

# Steering Team Reference Guide

Quality Framework

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# Project Charter

## QUALITY FRAMEWORK

### 1. Introduction

As part of a set of changes to the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) implemented during the 2017 legislative session, the Minnesota Legislature<sup>1</sup> directed the Minnesota Department of Health (MDH) to develop a measurement framework in collaboration with a broad group of stakeholders by mid-2018 that:

- Articulates statewide quality improvement goals;
- Fosters alignment with other measurement efforts;
- Identifies the most important elements for assessing the quality of care;
- Ensures clinical relevance; and
- Defines the roles of stakeholders.

Stakeholders include: consumer/patients, community and advocacy organizations representing diverse communities and patients; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health plan companies; health care purchasers; community health boards; and quality improvement and measurement organizations.

By September 30, 2018, MDH will provide a report to the Legislature that summarizes this initial phase of the framework development process, and makes recommendations on the type and appropriate maximum number of measures, and potentially includes policy recommendations. While this project charter covers only the time period up to the delivery of the legislative report, MDH anticipates that many of the issues identified here will need further discussion and shaping after this initial phase of work.

### 2. Scope

The framework will be a written document that includes guiding principles for a system of health quality improvement and measurement, articulates a value proposition for statewide quality measurement across the spectrum of stakeholders, responds to the legislatively-established criteria, and establishes principles for ongoing framework evaluation, maintenance, and updates.

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<sup>1</sup>2017 Minnesota Session Laws, Chapter 6, Article 4, Section 3.

We assume commitment to measurement of health care quality in Minnesota, outside of federal requirements, will remain an important goal for stakeholders. At the same time, we believe there will be new ideas in:

- What components of care to measure;
- What data sources to use for measurement;
- How to use data to understand health care quality and aims for improvement;
- How decisions about quality improvement and measurement priorities for Minnesota; and should be set, and the role of stakeholders in shaping those priorities.

It is not within the scope of this project to identify specific quality measures for the standardized statewide measure set. Rather, MDH will use the framework to inform the statewide measure set beginning with the 2019 report year.<sup>2</sup> MDH will not require providers to report new measures during the 2019 report year. It is not within the scope of this project to develop payment mechanisms related to quality measurement and improvement.

### 3. Objectives and Topics

The framework criteria are described within this section, with proposed topics within each area, and a list of key data sources at the end.

#### 3.1. Articulates statewide quality improvement goals

- Guiding principles for health quality improvement and measurement
- Value proposition for statewide quality measurement
- Principles for the ongoing evaluation, review, and maintenance of the framework over time

#### 3.2 Fosters alignment with other measurement efforts

- Identification of which state, federal, and national health quality improvement and measurement initiatives to align with and how

#### 3.3 Identifies the most important elements for assessing the quality of care

- Provider, system, community, and patient factors that contribute to health quality and outcomes and their data sources
- Role of quality measure data, uses, and users

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<sup>2</sup>Selected physician clinic measures (including specifications and timelines) must align with those used in the federal Merit-based Incentive Payment System (MIPS) unless a particular diagnosis, condition, service, or procedure is not reflected in the federal measures in a way that meet local needs. Measures for which physician clinics must submit data will be limited to 6 for single-specialty physician practices, and 10 for multi-specialty physician practices. Measures that are derived from administrative claims data and the health information technology survey, are excluded from the measure cap.



### 3.4 Ensures clinical relevance

- Criteria to guide the identification of gaps and the consideration of measures for quality improvement and measurement

### 3.5 Defines the roles of stakeholders

- Stakeholder roles in health quality improvement, measurement, and the evaluation, review, and maintenance of the framework over time

### Data sources

- Stakeholder engagement (e.g., key informant interviews, small group discussions, surveys, public comment)
- Environmental scan of other states' health care quality measurement systems
- Past Recommendations to MDH-SQRMS from Voices for Racial Justice and Its Community Partners
- Documentation from local, federal, and national quality measurement and improvement programs and initiatives
- Minnesota Statutes, 62U.02
- Minnesota Rules, Chapter 4654

## 4. Approach

In developing recommendations on these questions, MDH will use a mixed-mode approach to gather input from a wide variety of stakeholders and data sources. This will include but not be limited to an environmental scan of other states' quality measurement systems and measure sets, key informant interviews, stakeholder discussions, requests for public comment, and other documents and information sources as indicated throughout Section 4 of this charter.

### 4.1. Environmental scan of health care quality measurement systems in other states

MDH obtained an environmental scan of health care quality measurement systems in other states. We will use the results to inform our project design, including stakeholder questions and framework topics.

### 4.2. Conduct stakeholder engagement meetings

**4.2.1.** Identify key stakeholders that align with the criteria cited in statute plus state agency representatives, researchers, and quality measurement experts to engage in meetings and conversations statewide. Use the steering team; advisory bodies to related public and private initiatives; and contributors to the SQRMS stratification and risk adjustment assessment projects.

**4.2.2.** Conduct stakeholder engagement meetings to address the topics defined in Section 4 of this charter. Meetings will be facilitated by a neutral party using consultants from Minnesota's Management Analysis and Development (MAD) group.

## 4.3. Compile themes and recommendations to develop framework

**4.3.1.** Development of themes and recommendations is expected to be an iterative process through the duration of the project. The project team will periodically consult the steering team to provide input on themes and recommendations, and to guide discussion topics for stakeholder engagement meetings

## 5. Deliverables

This project is expected to include incremental deliverables as the work progresses. The project team will maintain a public [webpage](#) with study information and updates.

Final deliverables will include: a framework; and a written report submitted to the Minnesota Legislature in September 2018. The report will include an executive summary, framework, recommendations, and methodology documentation.

Presentations will be provided to project partners and invited attendees (in person and/or webinar).

Accessible PDF versions of the framework and legislative report will be posted to the SQRMS web site.

## 6. Partners, Roles, and Responsibilities

Key partners in this study include MDH staff, facilitators, and an expert steering team.

### Project Team

Project team members are MDH staff and consultants. They will meet regularly to collectively design, guide implementation, interpret results, and determine next steps of the assessment.

#### MDH staff

- Stefan Gildemeister, [stefan.gildemeister@state.mn.us](mailto:stefan.gildemeister@state.mn.us)
- Denise McCabe, [denise.mccabe@state.mn.us](mailto:denise.mccabe@state.mn.us)
- Sarah Evans, [sarah.evans@state.mn.us](mailto:sarah.evans@state.mn.us)

#### Consultants

**Consultants** will assist with planning, data collection and analysis, stakeholder engagement, development of the framework, legislative recommendations, and meeting facilitation.

- Lisa Anderson (MAD), [lisa.anderson@state.mn.us](mailto:lisa.anderson@state.mn.us)

- Stacy Sjogren (MAD), [stacy.sjogren@state.mn.us](mailto:stacy.sjogren@state.mn.us)

## Steering Team

We have recruited a steering team of stakeholders who have served in an advisory capacity to or have participated in a related MDH or Department of Human Services initiative, or participated in the MDH quality measure stratification or risk adjustment projects. The Steering Team will provide guidance to MDH as it develops quality framework in collaboration with stakeholders broadly. The Steering Team will:

- Assist with the identification, articulation, and prioritization of framework objectives;
- Advise on the key topics and questions to use in outreach with a broader stakeholder audience;
- Help identify stakeholders throughout the State to engage with on this project;
- Synthesize input from the broader stakeholder community to contextualize and articulate themes and recommendations, and help build a roadmap, if necessary, towards a Minnesota quality framework; and
- Discuss ideas for ongoing framework evaluation, maintenance, and updates.

The proposed expertise/roles needed to address the study topics and provide state and national perspective include:

<b>Expertise:</b>	<b>Perspective:</b>	<b>Team Member</b>
Rural health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery	Kelly Fluharty, Winona Health
Health equity	Diverse communities, patients, and consumers	Monica Hurtado, Voices for Racial Justice
Health information technology (HIT), quality measurement, care provider	Leveraging HIT; quality improvement and measurement; care delivery; health care policy	Kevin Larsen, MD, Center for Medicare & Medicaid Innovation
Quality improvement organization	Quality improvement and measurement	Jennifer Lundblad, Stratis Health; *Co-chair
Health care purchaser	Care quality and value; Medicaid	Ross Owen, Hennepin Health
Minnesota Department of Health	Health care policy	Diane Rydrych, MDH *Co-chair
Urban health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery; measurement science	David Satin, MD University of Minnesota and University of Minnesota Physicians
Quality measurement organization	Quality measurement and reporting; historical perspective on measurement in MN	Julie Sonier, MN Community Measurement

An individual may represent more than one type of expertise in order to find the most complementary balance of perspectives while keeping the overall number of steering team members to a manageable number.

## 7. Communications and Outreach

The project team will prepare a plan for communication within the agency, as well as to the steering team and the public.

## 8. Timeline

Phase	Start	Completion
1. Project design	January	March
2. Data collection/stakeholder engagement	April	May
3. Analysis; development of framework and recommendations; report writing	April	June
4. Issue proposed framework with a 30-day public comment period	July	July
5. Finalize framework	August	September
6. Write and remit report to Legislature	July	September

## 9. Acronyms

Several acronyms used for this project include the following:

- **APCD:** All Payer Claims Database
- **CMS:** Centers for Medicare & Medicaid Services
- **DHS:** Department of Human Services
- **FQHC:** Federally Qualified Health Center
- **HCH:** Health Care Homes
- **HEP:** Health Economics Program
- **HIE:** Health Information Exchange
- **HIT:** Health Information Technology
- **ICSI:** Institute for Clinic Systems Improvement
- **IHP:** DHS Integrated Health Partnerships
- **IOM:** Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine)
- **IPPS:** Inpatient Prospective Payment System
- **MACRA:** Medicare Access and Children’s Health Insurance Program (CHIP) Reauthorization Act of 2015
- **MAD:** Management Analysis & Development
- **MBQIP:** Medicare Beneficiary Quality Improvement Project

## PROJECT CHARTER

- **MCHP:** Minnesota Council of Health Plans
- **MDH:** Minnesota Department of Health
- **MHA:** Minnesota Hospital Association
- **MIPS:** Merit-based Incentive Payment System
- **MMA:** Minnesota Medical Association
- **MNCM:** MN Community Measurement
- **MNHAG:** Minnesota Health Action Group
- **NQF:** National Quality Forum
- **NQS:** National Quality Strategy
- **OPPS:** Outpatient Prospective Payment System
- **QI:** Quality Improvement
- **QMEP:** Quality Measurement Enhancement Project
- **SIM:** Statewide Innovation Model
- **SNC:** Safety Net Coalition
- **SQRMS:** Minnesota Statewide Quality Reporting and Measurement System
- **VRJ:** Voices for Racial Justice

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# Steering Team Charter

## QUALITY FRAMEWORK

### Purpose and Roles

#### Members

The Steering Team will provide guidance to the Minnesota Department of Health (MDH) as it develops a quality framework in collaboration with a broad group of stakeholders. The Steering Team will:

- Assist with the identification, articulation, and prioritization of framework objectives;
- Advise on the key topics and questions to use in outreach with a broader stakeholder audience;
- Help identify stakeholders throughout the state to engage with on this project;
- Synthesize input from the broader stakeholder community to contextualize and articulate themes and recommendations, and help build a roadmap, if necessary, towards a Minnesota quality framework; and
- Discuss ideas for ongoing framework evaluation, maintenance, and updates.

Steering Team members are expected to leverage their expertise and insight to meaningfully contribute to the Steering Team and overall project. The MDH project team seeks to build a shared understanding of objectives, findings, and recommendations with the Steering Team as we move through the project stages and develop the framework.

#### Membership

We have recruited a steering team of stakeholders who, as individuals, represent a range of expertise and experience. As an initially small group – co-chairs are still considering ideas for expanding the team – the team will be nimble for the near-term challenges and creative to establish a longer-term roadmap, if necessary.

<b>Expertise:</b>	<b>Perspective:</b>	<b>Team Member</b>
Rural health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery	Kelly Fluharty, MPH, Winona Health

## STEERING TEAM CHARTER

<b>Expertise:</b>	<b>Perspective:</b>	<b>Team Member</b>
Health equity, authentic community engagement	Diverse communities, patients, and consumers	Monica Hurtado, Voices for Racial Justice
Health information technology (HIT), quality measurement, care provider	Leveraging HIT; quality improvement and measurement; care delivery; health care policy	Kevin Larsen, MD, Center for Medicare & Medicaid Innovation
Quality improvement organization	Quality improvement and measurement	Jennifer Lundblad, Stratis Health; *Co-chair
Health care purchaser	Care quality and value; Medicaid	Ross Owen, Hennepin Health
Minnesota Department of Health	Health care policy	Diane Rydrych, MDH; *Co-chair
Urban health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery; measurement science	David Satin, MD University of Minnesota and University of Minnesota Physicians
Quality measurement organization	Quality measurement and reporting; historical perspective on measurement in MN	Julie Sonier, MN Community Measurement

### Co-Chairs

Jennifer Lundblad and Diane Rydrych will co-chair the Steering Team. The co-chairs will assist the project team in preparing for and facilitating Steering Team meetings, and summarizing key learnings and decisions.

### Project Team: Consultants

Minnesota Management and Budget's Management Analysis and Development (MAD) consultants will help facilitate Steering Team meetings, and document meeting content and outcomes. Consultants will coordinate with MDH staff and co-chairs to prepare for and debrief meetings. The project consultants are Lisa Anderson and Stacy Sjogren.

### Project Team: MDH Staff

MDH staff will coordinate with co-chairs and MAD consultants to prepare for and debrief meetings. MDH staff will provide a program perspective during Steering Team meetings. These MDH staff include:

- Stefan Gildemeister, Health Economics Program Director
- Denise McCabe, Health Economics Program Supervisor

- Sarah Evans, Health Economics Program Senior Planner

## Meeting Schedule and Aims

Steering Team members are expected to participate in approximately six conference calls or in-person meetings over the course of the project. If a member is unable to participate in a meeting, provide written or verbal comments to the co-chairs in advance of any meeting. Members are expected to bring the perspectives that they represent (not only of their organizations).

- March 12: Orientation to project; review and discuss objectives and scope, and proposed data collection plan
- Late March/early April: Discuss framework principles, and finalize project objectives, key questions, and data collection plan
- Late April: Discuss and synthesize input from stakeholders
- Mid-May: Discuss and synthesize input from stakeholders and develop recommendations
- Early June: Discuss draft framework
- Late August/early September: Finalize framework



# Steering Team Roster

## QUALITY FRAMEWORK

**Kelly Fluharty**, Community Care Organization Manager, Winona Health

**Monica Hurtado**, Racial Justice and Health Equity Organizer, Voices for Racial Justice

**Kevin Larsen**, MD, Enterprise Lean and Health IT Advisor, Centers for Medicare & Medicaid Services

**Jennifer Lundblad**, PhD, President and Chief Executive Officer, Stratis Health

**Ross Owen**, Health Strategy Director, Hennepin Health

**Diane Rydrych**, Director, Health Policy Division, MDH

**David Satin**, MD, Family Medicine Physician, University of Minnesota and University of Minnesota Physicians

**Julie Sonier**, President, MN Community Measurement

# Statewide Quality Reporting and Measurement System

2017 LEGISLATIVE UPDATE

## Background

As part of Minnesota's 2008 health reform initiative, the Commissioner of Health is required to establish a standardized set of quality measures for health care providers.<sup>1</sup> The goal is to create a more uniform and parsimonious approach to quality measurement to enhance market transparency and drive health care quality improvement through an evolving measurement and reporting strategy. This standardized quality measure set is called the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System), and it is administered by the Minnesota Department of Health (MDH).

## Measurement Framework

As part of a set of changes to the Quality Reporting System implemented during the 2017 legislative session, the Minnesota Legislature<sup>2</sup> directed MDH to develop a measurement framework in collaboration with a broad group of stakeholders by mid-2018 that:

- Identifies the most important elements for assessing the quality of care;
- Articulates statewide quality improvement goals;
- Ensures clinical relevance;
- Fosters alignment with other measurement efforts; and
- Defines the roles of stakeholders.

In developing the framework, MDH will consult with stakeholders including consumer, community and advocacy organizations representing diverse communities and patients; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health plan companies; health care purchasers; community health boards; and quality improvement and measurement organizations.

At the conclusion of the measurement framework development, MDH will provide a report to the Legislature that summarizes the framework development process and makes recommendations on the type and appropriate maximum number of measures.

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<sup>1</sup>Minnesota Statutes, section 62U.02.

<sup>2</sup>2017 Minnesota Session Laws, Chapter 6, Article 4, Section 3.

In addition, MDH, will use the framework to update the statewide measures for the 2019 report year via the Quality Reporting System administrative rule.<sup>3</sup> Physician clinic quality measures (including specifications and timelines) must align with those used in the federal Merit-based Incentive Payment System (MIPS)<sup>4</sup> unless a particular diagnosis, condition, service, or procedure is not reflected in the federal measures in a way that meet local needs, as determined through multi-stakeholder consultation. Furthermore, the number of quality measures for which physician clinics must submit data will be limited to 6 for single-specialty physician practices, and 10 for multi-specialty physician practices.

## Other Modifications

Another change implemented by the 2017 Legislature restricts MDH from requiring physician clinics and hospitals to use a vendor to administer or collect data to meet Quality Reporting System requirements. Since working with a vendor certified by the Centers for Medicare & Medicaid Services (CMS) represents documented best practices, aligns with CMS requirements, and is consistent with MDH's approach over seven years, we plan to discontinue the patient experience of care survey requirement for physician clinics and hospitals.

Lastly, Minnesota Management and Budget is no longer required to use the Quality Incentive Payment System (QIPS) for participants in the state employee group insurance program.<sup>5</sup> Since the Department of Human Services—the only other purchaser using the QIPS framework to offer pay-for-performance incentives to providers—discontinued its participation in QIPS, MDH will pause updating the framework until future market or legislative changes prompt MDH to resume its updates, potentially with modifications to the methodology.

