MN Community MEASUREMENT©

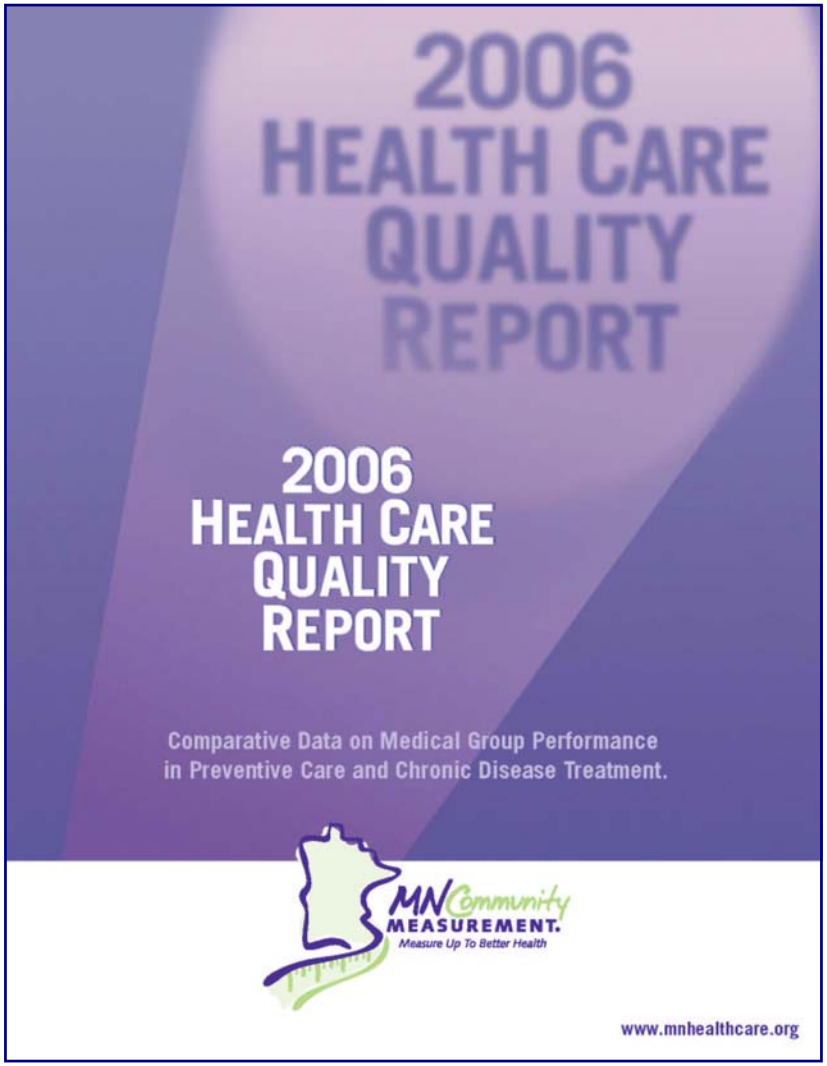
CHCS Conference
July 24, 2007

MN Community Measurement

Accelerating the Improvement of Health Through Public Reporting

- The trusted source of information across the spectrum of care and the IOM six aims
- Used by providers to improve care and by patients to make better decisions
- Our community works together on measurement

2006 Health Care Quality Report



- Reports on 14 quality measures
- Reports results of more than 100 medical systems
  - 73 multi-specialty groups
  - 22 single-specialty groups
  - 21 urgent/convenience care
  - 90% of Minnesotans get their care from these providers

Technical Issues

- Clinical or administrative data
- Measurement Selection
- Measurement Specification
- Individual physician reporting
- Comparison standards
- Data validation

2007 Direct Data Submission
Advantages

- All patients represented
- Faster results
- Not dependent on aggregation across health plans
- Larger sample – site level reporting
- Increased provider confidence in data
- Used with electronic or paper records
- New measures available

Direct Data - Challenges

- Cost to providers
- Consistent use of specifications
- Audit process
- Limited payer data

Preliminary Results
more data available

- 68,856 eligible diabetics at the 2007 DDS clinics
  - 41,831 eligible diabetics in 2006 MNCM health care quality report
- Over 20,000 sampled patients in 2007 DDS
  - 8,401 sampled patients in 2006 MNCM report
- 74 medical groups in 2006 to 202 clinic sites in 2007

