
<td>• Submits data collected to MDH</td>
</tr>
<tr>
<td>• Publicly reports summary data</td>
<td>• Works with groups of stakeholders to review and maintain measures</td>
<td>• Develops and implements educational activities and resources</td>
<td></td>
</tr>
<tr>
<td>• Develops vision for further evolution of the Quality Reporting System</td>
<td>• Develops and implements educational activities and resources</td>
<td>• Supports the Health Care Homes Benchmarking Portal</td>
<td></td>
</tr>
</tbody>
</table>

**MDH**

**Minnesota Department of Health**
Rulemaking and Opportunities for Stakeholder Input

1. MDH invites interested stakeholders to submit recommendations for standardized measures to MDH, and to comment on Stratis Health’s hospital measure recommendations through July 5.

2. MDH is holding a public forum today to present measure recommendations, and take questions and comments.

3. MDH will publish a proposed rule by mid-August or September with a 30-day public comment period.

4. MDH adopts the final rule by the end of the year.
Quality Rule Appendices

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

Minnesota Department of Health

December 2015
Alignment

State

Health Care Homes
Integrated Health Partnerships Demonstration
Quality Incentive Payment System
Accountable Communities for Health
Office of Health Information Technology
Community Wellness Grant
Minnesota Stroke Registry
Minnesota Asthma Program
Health Promotion & Chronic Disease programs

Federal

Hospital Inpatient and Outpatient Quality Reporting Programs
Hospital Value-Based Purchasing
Hospital-Acquired Condition Reduction Program
Medicare Beneficiary Quality Improvement Project (MBQIP)
Meaningful Use
Physician Quality Reporting System (PQRS)
# 2016 Clinic Quality Measures

<table>
<thead>
<tr>
<th>Cycle A</th>
<th>Cycle B</th>
<th>Cycle C</th>
<th>Other Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal Diabetes Care*</td>
<td>Pediatric Preventive Care</td>
<td>Optimal Asthma Control*</td>
<td>Health Information Technology (HIT) Survey</td>
</tr>
<tr>
<td>Optimal Vascular Care*</td>
<td>Adolescent Mental Health and/or Depression Screening*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Remission at Six Months*</td>
<td>Overweight Counseling</td>
<td>Asthma Education and Self-Management*</td>
<td>Patient Experience of Care Survey* (every-other year)</td>
</tr>
<tr>
<td></td>
<td>Total Knee Replacement</td>
<td>Colorectal Cancer Screening*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spinal Surgery</td>
<td>C-section Rate</td>
<td></td>
</tr>
</tbody>
</table>

*Quality measures used for Health Care Homes (HCH) benchmarking
Mental Health Screening and Results for Adolescents Age 12-17 who had a Well-Child Visit in 2014

- 65,700 patients, or 60% not screened
- 43,300 patients, or 40% screened

10% Showed signs of a mental health condition
90% No signs of a mental health condition

Service dates: January 1 through December 31.
Total Knee Replacement & Spinal Surgeries, 2013

- **Total Knee Replacement (primary)**: 5,437 patients, 1,957 with pre and post functional status scores.
- **Spinal Surgery: Lumbar Fusion**: 761 patients, 940 without pre and post functional status scores.
- **Spinal Surgery: Lumbar Discectomy/Laminotomy**: 569 patients, 1,001 without pre and post functional status scores.

Procedure dates: January 1 through December 31.

MDH Department of Health
Child Asthma Component Measures 2012-2014

Service year: July 1 through June 30.
PPS Hospital Readmissions Reduction Program Composite

Composite measure includes individual 30-day readmissions measures for: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and elective total hip and total knee arthroplasty.

Discharge dates: July 1, 2011 through June 30, 2014.