## Stay Informed

MDH will provide updates on the Quality Reporting System measurement framework initiative—including opportunities for input—through the Quality Reporting System website, announcements, and additional methods. Visit [Health Care Quality Measures \(http://www.health.state.mn.us/healthreform/measurement\)](http://www.health.state.mn.us/healthreform/measurement).

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<sup>3</sup>Minnesota Rules, chapter 4654.

<sup>4</sup>The federal [Quality Payment Program \(https://qpp.cms.gov\)](https://qpp.cms.gov) implements provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Clinicians that bill Medicare Part B more than \$30,000, provide care for more than 100 Medicare Part B patients, and are not participating in an Advanced Alternative Payment Model are part of the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program. MIPS participants may earn a performance-based payment adjustment to Medicare payment that is based on quality, improvement activities, advancing care information, and cost.

<sup>5</sup>QIPS is a statewide pay-for-performance system for physician clinics that is built on the measures of the Quality Reporting System. Since 2010, Minnesota Management and Budget and the Department of Human Services (DHS) have used the Quality Incentive Payment System to make incentive payments to clinics based on their performance on specified quality measures. DHS ended its involvement in 2016 due to changes in federal Medicaid managed care regulations.

QUALITY REPORTING SYSTEM: 2017 LEGISLATIVE UPDATE

Minnesota Department of Health  
PO Box 64882  
St. Paul, MN 55164-0882  
651-201-3550  
health.sqrms@state.mn.us  
[www.health.state.mn.us/healthreform/measurement](http://www.health.state.mn.us/healthreform/measurement)

10/2/2017

*To obtain this information in a different format, call: 651-201-3550. Printed on recycled paper.*

**62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.**

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures for use by health plan companies as specified in subdivision 5. As part of the standardized set of measures, the commissioner shall establish statewide measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. The statewide measures shall be used for the quality incentive payment system developed in subdivision 2 and the quality transparency requirements in subdivision 3. The statewide measures must:

(1) for purposes of assessing the quality of care provided at physician clinics, including clinics certified as health care homes under section 256B.0751, be selected from the available measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended, unless the stakeholders identified under paragraph (b) determine that a particular diagnosis, condition, service, or procedure is not reflected in any of the available measures in a way that meets identified needs;

(2) be based on medical evidence;

(3) be developed through a process in which providers participate and consumer and community input and perspectives are obtained;

(4) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(5) seek to avoid increasing the administrative burden on health care providers; and

(6) place a priority on measures of health care outcomes, rather than process measures, wherever possible.

The measures may also include measures of care infrastructure and patient satisfaction.

(b) By June 30, 2018, the commissioner shall develop a measurement framework that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the commissioner shall use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. No more than six statewide measures shall be required for single-specialty physician practices and no more than ten statewide measures shall be required for multispecialty physician practices. Measures in addition to the six statewide measures for single-specialty practices and the ten statewide measures for multispecialty practices may be included for a physician practice if derived from administrative claims data. Care infrastructure measures collected according to section 62J.495 shall not be counted toward the maximum number of measures specified in this paragraph. The commissioner shall develop the framework in consultation with stakeholders that include consumer, community, and advocacy organizations representing diverse communities and patients; health plan companies; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health care purchasers; community health boards; and quality improvement and measurement organizations. The commissioner, in consultation with stakeholders, shall review the framework at least once every three years. The commissioner shall also submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 30, 2018, summarizing the development of the measurement framework and making recommendations on the type and appropriate maximum number of measures in the statewide measures set for implementation on January 1, 2020.

(c) Effective July 1, 2016, 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. On or after January 1, 2018, the commissioner may require measures to be stratified by other sociodemographic factors or composite indices of multiple factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

(d) The statewide measures shall be reviewed at least annually by the commissioner.

**Subd. 2. Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

**Subd. 3. Quality transparency.** (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue periodic public reports on trends in provider quality at the statewide, regional, or clinic levels.

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph (c), that are correlated with health disparities and have an impact on performance on cost and quality measures. The risk adjustment method may consist of reporting based on an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

(c) Physician clinics and hospitals shall submit standardized information for the identified statewide measures to the commissioner or the commissioner's designee in the formats specified by the commissioner, which must include alternative formats for clinics or hospitals experiencing technological or economic barriers to submission in standardized electronic form. The commissioner shall ensure that any quality data reporting requirements for physician clinics are aligned with the specifications and timelines for the selected measures as defined in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional

data on race, ethnicity, preferred language, country of origin, or other sociodemographic factors as identified under subdivision 1, paragraph (c), and as required for stratification or risk adjustment. None of the statewide measures selected shall require providers to use an external vendor to administer or collect data.

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1 to 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, including providers serving high concentrations of patients and communities impacted by health disparities; health plan companies; consumers, including consumers representing groups who experience health disparities; employers or other health care purchasers; and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** Health plan companies shall use the standardized set of measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

**History:** 2008 c 358 art 4 s 5; 2009 c 101 art 2 s 109; 2015 c 71 art 9 s 4-7; 1Sp2017 c 6 art 4 s 3

**CHAPTER 4654**  
**DEPARTMENT OF HEALTH**  
**HEALTH CARE QUALITY MEASURES**

4654.0100	APPLICABILITY.
4654.0200	DEFINITIONS.
4654.0300	PROVIDER SUBMISSION REQUIREMENTS.
4654.0400	DATA VALIDATION PROCEDURES.
4654.0500	MEASUREMENT DEVELOPMENT AND REVIEW PROCESS.
4654.0600	USE OF QUALITY MEASURES BY HEALTH PLAN COMPANIES.
4654.0700	VARIANCES.
4654.0800	INCORPORATION BY REFERENCE.

**4654.0100 APPLICABILITY.**

This chapter applies to all providers who are required to submit standardized information on quality measures associated with patient care under Minnesota Statutes, section 62U.02, and all health plan companies that collect data related to quality measures from providers.

**Statutory Authority:** *MS s 62U.02*

**History:** *34 SR 905*

**Published Electronically:** *January 13, 2010*

**4654.0200 DEFINITIONS.**

Subpart 1. **Scope.** For purposes of this chapter, the following terms have the meanings given them in this part.

Subp. 2. **Administrative data.** "Administrative data" means information contained on a health care claim or equivalent encounter transaction provided by a provider to a health plan company or third-party administrator.

Subp. 2a. **Ambulatory surgical center.** "Ambulatory surgical center" is an outpatient surgical center and has the meaning given in Minnesota Statutes, section 144.55, subdivision 2a, and is also certified under the Medicare program.

Subp. 3. **Applicable quality measure.** "Applicable quality measure" means a quality measure that pertains to a service provided by a physician clinic, hospital, or ambulatory surgical center.

Subp. 4. **Clinical staff.** "Clinical staff" means physicians, advanced practice registered nurses, and physician assistants.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of health.



Subp. 6. **Complete submission.** "Complete submission" means quality measures that a data submitter has submitted to the commissioner or commissioner's designee containing the required quality measures in a format that allows for further review and verification of the data's accuracy.

Subp. 7. **Data submitter.** "Data submitter" means a physician clinic, hospital, or ambulatory surgical center.

Subp. 8. **Health plan company.** "Health plan company" has the meaning given in Minnesota Statutes, section 62U.01, subdivision 8.

Subp. 9. **Hospital.** "Hospital" means any entity licensed under Minnesota Statutes, section 144.50, subdivision 2.

Subp. 10. **Material error.** "Material error" means omission of data or submission of inaccurate information that significantly changes the results of the analysis of quality measures.

Subp. 11. [Renumbered Subp. 2a]

Subp. 12. **Payer mix.** "Payer mix" means the distribution of insurance coverage for a provider's patient population including private insurance, Medicare, state public programs, self-pay, and uninsured.

Subp. 13. **Physician clinic.** "Physician clinic" means any location where primary or specialty care ambulatory services are provided for a fee by one or more physicians in the state of Minnesota. Physician clinic includes ambulatory surgical centers and hospital-based outpatient locations that provide primary or specialty care ambulatory services for a fee. With the exception of ambulatory surgical centers, multiple clinic locations may be considered a single physician clinic when the multiple locations have common ownership and a majority of common clinical staff working across the multiple locations, and the total clinical staff across all locations is no greater than 20 full-time equivalent employees.

Subp. 14. **Provider or health care provider.** "Provider" or "health care provider" has the meaning in Minnesota Statutes, section 62U.01, subdivision 10.

Subp. 15. **Publicly reported measure.** "Publicly reported measure" means a standardized quality measure established by the commissioner that is stated in Appendix A, B, or C, which is incorporated by reference in part 4654.0800.

Subp. 16. **Quality measure.** "Quality measure" means a specific qualitative or quantitative indicator that measures health outcomes, processes, structures, or patient experience, access, or safety, or other desirable results for a defined population of patients. Quality measure does not include information:

- A. associated with assessing medical necessity for an individual patient;
- B. used to determine medical appropriateness of treatment for a particular patient;
- C. related to patient safety or adverse health events for an individual patient;
- D. related to a health care provider's qualifications or scope of practice; or

E. necessary to detect and prevent fraud and abuse in the billing and payment of services.

Subp. 17. **Risk adjustment.** "Risk adjustment" means a process that adjusts the analysis of quality measurement by accounting for those patient-population characteristics that may independently affect results of a given measure and are not randomly distributed across all providers submitting quality measures. Risk adjustment characteristics include, for example, severity of illness, patient demographics, or payer mix.

Subp. 18. **Standardized electronic information.** "Standardized electronic information" means the specific required data format as described in Appendix E, which is incorporated by reference in part 4654.0800.

Subp. 19. **Standardized quality measure.** "Standardized quality measure" means:

A. any measure listed in Appendix A, B, C, or D, which is incorporated by reference in part 4654.0800;

B. any measure required to be reported under Minnesota Statutes, section 62U.05 or 256B.0751, subdivision 6, paragraph (a);

C. any quality measure that a health plan company or provider is required to collect or report by the Minnesota Department of Human Services;

D. any structural quality measure; or

E. any quality measure that a health plan company is required to collect or report by federal or state law or regulation.

Subp. 20. **Structural quality measure.** "Structural quality measure" means a measure of provider capacity, scope of services, or feature of the setting in which care is delivered that is independent of the care delivered to any individual patient.

Subp. 21. **Third-party administrator.** "Third-party administrator" means a vendor of risk management services or an entity administering a self-insurance or health insurance plan as defined in Minnesota Statutes, section 60A.23, subdivision 8.

Subp. 22. **Urgent care center.** "Urgent care center" means a medical facility where ambulatory patients can walk in without an appointment and receive services required to treat an illness or injury that would not result in further disability or death if not treated immediately, but requires professional attention and that has the potential to develop such a threat if treatment is delayed. Urgent care center does not include physician clinics offering extended hours for patient care.

**Statutory Authority:** *MS s 62U.02; 62U.06*

**History:** *34 SR 905; 35 SR 802; 36 SR 615; 37 SR 747*

**Published Electronically:** *January 9, 2013*

**4654.0300 PROVIDER SUBMISSION REQUIREMENTS.****Subpart 1. Physician clinics.**

A. Each physician clinic, except ambulatory surgical centers, must register annually with the commissioner or commissioner's designee beginning January 1, 2010, as specified in Appendix E.

B. Each physician clinic, except ambulatory surgical centers, must submit to the commissioner or commissioner's designee data required to calculate the applicable quality measures, including the data necessary to perform risk adjustment for each applicable quality measure in Appendix A, which is incorporated by reference in part 4654.0800, according to the schedule for each measure in Appendix A for all health care services provided by the physician clinic. The physician clinic must submit the data using the standardized electronic format and procedures specified in Appendix E, which is incorporated by reference in part 4654.0800.

C. Each physician clinic with an electronic medical record in place for an entire measurement period must report on a full population basis in the subsequent reporting cycle.

D. If less than ten percent of a physician clinic's population is age 18 or older, that physician clinic is exempt from reporting on quality measures in Appendix A applicable to patients age 18 or older.

**Subp. 2. Hospitals.**

A. Each hospital must submit to the commissioner or commissioner's designee data required to calculate the applicable quality measures, including the data necessary to perform risk adjustment for each applicable quality measure in Appendix B, which is incorporated by reference in part 4654.0800, according to the schedule for each measure in Appendix B for all relevant health care services provided by the hospital. The hospital must submit the data using the standardized electronic format and procedures specified in Appendix E, which is incorporated by reference in part 4654.0800.

B. If less than ten percent of a hospital's patient population is age 18 or older, that hospital is exempt from reporting on quality measures in Appendix B applicable to patients age 18 or older.

Subp. 3. [Repealed, 39 SR 1046]

Subp. 4. **Provider subcontractors.** The commissioner or commissioner's designee will accept data submitted on behalf of a provider by a single subcontractor.

**Statutory Authority:** *MS s 62U.02; 62U.06*

**History:** *34 SR 905; 35 SR 802; 38 SR 848; 39 SR 1046*

**Published Electronically:** *January 22, 2015*

**4654.0400 DATA VALIDATION PROCEDURES.****Subpart 1. Complete submissions.**

A. The commissioner or commissioner's designee must notify a data submitter of a data transmission receipt within two business days of a data submission. Within 30 days after receipt of the data transmission, the commissioner or the commissioner's designee must notify the data submitter whether the data qualifies as a complete submission.

B. If a data submitter receives notice that a data submission is incomplete, the commissioner or commissioner's designee must state in the notice why the data submission is incomplete. The data submitter must resubmit the complete data or request an extension or reconsideration within ten business days after the data submitter receives the notice.

**Subp. 2. Material error.**

A. If the commissioner or commissioner's designee notifies a data submitter of a material error in a complete submission, the data submitter must file a corrected submission or request an extension or reconsideration within ten business days.

B. If a data submitter discovers a material error in a complete submission, the data submitter must immediately inform the commissioner or commissioner's designee of the error and, within 15 business days, file a corrected submission.

**Subp. 3. Dispute resolution.** If a data submitter disagrees with the commissioner or commissioner's designee's determination that a submission is incomplete or that it contains a material error, the data submitter may submit a written request for reconsideration to the commissioner within ten business days, stating its reasons that the submission should be considered complete or why it does not contain a material error. The commissioner's decision on the request for reconsideration is final.

**Subp. 4. Cooperation with data validation procedures.** Data submitters must cooperate with the commissioner or the commissioner's designee in carrying out data validation by doing the following:

- A. attest to the accuracy of data submissions;
  - B. respond to data validation requests by the commissioner or the commissioner's designee;
- and
- C. document calculation of all applicable measures and maintain the record for two years.

**Statutory Authority:** *MS s 62U.02*

**History:** *34 SR 905*

**Published Electronically:** *January 13, 2010*

**4654.0500 MEASUREMENT DEVELOPMENT AND REVIEW PROCESS.**

Subpart 1. **Review process.** The commissioner must review the standardized quality measures contained in "Minnesota Statewide Quality Reporting and Measurement System: Appendices to Minnesota Administrative Rules, chapter 4654," in part 4654.0800, and propose additions, deletions, or modifications by August 15 of each year. If the commissioner determines that a standardized quality measure should be added, deleted, or modified, the commissioner will use the expedited rulemaking process under Minnesota Statutes, section 14.389.

Subp. 2. **Recommendation process.** The commissioner shall consider recommendations for addition, removal, or modification of standardized quality measures that are submitted by June 1 of each year. To the extent practicable, recommendations must address how addition, removal, or modification of a quality measure relates to one or more of the following criteria:

A. the magnitude of the individual and societal burden imposed by the clinical condition being measured by the quality measure, including disability, mortality, and economic costs;

B. the extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in clinical processes;

C. the relevance of the quality measure to a broad range of individuals with regard to:

(1) age, gender, socioeconomic status, and race/ethnicity;

(2) the ability to generalize quality improvement strategies across the spectrum of health care conditions; and

(3) the capacity for change across a range of health care settings and providers;

D. the extent to which the quality measure has either been developed or accepted, or approved through a national consensus effort;

E. the extent to which the results of the quality measure are likely to demonstrate a wide degree of variation across providers; and

F. the extent to which the quality measure is valid and reliable.

**Statutory Authority:** *MS s 62U.02*

**History:** *34 SR 905*

**Published Electronically:** *January 13, 2010*

**4654.0600 USE OF QUALITY MEASURES BY HEALTH PLAN COMPANIES.**

Subpart 1. **Required quality measures.** A health plan company may not require providers to use or report quality measures that are not standardized quality measures. Health plan companies and providers may voluntarily use and report quality measures that are not standardized quality measures. In addition, a health plan company may do the following:

A. derive quality measures from any data source not submitted to the health plan company by a provider; and

B. derive quality measures from administrative data.

Subp. 2. **Required use or report of quality measures.** For purposes of this part, requiring a provider to use or report a quality measure means contractually mandating, as a nonnegotiable condition of conducting business with a health plan company, that a provider use or report a specific quality measure.

**Statutory Authority:** *MS s 62U.02*

**History:** *34 SR 905*

**Published Electronically:** *January 13, 2010*

#### **4654.0700 VARIANCES.**

The commissioner may grant a variance to a data submitter for a reported quality measure collection or submission specification if the data submitter demonstrates good cause. To request a variance, a data submitter must submit a petition, according to the requirements of Minnesota Statutes, section 14.056, and demonstrate that it meets the following criteria:

A. failure to grant the variance would result in hardship or injustice to the data submitter;

B. the variance is consistent with the public interest, including patient safety; and

C. the variance does not prejudice the substantial legal or economic rights of any person or entity.

**Statutory Authority:** *MS s 62U.02*

**History:** *34 SR 905*

**Published Electronically:** *January 13, 2010*

#### **4654.0800 INCORPORATION BY REFERENCE.**

"Minnesota Statewide Quality Reporting and Measurement System: Appendices to Minnesota Administrative Rules, Chapter 4654," issued by the Minnesota Department of Health, December 2017, is incorporated by reference. It is available through the Minitex interlibrary loan system and the Minnesota Department of Health's Health Care Quality Measures Web site at <http://www.health.state.mn.us/healthreform/measurement>. They are not subject to frequent change.

