

REGAINING LOST GROUND

What we know about healthcare quality in Minnesota during the COVID-19 pandemic and how we move forward

BY JULIE J. SONIER, MPA

In March 2020, as it became evident that the COVID-19 pandemic would disrupt just about every aspect of healthcare, several important questions emerged about healthcare quality:

- How would the pandemic affect access, utilization and quality of care?
- Would it have disproportionate impacts on groups of people who already experience significant disparities in outcomes, such as Minnesotans of color and people who are insured through state public programs?
- Given the situation, was it still feasible and safe to collect data about healthcare quality?
- Should quality measures be changed to reflect the new realities of how care was being delivered during the pandemic?
- Should quality measures continue to be publicly reported for 2020?

These conversations began immediately at MN Community Measurement (MNCM), a nonprofit that convenes stakeholders, including healthcare providers, health plans, state government, employers and consumers to decide on common priorities for measurement of healthcare quality, cost and equity and to guide its vision of empowering healthcare decision makers with meaningful data to drive improvement. As a trusted source of objective data, MNCM plays a unique role in gathering and disseminating information about healthcare quality, cost and equity in Minnesota. This information is widely used to inform strategies for improving health outcomes and reducing disparities.

Data collection

Typically, data collection for healthcare quality measures happens in the first few months of the year, for care provided in the previous year. For example, data about quality metrics for 2019 were collected in the early part of 2020. MNCM collects data for quality measures from two main sources: direct submission of clinical data from medical groups and health plans or third-party chart audits for Healthcare Effectiveness Data and Information Set (HEDIS) measures.

In March 2020, as the pandemic began to disrupt business operations everywhere, MNCM was wrapping up its collection of clinical data for 2019 quality metrics related to optimal care of asthma, diabetes and vascular disease, as well as depression care outcomes, adolescent mental health screening and colorectal cancer screening. Data collection for these measures was not substantially impacted by the pandemic. For several HEDIS measures that require data to be extracted from medical charts, some health plans had to suspend data collection due to concerns about placing extra burden on providers and concerns about the safety of workers who in some cases would need to visit medical group offices in person to collect the relevant data. As a result, many HEDIS measures for 2019 were unable to be reported. For care provided in 2020, data collection was able to take place in early 2021 using normal procedures and timelines for measures collected directly by MNCM and for HEDIS measures.

Changes to quality measures

Beginning in March 2020, there was a rapid shift of many patient visits that would have previously been in-person office visits to telehealth. Because of this shift, two changes to healthcare quality measures were needed: inclusion of telehealth visit codes in the definitions of measure denominators, to ensure that the measures continue to capture the full relevant population of patients; and adjustment to some measure definitions to allow use of patient-reported home blood pressure readings, if taken using a digital device. Both changes were implemented for measurement of care provided in 2020 and future years, and are in alignment with changes made at the national level by the National Committee for Quality Assurance (NCQA).

Public reporting

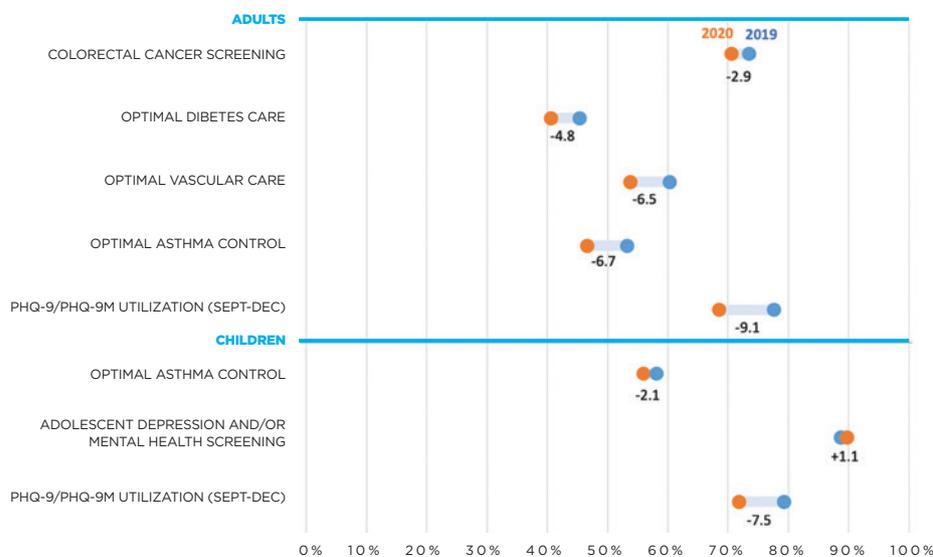
MNCM collected input on how and whether to continue public reporting of quality measures for 2020 in two ways: consultation with its Measurement and Reporting Committee (MARC), which includes people representing the perspectives of healthcare providers, health plans, state government, employers, consumers and public health agencies; and gathering public input via a community survey during the summer of 2020. Both the stakeholder conversations and the survey responses were also used to better understand the factors affecting care delivery and care quality during the pandemic.