Measurement Criteria

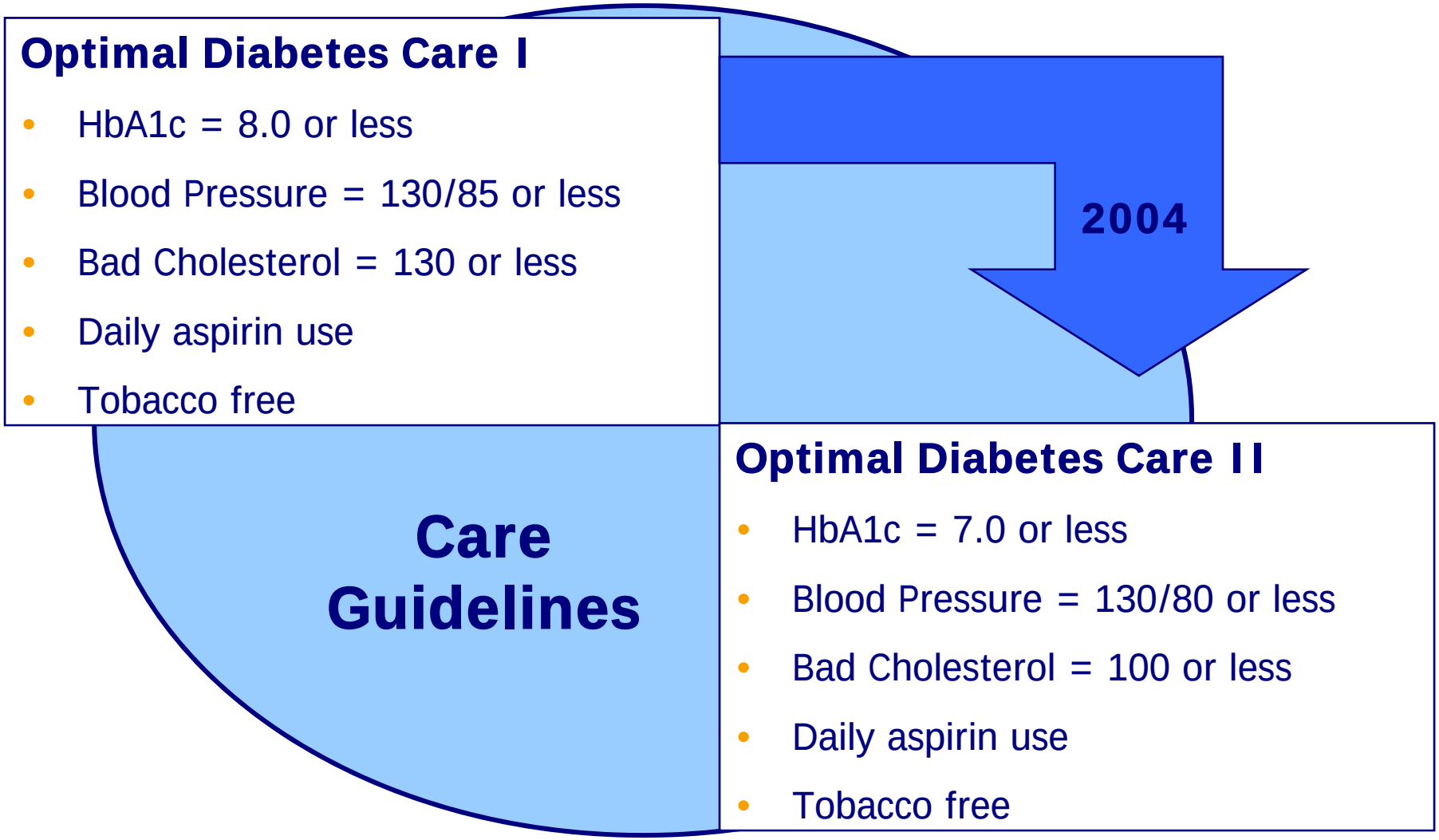
- Significant impact on patients
- Room for improvement
- Evidence based standard of care
- Aligned with national measures
- Ability to test validity
- Feasible data collection

Measurement Specifications

Example: % of Diabetics with HbA1c<7.0

- Sample size
- Diagnosis and exclusions
- Method of attribution to provider
- Time period
- Weighting for multiple data sources
- Continuous or discrete results