**Statutory Authority:** *MS s 14.389; 62U.02; 62U.06*

**History:** *34 SR 905; 35 SR 802; 36 SR 615; 37 SR 747; 38 SR 848; 39 SR 1046; 40 SR 781; 41 SR 781; 42 SR 865*

**Published Electronically:** *January 29, 2018*

# Quality Measures: 2018 Report Year

STATEWIDE QUALITY REPORTING AND MEASUREMENT SYSTEM

## Physician Clinic Quality Measures

- Optimal Diabetes Care
- Optimal Vascular Care
- Depression Care: Remission at Six Months
- Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening
- Optimal Asthma Control – Adult and Child
- Asthma Education and Self-Management – Adult and Child
- Colorectal Cancer Screening
- Total Knee Replacement Outcome Measures
- Spinal Surgery: Lumbar Spinal Fusion Outcome Measures
- Spinal Surgery: Lumbar Discectomy/Laminotomy Outcome Measures
- Health Information Technology Ambulatory Clinic Survey

## Hospital Quality Measures

### Prospective Payment System Hospital

- Hospital Value-Based Purchasing Total Performance Score
- Hospital Readmissions Reduction Program Excess Readmission Score
- Hospital Acquired Condition Reduction Program Score

### Critical Access Hospital

#### INPATIENT

- ED-1a: Median time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate
- ED-2a: Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate
- READM-30-HF: Heart Failure 30-Day Readmission Rate
- READM-30-PN: Pneumonia 30-Day Readmission Rate
- REAM-30-COPD: Chronic Obstructive Pulmonary Disease 30-Day Readmission Rate
- IMM-2: Influenza Immunization
- PC-01: Elective Delivery

## OUTPATIENT\*

- OP-2: Fibrinolytic Therapy Received within 30 Minutes
- OP-3a: Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate
- OP-5: Median Time to ECG
- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
- OP-22: ED-Patient Left without Being Seen
- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation within 45 Minutes of Arrival
- CAUTI: Catheter Associated Urinary Tract Infection
- OP-27/HCP: Healthcare Personnel Influenza Vaccination Coverage [combined measure]
- Emergency Department Transfer Communication Composite

## Prospective Payment System and Critical Access Hospitals

- Emergency Department Stroke Registry Indicators: Door-to-Imaging Initiated Time and Time to Intravenous Thrombolytic Therapy
- IQI-91: Mortality for Selected Conditions
- PSI-4: Death Rate among Surgical Inpatients with Serious Treatable Complications
- PSI 90: Patient Safety and Adverse Events Composite
- Health Information Technology Hospital Survey

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03/2018 – Updated

*Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.*

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\*In March 2018, MDH removed OP-1: Median Time to Fibrinolysis, OP-4: Aspirin at Arrival, OP-20: Door to Diagnosis Evaluation by a Qualified Medical Professional, OP-21: Median Time to Pain Management for Long Bone Fracture, and OP-25: Safe Surgery Checklist Use to maintain alignment with Medicare Beneficiary Quality Improvement Project reporting requirements for critical access hospitals. OP-1, OP-4, OP-20, and OP-21 are removed effective with April 1, 2018 discharge dates, and OP-25 effective with January 1, 2018 discharge dates.



# Data Analytics Subgroup Phase Two Report

August 31, 2016

The full report is available at:

[Data Analytics Subgroup Phase Two Report](#)

(<http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs-289330.pdf>)

## Executive Summary

Minnesota has made a significant commitment to a vision of shared accountability across and among health care organizations and other service providers to improve the health of individuals and communities, increase the quality of health care, and reduce health care costs. This transformation requires a commitment to a shared vision and the willingness to work through complex issues. In that vein, the Data Analytics Subgroup, formed to advise the two Task Forces for the Minnesota Accountable Health Model – SIM project, has completed initial work on the “what, why, and how” of aligning data analytics among organizations throughout Minnesota.

The effort described in this report builds upon work conducted in 2015 to identify data analytic elements to support care models that involve shared accountability; the report of that Phase One report can be found at [The MN DHS website \(www.dhs.state.mn.us/healthreformmn\)](http://www.dhs.state.mn.us/healthreformmn). This report provides insight into what occurred between Phase One and the start of Phase Two in early 2016, and how Phase Two expanded the scope of data analytic elements recommended for alignment to include those that address social or environmental determinants of health.

The Phase Two Data Analytics Subgroup believes that the elements identified below are critical to the work of accountable entities, including the Accountable Communities for Health (ACHs) and Accountable Care Organizations (ACOs), which are bringing physical and behavioral health organizations, as well as social services organizations together to improve the individual and collective health of Minnesotans. These elements include:

- Mental health and substance use (current diagnosis or unmet need);
- Race, ethnicity, and language;
- Access to reliable transportation;
- Social services already being received;
- Housing status or situation; and
- Food insecurity.

The Subgroup unanimously supported the sharing and use of the data elements to improve population health, but there was healthy debate about how to tie the elements to current and future health reform efforts. Most of the Subgroup agreed with the idea that the State of Minnesota should include all six elements in reporting and/or payment structures for all future alternative payment and quality measurement arrangements in the state, and that all involved stakeholders should leverage contracts, legislation, and regulations (as needed) to achieve this inclusion. A few of the Subgroup members prefer a more phased and voluntary approach, involving working with industry stakeholders and subject matter experts to agree on a community standard. The Subgroup as a whole recognizes that it is important for leadership from the State of Minnesota, including but not limited to the Department of Health and Department of Health Services, stay involved to ensure policy and regulation support regardless of whether it is required or voluntary. This report should serve as a starting point for future work to identify the mechanisms for collecting, documenting and taking action on each data analytic element to ensure their future use across the spectrum of physical and behavioral health and social services in Minnesota.

## Draft Principles for the Minnesota Statewide Quality Improvement Roadmap

### Source: Health Information Technology Trailblazer Project

- The improvement of health and health care for Minnesota citizens and communities is the central focus of the statewide quality measurement and improvement roadmap.
- Collaboration across patients, providers, settings of care, payers, and the public and private sector is necessary for achieving statewide quality improvement.
- To achieve real improvement, all stakeholders (e.g. consumers, practitioners, practices, hospitals, payers, community) must have access to data/information that is timely, actionable, and appropriate to the stakeholder for use in decision making.
- Quality measures, their reporting, and feedback of information should be focused on delivering the highest value, with the least possible administrative burden; and must be aligned across care settings and integrated into workflows, so that a patient's entire care team can be aware of and accountable for care delivery performance, and fully able to evaluate clinical outcomes.
- Quality measurement programs, whether in the public or private sector, should rely on an aligned, parsimonious core set of measures that are meaningful, valid, standardized to the extent possible, and tied to priorities.
- Standardizing electronic clinical data and using health information technology for quality measurement and reporting is essential for providers, state and federal government officials, and other stakeholders to improve quality and support value-based payment of health care services.
- New infrastructure should consider how to leverage existing assets, but also take into account new initiatives in progress and technologies under development.
- Public reporting of quality data must be timely, focused on delivering information that is meaningful to patients and usable to inform health care decisions.

## Recommendations from Voices for Racial Justice and Its Community Partners to MDH for the Statewide Quality Reporting and Measurement System

This document contains excerpts from two reports:

(1) In 2016, Voices for Racial Justice (VRJ) and MDH worked together on a project related to reporting stratified results from the Quality Reporting System. VRJ engaged with members of communities disproportionately impacted by health inequities and community-based organizations to develop findings and recommendations—including feedback on the broader topic of government data. The executive summary is included in this document. The full report is available at: [Advancing Health Equity by Sharing Data from the Minnesota Statewide Quality Reporting and Measurement System - Supplemental Information](http://www-dev.health.state.mn.us/healthreform/measurement/report/VRJsqrmsReportFeb2017.pdf) (<http://www-dev.health.state.mn.us/healthreform/measurement/report/VRJsqrmsReportFeb2017.pdf>).

(2) In 2015, MDH conducted a study of stratifying Quality Reporting System measures based on race, ethnicity, language, and other socio-demographic factors that are correlated with health disparities and impact performance on quality measures as required by 2014 Minnesota Laws. MDH worked with VRJ to obtain input from community representatives using culturally appropriate methods. The appendix of community recommendations are included in this document. The full report is available at: [Stratifying Health Care Quality Measures Using Socio-demographic Factors](http://www.health.state.mn.us/healthreform/measurement/SQRMSreportMarch2015.pdf) (<http://www.health.state.mn.us/healthreform/measurement/SQRMSreportMarch2015.pdf>).

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# Advancing Health Equity by Sharing Data from the Minnesota Statewide Quality Reporting and Measurement System

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Report to the Minnesota Department of  
Health

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By Voices For Racial Justice and Its  
Community Partners

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## Executive Summary

Minnesota’s serious and persistent health disparities experienced by racial, ethnic, and other populations cannot be effectively addressed unless the disparities experienced by each group can be identified and quantified through health data. Since 2009, our organization—Voices for Racial Justice (Voices)—has collaborated with other advocates in making recommendations to state agencies, task forces, and commissions that address the inadequacies of government data collection and reporting methods to identify and address health disparities experienced by different populations.

In 2014 and 2015, the Minnesota Legislature enacted requirements for the Minnesota Department of Health (MDH) to add data on the social determinants of health to health care quality measures in the Statewide Quality Reporting and Measurement System (Quality Reporting System). MDH asked us to assist them in implementing these new requirements by obtaining input from communities disproportionately impacted by health disparities (referred to as “communities” or “the community”) on the collection and use of these data. We trained community Health Equity Champions, and conducted interviews and held listening sessions with community members and representatives of community-based organizations.

## Findings and Recommendations

Those involved in this work—i.e., community members, Health Equity Champions, Voices staff, MDH staff—struggled with this project. Community members have been investing time and effort since 2009 on the broader issue of developing or getting data from government agencies. We have broad interests in this topic; yet, this data project was narrow in scope, primarily technical in its focus, and very limited in its usefulness to help us reach our goals to affect health disparities in Minnesota. The Quality Reporting System, by focusing on limited technical measures of clinical quality for a handful of health conditions, intersects with just a narrow aspect of what we value as the key contributors to healthy people and communities.

While we appreciate that MDH asked us to be a part of this project and value the MDH team’s effort to bring authentic engagement practices to it, the community members struggled deeply to stay within the bounds of the Quality Reporting System, and community conversations tended to focus on the upstream social determinants of health and related data.

In light of these challenges, MDH program staff encouraged us to share our feedback on the broader topic of government data: approach to research, issues concerning collection and analysis methods, use and dissemination of data and research findings, and **structural racism** (barriers) experienced by the community in becoming an equal participant and change agent.

### Findings

- **It is imperative that MDH makes progress on its goal of strengthening the collection, analysis, and use of data** to advance health equity that it put forth in its 2014 Advancing Health Equity report, and it can make great strides through meaningful community engagement.

- MDH’s data collection, analysis, and dissemination activities are largely lacking authentic community input. We are generally involved late in projects and asked to review finished projects.
- It is difficult for communities to systematically access and understand the various datasets MDH holds for a variety of reasons including: how MDH disseminates information (e.g., MDH communicates information exclusively in English, relies on listservs which people may not know about and its website which is difficult to navigate, etc.); how data access and use are governed in law and rule; and the lack of technical assistance to communities to make data and reports meaningful and understandable.
- There are substantial structural barriers to the community rising to become an equal partner in the effort to develop and use data to reduce health disparities. This includes the availability of resources to participate in discussions and gain technical experience, the fact that much of MDH’s work is embedded in complex legal and administrative processes into which the community has little insight (e.g., rulemaking), and MDH’s reporting style which is very technical and relies on the written word whereas the community benefits from storytelling and in-person discussions.
- There is significant community distrust of MDH due to historical barriers and trauma. The absence of the community’s voice and participation in MDH’s data activities exacerbates distrust and missed opportunities to co-create strategies to advance health equity. Additionally, distrust creates tension which MDH shies away from, and this avoidance compounds the community tension and distrust.
- While our projects with MDH on the Quality Reporting System have been promising and a step in the right direction to advance health equity, **MDH and its partners fail to use authentic community engagement in its evolution of the Quality Reporting System.**
  - MDH obtains data collection and analytics, provider education, and measure recommendation services, but does not obtain community engagement services. Additionally, the vendors that MDH works with are in the health care industry and do not represent communities that are impacted by health disparities.
  - The measures in the Quality Reporting System were developed largely by health care experts without the input of communities that experience health disparities.

## Recommendations

- MDH should create a Community Data Sharing Advisory Committee comprised of representatives of communities impacted by health disparities. This Committee will advise MDH on how to collect, analyze, and share health data and analyses with communities. The Committee will create a partnership between MDH and communities where communities are decision-makers, they are engaged throughout the entire process, trust is intentionally developed, and partnership strives to create solutions for the short- and long-term trajectory of data collection, analysis, and dissemination.
  - The Advisory Committee must be co-facilitated by a person from the communities of color impacted by health disparities and an MDH staff
  - The Advisory Committee will intentionally include members of the different communities disproportionately impacted by health disparities.

- The Advisory Committee will start by defining membership, the process they will follow, and the frequency with which they will meet.
  - This Advisory Committee will adhere to the Principles of Authentic Community Engagement.
- MDH should create a Community-Based Participatory Research Center to implement advisory committee research recommendations.
    - This Research Center will adhere to agreed-upon the principles of community-based participatory research.
    - The Advisory Committee will guide the work of the Research Center, providing advice on how to engage communities impacted by health disparities to be partners in setting priorities around data, as well as implementation of innovative practices. The ultimate goal of this coordination of efforts between the Advisory Committee and the Research Center will be to have more meaningful data available with the intentional purpose of addressing health disparities and achieving health equity.
  - The Community Data Sharing Advisory Committee and Community-Based Participatory Research Center could be launched with a Quality Reporting System project as a proof of concept, and then the Committee and Center’s scope could be expanded to include other MDH programs and datasets.
  - MDH should have ongoing, shared, high-level discussions with community leaders to work on legislative solutions that enable the agency to meet the expectation the community has with regard to technical support, process changes, and data access.
  - With regard to the Quality Reporting System in particular, we recommend that:
    - MDH include authentic community engagement in its structuring of the Quality Reporting System.
    - When MDH develops new quality measures, it authentically include the community.
    - MDH provide data to the community by ensuring raw data and companion materials are accessible through the MDH website and mobile site, and making reports and visuals available at events hosted by communities with staff on-hand who can explain the data using culturally competent methods.





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# Stratifying Health Care Quality Measures Using Socio-demographic Factors

Minnesota Department of Health

*Report to the Minnesota Legislature 2015*

**March 2015**

## Appendix G: Community Recommendations

Voices for Racial Justice (2014) synthesized past recommendations and plans from the following reports:

- Collection of Racial/Ethnic Health Data by the Minnesota Departments of Health and Human Services. (January 2011)<sup>37</sup>;
- Race, Ethnicity and Language Work Group Recommendations to the Governor’s Health Care Reform Task Force. (May 2012)<sup>38</sup>; and
- Advancing Health Equity in Minnesota.” Minnesota Department of Health (February 2014).

Voices for Racial Justice states:

- The 2014 legislation recognizes that the time has come for the state to act on the plans and recommendations that have been made in a number of significant state agency, task force and commission reports dating back to 2011 that addressed the inadequacies of current data collection and reporting methods in identifying and addressing health disparities experienced by RESD populations. The 2014 legislation calls for an implementation plan and budget for moving forward with changes to statewide data collection and reporting methods.

Voices for Racial Justice calls this summary, “The Framework of a State Health Equity Plan to Make Health Disparities Visible.”

- 1) **Identify and measure health disparities for each RESD population.** Minnesota’s serious health disparities experienced by racial, ethnic and socio-demographic (RESD) populations cannot be effectively addressed unless the disparities experienced by each RESD group can be identified and quantified through health care data.
- 2) **Expand and improve RESD categories.** Existing categories for dividing data by race, ethnicity, language and socio-demographic factors are inadequate. More detailed categories are needed and the categories must be developed in partnership with the RESD communities so that they match the ways in which RESD community members identify themselves. Data collection systems should be designed with flexibility so that categories can be changed in the future as needed to adapt to state demographic changes. Categories should be more expansive and granular than national U.S. Office of Management and Budget (“OMB”)<sup>39</sup> standards, but should be able to be aggregated into the OMB standards.
- 3) **Establish a statewide standard construct for RESD data.** A uniform data construct should be developed so that all health data collected uses the same categories for race, ethnicity, language and socio-demographic factors. The uniform construct should be used by the Minnesota Department of Health and the Minnesota Department of Human Services, but also by licensing boards, governmental agencies, health plans, hospitals, clinics, health care homes, nonprofit agencies, quality and performance measurement programs and others who collect, analyze and report health data. All entities that are required to collect maintain or report health data or who

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<sup>37</sup>Recommended Questions and Variables for Standard Race, Ethnicity, and Language Data Collection. Retrieved from [mn.gov/commerce/insurance/images/ExchATF-RELquestions-variables8-29-12.pdf](http://mn.gov/commerce/insurance/images/ExchATF-RELquestions-variables8-29-12.pdf).

<sup>38</sup>Recommended Questions and Variables for Standard Race, Ethnicity, and Language Data Collection. Retrieved from [mn.gov/commerce/insurance/images/ExchATF-RELquestions-variables8-29-12.pdf](http://mn.gov/commerce/insurance/images/ExchATF-RELquestions-variables8-29-12.pdf).

<sup>39</sup>[www.whitehouse.gov/omb/fedreg\\_1997standards/](http://www.whitehouse.gov/omb/fedreg_1997standards/)

participate in health data measurement and reporting programs should be using the expanded RESD categories and following the statewide standard construct.