Stakeholders made it clear that, for ongoing measurement, standards of quality should not be lowered because of the pandemic. While it was considered likely that Minnesota would see declines in overall performance for many if not most measures, stakeholders believed it was important to continue data collection and measurement to understand the impacts of the pandemic and use these insights to regain momentum toward quality improvement.

MNCM's public survey consisted of three questions, addressing:

- Opinions about whether and how quality measures for 2020 should be publicly reported.

FIGURE 1
CHANGE IN QUALITY MEASURES, 2019 TO 2020
 (statewide averages)



- Issues related to virtual care delivery that could affect quality measurement (e.g., missing data for labs and vital signs).
- Any other concerns related to quality measurement and reporting for 2020 dates of service.

A total of 121 people responded to the survey, and the survey results formed the basis for MARC discussion in fall of 2020 of options for public reporting. Based on the survey results, there was strong support for continued public reporting of quality, including reporting of results by medical group and clinic location. Given the fact that some care systems shifted care to different locations and/or closed clinics in response to the pandemic, MARC recommended to MNMCM's Board of Directors that public reporting for 2020 be at the medical group level and not include results for individual clinic locations.

Quality results for 2020

Not surprisingly, statewide results for nearly all quality measures declined in 2020, as shown in **Figure 1**. For adults, measures for diabetes, vascular disease and asthma declined by about 5 to 7 percentage points, while the percentage of

adults who were up-to-date on colorectal cancer screening declined by nearly 3 percentage points. Of particular note, a process measure for whether adults who had previously been diagnosed with depression were reassessed during subsequent encounters declined by over 9 percentage points between September and December 2020 compared to the same period in 2019. (Depression outcome measures are also included in a recent summary report published by MNMCM but are excluded here since the most recent outcome measures primarily pertain to care delivered in 2019, prior to the pandemic.)

For children, declines in results for quality measures were less than those for adults, and the percentage of adolescents who received depression/mental health screening increased. Like adults, the percentage of children previously diagnosed with depression who were reassessed using the PHQ-9/PHQ-9M during a subsequent visit fell substantially, from 79 percent to just under 72 percent.

It is important to understand the 2020 quality measure results in the context of overall changes in utilization of care. Using the example of adolescent mental health screening, even though the *percent-* of adolescents who received screening

at a well-child visit increased, the overall *number* of such visits fell dramatically—with the result that fewer adolescents overall were screened.

Figure 2 illustrates notable changes in the numbers of people included in the denominator for most measures, reflecting shifts in healthcare utilization patterns. For most measures, inclusion is triggered by having a healthcare visit during the year. A decline in the number of people included in the optimal diabetes care measure, for example, means that fewer people with diabetes had any provider visits (either in-person or via telehealth) during the year. This is concerning because it indicates a gap in providers' knowledge of how well these patients are doing in managing their condition. Measures for children showed especially large declines in the denominators, ranging from a 16 percent decline for asthma control to 27 percent for utilization of the PHQ-9/PHQ-9M for patients previously diagnosed with depression. Declines in the number of patients included in each measure were generally broad-based, affecting people of all ages, genders, health insurance coverage types, socioeconomic status, races, and Hispanic/non-Hispanic ethnicity.

Minnesota has wide and longstanding disparities in quality measures by race, Hispanic ethnicity and other factors; a priority concern has been whether these disparities would grow because of the pandemic. The data for 2020 show that existing disparities by race and Hispanic ethnicity did not grow wider in 2020 with some exceptions (disparities compared to statewide averages grew in optimal diabetes care for Black patients, colorectal cancer screening for Black and Hispanic/Latinx adults and optimal asthma control for Indigenous/Native children).

Based on insights provided by MNMCM stakeholders, there are three main factors specific to COVID-19 that likely influenced the results of quality measures in 2020. These include patient barriers, provider staffing and capacity and changes in care delivery.

