Tracking outcomes in Minnesota health care

By Linda Picone

If you don’t measure it—whatever “it” happens to be—you can’t improve, or even know whether you need to improve.

That’s where MN Community Measurement (MNCM) comes in. “Our mission is to empower decision-makers to drive improvement,” says Julie Sonier, MPA, president.

In 2005, MNCM was created as a nonprofit by Minnesota health plans and the Minnesota Medical Association to collaboratively gather and report health care data. (The idea of comparing quality of care had started several years earlier and the state’s major health plans worked together to combine data for some kinds of care and then report the outcomes.) MNCM’s board includes stakeholders from every part of health care—hospitals, physicians, health plans, employers, professional associations and consumers.

The impetus behind MNCM was to find out how health care providers in Minnesota were doing so that they could do better for their patients. “We spend an awful lot of money in the United States and we don’t get anywhere near the kinds of outcomes that we feel we should be getting,” Sonier says. “There are many examples of where we lag behind the rest of the world in health care outcomes.”

Gathering data

Initially, data was submitted to MNCM voluntarily by providers. After the first year, 90 medical groups were providing data. By 2008, 85 percent of the state’s primary care providers chose to provide data. That year, the Minnesota Legislature passed a law that required all providers to submit data to MNCM. Today, data is collected from health plans and also submitted directly by clinics and medical groups through a secure dedicated web portal.

Sonier says that although quality measurement is important, gathering and sharing data in specific formats adds to the workload of providers; MNCM is conscious of that and works to make sure it is not duplicating data-gathering of other entities. “Minnesota has been ahead of the nation in measuring the stuff that matters,” she says. “But we align where we can.”

MNCM has a multi-stage process for developing measures and collecting data. After initial research on a concept or procedure, a workgroup made up of a variety of stakeholders is put together to develop a measure, get public comments and run a pilot to test the measure. Once the data for the pilot is collected and reviewed, a decision is made about whether to include the measure in public reporting for future years.

Reviewing measurements

MNCM collects data on both processes—such as breast cancer screening, eye exams for people with diabetes or follow-up for...
people with depression—and outcomes, such as controlling high blood pressure, functional status of patients after knee replacement or 12-month response to depression treatment. “For process measures, we can often see very rapid improvement,” Sonier says. “All the providers have to do is get a process in place to make sure that certain steps are followed.” MNCM also looks at efficiency measures, such as total cost of care and average unit price.

In a simple example, she says the difference between measuring process and measuring outcomes would be measuring whether a person with diabetes regularly gets their blood sugar tested (process) vs. measuring whether their blood sugar is under control (outcome). The former is important and might lead to better blood sugar control—that would be the expectation—but it doesn’t indicate whether the person with diabetes actually has blood sugar levels under control.

The list of measures MNCM collects and reports is long. A committee reviews all of the measures every year to determine whether the measure is still doing what it’s supposed to do. “It’s important to keep looking at the measures we collect and make sure they’re still worth it,” Sonier says.

That can result in some measures being dropped. For example, Sonier says, a measure on providing overweight counseling—a process measure that had “topped out”—was dropped. For any measure, she says, “if everyone is at 90 percent or higher, there’s a question of whether that is still of value to the community or whether we should focus on something else.”

Another measure, the percentage of births by cesarean sections, was dropped for several reasons, she says: Minnesota’s rate of C-sections is lower than the national average; most of the data on C-sections comes from hospitals, rather than provider clinics, so it’s harder to collect; and, more important, “there is uncertainty about what is the right level of C-sections,” so measuring them can’t lead directly to improvement because it’s not clear what the right level of improvement would be.

**How is the data used?**
Sonier says one way that MNCM measures and data are being used is in contracting arrangements between health plans and providers. “It’s an important source of information for contracts, which is one of the reasons it’s important to employers as well.”

MNCM data and the reports it generates also give physician clinics the ability to benchmark themselves against other providers, “to get that sense of ‘how are we doing?’” Sonier says. Consumers also access the MNCM website to get information about the clinics they go to and to compare costs of different providers.

“One question we get a lot, because we’re talking about outcome measures, is how we account for patients of different socioeconomic status and potentially different barriers to health care,” she says. “How do you deal with that in the measurements? Someone in a low-income neighborhood may have difficulty finding healthy food, maybe even filling their prescriptions.”

To address these differences, MNCM has developed a method that adjusts outcome data for socioeconomic status, based on economic data about the ZIP codes where a clinic’s patients live.

The annual Health Care Cost & Utilization report looks at the total cost of health care, resource use and relative price, utilization and average cost per procedure.

MNCM reports spotlight data and trends so that provider clinics not only see how they are doing themselves, but also look at what others are doing. “We are trying to shine more of a light on some of the best practices,” Sonier says. MNCM has issued reports on depression, quality of care for chronic conditions and, most recently, on preventive health measures—including cancer screening, infectious disease screening and vaccinations for children and adolescents.

Sonier cites Entira Family Clinics as an example of a best practice, shared after an MNCM report. In a press release announcing the 2018 depression report, MNCM included a quote from Tim Hernandez, MD, Entira CEO: “Of all the metrics that we are being measured on through MNCM, the depression remission measure has had the greatest impact on changing our care delivery. In order to be successful, one has to develop strategies to reach out to patients between visits. People who are struggling with mental health problems need between-visit care perhaps more than people with other medical conditions. Finally, as we begin to manage adolescents who suffer with depression, we have had to use different strategies, such as texting, to reach different generations. The care coordination program that we developed for the depression remission measure became the foundation for our Health Care Home.”

Sonier says that, for at least the last decade, there have been a lot of conversations at all levels about value in health care. “Defining what value is, by developing measures and collecting data, is a big part of what we do—and the participation and collaboration of stakeholders across the spectrum of health care is essential.” MM

To see the latest MN Community Measurement reports, get more information about the measurement process, learn about how to submit data, see comparative health scores and more, go to mncm.org.

Linda Picone is editor of Minnesota Medicine.