

Truths & Myths about Direct Data Submission of Clinical Data for Measurement, Reporting and Rewards

IHA P4P Summit

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Mini Summit II

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Minnesota's Journey so far...

- Landscape
- Market Conditions
- Direct Data Submission (DDS)
Defined
- Lesson Learned
- Myths and Truths
- What We Still Need to Learn

Landscape

- 2004 to 6 - MN Community Measurement (MNCM) produces first public report on diabetes using aggregated health plan data
- 2006 Buyers Health Care Action Group (BHCAG) pays rewards for the first time based on MNCM data through MN BTE program
- Employers were
 - Appalled at low performance
 - Dissatisfied with lack of specificity in measures, especially with large groups made up of 20+ clinics
- MNCM plans to pilot use of clinical data in the future

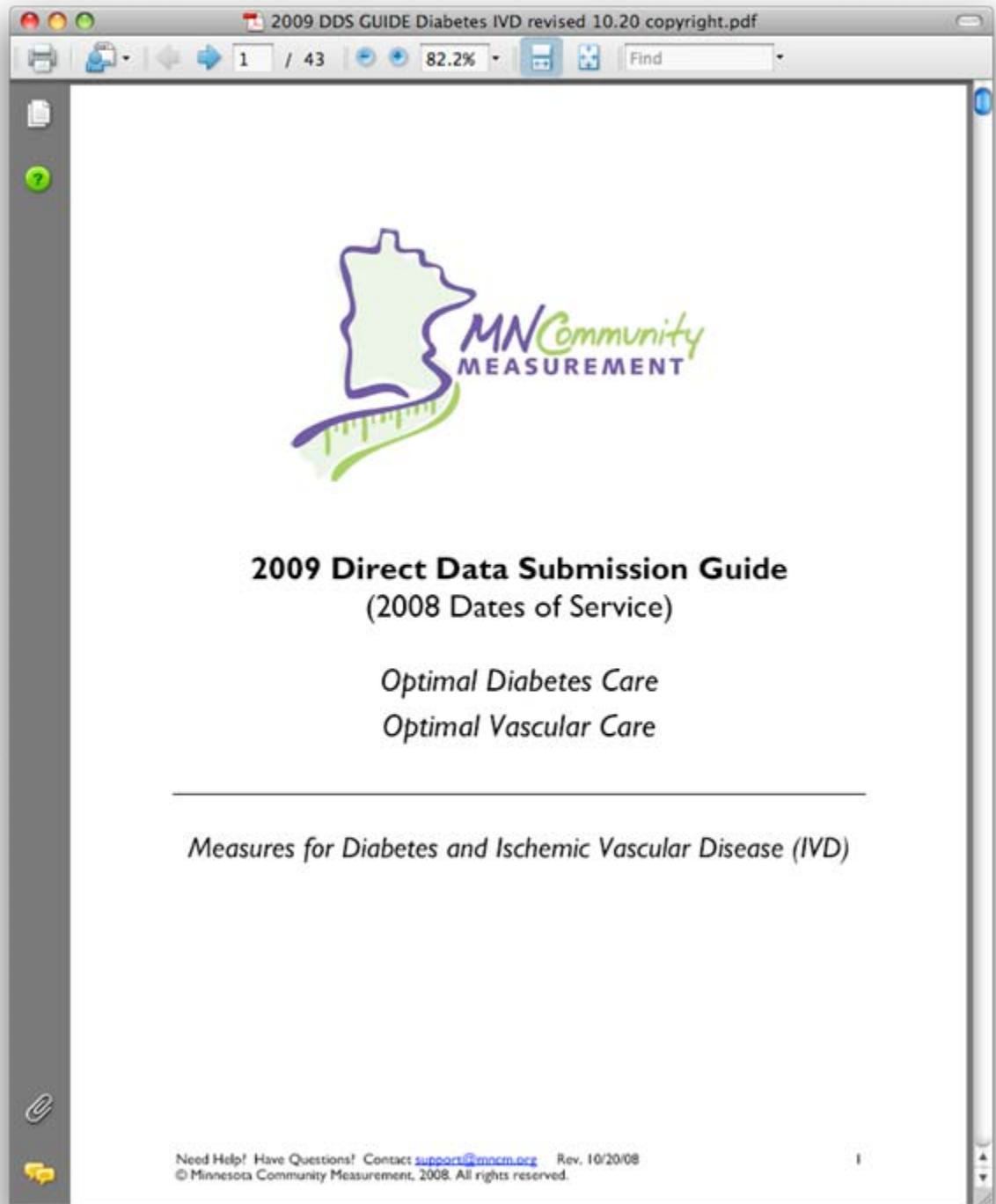
Conditions Were Ripe for Direct Data Submission (DDS)