Use of Composite Measures
Optimal Diabetes Care



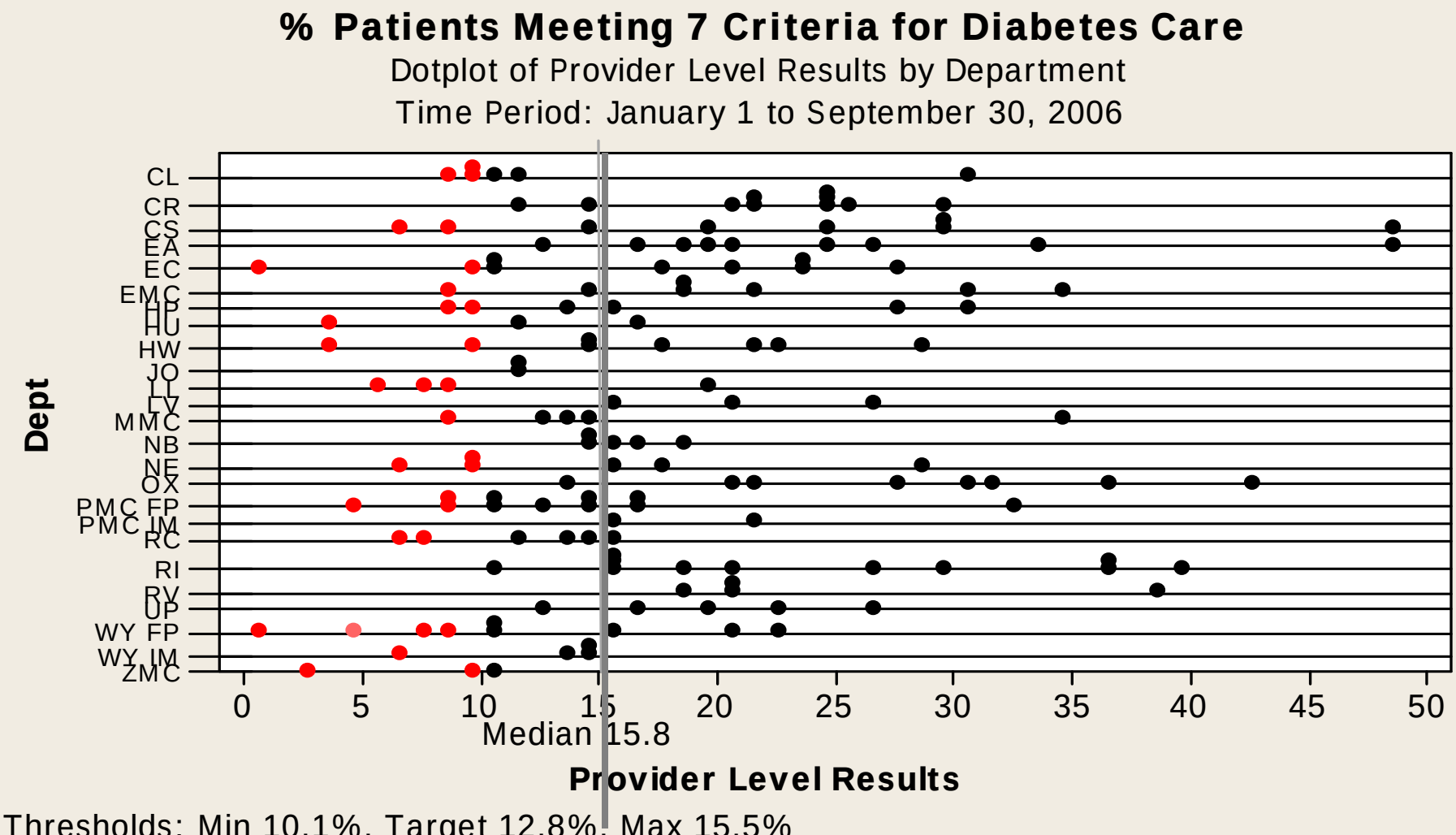
Composite Measures

- Provides summary of information for consumers
- Outcome or process measures
- Focus for pay-for performance or improvement
- Continuous or discrete methods

Concerns with individual physician reporting

- More data needed ($)
- Smaller sample size = higher confidence interval
- Attribution issues
- Risk selection issues
- Does not reflect the system of care

Do individual MD results matter?