- 4) **Improve methods of obtaining RESD information.** Methods of requesting information from patients on their race, ethnicity, language and socio-demographic factors should be improved. Different methods of asking for and collecting RESD information are needed for the different populations to reflect the different ways in which each population interacts with the health care system, health care providers and governmental agencies. Methods of requesting RESD information should include informing patients about why the information is being requested, how it will be used, and how the privacy and security of the information will be protected. Training and tools should be developed for use by those organizations and staff persons who are responsible for obtaining health care information from patients. Methods, training and tools should be developed in authentic partnerships with the RESD communities themselves.
- 5) **Protect and preserve health data privacy and security.** All changes to health data collection and reporting systems and methods must be made in ways that protect and preserve the privacy and confidentiality of information about individual patients and in full compliance with laws governing data privacy and security. Public reports on health disparities of RESD populations should only contain aggregated, summary data that does not identify individual patient information.
- 6) **Authentically partner with RESD communities.** State and local governmental agencies, health care organizations and policymakers should develop and implement health equity data policies and systems in partnership with RESD communities using authentic community engagement methods that enable RESD communities to participate in policymaking and system change that directly affect them. Aggregate, summary data on health disparities should be made freely available to RESD communities so that they can identify and address the disparities their members' experience.
- 7) **Establish a long-term state health equity data plan.** A long-term plan is needed for improving health data systems to better identify, quantify and address health disparities, including the actions and activities that are needed and a timeline and budget for implementation. The elements of the plan are described in more detail in the Minnesota Department of Health's report on "Advancing Health Equity in Minnesota."

The following recommendations are based on the community engagement activity undertaken by Voices for Racial Justice on behalf of MDH in response to the 2014 legislation. These recommendations are intended to supplement and expand the previously delineated recommendations.

- 1) **Improve Categories of Race, Ethnicity and Language (REL).** The "Recommended Questions and Variables for Standard Race, Ethnicity, and Language Data Collection"<sup>38</sup> are an acceptable set of categories to use as a starting point to collect REL data. However, the categories should continue to be evaluated, modified and continuously improved. In particular, more work is needed to improve questions and categories for Black/ African American and American Indian/Native American Communities.
- 2) **Develop Other Socio-demographic Data Categories.** Income, gender identity, sexual orientation and disabilities are sensitive and personal questions. Additional work is needed to develop categories for these characteristics and methods of asking patients and consumers for this information, including ways to explain why this data is important and how it will be used and shared.
- 3) **Explain Data Privacy and Security Protections.** When RESD information is requested, consumers and patients should be informed about how current health data privacy and security

laws protect their health care information from misuse or disclosure. Explaining these protections is likely to improve their willingness to provide the information requested.

- 4) **Communicate the Purpose and Use of RESD Data.** Consumers, patients and RESD communities would benefit from understanding why RESD information is needed and how it will be beneficial to patients and communities. The benefit and potential impact of collecting socio-demographic data needs to be clearly defined and communicated with patients, consumers and communities. Consumers, patients and communities should be reassured that their treatment will not be negatively impacted by their RESD factor(s), income or ability to pay for the services needed. Public awareness and education about this should be undertaken both within the health care system at the individual patient or consumer level and in the larger community.
- 5) **Build Community Trust of the Health Care System.** There is a general issue of lack of trust which needs to be acknowledged by those who work in and lead health care organizations. Many interviewees expressed fear that their socio-demographic data would be used against them. To improve trust, there is a critical need for health care organizations to hire people who look more like the people they are working with and share their RESD factors.
- 6) **Provide Training on community engagement methods.** Health care organizations would be better able to improve care and reduce inequities by learning best practices for authentically engaging RESD communities disproportionately impacted by inequities. Training is critical in order to build the trust that is needed to better serve RESD patients and reduce inequities. Training should include learning how to understand and address institutional racism and discrimination.
- 7) **Make Aggregate Health Equity Data Available to Communities.** A plan to make data collected available to the community should be developed by every health care organization and by research, public health and quality measurement organizations that collect health data. In addition, MDH should become more intentional in making RESD data accessible not only to mainstream organizations but to RESD communities and the broader community in general. Socio-demographic data collected by the health care system should be used to create public reports easily accessible online. This transparency of the process will motivate actions and collaborations between systems and communities, which in the end will make everybody accountable to create a healthier community. The dissemination of this information is part of MDH's role in collecting information "used to inform policy makers, consumers, and other stakeholders in Minnesota's health care system."<sup>40</sup> Community access to this information on inequities is an essential element to succeed in efforts to create a healthy community by expanding the possibilities for government and health care system leaders to co-create solutions with the affected communities. It will make it easier to identify needs and set priorities for the allocation of resources that are more equitable. It will also enhance the opportunity to improve quality of health care services and patient experience while decreasing costs. Information should be widely disseminated in multiple forms, not only digitally but also in various written forms. The language used should be understandable not only by the experts, but by community-based organizations and regular citizens.
- 8) **Develop Inclusive, Culturally Appropriate Methods of Collecting RESD Data.** The collection of RESD data should be undertaken in ways that are culturally appropriate for the particular patient or RESD community. The best way to achieve this goal is by intentionally involving the communities in developing and implementing the plan for how to collect, use and share this data.

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<sup>40</sup>[www.health.state.mn.us/health/economics](http://www.health.state.mn.us/health/economics)

Further, different methods are appropriate for different patients and communities. Because most respondents expressed a preference for data to be collected using either paper forms or being asked verbally, rather than requesting the information electronically, it may be preferable to use a combination of both written and verbal requests, such as general questions about Race Ethnicity and Language (REL) and Socio-Economic Status (SES) can be collected by paper at registration at the clinic, and more sensitive information such as gender identity, sexual orientation and disability requested in the exam room by the health care provider, nurse or medical assistant. Language used for the questions should be at 6<sup>th</sup> grade level or lower in order to be understandable to as many patients and consumers as possible. The plan for collecting the information should be designed to avoid people being asked multiple times for the same information.

- 9) **Develop a uniform construct for collecting RESD data across all systems.** Socio-demographic data needs to be collected using consistent standards across the entire health care system in the state to be able to make comparisons around quality improvement. This is an important recommendation of earlier reports. This will make the efforts more effective by allowing data from multiple sources to be used and to allow comparisons of outcomes in different parts of the system. Further, other governmental agencies and systems beyond health care—such as education, housing, transportation, social services, etc.—should also use the same uniform standards for collecting RESD data. This will create better opportunities to collaborate across different parts of government and society and allow development of a more comprehensive strategy for achieving healthier communities.
- 10) **Understand Providers’ Perspectives on Collecting RESD Data.** Safety Net Providers serving high concentrations of RESD patients and communities should also be consulted in developing the plan for implementing RESD data changes. Those interviewed for this report recommended the following changes to improve data on disparities:
  - Additional RESD data categories that should be explored are:
    - Mental health
    - Housing stability
    - Employment status
    - Education level
    - Social support
    - Health literacy
  - Statewide provider quality measures should be risk-adjusted to reflect RESD status of patients and populations served. Adjustments must go beyond race, ethnicity and language to also include additional social determinants of health and socio-demographic risk factors that have an impact on health, access to services, quality of care, patient satisfaction and other health system quality indicators.
  - Comparison of rural and urban populations.
  - The state has a vital role in advancing RESD data stratification and risk adjustment methods. The science and existing practices are still emerging. The state should commit resources and expertise to improving data collection and risk adjustment methods in order to better identify and address health disparities.
- 11) **Understand Social Determinants of Health.** Interviewees felt that there is also a need for greater awareness and understanding by people who work in the health care system of how social determinants like economic status and challenges around jobs affect the health and patients and communities.

- 12) **Develop Awareness of Structural Racism and Discrimination.** Health care providers, health care professionals, and health care and government leaders within Minnesota's health care system would benefit from understanding how structural racism and structural discrimination based on socio-demographic factors has adversely impacted RESD communities and patients as well as the entire community at large by increasing health disparities. With increased awareness they will be better prepared to be intentional in changing the system.
- 13) **Recognize Challenges New Immigrants Face.** The systems need to recognize that immigrants face unique challenges which are impacting their health and treatment. This situation is even more challenging for immigrants who are undocumented and even less likely to provide RESD data or to trust that the information provided will not be used in a way that will negatively impact them.
- 14) **Work with Communities to Improve Health Equity Data.** The health care system needs to work with communities to define and then communicate how socio-demographic data collected will be used and shared. Assessing the challenges and strengths of communities disproportionately impacted by health inequities should be an ongoing effort.



Despite overall improvements in public health and medicine, disparities in health and healthcare persist. Disparities are differences caused by inequities that are linked to social, economic, and/or environmental disadvantages. Widespread recognition of health and healthcare disparities has prompted the U.S. Department of Health and Human Services (HHS) as well as many other organizations in the public sector and the private sector to prioritize health equity as a key component of healthcare quality improvement. Achieving health equity requires eliminating disparities in health outcomes by addressing social risk factors that adversely affect excluded or marginalized groups.

Performance measurement is an essential tool for monitoring health disparities and assessing the level to which interventions known to reduce disparities are employed. Measures can help to pinpoint where people with social risk factors do not receive the care they need or receive care that is lower quality. Yet, there is no systematic approach for HHS and other stakeholders (e.g., providers, hospitals, health plans, etc.) to use measures for eliminating disparities and promoting health equity. To support this aim, the National Quality Forum (NQF), funded by HHS, convened a group of experts to develop a roadmap that demonstrates how healthcare performance measures, and associated policy levers, can be used to eliminate disparities.

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## NQF'S ROADMAP TO REDUCE DISPARITIES

The roadmap primarily focuses on ways the U.S. healthcare system (i.e., providers and payers) can use more traditional pathways to eliminate disparities; however, it also identifies areas where collaboration and community partnerships can be used to expand the healthcare system's role to better address disparities. Although the primary audience for the roadmap is public- and private-sector payers, achieving health equity will require a meaningful commitment and efforts from all stakeholders.

The roadmap lays out four actions, "Four I's for Health Equity," to promote health equity and reduce disparities:

- 1. Identify** and prioritize reducing health disparities
- 2. Implement** evidence-based interventions to reduce disparities
- 3. Invest** in the development and use of health equity performance measures
- 4. Incentivize** the reduction of health disparities and achievement of health equity

# A Roadmap for Promoting Health Equity and Reducing Disparities



## HOW THE DISPARITIES ROADMAP COULD BE USED

The actions presented in the roadmap allow multiple stakeholders to identify how they can begin to play a part in reducing disparities and promoting health equity. For example:

- Hospitals and/or health plans can identify and prioritize reducing disparities by stratifying performance measures that can detect and monitor known disparities and distinguish which they can address in the near, medium, and long-term.
- Clinicians can implement evidence-based interventions by connecting patients to community-based services or culturally tailored programs shown to mitigate the drivers of disparities. Healthcare organizations and

researchers can test new interventions to add to the current evidence base.

- Measure developers can work with patients to translate concepts of equity into performance measures that can directly assess health equity.
- Policymakers and payers can incentivize the reduction of disparities and the promotion of health equity by building health equity measures into new and existing healthcare payment models.

These are only a few of the many ways the roadmap can be implemented and only some of the stakeholders that can act on its recommendations.



## IDENTIFY AND PRIORITIZE REDUCING HEALTH DISPARITIES

The volume of existing measures can make prioritization a challenge, but measures that can help to monitor and reduce disparities should be prioritized. Disparities-sensitive measures detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups. NQF's Disparities Committee recommended four criteria to help stakeholders identify and prioritize measures that can detect disparities:

**1. Prevalence**—How prevalent is the condition among populations with social risk factors?

What is the impact of the condition on the health of populations with social risk factors?

**2. Size of the disparity**—How large is the gap in quality, access, and/or health outcome between the group with social risk factors and the group with the highest quality ratings for that measure?

**3. Impact of the quality process**—How strong is the evidence linking improvement in performance on the measure to improved outcomes in the population with social risk factors?

**4. Ease and feasibility of improving the quality process (actionable)**—Is the measure actionable among the population with social risk factors?

TABLE 1. EXAMPLES OF DISPARITIES-SENSITIVE MEASURES

Measure Title	Description
<b>NQF Measure 0018:</b> Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of Hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
<b>NQF Measure 0059:</b> Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
NQF Measure 0034: Colorectal Cancer Screening	Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer .
<b>NQF Measure 0004:</b> Initiation and Engagement of Alcohol and Other Drug Dependence	Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received Initiation and engagement of alcohol and other drug dependence treatment
<b>NQF Measure 0278:</b> Low birth weight (PQI9)	The number of low birth weight infants per 100 births

## IMPLEMENT EVIDENCE-BASED INTERVENTIONS TO REDUCE DISPARITIES

Many studies have documented interventions that reduce disparities; however, these interventions are rarely implemented in practice. A large body of evidence and guidance demonstrates how all stakeholders can play a role in reducing disparities. Clinicians and allied health professionals can work with communities to deliver culturally tailored lifestyle education programs and deploy community health workers. Provider organizations can ensure

that their workforce has the knowledge, attitudes, skills, and resources to advance health equity. Payers should incentivize and monitor the use of interventions to reduce disparities. Lastly, and most importantly, patients and families can and should be involved in the development and evaluation of interventions designed to reduce disparities. Although further investment in research and demonstration projects is needed, there is enough evidence for stakeholders to act now. Performance measures can then be used to monitor the extent to which these health promoting activities occur.

## INVEST IN THE DEVELOPMENT AND USE OF HEALTH EQUITY PERFORMANCE MEASURES

The Committee recognized a need for both disparities-sensitive measures (i.e., measures that can detect disparities) and measures that directly assess whether interventions that promote health equity are employed (i.e., health equity measures). To guide the selection and development of health equity measures, the Committee identified five domains of measurement of health equity, which represent a prioritized set of goals that must be achieved for the U.S. healthcare system to promote health equity:

1. Adopt and implement a **culture of equity**. A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, the creation of environments where all individuals, particularly those from diverse and/or stigmatized backgrounds, feel safe in addressing difficult topics, e.g., racism, and advocating for public and private policies that advance equity.
2. Create **structures** that support a culture of equity. These structures include policies and procedures that institutionalize values that promote health equity, commit adequate resources for the reduction of disparities, and enact systematic collection of data to monitor and provide transparency and accountability about the outcomes of individuals with social risk factors. These structures also include continuous learning systems that routinely assess and the needs of individuals with social risk factors, develop culturally tailored interventions to reduce disparities, and evaluate their impact.
3. Ensure **equitable access to healthcare**. Equitable access means that individuals with social risk factors are able to easily get care. It also means care is affordable, convenient, and able to meet the needs of individuals with social risk factors.

4. Ensure **high-quality care** within systems that continuously reduces disparities. Performance measures should be routinely stratified to identify disparities in care. In addition, performance measures should be used to create accountability for reducing, and ultimately, eliminating disparities through effective interventions.
5. **Collaborate and partner with** other organizations or agencies that influence the health of individuals (e.g., neighborhoods, transportation, housing, education, etc.). Collaboration is necessary to address social determinants of health that are not amenable to what doctors, hospitals, and other healthcare providers are trained and licensed to do.

The Committee also identified measure concepts that measure developers can translate into performance measures to assess progress towards meeting the goals of the domains of measurement.

## INCENTIVIZE THE REDUCTION OF HEALTH DISPARITIES AND ACHIEVEMENT OF HEALTH EQUITY

The increased use of performance measures offers numerous ways to incentivize the reduction of disparities. For instance, accountable care models can include health equity measures that are linked to payment to spur both improvement and innovation. Reporting the results of disparities-sensitive and health equity measures can provide transparency as well as help identify and address disparities. Public and private payers can adjust payments to providers based on social risk factors or offer additional payments for primary care or disease management programs (e.g., in-home monitoring of blood pressure). Acknowledging that leveraging payment models is only one way of incentivizing and supporting the achievement of health equity, the Committee developed a set of recommendations to provide the necessary support for reducing disparities and promoting health equity.

## RECOMMENDATIONS

### RECOMMENDATION 1:

#### **Collect social risk factor data.**

Data are the bedrock of all measurement activities; however, data on social risk factors are currently limited. As such, stakeholders must invest in the necessary infrastructure to support data collection. There is a general need for data collection related to social risks like housing instability, food insecurity, gender identity, sexual orientation, language, continuity of insurance coverage, etc.

### RECOMMENDATION 2:

#### **Use and prioritize stratified health equity outcome measures.**

Stakeholders should first conduct a needs assessment to identify the extent to which they are meeting the goals outlined in the roadmap. The domains of measurement should be considered as a whole rather than aiming to make progress in only one area. Stakeholders must actively identify and decommission measures that have reached ceiling levels of performance and where there are insignificant gaps in performance.

### RECOMMENDATION 3:

#### **Prioritize measures in the domains of Equitable Access and Equitable High-Quality Care for accountability purposes.**

Some measures within the domains of measurement are more suitable for accountability and others, for quality improvement. The majority of measures that fall within the domains of *Culture for Equity*, *Structure for Equity*, and *Collaboration and Partnerships* should be used primarily for quality improvement initiatives and are less appropriate for accountability. Measures that are aligned with the domains of *Equitable Access to Care* and *Equitable High-Quality Care* may be more suitable for accountability.

### RECOMMENDATION 4:

#### **Invest in preventive and primary care for patients with social risk factors.**

Equitable access starts with unconstrained access to primary care. People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on continuity with a trusted

primary care physician. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing resources and services to align with these needs is vital to improving health equity. Ultimately, incentives are needed to prioritize support for traditionally underfunded preventive activities.

### RECOMMENDATION 5:

#### **Redesign payment models to support health equity.**

Payment models designed to promote health equity have the potential to have a large impact on reducing disparities. For example, health plans can provide upfront payments to fund infrastructure for achieving equity and addressing the social determinants of health. Health plans can also implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care. The Committee noted that purchasers could use mixed model approaches, combining payment models based on their specific goals (e.g., upfront payments and pay-for-performance to reduce disparities). Payment models can also be phased, using pay-for-reporting, then pay-for-performance incentives.