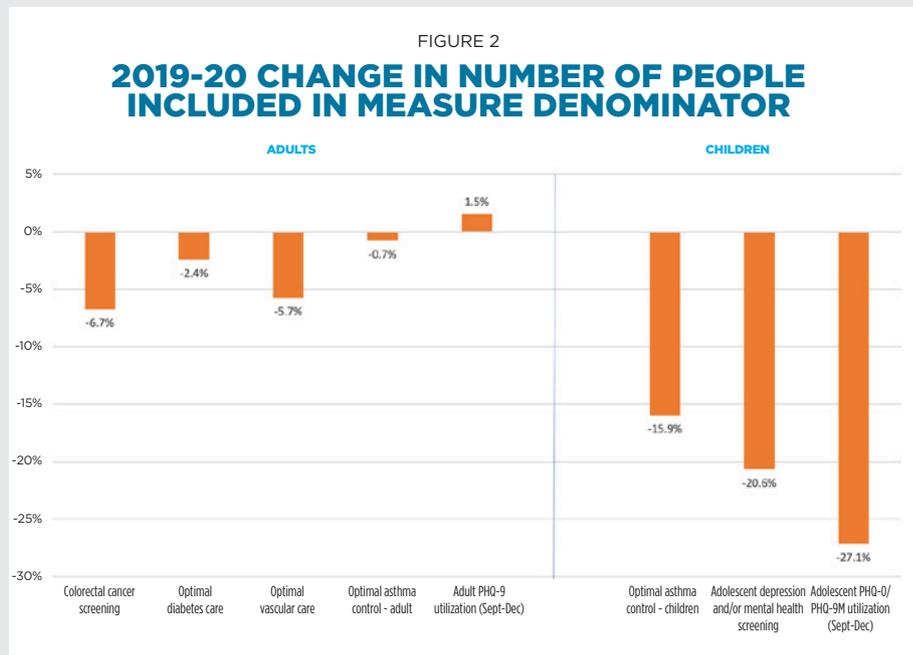
Patient barriers. Many patients made the decision to defer healthcare, out of

concern for safety, for financial reasons or because other priorities were more important. Other types of patient barriers included barriers to accessing care via telehealth due to lack of familiarity with technology, difficulty accessing devices or broadband connections or language barriers. There is anecdotal evidence, however, that the availability of telehealth served as an *enabling* factor for some patients, by removing transportation and distance barriers.

Provider staffing and capacity. Factors related to provider staffing and capacity that likely influenced quality measures included staff furloughs, burnout, turnover and diversion to higher priority needs; some clinic locations being repurposed or closed; some services being restricted or shut down (e.g., colonoscopies); shortages of testing supplies and/or lab capacity; and capacity restrictions in clinics for safety reasons.

Care delivery. Other factors that disrupted the way that care was delivered presented barriers to gathering data that is used in measuring quality outcomes. These included the fact that with patients being less likely to access care, providers had fewer opportunities to use visits to deliver preventive services and manage chronic conditions. In addition, providers reported some difficulty adjusting workflows to gather patient-reported outcome (PRO) survey tools via telehealth and difficulty getting patients to complete PRO tools outside of the office setting. Finally, providers also noted a higher likelihood of missing lab tests and blood pressures for care delivered via telehealth.

Although these declines in healthcare quality performance measures in 2020 are not unexpected, they are concerning because they mean that either patients are not getting the care they need to achieve the best outcomes and/or that providers are missing key information that they need to help patients manage chronic conditions like asthma, diabetes and vascular disease.



Looking forward

Avoiding long-term health impacts requires proactively addressing the gaps in care that have occurred because of the pandemic. Doing this effectively will involve three key strategies:

- Outreach to patients who “fell off the radar” in 2020, especially children and people with chronic disease.
- Similarly, for those who did receive care but have gaps in key pieces of information—like hemoglobin A1c, blood pressure, or patient-reported outcome tools—filling these gaps is essential to ensure that patients have the best opportunity for optimal outcomes.
- Finally, it is more important than ever to communicate with patients to ensure they receive preventive care like cancer screenings to catch disease at earlier stages when it is more treatable.

Although healthcare providers must play a leading role in “righting the ship” and regaining momentum toward higher quality and better outcomes for patients, other stakeholders have important roles to play as well. Health plans and employers have roles to play in outreach and education and in making sure that financial incentives reward both quality improvement and disparities reduction.

Most observers agree that telehealth has important potential for innovation in how healthcare is delivered and will remain an

important part of the landscape, but it also has potential pitfalls. We must ensure that we set the same expectations of quality and outcomes for care delivered via telehealth as for in-person care. Based on the data for 2020 and insights provided by MNCM stakeholders about gaps in information that clinicians have available to them when delivering care via telehealth, it seems clear that we still have many lessons to learn about how best to integrate telehealth into the overall healthcare delivery system and how to ensure that we reap the potential benefits of telehealth while avoiding the pitfalls. **MM**

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