- Higher than 1.0 equals more readmissions than expected
- Lower than 1.0 equals fewer readmissions than expected
Health Equity

“...the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available.” Minn. Stat. 62U.02

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Dates of Service</th>
<th>Data Submission Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Optimal Asthma Control – Adult</td>
<td>07/01/2016 – 06/30/2017</td>
<td>07/01/2017 – 08/15/2017</td>
</tr>
<tr>
<td>2. Optimal Asthma Control – Child</td>
<td></td>
<td>NEXT YEAR</td>
</tr>
<tr>
<td>3. Colorectal Cancer Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Optimal Diabetes Care</td>
<td>01/01/2017 – 12/31/2017</td>
<td>01/01/2018 – 02/15/2018</td>
</tr>
<tr>
<td>5. Optimal Vascular Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Stratification Example

- Stratification enables the identification of health care disparities for different patient groups based on some characteristic.
- MDH can better meet community needs by designing more targeted interventions.
- Communities impacted by health disparities can use data to address disparities.

Vascular Rates by ZIP Code

Source: MDH Health Economics Program analysis of Quality Reporting System data.
Update

Statewide Quality Reporting and Measurement System Risk Adjustment Assessment

MDH has been directed by the Legislature to assess the Quality Reporting System risk adjustment methodology to identify changes that may be needed to alleviate potential harm and unintended consequences of the existing methodology for patient populations who experience health disparities and the providers who serve them.
Submitting Comments

- MDH invites interested stakeholders to:
  - Submit recommendations on the addition, removal, or modification of standardized quality measures for 2017 reporting; and
  - Review and comment on the Hospital Quality Reporting Steering Committee's measure recommendations for 2017 reporting.

- Interested persons or groups must submit recommendations, comments, and questions **by July 5** to:
  - Denise McCabe, Minnesota Department of Health
    - P.O. Box 64882, St. Paul, MN 55164-0882
    - (651) 201-5530; fax: (651) 201-201-5179
    - health.reform@state.mn.us
## Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Statewide Quality Reporting and Measurement System</td>
<td><a href="http://www.health.state.mn.us/healthreform/measurement">www.health.state.mn.us/healthreform/measurement</a></td>
</tr>
<tr>
<td>Subscribe to MDH’s Health Reform list-serv to receive updates</td>
<td><a href="http://www.health.state.mn.us/healthreform">www.health.state.mn.us/healthreform</a></td>
</tr>
<tr>
<td>Submit comments during our open comment period through July 5</td>
<td><a href="http://www.health.state.mn.us/healthreform/measurement/recommendations">www.health.state.mn.us/healthreform/measurement/recommendations</a></td>
</tr>
</tbody>
</table>
Contact Information

- For questions about the Statewide Quality Reporting and Measurement System, contact:

  Denise McCabe
  Quality Reform Implementation Supervisor
  Denise.McCabe@state.mn.us
  651.201.3569
Hospital Measure Recommendations
Vicki Tang Olson, Stratis Health

2017 Statewide Quality Reporting and Measurement System (SQRMS)
June 29, 2016
Objectives

• Share the process used for 2017 hospital measures recommendations
• Review recommended changes to the 2017 hospital slate of measures
2016 Hospital Measures Recommendation Process
Recommendations Process

- **MDH focus**
- Review VBP, RRP, HAC, MBQIP changes
- Identify other potential measures
- Convene team
- Team discussion
- Final Slate of Measures
2017 Hospital Recommended Slate of Measures
Hospital Slate of Measures

- Readmission Reduction (RRP) Program
- Value- Based Purchasing (VBP) Program
- Hospital Acquired Condition (HAC) Program
- Medicare Beneficiary Quality Improvement Program (MBQIP)
- CAH Hospitals
- Additional Measures for MN
PPS Measures
Alignment with VBP, RRP and HAC programs
Value-Based Purchasing

• FY2017
  o Total Performance Score
  o Unweighted and weighted domain score for clinical process of care, patient experience of care, outcome and efficiency
  o Measure scores
FY2017 VBP Fact Sheet
Hospital Acquired Conditions Program Score

• FY2017
  ➢ Total HAC score
  ➢ Domain 1 score
  ➢ Domain 2 score
  ➢ Measure scores
FY 2017 HAC Reduction Program Domain Weighting and Measures
(Payment adjustment effective for discharges from October 1, 2016 - September 30, 2017)