- BHCAG BTE agrees to pay rewards based on DDS
- MNMCM recruits groups who complained about health plan data; not valid, too late, too general, not actionable
- January 2007 - **30** provider groups submit clinical data on diabetes care to MNMCM for public reporting and P4P
- October 2007 - **36** groups submit clinical data on CAD for MN Bridges to Excellence rewards
- January 2008 – BHCAG BTE and BCBSMN agree to pay based on DDS, **60** groups for both diabetes and CVD
- April 2008 MN Legislature mandates common measures for public reporting, aligned P4P, and data submission
- February 2009 – **77** groups for both diabetes and CVD

Direct Data Submission Defined

- Providers submit data to MNCM's portal
- Denominator pulled from Practice Management System (PMS) or Electronic Medical Record (EMR) and certified; includes all established patients, all payers & uninsured
- Numerators (lab values, BP, smoking status, aspirin use) produced from EMR or paper charts
- Data on full population required if using an EMR, random sample of 60 patients/clinic/condition/specialty if using paper charts
- Must include all clinics/practices within a group
- Attribution determined by medical group
- On-site validation conducted by MNCM

MNCM DDS Guide
Includes specifications,
data elements, details on
how to submit to MNMCM
portal for paper and
EMRs. Tips learned from
previous experience.



Feedback After the First Submission

- Challenged by specifications
- Frustrated by inadequacy of PMSs and EMRs to produce reports
- Appreciated more timely (four months later) feedback
- Best practices of highest performers:
 - Conduct internal transparent reporting
 - Prepare “lists” of patients needing specific interventions; “work the list”
 - Work in teams with Certified Diabetic Educators
- Some providers hadn’t seen scores of other clinics in their group before they were posted on the web
- Huge variation within groups
- No arguing about the validity, just the specifications