Comparison Standards

- All patients or by population
- Sample size
- Population weights
- Benchmarks
  - National (same specifications?)
  - Performance goal (is it reasonable?)
  - Top performers (random variation?)
  - Average

Validity Testing

- Data file review
- Missing data
- Smell test
  - compare to pilot data
  - reasonable trend
  - common sense
- Provider review

How Do We Address Data Disputes?

- Agreement on standards
- Transparent processes
- Reliable and comparable data collection
- Audit and appeals processes

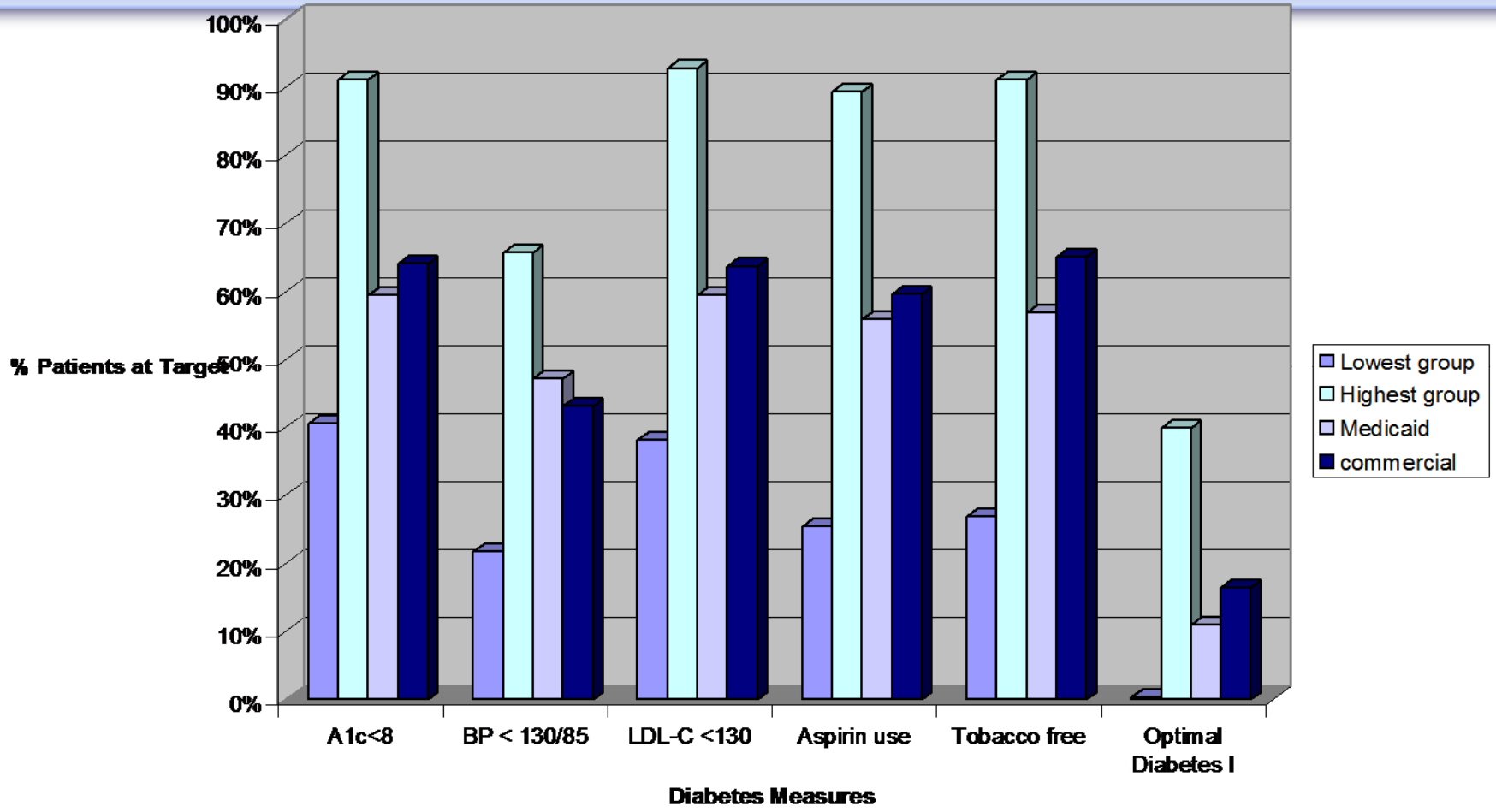
What is the impact of population differences?