Domain 1 (AHRQ Patient Safety Indicators) 15%

Domain 2 (CDC NHSN Measures) 85%

**DOMAIN 1**

<table>
<thead>
<tr>
<th>AHRQ* PSI 90 Measure</th>
<th>Score 1-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI 3 Pressure ulcer rate</td>
<td></td>
</tr>
<tr>
<td>PSI 6 Inpatient pneumonia rate</td>
<td></td>
</tr>
<tr>
<td>PSI 7 Central venous catheter-related bloodstream infection rate</td>
<td></td>
</tr>
<tr>
<td>PSI 8 Postoperative hip fracture rate</td>
<td></td>
</tr>
<tr>
<td>PSI 12 Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)</td>
<td></td>
</tr>
<tr>
<td>PSI 13 Postoperative sepsis rate</td>
<td></td>
</tr>
<tr>
<td>PSI 14 Wound dehiscence rate</td>
<td></td>
</tr>
<tr>
<td>PSI 15 Accidental puncture and laceration rate</td>
<td></td>
</tr>
</tbody>
</table>

*The Agency for Healthcare Research and Quality

**DOMAIN 2**

<table>
<thead>
<tr>
<th>CDC NHSN* Measure</th>
<th>Average Score 1-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI SIR rate</td>
<td>1-10</td>
</tr>
<tr>
<td>CAUTI SIR rate</td>
<td>1-10</td>
</tr>
<tr>
<td>SSI Color Abdominal Hysterectomy</td>
<td>1-10</td>
</tr>
<tr>
<td>MRSA</td>
<td>1-10</td>
</tr>
<tr>
<td>CDI</td>
<td>1-10</td>
</tr>
</tbody>
</table>

*Centers for Disease Control and Prevention National Healthcare Safety Network

New standard population data will not be used until FY2018.
Readmissions Reduction Program

FY2017

- Discharges from July 1, 2012 to June 30, 2015
  - 30-day Readmissions Acute Myocardial Infarction (AMI),
  - 30-day Readmissions Heart Failure (HF)
  - 30-day Readmissions Pneumonia (PN);
  - 30-day Readmissions Chronic Obstructive Pulmonary Disease (COPD)
  - 30-day Readmissions Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)
  - 30 day Readmissions Coronary Artery Bypass Graft (CABG) surgery
Readmissions Composite Score

Summary of weighted excess readmissions score

Composite score = (AMI Cases x excess ratio) + (Pneumonia Cases x excess ratio) + (Heart Failure Cases x excess ratio) + (Hip/Knee Cases x excess ratio) + (COPD Cases x excess ratio) + (CABG Cases x excess ratio)
Data Submission of VBP, RRP and HAC results

- Results in summer
- Final results in October
- Hospital Compare in December
- Required for MN in January
Alignment of Individual Measures for CAH
Inpatient Measures - CAH

- ED-1a Median time from ED arrival to ED departure for admitted ED patients
- ED-2a Median time from admit decision time to ED departure time for admitted patients
- Catheter associated Urinary Tract Infection (CAUTI) event
- PC-01 Early elective deliveries
- Imm-2 Influenza immunization
Outpatient Measures - CAH

OP-1  Median time to fibrinolysis
OP-2  Fibrinolytic therapy received within 30 minutes of emergency department
OP-3  Median time to transfer to another facility for acute coronary intervention
OP-4  Aspirin at arrival
OP-5  Median time to ECG
Outpatient Measures - CAH

- **OP-18** Median time from ED arrival to ED departure for discharged ED patients
- **OP-20** Door to diagnostic evaluation by a qualified medical professional
- **OP-21** ED-median time to pain management for long bone fracture
Outpatient Measures Continue - CAH

• OP-22 ED-patient left without being seen

• OP-23 ED-head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival.

• OP-25 Safe surgery checklist

• OP-27 Influenza Vaccination Coverage among Healthcare Personal (combined with HCP)
30 Day Readmissions Continue - CAH

• Heart Failure
• Pneumonia
• Chronic Obstructive Pulmonary Disease
All PPS/CAH Hospitals
Measures Continue

• HCAHPS Patient Experience of Care
• Minnesota Stroke Registry Indicators
  – Door-to-imaging initiated time
  – Door-to-needle time to intravenous thrombolytic therapy
• AHRQ IQI 91 Mortality for Selected Conditions
• AHRQ PSI 90 Patient Safety for Selected Indicators
• AHRQ PSI 04 Death Rate among Surgical Inpatients with Serious Treatable Complications
• HIT Survey
End of Life Measure