### RECOMMENDATION 6:

#### **Link health equity measures to accreditation programs.**

Integrating health equity measures into accreditation programs can increase accountability for reducing disparities and promoting health equity. These measures can be linked to quality improvement-related equity building activities. Organizations like the National Committee for Quality Assurance (NCQA) and URAC have already aligned with this strategy.

### RECOMMENDATION 7:

#### **Support outpatient and inpatient services with additional payment for patients with social risk factors.**

Social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social

risk factors and “social complexity” as a payment concept.

**RECOMMENDATION 8:  
Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.**

Payers should consider additional payments to assist organizations in developing the infrastructure to provide high-quality care for people with social risk factors. There is a need to adjust for social risk factors as well as stratify performance scores by social risk to ensure transparency and drive improvement. In addition, relevant stakeholders should prospectively monitor the financial impact of value-based purchasing programs on organizations caring for individuals with social risk factors.

**RECOMMENDATION 9:  
Fund care delivery and payment reform demonstration projects to reduce disparities.**

The evidence base for many care delivery and payment reform interventions to reduce healthcare

disparities is still limited. There is a need to better understand what work is being done to reduce disparities, what interventions are effective, and how these interventions can be replicated in practice (e.g., implementation science). Future research and demonstration projects should be conducted in partnership with researchers to ensure they are rigorous and scientifically sound.

**RECOMMENDATION 10:  
Assess economic impact of disparities from multiple perspectives.**

There is limited understanding of the economic impact of disparities. Quantifying the costs in terms such as lost productivity, quality adjusted life years, readmission rates, emergency department use, etc., could help organizations understand the imperative to invest in health equity.

The full NQF report, A Roadmap to Reduce Health and Healthcare Disparities through Measurement, can be accessed on the NQF website. To receive updates about NQF’s disparities-related work, please [sign up here](#).

**GLOSSARY OF TERMS**

**Social risk factors:** Economic and social conditions that may influence individual and group differences in health and health outcomes. These factors may include age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and many others.

**Performance measure:** an assessment tool that aggregates data to assess the structure, processes, and outcomes of care within and between entities—typically specifies a numerator (what/how/when), denominator (who/where/when), and exclusions (not).

**Measurement Roadmap:** A conceptual model to provide structure for organizing currently available measures. It identifies areas where gaps in measurement exist and prioritizes areas for future measure development by

organizing ideas about what is important to measure for a topic area and how measurement should take place (e.g., whose performance should be measured, in which care settings, and for which individuals).

**Disparities-sensitive measure:** A measure that detects differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among population or social groups.

**Domain of measurement:** A domain of measurement is a categorization/grouping of high-level ideas and measure concepts that further describes the measurement roadmap, and a subdomain is a smaller categorization/grouping within a domain.

**Health disparity:** A health difference that is closely linked to social, economic, or environmental factors. A

healthcare disparity is a difference in the quality of healthcare that is not due to clinical factors.

**Health equity measure:** A performance measure that assesses the use of evidence-based interventions that reduce disparities in health or healthcare.

**Measure concept:** An idea for a measure that includes a description of the measure, including planned target and population.

**Stratification:** A process by which clinicians, providers, and other entities report measures by different groups of patients (male, female, African American, white, etc.) or combination of groups to find potential differences in care. An example is examining a measure of how many patients received routine mammography by how many African American women received the recommended care.

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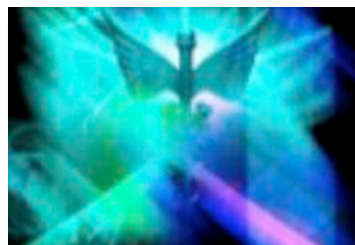




# Meaningful Measures

**November 28, 2017**

**Jean Moody-Williams, RN, MPP  
Pierre Yong, MD, MPH, MS  
Theodore G Long, MD, MHS**



# A New Approach to Meaningful Outcomes

**Empower patients and doctors to make decision about their health care**



**Usher in a new era of state flexibility and local leadership**

**Support innovative approaches to improve quality, accessibility, and affordability**

**Improve the CMS customer experience**

# Meaningful Measures Objectives

Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity, which can help:

- *Address high impact measure areas that safeguard public health*
- *Patient-centered and meaningful to patients*
- *Outcome-based where possible*
- *Relevant for and meaningful to providers*
- *Minimize level of burden for providers*
  - *Remove measures where performance is already very high and that are low value*
- *Significant opportunity for improvement*
- *Address measure needs for population based payment through alternative payment models*
- *Align across programs and/or with other payers (Medicaid, commercial payers)*



# Meaningful Measures Framework

## Meaningful Measure Areas Achieve:

- ✓ High quality healthcare
- ✓ Meaningful outcomes for patients

Criteria meaningful for patients and actionable for providers

### Draws on measure work by:

- Health Care Payment Learning and Action Network
- National Quality Forum – *High Impact Outcomes*
- National Academies of Medicine – *IOM Vital Signs Core Metrics*

### Includes perspectives from experts and external stakeholders:

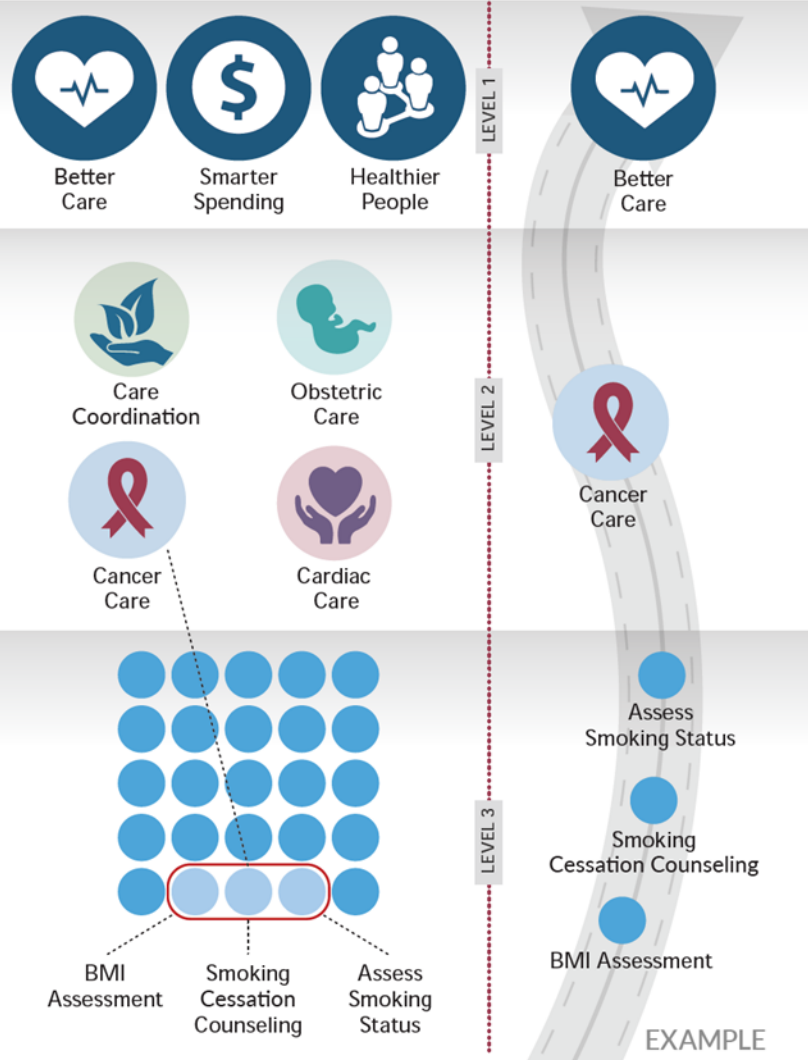
- Core Quality Measures Collaborative
- Agency for Healthcare Research and Quality
- Many other external stakeholders

Quality Measures

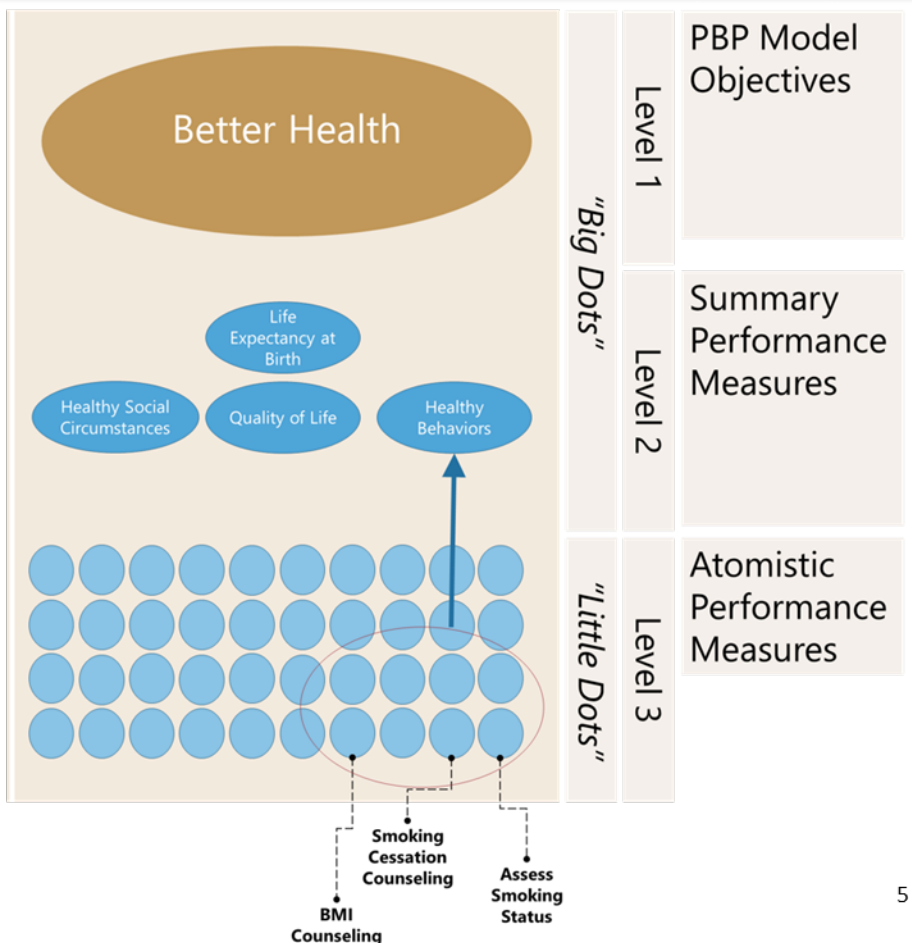


# Use Meaningful Measures to Achieve Goals, while Minimizing Burden

GRANULARITY



## Drawing from the HCP LAN "Big Dot" Work



# Meaningful Measures

## Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Seamless Transfer of Health Information

## Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience and Functional Outcomes

## Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:

- Healthcare-Associated Infections
- Preventable Healthcare Harm



## Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

## Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:

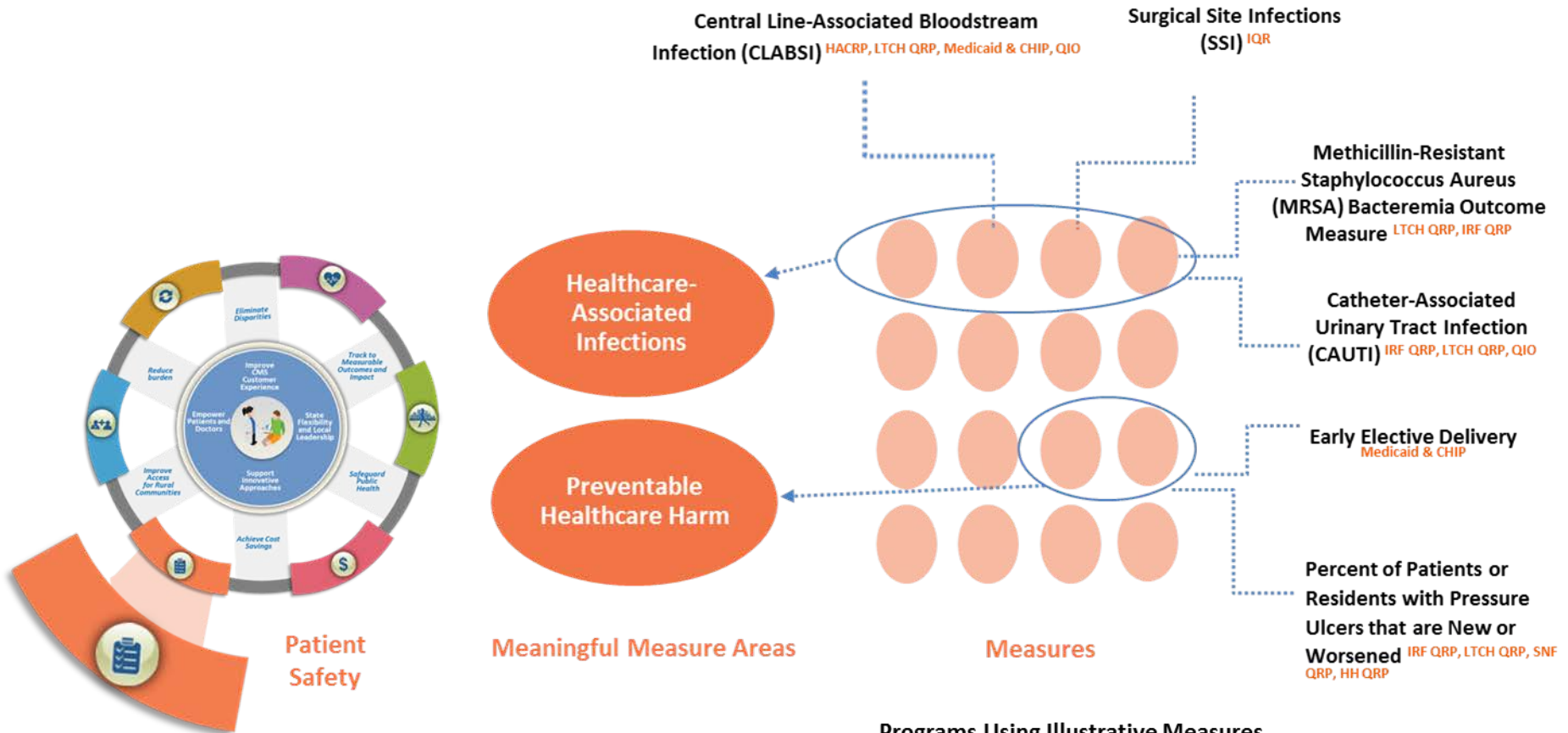
- Equity of Care
- Community Engagement

## Make Care Affordable

Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

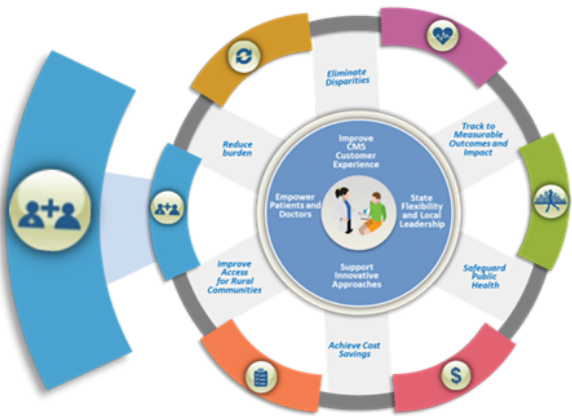
# Make Care Safer by Reducing Harm Caused in the Delivery of Care



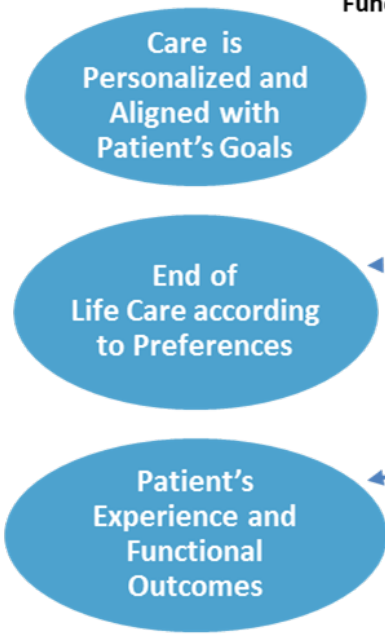
## Programs Using Illustrative Measures

- Hospital-Acquired Condition Reduction Program (HACRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Medicaid and CHIP (Medicaid & CHIP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Hospital Inpatient Quality Reporting (IQR) Program
- Home Health Quality Reporting Program (HH QRP)
- Quality Improvement Organization (QIO)

# Strengthen Person & Family Engagement as Partners in their Care



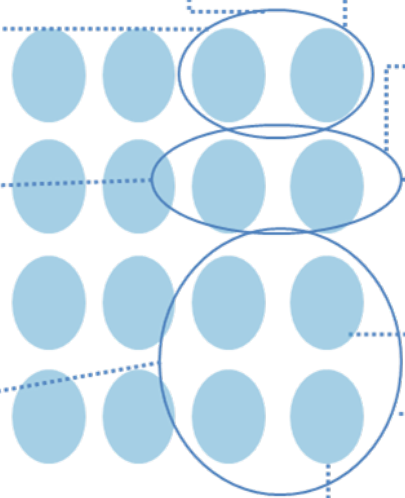
Person- and Family-Centered Care



Meaningful Measure Areas

The Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

IRF QRP, LTCH QRP, SNF QRP, HH QRP



Measures

Care plan <sup>QPP</sup>

Hospice Visits while Death is Imminent <sup>HQRP</sup>

CAHPS<sup>®</sup> Hospice Survey: Getting Emotional and Religious Support <sup>HQRP</sup>

CAHPS In-Center Hemodialysis Survey <sup>ESRD QIP</sup>

Home and Community Based Services CAHPS <sup>Medicaid & CHIP</sup>

Functional Status Assessment for Total Hip Replacement <sup>QPP</sup>

## Programs Using Illustrative Measures

- Quality Payment Program (QPP)
- Hospice Quality Reporting Program (HQRP)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Medicaid and CHIP (Medicaid & CHIP)
- Home Health Quality Reporting Program (HH QRP)



