Mission: Accelerate the improvement of health by publicly reporting health care information

A community effort of providers, purchasers, consumers and health plans

- Participating in:
  - Medicare Better Quality Information
  - Minnesota’s QCare Initiative
  - RWJF Aligning Forces for Quality
  - Minnesota Bridges to Excellence
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
• The current payment system actually impedes progress toward the six aims
• There is no incentive for redesign of systems of care
• Payment incentives can drive behavior for better quality
• Incentive alone will not be enough
  – EMR
  – Public reporting
  – Patient incentives
Why Use a Combined Measurement Process Across the Market?

- Focus medical group improvement effort
- Signal strength: alignment increases the impact
- Efficient data collection
- Reliable source for consumers
Why Work Together on Payment?

“Poor Quality is an equal opportunity problem.”

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

Measurement Issues for Government Programs

- Total population vs. Medicaid population
- Disparities and Risk Adjustment
- Appropriateness of Measures for the population
Role of MNCM

• Builds on an accepted state-wide process
• Data is broad – includes commercial insured, public programs, and Medicare
• Results being used by health plans, public programs, employers
• Composite measures available for diabetes and vascular care
Why Composite Measures?

• The Optimal Diabetes composite has four outcome measures, one process measure
  – Individual measures were process measures
  – Rates were relatively high with little variation

• Composite is a more complete measure
  – Takes the whole patient into account
  – Reflects performance of entire care system

• Performance is more easily understood
  – One score vs. many individual measure rates
Optimal Diabetes Care Measures

Optimal Diabetes Care I
- HbA1c = 8.0 or less
- Blood Pressure = 130/85 or less
- Bad Cholesterol = 130 or less
- Daily aspirin use
- Tobacco free

Optimal Diabetes Care II
- HbA1c = 7.0 or less
- Blood Pressure = 130/80 or less
- Bad Cholesterol = 100 or less
- Daily aspirin use
- Tobacco free
Steady Improvement in Diabetes Care

Optimal Diabetes Care:
all cardiovascular measures at target

<table>
<thead>
<tr>
<th>Year</th>
<th>Optimal Diabetes Care I</th>
<th>Optimal Diabetes Care II</th>
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<tbody>
<tr>
<td>2002</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>2004</td>
<td>12%</td>
<td>4%</td>
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<tr>
<td>2005</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>2006</td>
<td>20%</td>
<td>9%</td>
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MnBTE Process

- Medical Groups recognized based on MNCM results
- Standard patient attribution process applied to identify payment amounts per group
- Groups can be rewarded at the site level with new direct data submission process
- Providers receive one aggregate check from all participants
Priorities for Alignment

Examples:

- Condition or treatment goal
- Measure definitions
- Assessment process
- Payment threshold
- Payment process

- HbA1c management for diabetes
- HbA1c 7.0 or less
- Same data collection, population, sample size
- X% of pts at target, or most improved
- Timing and amount