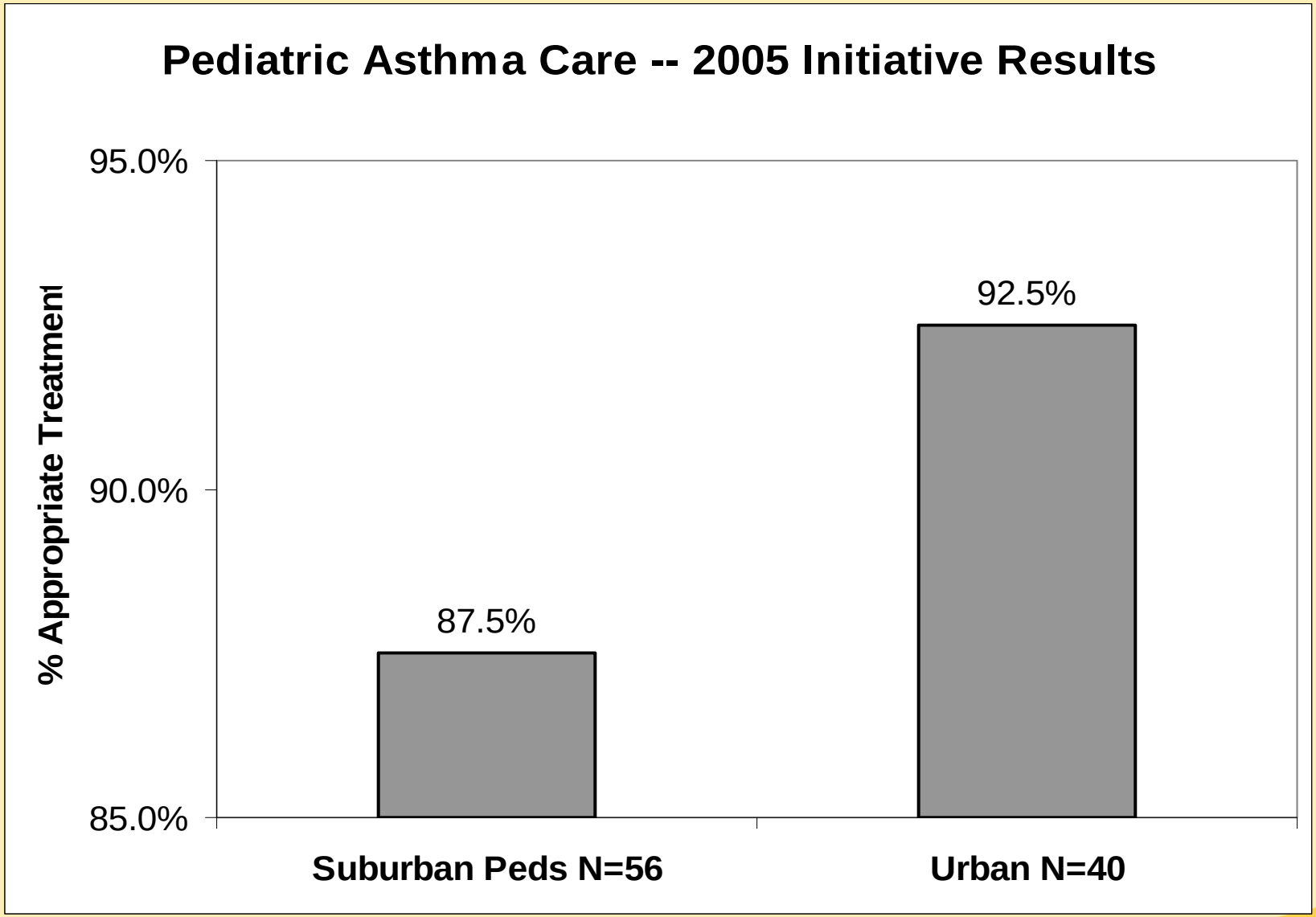
"Poor Quality is an equal opportunity problem."

Differences between socio-demographic groups is small compared to the gap in recommended care.