# Promote Effective Communication & Coordination of Care



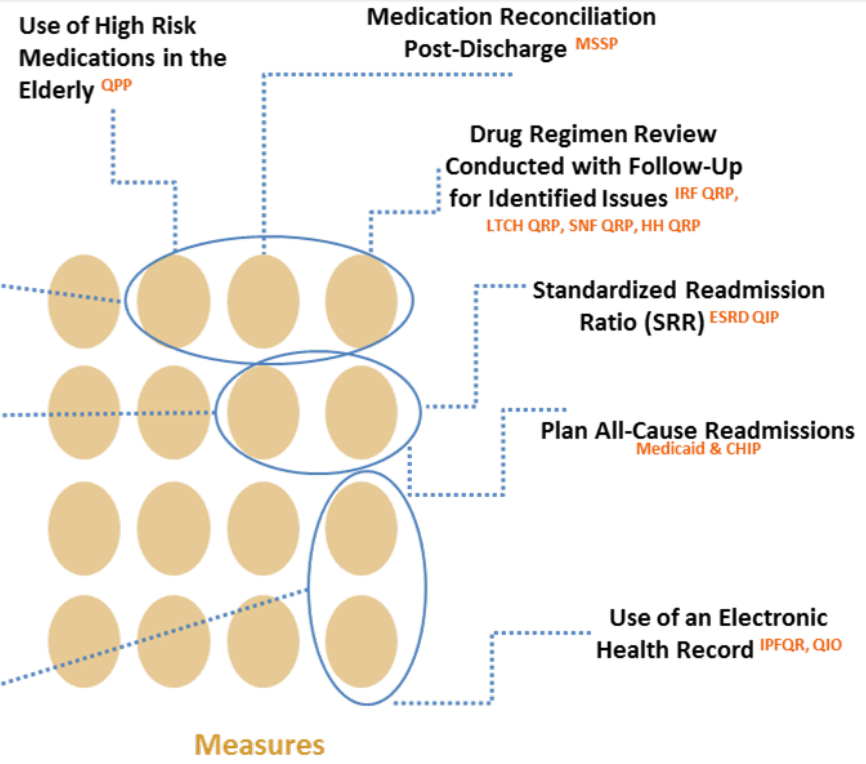
Effective Communication and Care Coordination

Medication Management

Admissions and Readmissions to Hospitals

Seamless Transfer of Health Information

Meaningful Measure Areas



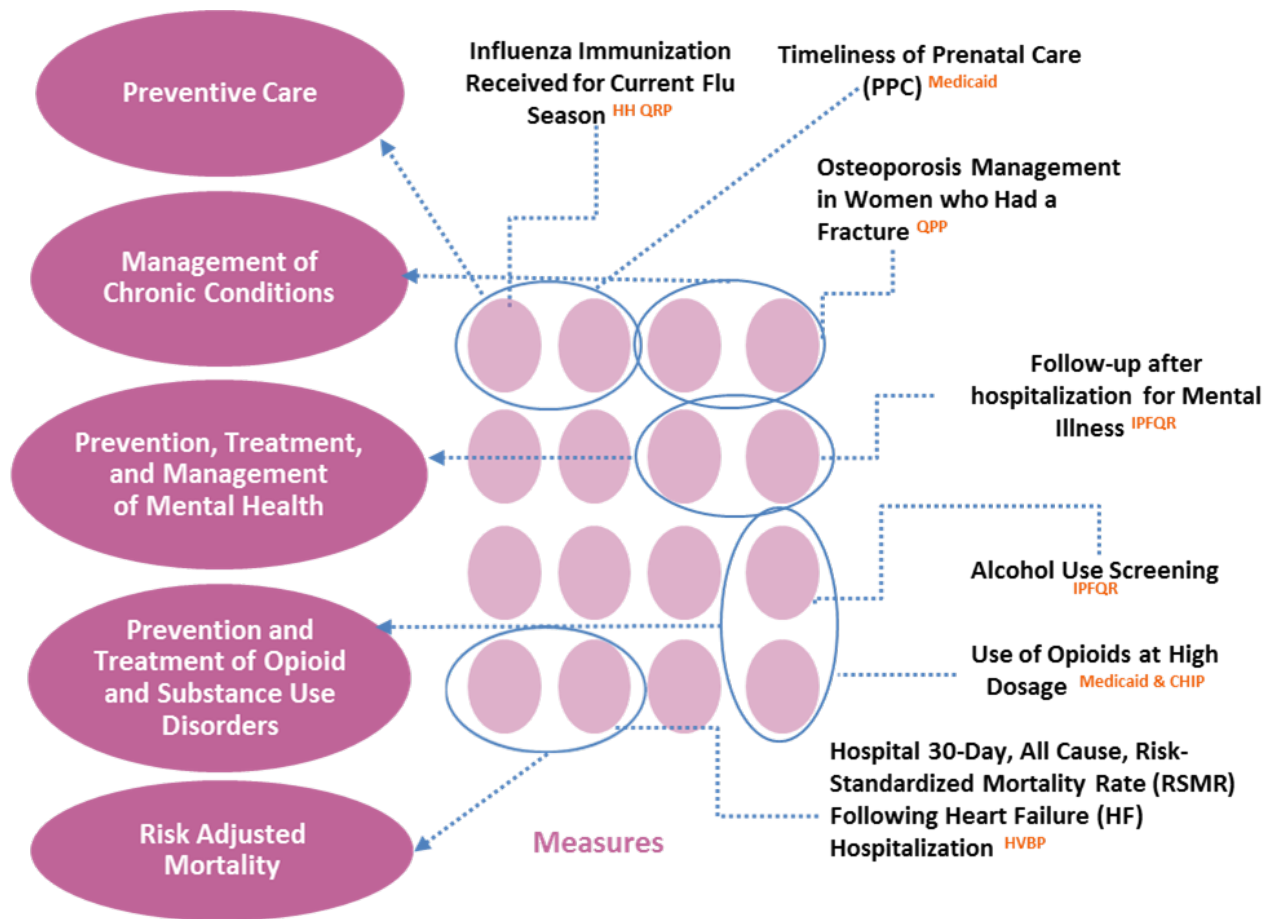
Programs Using Illustrative Measures

- Quality Payment Program (QPP)
- Medicare Shared Savings Program (MSSP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Home Health Quality Reporting Program (HH QRP)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Medicaid and CHIP (Medicaid & CHIP)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Quality Improvement Organization (QIO)

# Promote Effective Prevention & Treatment of Chronic Disease



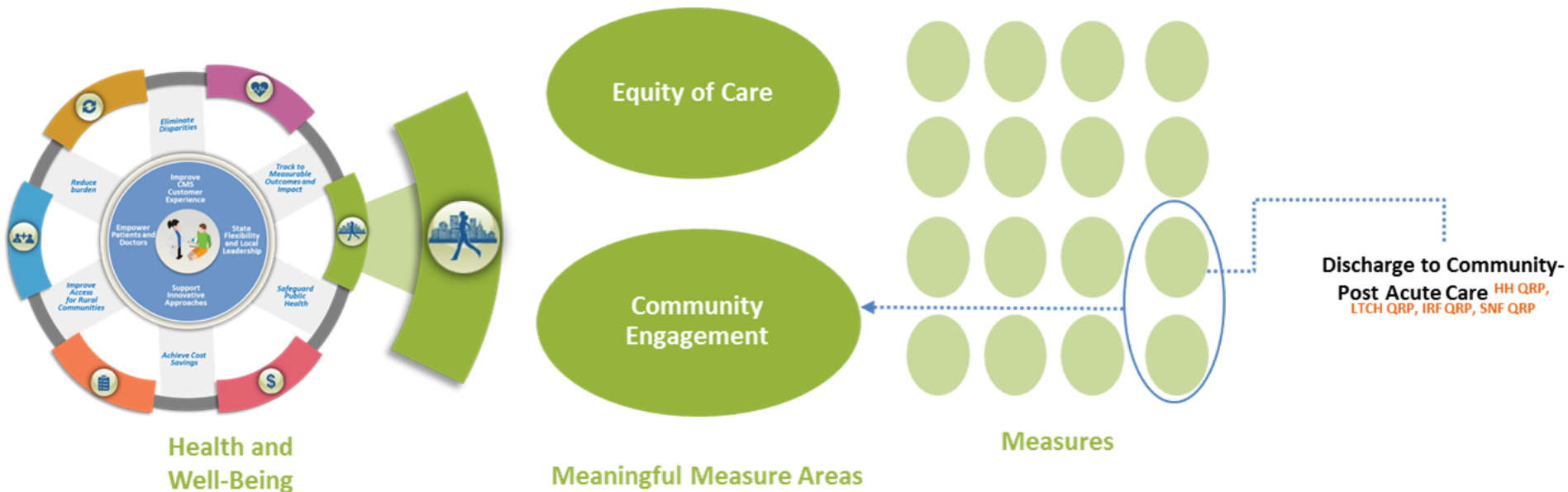
Prevention and Treatment of Leading Causes of Morbidity and Mortality



## Programs Using Illustrative Measures

- Home Health Quality Reporting Program (**HH QRP**)
- Medicaid and CHIP (**Medicaid & CHIP**)
- Quality Payment Program (**QPP**)
- Inpatient Psychiatric Facility Quality Reporting (**IPFQR**) Program
- Hospital Value-Based Purchasing (**HVBP**) Program

# Work with Communities to Promote Best Practices of Healthy Living

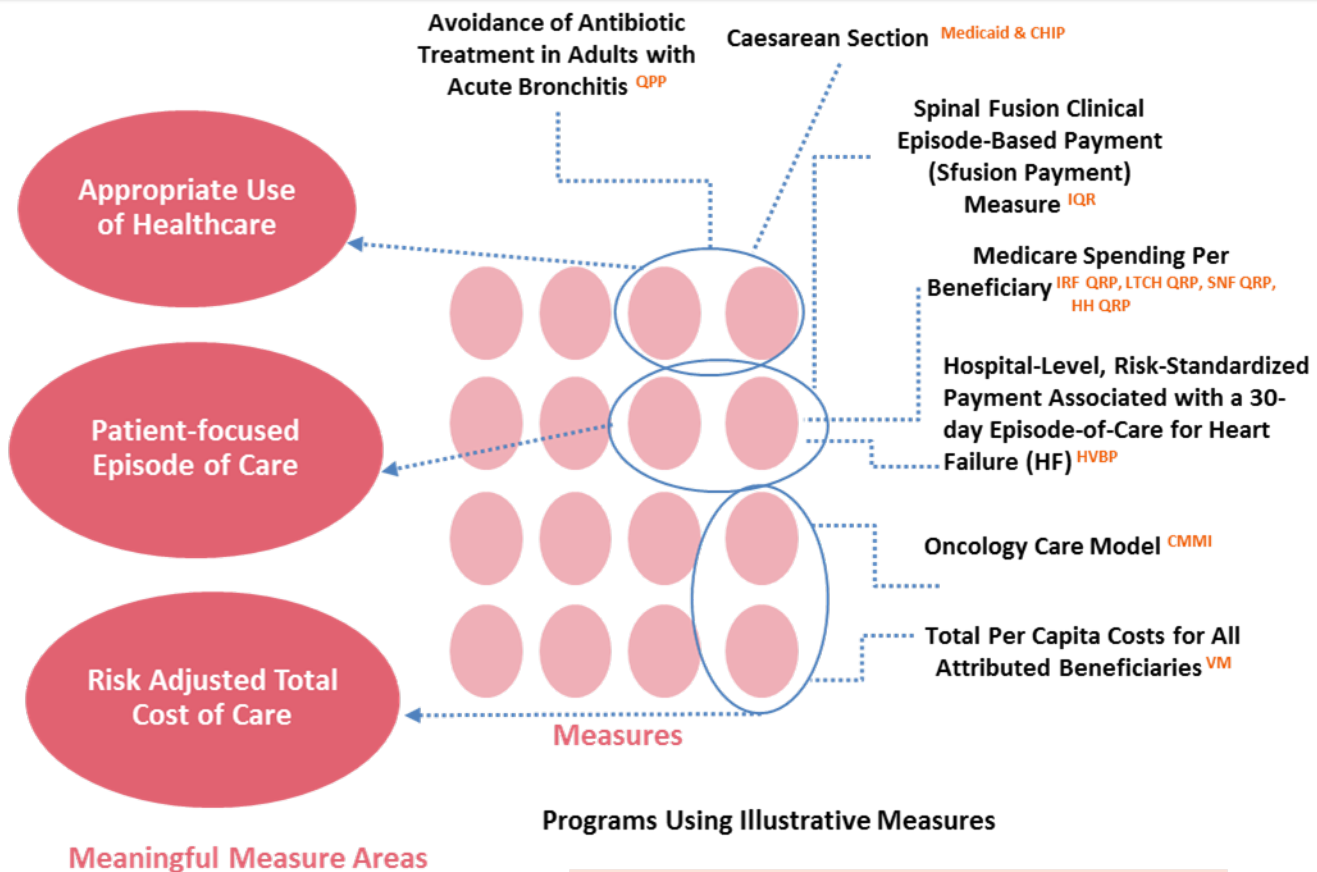


## Programs Using Illustrative Measures

- Home Health Quality Reporting Program (HH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)



# Make Care Affordable



- Quality Payment Program (**QPP**)
- Hospital Inpatient Quality Reporting (**IQR**) Program
- Hospital Value-Based Purchasing (**HVBP**) Program
- Center for Medicare and Medicaid Innovation (**CMMI**)
- Value Modifier (**VM**) Program
- Home Health Quality Reporting Program (**HH QRP**)
- Skilled Nursing Facility Quality Reporting Program (**SNF QRP**)
- Long-Term Care Hospital Quality Reporting Program (**LTCH QRP**)
- Inpatient Rehabilitation Facility Quality Reporting Program (**IRF QRP**)

# Meaningful Measures Next Steps

- Get stakeholder input to further improve the Meaningful Measures framework
- Work across CMS components to implement the framework
- Evaluate current measure sets and inform measure development



Give us your feedback!

[MeaningfulMeasuresQA@cms.hhs.gov](mailto:MeaningfulMeasuresQA@cms.hhs.gov)

# Meaningful Measures

## Question & Answer





Quality Payment  
PROGRAM

**AN INTRODUCTION TO:**  
The Merit-based Incentive  
Payment System (MIPS) in 2017





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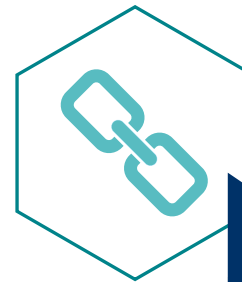


## How to Use This Guide



### Table of Contents

The table of contents is **interactive**. Click on a chapter to read that section, and then click on the chapter title to go back to the table of contents.



### Hyperlinks

**Hyperlinks** to our Quality Payment Program [website](#) are included throughout the guide to direct you to more information and resources.



### Resources

This guide includes an icon to let you know there are more resources on the topic you're reading about.

**Please note:** This guide was prepared as a service to the health care industry and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.





# PROGRAM OVERVIEW





## What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program (QPP), that provides for **two participation tracks**:

<p><b>Merit-based Incentive Payment System</b></p>  <p><b>MIPS</b></p>	<p><b>Advanced Alternative Payment Models</b></p>  <p><b>APMs</b></p>
<p>You may receive a performance-based payment adjustment for providing evidence-based and practice-specific quality care supported by technology and reporting on your progress.</p>	<p>These are innovative payment models; if you decide to participate in one through Medicare Part B, you may earn an incentive payment.</p>

The Quality Payment Program takes a comprehensive approach to payment. Instead of basing payment only on a series of billing codes, the Quality Payment Program adds consideration of quality through a set of evidenced-based measures that were primarily developed by clinicians. The program recognizes and encourages improvements in clinical practice. All of these efforts are increasingly supported by advances in technology that allow for the easy exchange of needed information while protecting patient privacy. The program provides special provisions for those participating in certain new models of care that provide an alternative to fee-for-service.

**Please note** that this guide focuses on the MIPS track. For more information on how to participate in APMs, visit the [QPP page of the CMS.gov](#). Additionally, clinicians participating in a MIPS APM should refer to the MIPS APMs fact sheet for more information.





## What is MIPS?

MIPS is 1 of 2 tracks of the Quality Payment Program. MIPS combines 3 Medicare “legacy” programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program.

**Under MIPS, there are 4 performance categories that will affect your Medicare payments:**



Calendar Years 2016 (for the PQRS and VM programs) and 2017 (for the Medicare EHR Incentive Program for Eligible Professionals) were the final reporting years for these programs, while 2018 is the last year clinicians may receive a payment adjustment under these legacy programs.

Under MIPS, physicians and other clinicians submit measures and activities focused on quality – that assess evidence-based and specialty-specific standards as well as practice-based improvement activities; cost of services; and the use of certified electronic health record technology (CEHRT) to support interoperability.