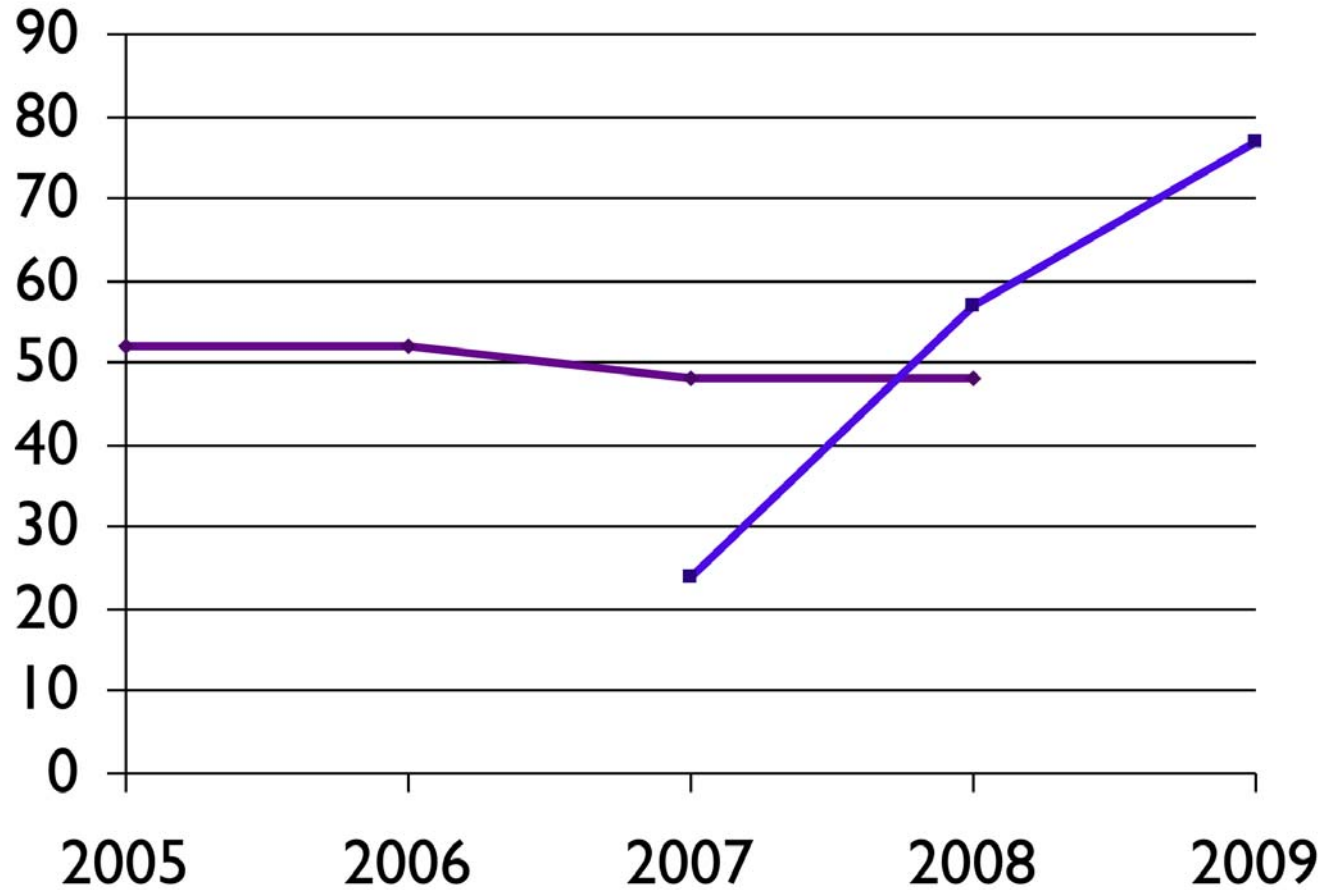
2008 DDS Support

- 2008 submission, BHCAG Foundation raised funds from pharmaceutical manufacturers and health plans to encourage DDS by providing in-kind support
- Recruited medical groups; asked for commitment to use technology in future
- 16 groups applied, including 7 Federally Qualified Health Centers (FQHCs)
- 10 groups with 28 clinics selected
 - 3 in transition to EMRs
 - 1 with EMR
 - 6 with paper charts and registries