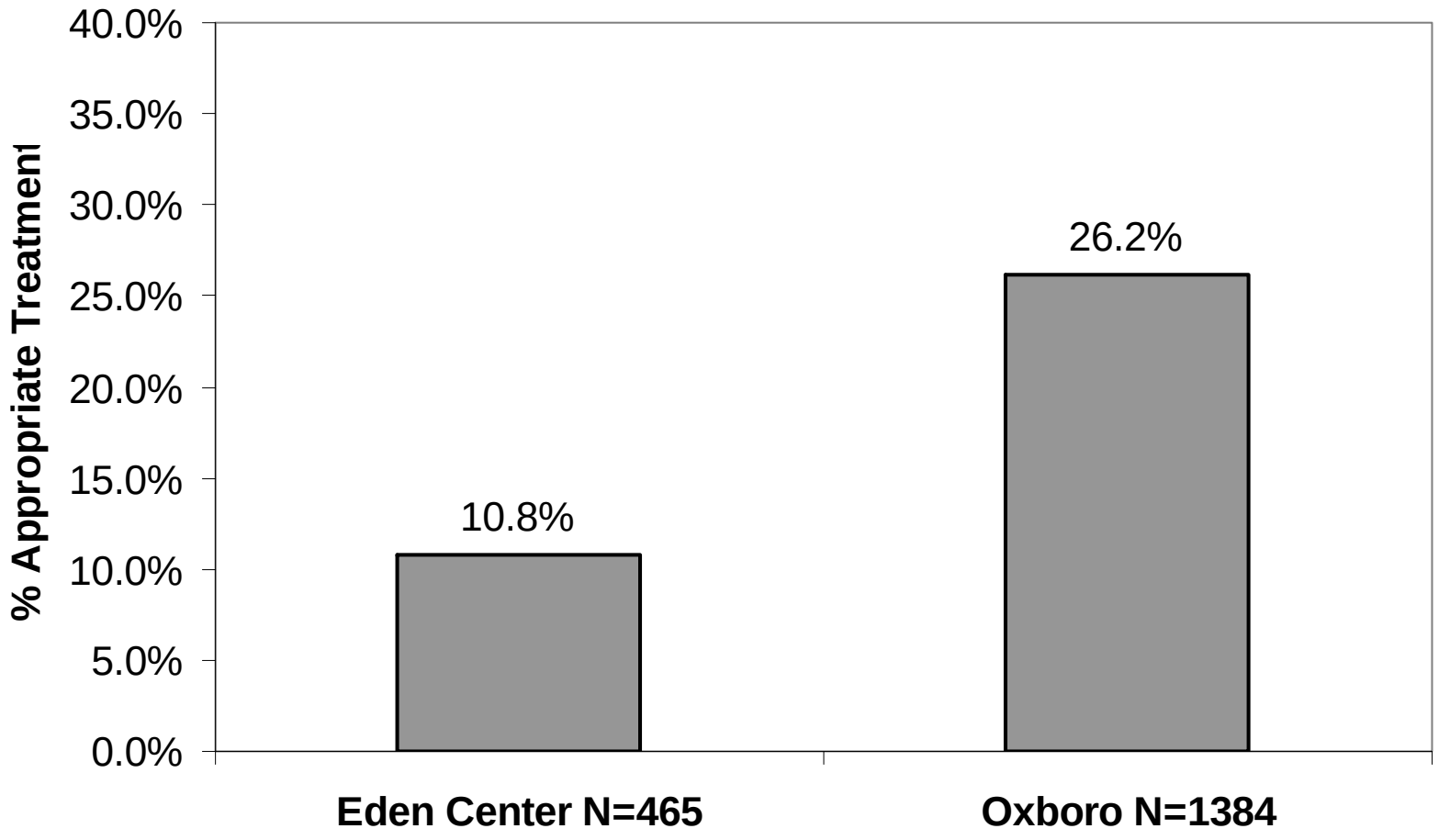
Asch, S. "Who is at Greatest Risk for Receiving Poor Quality Health Care?" New England Journal of Medicine. March 16, 2006.

