
Quality Framework Steering Team Meeting Summary

MAD Draft 9/13/2018

Meeting Date: September 6, 2018

Present

Steering Team: Kelly Fluharty, Deatrick LaPointe, Jennifer Lundblad, Ross Owen, Diane Rydrych, David Satin, Julie Sonier, Mark Sonneborn

MDH Staff: Rachel Cahoon, Marie Dotseth, Sarah Evans, Stefan Gildemeister, David Hesse, Denise McCabe

MAD Consultants: Lisa Anderson, Stacy Sjogren

Welcome

Jennifer Lundblad welcomed everyone to the final Quality Framework Steering Team Phase 1 meeting, reviewed the agenda, led introductions, reviewed goals, and reviewed the framework development arc. Diane reviewed the Steering Team Meeting 6 Summary. There was a request to clarify the term “recertification” on Page 2 to reflect the entire analogy and add it as a topic to a future conversation—such a practice has drawbacks and lends itself to partnership with the Institute for Clinical Systems Improvement (ICSI) or some sort of hybrid model. The acronym “QIPS—Quality Incentive Payment System” will also be spelled out in the final version of the summary.

Stakeholder Input

Physician-Consensus Measures of Performance to Advance Quality and Safety Work Group

Janet Silversmith from Minnesota Medical Association (MMA) provided an update on the Physician-Consensus Measures of Performance to Advance Quality and Safety Work Group.

Ms. Silversmith provided some context for this initiative. She expressed appreciation for conversations with MDH and MN Community Measurement (MNCM) about the future of quality measurement. MMA started thinking about measurement more strategically and “big picture”, which led to the framework legislation. MMA has a history of working on measurement standardization, and the organization acknowledges that measurement can drive improvement. However, MMA hears a lot about measurement burden and expense from members, and wants to alleviate that by fostering focus and

accountability. The 2015 Institute of Medicine's Vital Signs report advocates for measurement focus and parsimony and was a catalyst for MMA's work group.

The work group is composed of physician members and the work to-date is in draft form. The group convened to think about different approaches to measurement and focused on four pillars:

1. **Improve alignment between state and federal measures** – Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was an assertion of dominance by the federal measurement system, and Minnesota needs to figure out how to adjust
2. **Impose discipline (limitations) on the Statewide Quality Reporting and Measurement System (SQRMS)**
3. **Seek a more strategic approach to measurement**
4. **Expand physician leadership in measurement agenda**

They also recognized:

- Health is more than health care
- There is a need to be bold—change is needed, even if the change is hard
- Measure what matters (to the audience/stakeholders) and attribute appropriately

The work group concentrated on three audiences; individuals/patients, communities and the state level. The work group has a shared understanding that outcome measures should be prioritized and externally required process measures need clear connections to outcomes as rationale for the requirements. Members expressed that if the focus is on the right outcome, the process will follow.

The work group developed a **strategic vision** for measures that

- focuses on health and health care issues that are most relevant to individuals and communities,
- focuses on outcomes, drives improvement (is actionable),
- fosters health equity,
- facilitates coordination of care across different settings and levels of care, and
- reduces burden.

The work group also developed the following **measurement framework principles**:

- Person-centered and meaningful
- Systemic reach – different measures may be needed at different levels (e.g., individual, community, state)
- Parsimonious – focus on high-level, strategic, outcome measures
- Dynamic – regularly monitored to ensure relevance and value
- Fairness and equity
- Technical integrity

The group has established **standards for selecting core measures** (though the standards are still open for conversation), and hopes to define domains of measures and potentially identify specific measures in future work. Measure selection standards include:

- Importance for health
- Potential to improve quality/reduce variation
- Strength of linkage to goals (better health, better care, lower costs)
- Meaningful to stakeholders/audience
- Technical integrity
- Potential for broad system impact
- Feasibility and burden
- Accountability
- Differentiate measurement used for accountability (medical group/system attribution) from measurement used for policy and monitoring (state or community level)
- Outcomes-focused

Moving forward, the work group will:

- finalize principles and measure selection standards,
- explore role, scope and boundaries of state-mandated measurement (SQRMS) (e.g., in the context of MACRA and Medicare Advantage, is there a gap that the state can and should fill?),
- examine potential for unintended consequences (payment policy), and
- develop a blueprint for transitioning from where we are today to where we want to go.