• Reported through question on Health Information Technology (HIT)
• Stage 3 meaningful use Advance Directives measure

More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.
Future measures
Patient Safety Composite

• Continue focus on composite measures
  – Helpful to consumers who may not understand individual measures
  – Helpful to hospitals if there is access to individual measure performance to support improvement
• Identified as a priority by the Hospital Quality Reporting steering committee
Patient Safety Composite

2015-16
- Subgroup met
- Identified drivers
- Clarified assumptions

2016-17
- Develop framework
- Identify measures
- MAPS presentation

2017-18
- Determine weighting
- Test calculation
- Provide recommendation
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.

Prepared by Stratis Health under contract with Minnesota Community Measurement funded by the Minnesota Department of Health.
Changing Established Patient Criteria for DDS Measures

June 29, 2016

Dina Wellbrock
Project Manager
MN Community Measurement
MN Community Measurement

MNCM Mission:
• Accelerating the improvement of health through public reporting

MNCM Vision:
• To be the primary trusted source for health data sharing and measurement
• To drive change that improves health, patient experience, cost and equity of care for everyone in our community
• To be a resource used by providers and patients to improve care
• To partner with others to use our information to catalyze significant improvements in health

Collaborative effort of providers, hospitals, purchasers, government, consumers and health plans

© 2016 MN Community Measurement. All Rights Reserved.
MNCM by the Numbers

- More than 105,000 annual visitors to MNCM.org and MNHealthScores.org
- 132 medical groups included in the Total Cost of Care measure
- 98% of medical groups reporting data for:
  - Race
  - Hispanic ethnicity
  - Preferred language
  - Country of origin
- 75% using best practices

- 1,619 clinics registered to submit data to MNCM
- MEASURING INFLUENCE & IMPACT
- 100 provider-specific reports available to medical groups for quality improvement purposes on MNCM Data Portal

© 2016 MN Community Measurement. All Rights Reserved.
Reviewed Today

• Background
• What is “established patient criteria”?  
  • How is it used?
• Why change recommended?
• MARC review / Pilot testing
• Other considerations
• When will it take affect?
Background

Optimal Diabetes Care and Optimal Vascular Care measures first developed by HealthPartners in 2003 using health plan enrollment data

Measure stewardship transferred to MNCM with data reported by practices from evolving EHR

- Concerns over inappropriate attribution
- Pilot in 2007 proved use of CPT Evaluation & Management (E&M) codes too burdensome
What is established patient criteria?

• Visit counting criteria developed to establish a patient to a medical group
  • Looks at number of visits for condition as well as for any reason over past 2 measurement periods
• Only applies to certain clinical measures
• Measures include Optimal Asthma Control, Optimal Diabetes Care, Optimal Vascular Care, and Colorectal Cancer Screening
Example of Current Criteria

Patient seen by an eligible provider in an eligible specialty for a face-to-face visit for the condition at least two times during the last two measurement periods

AND

Patient seen by an eligible provider in an eligible specialty for a face-to-face visit for any reason at least one time during the current measurement period.
Recommended Change

Move to established patient criteria utilizing “established patient” E & M CPT codes to link the patient to the clinic/group.

Example: “new patient” E & M codes are 99201, 99202, 99203, 99204, 99205

“Established patient” codes are 99211, 99212, 99213, 99214, 99215

Also makes use of conditions present on the problem list
Why Change?

• Visit counting criteria excludes some patients
  • IVD example
• Increased consistency and standardized use of CPT E & M codes over time
• New measures recently implemented successfully using CPT codes for patient identification
• DDS Technical Advisory Committee feedback:
  • query simplification
  • cleaner billing data
  • Improved alignment with PQRS & MU
Presentation to MARC

• At May 2015 MARC meeting: Recommendation to change to E & M established patient codes
  • Preliminary approval
  • requested pilot testing on impact of change

Pilot testing goals:
  • comparison of visit counting to CPT code methodology
  • Understand impact on denominators
  • Understand impact of combination of problem list and/or visit diagnosis codes
Pilot Testing Results

Conducted in Fall 2015 with over 340,000 patients across 4 measures

Findings (presented to November 2015 MARC)