MN Community Measurement





Diabetes Care -- 2005 Initiative Results
Eden Center & Oxboro

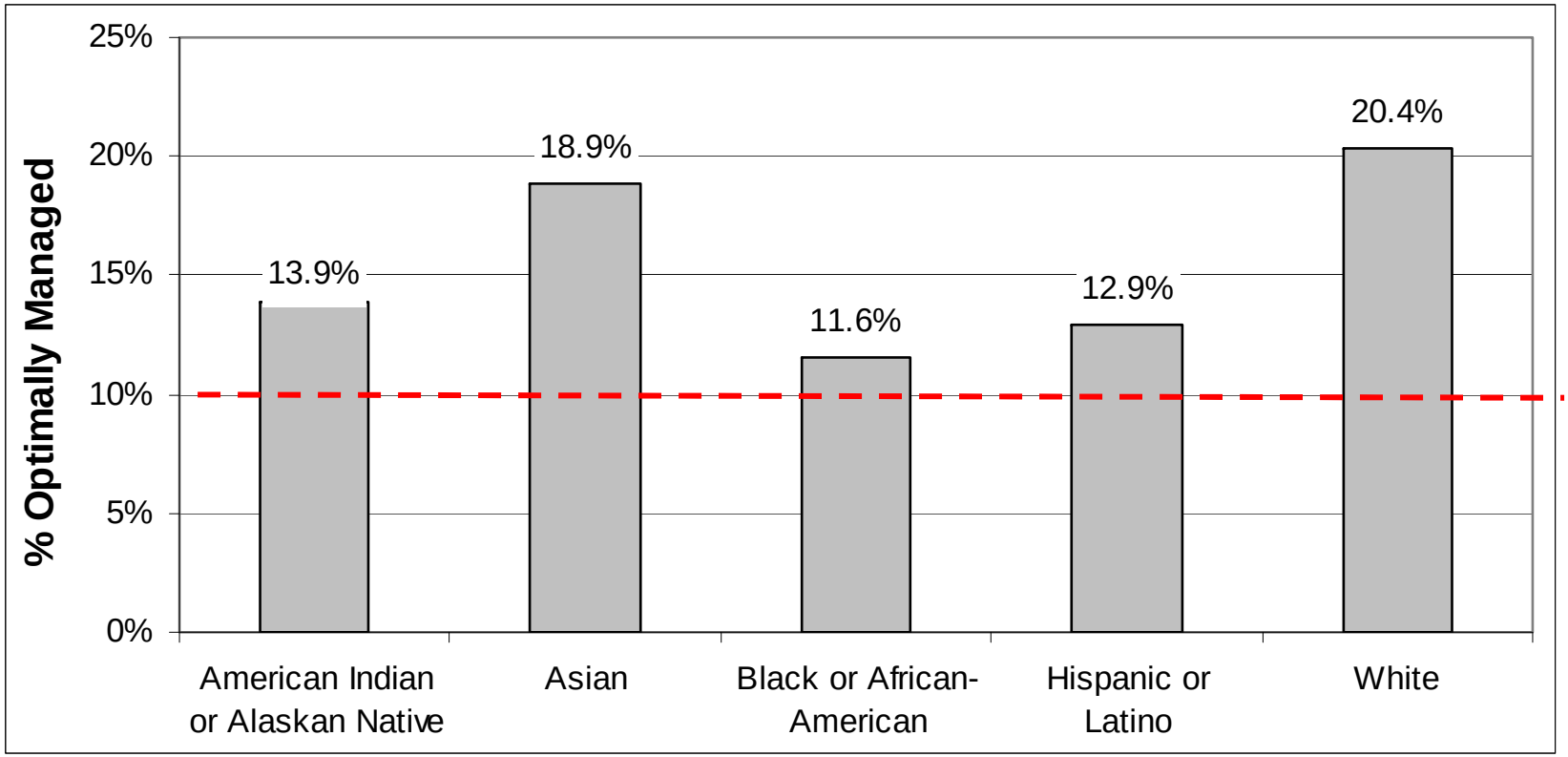


FAIRVIEW

Language and Race Collection

- We have race/language data information on our full population within HPMG
  - language on 98%
    - 8% Non-English
  - race on 75%
    - 25% Non-White
- Results from the health plan web site survey suggest that direct collection at the point of care is optimal.

1st Qtr 2007 Optimal Diabetes by Race



Minnesota Provider Groups' Average = 10%

(source: MN Community Measurement)

Minnesota Public Programs Pilot

- Includes Medicaid, MinnesotaCare, GAMC Managed Care Populations
- Use MNCM process for 9 measures
- Compare commercial and public program results
- Compare results are medical group level (45 groups)
- Joined MN BTE for 2007

Role of Regional Collaborations?