Questions from the Steering Team

The Steering Team posed the following questions about the work group. Ms. Silversmith provided answers based on the work group's perspectives. Several Steering Team members commented on the strong alignment between both groups, which operated independently of one another.

Q While there are federal and state measurement requirements, there is more burden out there, such as contractual measures with health plans. What are the groups' thoughts on other drivers of measurement burden?

A Providers get frustrated at the idea that measurement and quality improvement are not occurring apart from external measurement, because internal measurement is happening but not always recognized. It can be hard to tease apart where burden is most acute. This group thought about externally-driven measures and whether state, federal, or payer, and supports coordinating that measurement to the greatest extent possible.

Q The 2008 Health Reform was intended to address frustration with measure requirements from payers and to get on the same page. The federal government holding both health plans and providers accountable to different things causes complication. Alignment would require a concerted strategy on the federal side.

- A** When SQRMS launched, a lot of that was about ensuring consistent standardization of measure specifications, and pulling additional medical groups into measurement to drive quality improvement. We are in a different place today—we have made progress on standardizing specifications through the Minnesota Council of Health Plans and MNMCM, and the need to force measurement isn't there anymore. Today, it's not whether, but how to measure.
- Q** The MMA work group conversations seem similar to Quality Framework Steering Team conversations. How did the work group consider stakeholders and how they fit, especially insurers and employers?
- A** The work group started with community and individual stakeholders because they are the most fleshed out in terms of what is most relevant and important to them. What are the unintended consequences of measurement? Who is most likely to use the information? The work group has talked about other groups but to a lesser degree. This has been a challenging exercise, and it is unknown whether the work group will get to a set of measures that is stakeholder-specific, or land on a handful that are most meaningful at the state level.
- Q** There is a distinction between measures for accountability and those for monitoring or observation. What measures are under the sphere of influence of providers and what are under other broader or more social spheres? There is a middle layer. We do not want to hold individual doctors accountable for other social factors that affect health, but there is a place for health care at the table. We need a way to talk about that; we need mutually defined goals where health care is one of the players. How do we capture the value of that as an industry and recognize that it is not in the purview of health care alone to solve?
- A** The work group has had similar conversations. What matters to a community and what is affecting the health of that community? Community aspects are critical and we need to capture them. Who is responsible for that data? To whom should it be assigned? Who is the entity for accountability? Then have community stakeholders (for example, education and health care) figure out the responsibility to improve community health.
- Q** And how do we structure that? The opioid crisis has taught us we all need different ways of working together—there is no one industry, institution, or person at fault or responsible for the solution. There will be more scenarios like the opioid example, and we need more ways to think about how health care can get ahead of those issues and create policy conversations in response.
- Q** National research has suggested that doctors want to see zero external measures. Does this work group suggest zero additional external measures beyond what is included by the Merit-based Incentive Payment System (MIPS) and insurers?

- A** That has not been articulated by the work group. No one has suggested zero measures or that measurement from the payer community is sufficient. Work group members have expressed appreciation for comparative reporting that MNCM and SQRMS allow, but question if they are the right measures. Should these measures be maintained because we can and have been measuring? Where is there focus to inform what is driving the health of individuals and communities, and what are the gaps in our state and how do we fill them?
- Q** Is the work group open to radically different measures (e.g. number of healthy days in the year)?
- A** The group has had conversations about the role of functional outcomes measures (e.g. measuring daily functioning capabilities of individuals) that are innovative and new, and there is enthusiasm to measure in a different way.
- Q** The Quality Framework Steering Team has talked more about what kind of process needs to support the framework—like robust and authentic engagement of individuals and communities. Will the work group be talking about processes in its next phase? Or will there be deeper discussions about measures?
- A** The work group has worked to narrow its scope based on what they felt they could accomplish. The work group may comment on the process, but not the full scope of the process.

e-Health Advisory Committee

Sarah Evans updated the Steering Team on the interview with interested members of the e-Health Advisory Committee, which included a family physician, a physician representative, an electronic health records expert, and an education representative.