• Urgent Care visits are inappropriately pulled into denominator

• Using problem lists to identify conditions in conjunction with diagnosis codes is accurate; impacts denominator
  (asthma and vascular most impacted)

• Colorectal Cancer Screening – population based measure needs to include preventive services CPT codes
Impact on Denominators and Rates

- ODV: Visit Counting 47916, CPT Criteria 55988
- OVC: Visit Counting 27465
- OAC - Children: Visit Counting 5321, CPT Criteria 12214
- OAC - Adults: Visit Counting 11177, CPT Criteria 27251
Revised Established Patient Criteria Based on Pilot

For ODC, OVC, and OAC measures

Patient had an office visit performed or supervised by an eligible provider in an eligible specialty as an established patient for any reason at least once during the measurement period (CPT 99211, 99212, 99213, 99214, 99215, and ODC, OVC: 99395, 99396, 99397 OAC: 99392, 99393, 99394, 99395, 99396)
Revised Established Patient Criteria Based on Pilot, cont.d

For ODC, OVC, and OAC measures
Patient had condition coded for any contact during the measurement period AND/OR had condition present on active problem list at any time during the measurement period (query checks both sources).
Revised Established Patient Criteria Based on Pilot, cont. d

For Colorectal Screening measure
Patient had an office visit performed or supervised by an eligible provider in an eligible specialty as an established patient for any reason at least once during the measurement period (CPT 99211, 99212, 99213, 99214, 99215, 99396, 99397, 99386, 99387, G0402, G0438, G0349).
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
<th>Optimal Diabetes Care</th>
<th>Optimal Vascular Care</th>
<th>Optimal Asthma Control – Adults</th>
<th>Optimal Asthma Control – Children</th>
<th>Colorectal Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Office or other outpt visit evaluation &amp; management of established pt (10 min)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpt visit evaluation &amp; management of established pt (20 min)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpt visit evaluation &amp; management of established pt (30 min)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpt visit evaluation &amp; management of established pt (45 min)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpt visit evaluation &amp; management of established pt (60 min)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>99392</td>
<td>Periodic comprehensive preventive medicine established pt; ages 1 to 4</td>
<td></td>
<td></td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99393</td>
<td>Periodic comprehensive preventive medicine established pt; ages 5 to 11</td>
<td></td>
<td></td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99394</td>
<td>Periodic comprehensive preventive medicine established pt; ages 12 to 17</td>
<td></td>
<td></td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99395</td>
<td>Periodic comprehensive preventive medicine established pt; ages 18 to 39</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99396</td>
<td>Periodic comprehensive preventive medicine established pt; ages 40 to 64</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99397</td>
<td>Periodic comprehensive preventive medicine established pt; ages 65 and older</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99386</td>
<td>Initial comprehensive preventive medicine new pt; ages 40 to 64</td>
<td></td>
<td></td>
<td></td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>99387</td>
<td>Initial comprehensive preventive medicine new pt; ages 65 and older</td>
<td></td>
<td></td>
<td></td>
<td>●</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>HCPCS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0402</td>
<td>Initial preventive services exam new beneficiary first 12 months Medicare enroll</td>
</tr>
<tr>
<td>G0438</td>
<td>Annual wellness visit, personalized prevention plan of service; initial visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual wellness visit, personalized prevention plan of service; subsequent visit</td>
</tr>
</tbody>
</table>
Exclusions

Patients with only urgent care (UC) visits during the measurement period
Other Considerations

One year loss of ability to trend performance
Timeline

If adopted by MDH: Change to established patient criteria recommended to begin for Report Year 2017 (2016 Dates of Service).

Preliminary communication regarding the change sent December 15, 2015 through Measurement Minute to all clinics.
Contact

Dina Wellbrock
Project Manager
Support line: support@mncm.org

Connect with us!

On the web
MNCM.org
MNHealthScores.org

On social media
@mnhealthscores
facebook.com/mnhealthscores
Linkedin.com/company/mn-community-measurement
Questions?
Public Comment Themes

- Modifications to clinic measures
- Critical access hospital reporting requirements
- New measurement: Tobacco Use – Screening & Cessation Intervention