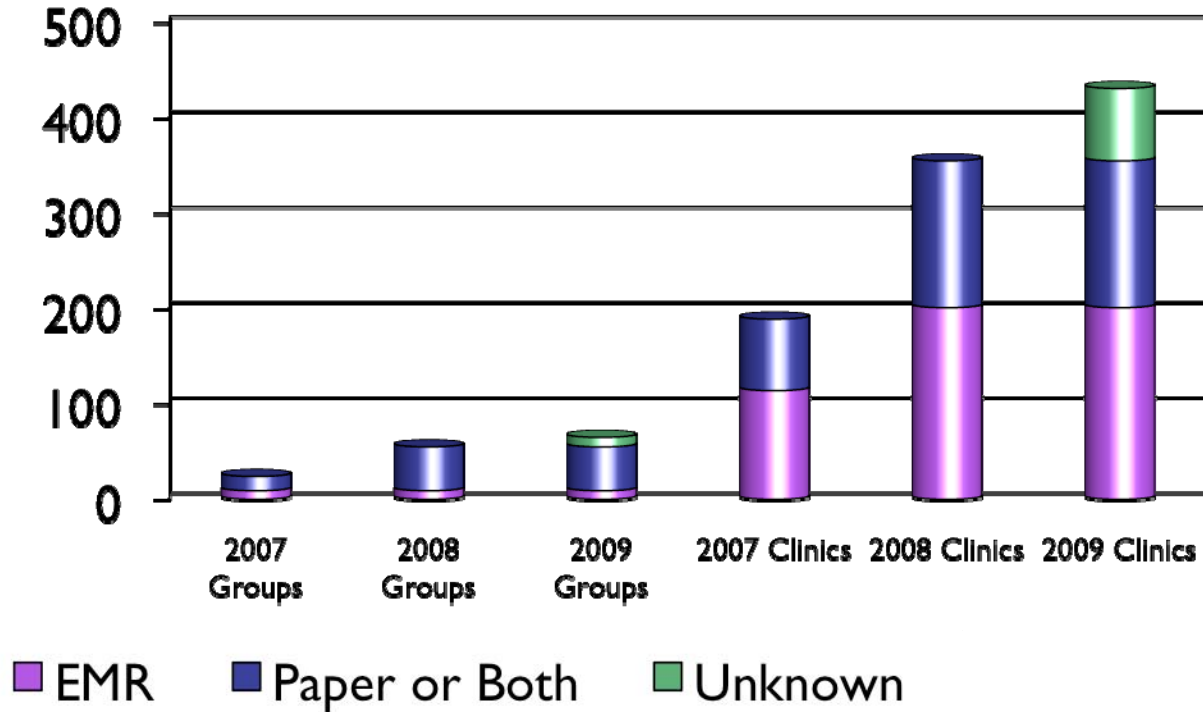
2008 DDS Support

- Provided trained nurses to abstract charts
- Challenges
 - 3 week time-frame
 - PMS couldn't produce denominators
 - Disorganized, inconsistent and incomplete charting increased resources and reduced scores
 - Not organized, not staffed adequately, disorganized
- Scores were low; ranged from 3-12, MN average of 10
- 7 completed the process and 5 “passed” validation