Interview participants generally agreed with the values and principles, and provided feedback on Principle 5. They felt strongly about articulating the need to measure what is most impactful and important to the population and balancing that with EHR capabilities and resources. They also questioned the notion of measuring “not what is easiest” as “easy” measures may be valuable, and felt that the concept of “signal strength” needed clarification and definition around what the system should change. Lastly, the group suggested adding a principle that recognizes diversity of care and of population served.

They also gave the following input:

- Focus on how to help providers improve care.
- Use efficient and effective data collection, and produce information that is actionable for multiple stakeholders.

- Promote efficiencies and help others down the line, leverage Minnesota’s eHealth expertise, simplify the system.
- Set up an advisory group to oversee the process, that is accountable and transparent in decision-making.
- Create a narrative on how framework will impact human lives—include providers in telling that story to increase buy-in.
- Tailor messaging about the framework to specific audiences.
- Use a design thinking approach—less front-end work, more feedback at shorter intervals.

Discussion

Members observed that areas where it sounded like the participants disagreed with the concepts presented in Principle 5 were most likely points of agreement. The Steering Team discussed rephrasing Principle 5 for clarity, since the meaning was somewhat lost when presented to external partners. The values and principles will be refined during Phase 2 of framework development.

One member commented that using qualitative methods and a design-thinking approach could assist with data collection transparency and community engagement. The community could engage by collecting data and distributing results, making them feel more a part of the larger system, and the system could make periodic checks on the process in a way that informs the community. When data is in the hands of the community, they can pursue grants and help keep their programs open. There was additional support for creating a feedback loop with the community as well as searching for the right intersections of current community and organizational work (ICSI, MNMCM, Stratis Health, etc.) that will support quality improvement and leverage current work.

Interview participants did not talk much about e-Health topics, as expected, such as opportunities to automate more measurement. It was noted that going forward, it may be worthwhile to tailor interview questions to illicit feedback from a specific lens of expertise.

Areas of intersection

Stacy asked if there were other areas of intersection the group had not yet discussed. Responses included:

- Technological innovation is missing. How do we take advantage of big data, synthesize data moving forward, and use it to help inform the continuing and evolving measurement strategy?
- The payer/provider intersection with quality improvement work happening in the community, with ICSI, MNMCM, Stratis Health, and at the federal level. What are the right places in the community for us to leverage connections and support quality improvement?

Transition from Phase 1 to Phase 2

Summary of Phases 1 & 2 table

Diane summarized changes to table. Stacy asked if the table accurately reflects input to date.

Additionally, will this table be clear to readers outside the context of Steering Team conversations?

- Phases 1 and 2 have references to developing an evaluation. Members recognized the need to further define evaluation in the context of implementation but recognized that this may not be feasible for Phase 2.
- What is the border between Phase 2 and implementation (or Phase 3)? We should be realistic about what we can do in Phase 2 and what we tee-up for Phase 3.
- The breakthrough and innovative flavor of what we are trying to do does not come through in Phase 2 or 3; we've lost the qualitative nature of some of the things that we've expressed.
- There needs to be a vision. It could be a bold statement that incorporates breakthrough and innovation.

Phase 2 Stakeholder Engagement

Stacy asked the group what perspectives should be continued, added, or strengthened for a Phase 2 guidance body.

The group discussed several models that allowed for a spectrum of group composition, from all members being representatives of their respective organizations to all members attending as individuals—understanding that the context of their input may be influenced by their affiliations—and some models that involved both. They deliberated over the fact that organizational representation is more conducive to buy-in, while individual involvement generates more creativity and opportunity for consensus. An additional option is to have members represent constituencies and not a single organization (e.g., health plans in general, not a single plan). One member reminded the group that no matter how the new group is composed, MDH staff must represent MDH. In addition, it was stated that the group will need the expertise and buy-in of those who will live with the system, like health plans. The group agreed that a consensus-based process is beneficial but had varying opinions on composition, with some support for each model.

Additional reflections:

- The form of the Phase 2 work group should follow function. In Phase 1, the workgroup laid the framework foundation and described scope. Phase 2 will focus on framework design and include buy-in, which may determine who is at the table. We need to think about who should be a part of the next phase of work and in what form.