- Measurement development
- Priority setting/regional focus
- Data collection
- Data aggregation
- Alignment of incentives
- Public reporting
- Quality improvement

Lessons Learned

- Give providers a reason to participate
- Test the measures with providers before public release
- Strive for useful information, not perfect information
- Don’t start with a data warehouse – define the measures
- Share talking points with providers
- Access to automated clinical data is the future

Questions or Comments

Jim Chase

Executive Director, MN Community Measurement

651-209-0390

chase@mnhealthcare.org

Issues in Physician Performance Measurement

Sarah Hudson Scholle, MPH, DrPH
Assistant Vice President, Research

July 24, 2007

NCQA
Measuring quality.
Improving health care.

… many critical considerations

- Intent of measurement
- Reporting options
- Accuracy of "claims-only" measures
- Stakeholder engagement
- Electronic and medical record data requirements and considerations
- Data pooling
- Accuracy of performance results
- Integrating cost and quality of care measurement
- Risk adjustment
- Auditing
- Benchmarking
- Linking measures across performance domains
- # of quality measures for different physician specialties
- Defining peer group comparisons
- Physician attribution
- Requisite number of observations
- Patient inclusion options
- Analysis time periods
- Data collection and sampling methods
- Composite scoring for quality measures
- Methods for evaluating physician cost of care performance
- Specifications for quality of care measures

… too little time today

… Focus of comments here

- Performance Domains & Data Sources
- Establishing physician "accountability"
- Minimizing chance of being "wrong"
- Measuring cost-of-care
- Measuring practice systems

Identifying Allowable Data Sources

	Electronic data: – Med., Lab, Pharm. Claims – Lab Values – Retrievable codes from EMRs/PMS	Paper medical Records	Survey of patients	Survey of practice personnel
Clinical quality	☑	?		
Cost of Care	☑			
Care Experience			☑	
Practice infrastructure				☑

Critical issues: data sources

- **Understanding trade-off between accuracy and feasibility for data sources**
  - **Defining allowable and non-allowable data sources**
  - **Data source substitution**
- **Defining key data source attributes**
  - **Quality of source data – comprehensiveness of source data for all patients**
  - **Quality of data linkage across multiple data sources (MD/practice identifier)**

Establishing Physicians' Accountability

- Logic & algorithm: which physician is accountable for which patient and quality event?
- Different rules for quality, cost, experience?
  - Rules based on administrative assignment
  - Rules based on "time under care of physician"
  - Rules for primary vs. specialty care
  - Rules based on "proportion of costs"
- Balancing multiple concerns
  - Attribution rule ↔ patient sample size ↔ # of measured physicians ↔ # of measured patients ↔ accuracy of attribution

Handling "chance of being wrong"

- Reasons for lack of accuracy/reliability
  - Sample size (# of pts in denominator)
  - Measure properties
  - Patient variables (gender, age, SES, severity)
- Options
  - Sample size requirements
  - Estimating reliability in distinguishing among physicians – more complicated when dealing with "composite scores"
  - Taking patient variables into account
    - Logic
    - Limiting comparisons across different specialties
    - Statistical adjustments/stratified reporting

Measuring cost of care

- Linking quality and cost measurement
- Issues of patient-mix differences between practices loom large
  - Proprietary tools available (episode and person-risk adjustments)
    - Risks and benefits of using tools (Transparency, "Upcoding", different diagnostic behaviors)
  - Dealing with unit price and utilization differences
- Standardization needs remain
  - Outlier costs, attribution, risk adjustment, comparison groups

Assessing Practice Systems

- Goals of measuring systems
  - actionable steps for improvement
  - reduce errors without blame
- Physician Practice Connections (PPC) tool
  - based on Chronic Care Model evidence & Six Sigma processes
  - Systems are positive correlated with higher clinical performance
- Issues -measuring systems is feasible but
  - Review of documentation or on-site audit needed
  - Relationship to electronic health records
  - Educating physicians and practice staff about systems is high priority
- Patient-Centered Medical Home demonstrations to use PPC adapted with input from medical specialty groups

PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

** Proposed Must Pass Elements

Contact

Sarah Hudson Scholle, MPH, DrPH
AVP, Research
2000 L Street NW, Suite 500
Washington, DC 20036
Phone: 202-955-1725
Email: scholle@ncqa.org