## Under MIPS

Medicare Part B clinicians that are eligible for MIPS can choose to participate in the MIPS performance-based payment system

For the 2017 transition year, MIPS eligible clinicians can choose the amount of data they submit to ensure CMS is assessing activities and measures that are meaningful to their practice

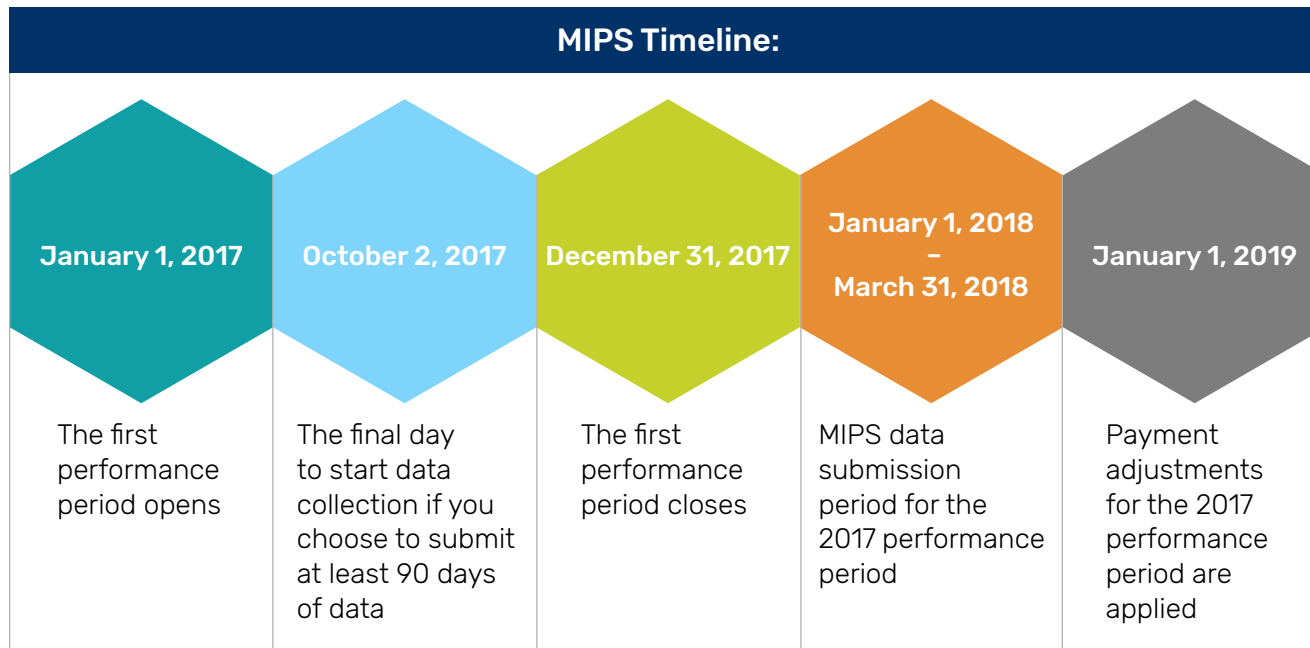


# HOW TO PARTICIPATE



## When Does Participation Begin?

The first MIPS performance period for the transition year is January 1, 2017 through December 31, 2017.



## Who Can Participate?

CMS describes professionals who are included for participation in MIPS as MIPS eligible clinicians. For the first two years of MIPS (CY 2017 and CY 2018), a MIPS eligible clinician is defined as the following:



Physicians\*



Physician Assistants



Nurse Practitioners



Clinical Nurse Specialists



Certified Registered Nurse Anesthetists

*\*Physicians (doctors of medicine, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors<sup>1</sup>)*

Any clinician group that includes one of the professionals listed above

<sup>1</sup>With respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.



## Can Clinicians Who Are Not Considered MIPS Eligible Clinicians Still Participate in MIPS?

Clinicians who are not eligible for MIPS now, because they are not in one of the categories listed on the previous page, can participate voluntarily. Voluntary participation allows clinicians to prepare and become familiar with the program in the event that they are included as MIPS eligible clinicians in future years, without any impact of the payment adjustment (neither positive nor negative).

### Non-Patient Facing MIPS Eligible Clinicians

CMS defines non-patient facing MIPS eligible clinicians as individual MIPS eligible clinicians who bill 100 or fewer patient-facing encounters (including Medicare telehealth services) during the applicable determination period. Groups are considered non-patient facing if more than 75 percent of their MIPS eligible clinicians have 100 or fewer patient-facing encounters (including Medicare telehealth services) during the applicable determination period. Non-patient facing MIPS eligible clinicians and groups are required to participate in MIPS and have alternative requirements for the Advancing Care Information and Improvement Activities performance categories.

### MIPS Eligible Clinicians in MIPS APMs

If clinicians are in a specific type of Alternative Payment Model called a MIPS APM, they may participate in MIPS through that APM and be scored using what is called the APM scoring standard. This APM scoring standard is designed to account for activities already required by the APM and eliminates the need for clinicians to duplicate the submission of certain quality and improvement activities data described later in this guide.



## Who is Excluded?

Clinician types that are not included in the general definition of a MIPS eligible clinician are excluded from the MIPS payment adjustment. In addition, certain clinicians who would otherwise be considered MIPS eligible clinicians may not be included in MIPS if they are a MIPS eligible clinician who meets the criteria for one of three exclusions, then the MIPS eligible clinician would be excluded from the MIPS payment adjustment.

1	Clinicians who enroll in Medicare for the first time during a MIPS performance period are exempt from reporting on measures and activities for MIPS until the following performance period.
2	Qualifying APM Participants (QPs) are not considered MIPS eligible clinicians and are excluded from the MIPS payment adjustment. Partial QPs who do not report on measures and activities that are required to be reported under MIPS for a given performance period for a year are not considered MIPS eligible clinicians and are excluded from the MIPS payment adjustment.
3	MIPS eligible clinicians or groups, that during the applicable determination period, do not exceed the low-volume threshold (have Medicare Part B allowed charges less than or equal to \$30,000 or provides care for 100 or fewer Part B-enrolled Medicare beneficiaries) are excluded from the MIPS payment adjustment for the performance period with respect to a year. Please note that the low-volume threshold is determined at the Taxpayer Identification Number (TIN)/ National Provider Identifiers (NPI) level for individual eligible clinicians, TIN level for Groups and Entity level for APMs.





## What is Pick Your Pace?

The first year of MIPS reporting under the QPP is CY 2017, which will serve as a transition year to help MIPS eligible clinicians prepare for future reporting. During the transition year, MIPS eligible clinicians have the option to “pick your pace” of participation from three different options:

<p><b>Test</b></p>	<ul style="list-style-type: none"> <li>MIPS eligible clinicians can submit some data after January 1, 2017 to be eligible for a neutral or small positive payment adjustment.</li> </ul>
<p><b>Partial</b></p>	<ul style="list-style-type: none"> <li>MIPS eligible clinicians submit data for a period of 90 consecutive days any time after January 1, 2017.</li> <li>October 2, 2017 is the last day to begin data collection to submit at least 90 days of data</li> <li>By submitting at least 90 days of data, MIPS eligible clinicians can be eligible for a positive payment adjustment.</li> </ul>
<p><b>Full</b></p>	<ul style="list-style-type: none"> <li>MIPS eligible clinicians who are prepared to fully participate can do so starting on January 1, 2017.</li> <li>MIPS eligible clinicians who submit a full year of data may qualify for a somewhat higher positive payment adjustment.</li> </ul>

\*For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities and Advancing Care Information performance categories.


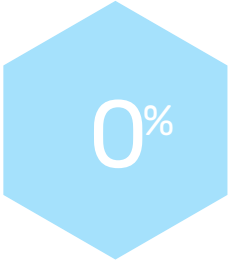




# PERFORMANCE CATEGORIES





Under MIPS, there are 4 performance categories that will affect your Medicare payments:

Quality	Cost	Improvement Activities	Advancing Care Information
 <p>60%</p> <p>weight</p>	 <p>0%</p> <p>weight</p>	 <p>15%</p> <p>weight</p>	 <p>25%</p> <p>weight</p>

**Note:** Performance category weights differ for eligible clinicians in MIPS APMs. In this section, we will explain the four performance categories and their requirements for participation.



## Performance Category

### Quality



The **Quality** performance category is worth 60% of the MIPS final score. The requirements of the Quality category were established to add flexibility for MIPS eligible clinicians to focus on the measures that are important to the quality of care in their practice and important to their patients.

#### Reporting Requirements for 2017

##### Test:

- Choosing the test option means that clinicians submit the minimally required data of one quality measure, for one patient for one day. This will let clinicians become familiar with the program while making sure they avoid the negative payment adjustment.

##### Partial:

- Submitting at least six quality measures, including at least one outcome measure, for 90 days or up to a full year. Under partial participation, CMS will analyze performance data, and clinicians have the chance to earn a modest positive payment adjustment.

##### Full:

- Full participation requires submitting data for the full year (Jan 1-Dec 31, 2017). Participating fully gives clinicians a greater chance to receive a higher positive payment adjustment.

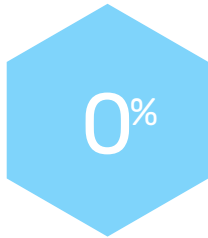
For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.



continued

## Performance Category

### Cost



The **Cost** performance category will be scored in 2017, but will not be weighted as part of the final score or used to determine payment adjustments. Therefore, the cost performance category is worth 0% of a MIPS eligible clinician's final score for the first performance period under MIPS.

Certain measures for MIPS eligible clinicians, including specific episode measures, will be calculated using cost based on administrative claims data, including specific episode measures, for Medicare patients only and only for patients that are attributed to them. Therefore, there are no submission requirements other than claims submission necessary under this category for clinicians.

### Improvement Activities



The **Improvement Activities** performance category assesses how much a MIPS eligible clinician participates in activities that improve clinical practice. **This performance category is worth 15% of the MIPS eligible clinician's final score.**

MIPS eligible clinicians will have the flexibility to choose from approximately 90 activities under 9 subcategories (categorized as either high-weighted or medium-weighted):

- |                             |   |   |
|-----------------------------|---|---|
| 1. Expanded Practice Access | 4. Beneficiary Engagement                 | 7. Achieving Health Equity                  |
| 2. Population Management    | 5. Patient Safety and Practice Assessment | 8. Integrating Behavioral and Mental Health |
| 3. Care Coordination        | 6. Participation in an APM                | 9. Emergency Preparedness and Response      |





*continued*

## Performance Category

### Improvement Activities

#### Reporting Requirements for 2017

The following are the different options under the “Pick Your Pace” approach adopted in the 2017 transition year of MIPS:

##### Test:

- Submit 1 improvement activity to avoid a negative payment adjustment.
- Activity may be high-weighted or medium-weighted.

##### Partial or Full:

- Choose 1 of the following combinations for a minimum of 90 consecutive days to qualify for a positive payment adjustment:
  - 2 high-weighted activities.
  - 1 high-weighted activity and 2 medium-weighted activities.
  - At least 4 medium-weighted activities.

##### Flexibilities:

- **Groups with 15 or fewer clinicians, non-patient facing MIPS eligible clinicians, or clinicians in a rural or health professional shortage area:** Attest that you completed up to 2 activities of any weight for a minimum of 90 consecutive days.

For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.





continued

## Performance Category

### Advancing Care Information



The **Advancing Care Information** performance category promotes patient engagement and the electronic exchange of health information using certified EHR technology. The Advancing Care Information performance category replaces the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use, and provides greater flexibility in choosing measures. This category is worth 25% of the MIPS eligible clinician's final score.

**In 2017, there are 2 measure set options for submission depending on the Certified EHR Technology (CEHRT) edition a clinician is using:**

- Advancing Care Information Objectives and Measures
- 2017 Advancing Care Information Transition Objectives and Measures

Depending on the CEHRT Edition, there will be different objectives from which the MIPS eligible clinician may choose to report.

**MIPS eligible clinicians using EHR technology certified to the 2015 Edition have two options from which they may choose to report:**

- Option 1: Advancing Care Information Objectives and Measures
- Option 2: Combination of the two measure sets

**MIPS eligible clinicians using EHR technology certified to the 2014 Edition have two options from which they may choose to report:**

- Option 1: 2017 Advancing Care Information Transition Objectives and Measures
- Option 2: Combination of the two measure sets





*continued*

## Performance Category

### Advancing Care Information

#### Reporting Requirements for 2017

**The Advancing Care Information performance category is comprised of a base score and a performance score. Submitting all required measures in the base score is necessary to earn any credit in the advancing care information performance category.**

#### Test:

- Submit all of the base score measures (either 4 or 5 depending on the CEHRT Edition) to avoid a negative payment adjustment.

#### Partial or Full:

- Submit the base score measures for a minimum of 90 consecutive days.
- Submit selected performance and/or bonus measures to receive a positive payment adjustment.

For 2017, please note that the MIPS payment adjustment is determined by performance across the Quality, Improvement Activities, and Advancing Care Information performance categories.

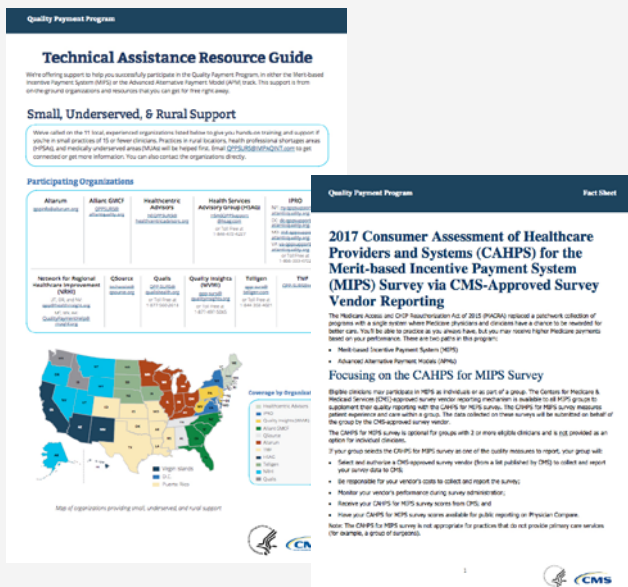
When choosing to submit data using a combination of EHR technologies certified to the 2014 and 2015 editions, you may not submit a measure from the ACI measure set that correlates to a 2017 ACI transition measure. For example, if you submit the Provide Patient Access 2017 ACI transition measure (worth up to 20%), you may not also submit the correlating ACI measures Provide Patient Access (worth up to 10%) and/or Patient-Generated Health Data (worth up to 10%). For additional information, see the Advancing Care Information fact sheet.





# RESOURCE LIBRARY





## Resource Library

- **QPP Overview Fact Sheet:** This fact sheet is designed to provide an overview of QPP, eligibility, scoring categories, and additional requirements.
- **Advancing Care Information Performance Category Fact Sheet:** This fact sheet is a guide to understanding the advancing care information performance category scoring methodology as well as the different types of measures.
- **Transforming Clinical Practice Initiative (TCPI):** TCPI is designed to support more than 140,000 clinician practices over the next 4 years in sharing, adapting, and further developing their comprehensive quality improvement strategies. Clinicians participating in TCPI will have the advantage of learning about MIPS and how to move toward participating in Advanced APMs. Click [here](#) to find help in your area.
- **Quality Innovation Network (QIN)-Quality Improvement Organizations (QIOs):** The QIO Program's 14 QIN-QIOs bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. More information about QIN-QIOs can be found [here](#).
- **If you're in an APM:** The Innovation Center's Learning Systems can help you find specialized information about what you need to do to be successful in the Advanced APM track. If you're in an APM that is not an Advanced APM, then the learning Systems can help you understand the special benefits you have through your APM that will help you be successful in MIPS. More information about the Learning Systems is available through your model's support inbox.
- **MIPS APMs Fact Sheet:** A resource for eligible clinicians practicing in MIPS APMs. This resource explains the alternate requirements and special scoring standards.





Glossary of Terms								
APM	CEHRT	CMS	EHR	MIPS	NPI	QCDR	QPP	TIN
Alternative Payment Model	Certified Electronic Health Record Technology	Centers for Medicare & Medicaid Services	Electronic Health Record	Merit-based Incentive Payment System	National Provider Identifier	Qualified Clinical Data Registry	Quality Payment Program	Taxpayer Identification Number





# Improving Health and Health Care Worldwide

Home / Engage with IHI / Initiatives / Triple Aim - The Best Care for the Whole Population at the Lowest Cost

## Initiatives

### Overview

Are You Ready to Pursue the Triple Aim? »

IHI Triple Aim Measures »

Materials »

Success Stories »

IHI Triple Aim Prototyping Partners »

### MORE INFORMATION?

Email: TripleAim@ihi.org



## The IHI Triple Aim

The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

### Why the Triple Aim?

The US health care system is the most costly in the world, accounting for 17% of the gross domestic product with estimates that percentage will grow to nearly 20% by 2020. [Source: National Healthcare Expenditure Projections, 2010-2020. Centers for Medicare and Medicaid Services, Office of the Actuary.] At the same time, countries with health systems that out-perform the US are also under pressure to derive greater value for the resources devoted to their health care systems. Aging populations and increased longevity, coupled with chronic health problems, have become a global challenge, putting new demands on medical and social services.

### Approach

In most health care settings today, no one is accountable for all three dimensions of the IHI Triple Aim. For the health of our communities, for the health of our school systems, and for the health of all our patients, we need to address all three of the Triple Aim dimensions at the same time.

Because the IHI Triple Aim entails ambitious improvement at all levels of the system, we advocate a systematic approach to change. Based on six phases of pilot testing with over 100 organizations around the world, IHI recommends a change process that includes: identification of target populations; definition of system aims and measures; development of a portfolio of project work that is sufficiently strong to move system-level results, and rapid testing and scale up that is adapted to local needs and conditions.

IHI believes that to do this work effectively, it's important to harness a range of community determinants of health, empower individuals and families, substantially broaden the role and impact of primary care and other community based services, and assure a seamless journey through the whole system of care throughout a person's life.

In the US environment many areas of health reform can be furthered and strengthened by Triple Aim thinking, including: accountable care organizations (ACOs), bundled payments, and other innovative financing approaches; new models of primary care, such as patient-centered medical homes; sanctions for avoidable events, such as hospital readmissions or infections; and the integration of information technology.

### TRIPLE AIM RESOURCES

Visit the Triple Aim Topic page for publications, tools, and other resources such as these:

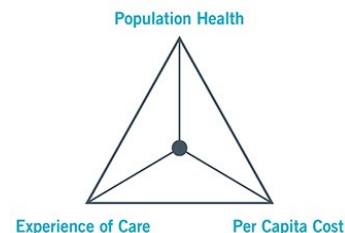
- A Guide to Measuring the Triple Aim
- Pursuing the Triple Aim: The First Seven Years

Learn More >>

### ARE YOU READY TO PURSUE THE TRIPLE AIM?

Use the assessment tool to find out.