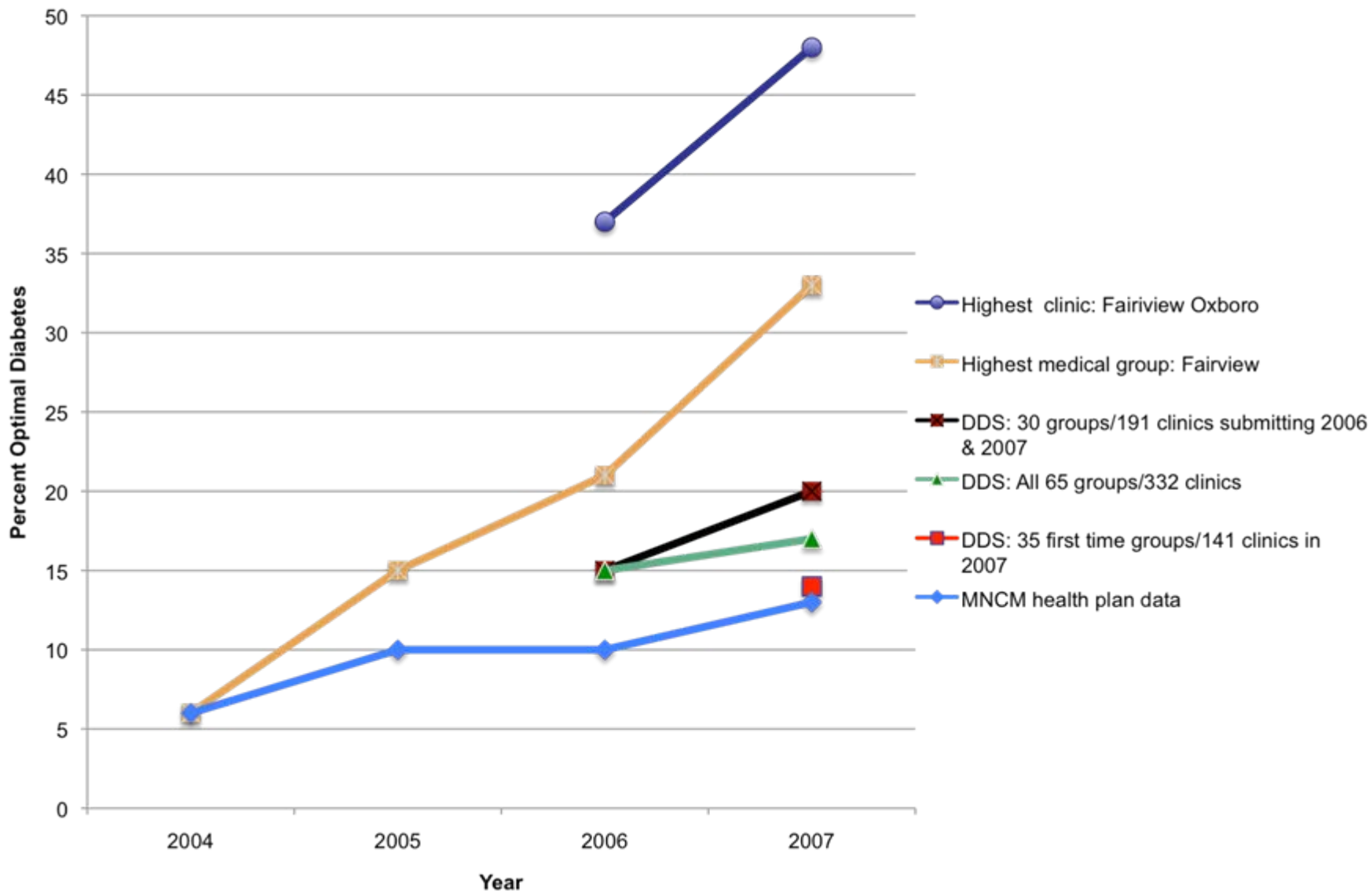
◆ # Groups Plan Data ■ # Groups DDS



DDS Participation by Group and Clinic



Optimal Diabetes Scores



Myth

We have to wait for everyone to implement an EMR in order to use clinical data for measurement

Truth

More than 50% of groups and clinics used paper records in 2007 and 2008

Most EMRs don't readily produce reports on quality anyway...

Myth

Health Information Exchanges will be the vehicle to collect data for measurement and public reporting

Truth

Provider submission of data is another means of collecting data

It engages providers in the process, produces scores they believe in and motivates improvement

Myth

Individual physician level is the best unit of measurement

Patients don't look at public reporting so its not effective in improving quality

Truth

DDS produces clinic level data for public reporting and physician level for internal uses.

Providers look at public reports; competition is alive and well and so is the Hawthorne Effect

Myth

Providers won't submit data to an outside entity for measurement and public reporting

- its too much work
- they're worried about sending personal health information
- they don't care

This will only happen in Minnesota!

Truth

Requires organization, focus, education, resources and visibility.

We're not the only ones...

- *Wisconsin*
- *Maine*
- *Cleveland*
- *Cincinnati*
- *Provider systems*

National comparable data could be motivating!

What We Still Need to Learn

- What will motivate the late adopters?
- What will keep groups from dropping out if they don't compare favorably?
- How to support internal measurement and submission for small, less resourced practices
- How many measures can they handle; when will they max out?
- How to improve EMR capabilities to measure and produce reports and lists
- How to integrate HIE and Performance Measurement?

Robert Wood Johnson Foundation Study

- December 2008-December 2009
- Interviewing 20 Minnesota medical groups
 - DDS participants and non-participants
 - Large and small groups
 - Rural and urban
- What motivated them to submit or kept them from participating?
- What would help?
- Two additional markets TBD

MNCM Future

- Increase user friendly process
- Require DDS for P4P for more health plans
- Expand to additional conditions and measures
 - PHQ-9 for depression
 - Race/Ethnicity/Language submission
 - Patient Experience
 - Specialty measures
- 2008 Minnesota legislation mandated DDS
 - Rules to be developed summer 2009
- Develop national network of clinical data users