- In terms of group size, the current group worked well given its small size, strong commitment and good dedication to the work. All voices were equal, heard and participatory. A larger group risks losing the qualities previously defined. We should be attentive to group size given these considerations.
- The Phase 2 group needs process stewards to help navigate inherent member biases and locked-in viewpoints. Members of the Steering Team that stay on for the next phase of work can be catalysts to move the process forward.
- The composition of the group is important, but we shouldn't torture ourselves over it. We need to keep in mind who will care about a state government process and what will be done with the results.

MDH offered the following considerations regarding stakeholder engagement:

- MDH cannot cede authority to advisory bodies to make decisions about the programs it is legislatively mandated to administer, although advisory bodies provide very important input that can shape decisions. We should assemble the best possible group, give the best possible advice, and listen as best we can. A hybrid approach to Phase 2 member selection—some members representing individuals, some representing organizations—will foster both creativity and commitment.
- The Health Commissioner can create advisory bodies on any topic at any time, a practice that is widely used. However, any recommendation that we move forward that impacts the community needs buy-in in order to be successfully implemented.

Report to the Legislature

Stefan provided an outline of the status report MDH will submit to the Legislature. Steering Team members will have the opportunity to review the report at the end of September.

Discussion

MDH has not spoken with legislators yet. MDH is proud of the progress of the framework. The legislature might have expected more progress, but it was important to ensure there was a strong process and not rush things. MDH, the project team, and the Steering Team undertook the following:

- Sought, collected, and used information from many different perspectives;
- Reviewed several reports and syntheses of reports;
- Took into account the ecosystem of other measurement, examined examples of what is already happening, and worked that into the methodology to prevent duplication; and
- Recognized and articulated that the framework is about measuring health, not just health care, which has universal support from stakeholders and made the scope broader and more complex.

In addition, MDH should explain that SQRMS exists within the context of MIPS, health plan measures, individual health system measures.

In terms of not having a fully developed framework at this point in the work, members reflected that:

- Initial expectations were for the work to end in Phase 3, or implementation. Now, having gone through the development process, it's clear why we are only so far, and the process is appreciated and appropriate. Statewide measurement exists within a much broader context of local and national measurement, and many perspectives are needed to navigate this work.
- Early on, input from stakeholders and this workgroup expanded the scope of this work to include measuring health in addition to clinical care. The broadened, universally supported scope elongated our work.

As related to the Legislative status report, Diane asked Steering Team members how each of them will talk about this experience, what was accomplished, what it means, and what its impact will be.

Members responded:

- Joining MDH to talk about the report and back it up with the public.
- Voicing support at annual conference.
- Talking with the Department of Human Services about aligning the quality framework with systems modernization and emphasizing the need for common policy and language.
- Using what has happened to teach courses.
- Reaching out to legislators.
- Helping in any way that is needed.
- Sharing in federal-level work groups.

In addition, one member said, "Not only is this the kind of thing where I can live with what's in here, but I strongly endorse everything that's in here and I think everyone can say that." A number of other members voiced their endorsements of the work thus far.

Next Steps

MDH will send the report to the Steering Team for review at the end of September and may convene a conference call with the Steering Team to discuss feedback in early October.

Steering Team Reflection

The Co-chairs thanked the Steering Team members for all their work. They also thanked MDH and MAD staff, and others involved in Phase 1 of the quality framework. They called for the group to celebrate its progress.

Members reflected that the process was fun, challenging, intellectually stimulating, creative, and inspiring. They felt that the work was meaningful, especially during a difficult time both politically and culturally, and that they learned from and were able to collaborate despite having different perspectives. Members were impressed by each other’s knowledge and thoughtfulness, and acknowledged that Minnesota excels in collaborative and innovative processes. Looking forward, members hope that the spirit of doing what is right for Minnesota continues and that people can still work together despite their differences in perspective.

Marie spoke on behalf of the Health Commissioner, who thanked the Steering Team for their honesty and commitment, and the staff for their support, and observed that we all do this work because we know that it matters. The Commissioner recognized how well this process worked and thinks MDH should use this approach for other health policy topics. Marie expressed that the environment where SQRMS began has evolved, so change is needed, and we cannot be complacent even when things “work well” in Minnesota. We still need to better understand roles, specifically the unique role of state government and MDH, and also understand how quality measurement improves the lives of Minnesotans.

Public Comment

There was no public comment.

Adjourn