### The IHI Triple Aim



### A PRIMER ON DEFINING THE TRIPLE AIM

The words "Triple Aim" and the terms that are part of its lexicon are often misused. This primer offers practical guidance on how to make sense of and use population-focused terminology and Triple Aim terminology.

Learn More >>

### Sign up for IHI news and a free QI course

Email\*

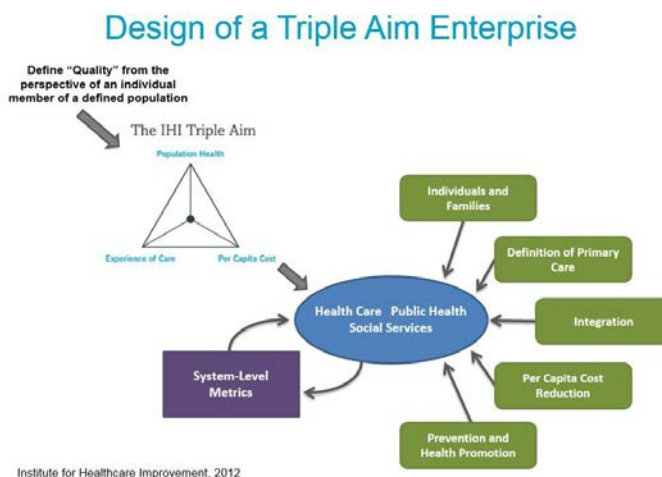
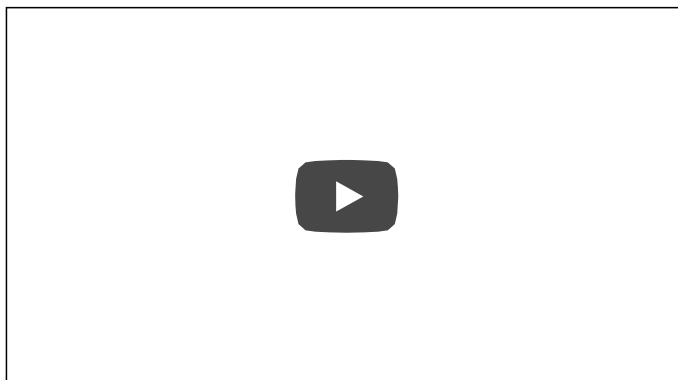
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### Concept Design

IHI's innovation team developed a concept design and described an initial set of components of a system that would fulfill the IHI Triple Aim. The five components are listed below, and a more detailed list can be found in the [Concept Design document](#).

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

### VIDEO: Design of a Triple Aim Enterprise



### Benefits to an Approach in Line with the IHI Triple Aim

Organizations and communities that attain the Triple Aim will have healthier populations, in part because of new designs that better identify problems and solutions further upstream and outside of acute health care. Patients can expect less complex and much more coordinated care and the burden of illness will decrease. Importantly, stabilizing or reducing the per capita cost of care for populations will give businesses the opportunity to be more competitive, lessen the pressure on publicly funded health care budgets, and provide communities with more flexibility to invest in activities, such as schools and the lived environment, that increase the vitality and economic wellbeing of their inhabitants.

For examples of organizations that have achieved results on the three dimensions of the Triple Aim, visit our [Success Stories page](#).

*The National Quality Strategy is a national effort to align public- and private-sector stakeholders to achieve better health and health care for all Americans.*

## About the National Quality Strategy

The National Quality Strategy (NQS) was first published in March 2011 as the **National Strategy for Quality Improvement in Health Care**, and is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS).

The NQS was developed through a transparent and collaborative process with input from a range of stakeholders. More than 300 groups, organizations, and individuals, representing all sectors of the health care industry and the general public, provided comments. Based on this input, the NQS established a set of **three overarching aims** that builds on the Institute for Healthcare Improvement's Triple Aim®, supported by **six priorities** that address the most common health concerns that Americans face. Stakeholders can use the **nine levers** to align their core business or organizational functions with the NQS to drive improvement on the aims and priorities.

## How the National Quality Strategy Works

Improving health and health care quality can occur only if all sectors—individuals, family members, payers, providers, employers, and communities—make it their mission. Members of the health care community can align to the NQS by doing the following:

- *Adopt the three aims to provide* better, more affordable care for the individual and the community.
- *Focus on the six priorities to guide efforts* to improve health and health care quality.
- *Use one or more of the nine levers to identify* core business functions, resources, and/or actions that may serve as means for achieving improved health and health care quality.

## Achieving Aims

The NQS pursues three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve health and the quality of health care.

- **Better Care:** Improve the overall quality by making health care more patient-centered, reliable, accessible, and safe
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government

## Setting Priorities

To advance these aims, the NQS focuses on six priorities:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family is engaged as partners in their care



- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

### Using Levers

The nine NQS levers below represent core business functions, resources, and/or actions that stakeholders can use to align to the Strategy. In many cases, stakeholders may already be using these levers but haven't connected these activities to NQS alignment.

- **Measurement and Feedback:** Provide performance feedback to plans and providers to improve care
- **Public Reporting:** Compare treatment results, costs, and patient experience for consumers
- **Learning and Technical Assistance:** Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals
- **Certification, Accreditation, and Regulation:** Adopt or adhere to approaches to meet safety and quality standards
- **Consumer Incentives and Benefit Designs:** Help consumers adopt healthy behaviors and make informed decisions
- **Payment:** Reward and incentivize providers to deliver high-quality, patient-centered care
- **Health Information Technology:** Improve communication, transparency, and efficiency for better coordinated health and health care
- **Innovation and Diffusion:** Foster innovation in health care quality improvement and facilitate rapid adoption within and across organizations and communities
- **Workforce Development:** Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers

### Measure Alignment

The NQS also addresses the proliferation of clinical quality measures currently used in national programs through the work of the HHS Measurement Policy Council (MPC). The MPC began convening in early 2012 to begin the work of aligning measures across HHS with the goal of establishing core sets of measures that are meaningful to different groups of stakeholders. Composed of senior-level representatives from across HHS, the MPC also focuses on new measure development, implementation, and policy so measures that have yet to be created will be aligned as well. For a list of topics and core measure sets, visit the Working for Quality site at [www.ahrq.gov/workingforquality](http://www.ahrq.gov/workingforquality).

### What You Can Do

The NQS supports the sharing of best practices in health and health care quality improvement at the national, State, and local level and will provide opportunities for the entire Nation to benefit from such collaboration. Learn more by visiting [www.ahrq.gov/workingforquality](http://www.ahrq.gov/workingforquality) and downloading the Stakeholder Toolkit, or tell us about your efforts by submitting comments to [NQStrategy@ahrq.hhs.gov](mailto:NQStrategy@ahrq.hhs.gov).



# The Six Domains of Health Care Quality

A handful of analytic frameworks for quality assessment have guided measure development initiatives in the public and private sectors. One of the most influential is the framework put forth by the Institute of Medicine (IOM), which includes the following six aims for the health care system.<sup>[1]</sup>



- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Existing measures address some domains more extensively than others. The vast majority of measures address effectiveness and safety, a smaller number examine timeliness and patient-centeredness, and very few assess the efficiency or equity of care.<sup>[2]</sup>

Frameworks like the IOM domains also make it easier for consumers to grasp the meaning and relevance of quality measures. Studies have shown that providing consumers with a framework for understanding quality helps them value a broader range of quality indicators. For example, when consumers are given a brief, understandable explanation of safe, effective, and patient-centered care, they view all three categories as important. Further, when measures are grouped into user-friendly versions of those three IOM domains, consumers can see the meaning of the measures more clearly and understand how they relate to their own concerns about their care.<sup>[3]</sup>

To learn more about grouping measures into categories, go to [Organizing Measures To Reduce Information Overload](#).

To learn more about selecting and reporting measures within categories that consumers understand, refer to:

- Hibbard J. Engaging Consumers in Quality Issues: While the road to engaging consumers is steep, it is fairly well marked. Washington, DC: National Institute for Health Care Management Foundation; October 2005. Available at <http://www.nihcm.org/pdf/ExpertV9.pdf> .
- Hibbard JH, Pawlson LG. Why Not Give Consumers a Framework for Understanding Quality? Joint Commission Journal on Quality Improvement 2004 June. 30(6); 347-351.
- Pillittere D, Bigley MB, Hibbard J, et al. Exploring Consumer Perspectives on Good Physician Care: A Summary of Focus Group Results. New York: The Commonwealth Fund; January 2003. Available at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=221323](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221323) .

<sup>[1]</sup> Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

<sup>[2]</sup> Institute of Medicine (IOM). Performance Measurement: Accelerating Improvement. Washington, D.C: National Academy Press; 2005.

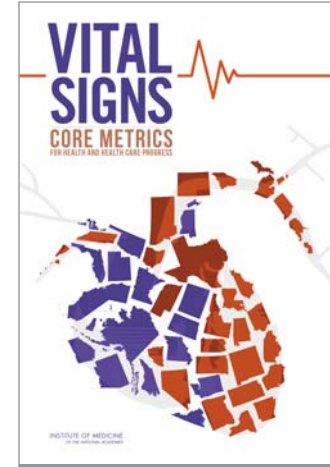
<sup>[3]</sup> Hibbard JH, Pawlson LG. Why Not Give Consumers a Framework for Understanding Quality? Joint Commission Journal on Quality Improvement 2004 June. 30(6); 347-351.

Source: <https://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html>



# Vital Signs

## Core Metrics for Health and Health Care Progress



**Thousands of measures are in use today** to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system. To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, and members of the public—must be alert to which measures matter most. What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?

With support from the Blue Shield of California Foundation, the California Healthcare Foundation, and the Robert Wood Johnson Foundation, the Institute of Medicine (IOM) convened a committee to identify core measures for health and health care. In *Vital Signs: Core Metrics for Health and Health Care Progress*, the committee uses a four-domain framework—healthy people, care quality, lower cost, and engaged people—to propose a streamlined set of 15 standardized measures, with recommendations for their application at every level and across sectors. Ultimately, the committee concludes that this streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

**A streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.**

### The Measurement Landscape

Health measurements are requested or required by many organizations for many purposes, including efforts to track population, community, and individual health; assessments of health care quality and patient experience; transparency monitoring; public reporting and benchmarking; system or professional performance requirements; and funder reporting. Many of these measures are very similar, with only slight variations in terminology and methodology. However, their differences are often significant enough to prevent direct comparisons across states, institutions, and individuals. In addition, many measures focus on narrow or technical aspects of health care processes, rather than on overall health system perfor-



mance and health outcomes. According to the committee, the growing number of clinical measures, even those that provide valuable information, draws attention to narrow, specific elements and away from system capacity and effectiveness.

The necessity to collect, analyze, and store data for such a large number of measures also imposes a significant burden on providers, organizations, and the health care system as a whole. Preliminary research commissioned by the committee finds that the growth in measurement and reporting activities results in considerable expense and requires substantial time commitments—without a matching return on investment. The establishment of a core set of measures could improve efficiency and ensure a focus on the most important health outcomes.






### The Core Measure Set

To select a core measure set, the committee first considers each candidate measure’s importance for health, likelihood to contribute to progress, understandability, technical integrity, potential to have broader system impact, and utility at multiple levels. Next, in considering how the measures should

operate as a set, the committee selects 15 measures that together have systemic reach, are outcomes-oriented, are meaningful at the personal level, are representative of concerns facing the U.S. health system, and have use at many levels. The core measures proposed by the committee are as follows:

- 1. Life expectancy:** Life expectancy is a validated, readily available, and easily understandable measure for a critical health concept. Because life expectancy depends on a full range of individual and community influences on health—from cancer to homicide—it represents an inclusive, high-level measure for health.
- 2. Well-being:** Well-being captures the subjective dimensions of health related to quality of life. Furthermore, levels of well-being often predict utilization of and satisfaction with health care. Self-reported well-being is a reliable indicator.
- 3. Overweight and obesity:** More than two-thirds of Americans are overweight or obese, a fact that has causes and consequences that extend beyond the health system—including socioeconomic, cultural, political, and lifestyle factors.

### BOX Core Measure Set with Related Priority Measures

 <p><b>1. Life expectancy</b>            Infant mortality            Maternal mortality            Violence and injury mortality</p>	 <p><b>7. Preventive services</b>            Influenza immunization            Colorectal cancer screening            Breast cancer screening</p>	 <p><b>11. Care match with patient goals</b>            Patient experience            Shared decision making            End-of-life/advanced care planning</p>
 <p><b>2. Well-being</b>            Multiple chronic conditions            Depression</p>	 <p><b>8. Care access</b>            Usual source of care            Delay of needed care</p>	 <p><b>12. Personal spending burden</b>            Health care-related bankruptcies</p>
 <p><b>3. Overweight and obesity</b>            Activity levels            Healthy eating patterns</p>	 <p><b>9. Patient safety</b>            Wrong-site surgery            Pressure ulcers            Medication reconciliation</p>	 <p><b>13. Population spending burden</b>            Total cost of care            Health care spending growth</p>
 <p><b>4. Addictive behavior</b>            Tobacco use            Drug dependence/illicit use            Alcohol dependence/misuse</p>	 <p><b>10. Evidence-based care</b>            Cardiovascular risk reduction            Hypertension control            Diabetes control composite            Heart attack therapy protocol            Stroke therapy protocol            Unnecessary care composite</p>	 <p><b>14. Individual engagement</b>            Involvement in health initiatives</p>
 <p><b>5. Unintended pregnancy</b>            Contraceptive use</p>		 <p><b>15. Community engagement</b>            Availability of healthy food            Walkability            Community health benefit agenda</p>
 <p><b>6. Healthy communities</b>            Childhood poverty rate            Childhood asthma            Air quality index            Drinking water quality index</p>		

The necessity to collect, analyze, and store data for such a large number of measures imposes a significant burden on providers, organizations, and the health care system as a whole.

**4. Addictive behavior:** Addiction, including to nicotine, alcohol, and other drugs, is prevalent in the United States, representing a complex challenge for the health system, communities, and families. Every year, substance abuse and addiction cost the country more than \$500 billion.

**5. Unintended pregnancy:** Unintended pregnancy, a significant challenge for both individual and community health, is a measure that aggregates a variety of social, behavioral, cultural, and health factors—particularly women’s knowledge about and access to tools for family planning.

**6. Healthy communities:** Individual health is a function of a wide range of socioeconomic and community factors, from infrastructure to social connections. Community health includes critical elements of health that fall outside the care system, such as housing, employment, and environmental factors.

**7. Preventive services:** Preventive services (for example, screening for hearing loss or counseling for tobacco cessation) present a valuable opportunity for both improving health and reducing costs.

**8. Care access:** A person’s ability to access care when needed is a critical precondition for a high-quality health system. Factors that could hamper access to care include lack of health insurance, clinician shortages, lack of transportation, cultural and linguistic barriers, and physical limitations.

**9. Patient safety:** Avoiding harm is among the principal responsibilities of the health care system, yet adverse outcomes are common. Ensuring patient safety will require a culture that prioritizes and assesses safety through a reliable index of organizational results.

**10. Evidence-based care:** Ensuring that patients receive care supported by scientific evidence for appropriateness and effectiveness is a central challenge for the health care system. Currently, an estimated one-third of U.S. health care expenditures

do not contribute to improving health. Aggregating carefully selected and standardized clinical measures can provide a reliable composite index of system performance.

**11. Care match with patient goals:** Systematically assessing each patient’s individual goals and perspectives ensures that the health care system is focusing on the aspects of care that matter most to patients.

**12. Personal spending burden:** Care that is too expensive can limit access to care, lead people to avoid care, or prevent them from spending money in other areas of value to them—with far-reaching economic impacts.

**13. Population spending burden:** Health care spending consumes a large portion of the U.S. gross domestic product, dwarfing the health care spending of other nations. This burden can be measured at national, state, local, and institutional levels.

**14. Individual engagement:** Given the effects of personal choices on health, as well as the increasing use of personal health devices, it is critical for individuals to be aware of their options and responsibilities in caring for their own health and that of their families and communities.

**15. Community engagement:** Across the United States, communities have and utilize different levels of resources to support efforts to maintain and improve individual and family health—for example, addiction treatment programs, emergency medical facilities, and opportunities for social engagement.

The committee recognizes that these 15 measures will not be sufficient to meet every interest for each organization, nor are there established methods for measurement in each area. To begin to accommodate these challenges, the committee identifies 39 additional priority measures that can act as surrogates while refinement is under way (see Box).



**Committee on Core Metrics for Better Health at Lower Cost**

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Refinement of the measures and methodology will require leadership from stakeholders across sectors.

**Implementation of the Core Measures**

Successful implementation of the core measures will depend on their relevance, reliability, and utility to stakeholders. Implementation challenges include multiple competing priorities for stakeholders, the sizable degree of change proposed, and the slow pace of change overall in the health system. Progress can be accelerated by ensuring that the core measurement set is applied by, and adds value to, existing measurement activities. The committee stresses that leadership will be required at nearly every level of the health system. CEOs of health care organizations, payers and employers, standards organizations, and public health agencies will have important roles in the uptake, use, and maintenance of the core measures as practical tools. The committee recommends that the Secretary of the Department of Health and Human Services, with support from the Executive Office of the President, lead the effort to refine, standardize, and implement core measures throughout the nation.

**Conclusion**

The set of core measures proposed by the committee is a tool for enhancing the efficiency and effectiveness of measurement. Ultimately, widespread application of a limited set of standardized measures could not only reduce the burden of unnecessary measurement but also align the incentives and actions of multiple organizations at multiple levels. *Vital Signs* lays the groundwork for the adoption of core measures that, if systematically applied, could yield better health at lower cost for all Americans. 



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For citation information, see Table 4-3 in the complete report, available at [www.nationalacademies.org/vitalsigns](http://www.nationalacademies.org/vitalsigns)