

## **Comments for the ONC HIT Policy Committee**

December 15, 2009

### **Richard D. Miller DO MHA FAAFP**

My name is Rick Miller and I am a family practice physician from Iowa. I have spent the last 14 year in various aspects of medical management in various settings including clinic, hospital, hospital system, payer, and quality improvement organizations. Most of this time has been spent in the application of evidence based medicine, quality improvement methods, and most recently in the use of clinical registries and databases to improve population health. In my current role I have responsibility for clinical quality improvement with Wellmark Blue Cross Blue Shield of Iowa and South Dakota. It is a privilege for me to be able to be here today and share the experiences we have had working with primary care groups in Iowa and South Dakota to improve the care received by the people we mutually serve.

Before I tell you about our experiences it is important to know the context in which we chose to work collaboratively with local clinicians. Pay for performance is not new. For the last 50 years we have had a pay for performance program based on productivity which measured services through the use of CPT and ICD codes and gave rewards in the form of predetermined fees. It was originally designed to improve access and has worked exceptionally well. Unfortunately it has also had unintended consequences due to a lack of incentives for quality and coordination of care to balance the volume incentives. In recent years significant attention has been drawn to problems with quality and fragmentation of care and there have been numerous attempts to improve these but few have been sustainable. These attempts often suffer from the fact that quality improvement efforts are not reimbursable and have a tendency to reduce demand for future medical services as the health of the population improves. This places providers in the uncomfortable position of improving quality while reducing the financial viability of their organization. Wellmark realized that in order to improve quality we needed to work directly with providers and to make the efforts sustainable there needed to be reasonable incentives for improvement. By creating appropriate incentives for quality and coordination of care we hope to restore balance to a system that is currently out of balance.

In 2004 and 2005 Wellmark engaged a small number of innovative primary care groups to experiment with methods to improve quality. These early efforts were marked by a high degree of variability in approaches to clinical conditions and measures and required manual data entry and analysis. We learned what did not work. It was recognized that in order to have a program with reliable and equitable measures we needed a system for data collection that was reliable, reproducible, and minimized the work associated with data management. We also had solid input from the participating clinicians that the only data that they trusted was the data that came from their own records. Consensus emerged that we needed a clinical registry tool with the ability to give clinicians real time data for patient reminders, visit planning, and performance feedback at any time.

During 2006 and 2007 we purchased a registry for the participating clinicians to use for all of their patients if desired and collaborated in choosing conditions to manage and corresponding measures from the National Quality Forum. Diabetes was the first condition followed the next year with hypertension. The result was a cultural and operational transformation for all parties. Wellmark had to learn how to manage a registry in a way that treated clinicians equitably and distributed awards accurately based on performance. For clinicians it was a more personal transition that required changes in the way patients were cared for in order to be successful. Data needed to be monitored, patient outreach was needed, visits needed to be planned, and care teams became more important. Several clinics and clinic systems hired health coaches to work with their clinicians.

From 2007 to 2008 we saw tremendous growth in participation and improvements in performance. We currently have over half of all primary care clinicians in Iowa and South Dakota volunteering to participate. In the diabetes suite we have process measures that include necessary diabetic testing and outcomes measures of blood sugar (HbA1c), blood pressure, and LDL cholesterol. Process measures improved from an average of 41% of patients receiving a given test or service to an average of 80%. Similar improvements were seen in outcomes measures which went from an average of 35% of patients who were adequately controlled to an average of 73% controlled. Likewise in the hypertension suite, the number of patients who were adequately controlled went from a reported 14% (may be falsely low due to poor documentation, national averages are around 30 – 35%) to 76%. During this time clinician performance became bimodal with a clearly identifiable low performance group and a high performance group. The high performance group was characterized by regular use of a registry, the use of teams to provide care, patient outreach, regular feedback to clinicians, and a clinical champion at each site. For example, one clinic had a diabetic patient that had been labeled as non-compliant because he would not come in for regular diabetes checks and was not well controlled. After identifying in the registry that he was not getting the services he needed and not well controlled, the clinic reached out to him several times. They were about to give up when he called in to tell them that he had moved, had a new phone number and needed to come in for an appointment. At last report he was fairly well controlled and was coming in for most of his regular check-ups. In 2008 the number of clinical suites increased to include asthma, immunizations under two years of age, and cancer screenings.

2009 has been a year of analysis and learning to determine appropriate next steps. The early data shows that we have increased the number of office visits and necessary testing for diabetes and hypertension. Drug utilization has increased as individuals are adequately treated and become more compliant. Emergency utilization appears to be trending downward and the effects on hospital utilization cannot yet be determined. In the data there was a poor correlation between improved process measures (testing) and use of services reflecting improved health. However, there was a significant correlation between improved outcomes measures and reduced need for services. This would suggest that the emphasis should be

placed on outcomes measures which can only be obtained from clinical records. Several clinics using the registry had excellent performance on getting patients the tests they needed but did not have very many patients whose chronic disease was well controlled. Since they had data to identify the patients who were not well controlled, and incentives to improve control rates, they have been very motivated to do so. As we move toward outcomes measures we will need to develop good clinical risk assessment tools to risk adjust the data. There is also a recognition that we will need to address the care of individuals with multiple conditions who may have multiple clinicians managing their care. Discussions are occurring to determine the best way to capture and reflect the care of multiple conditions. In 2010 we will engage cardiologists and primary care clinicians to pilot shared performance data, coordination of care measures, and shared care plans. To accomplish this we will need to have continued access to registry data and new access to information exchanged electronically that reflects coordination of care.

The critical ingredient in this type of collaboration is trust. Payers need to be confident that the data being entered is accurate. Providers need actionable data and to have their performance accurately represented, and consumers need safeguards to ensure that their information is not misused. Collaborations and sharing of data create this kind of trust over time, and by aligning goals and incentives patient care can be substantially improved. At the start of our journey we had many questions about why this was all necessary and what Wellmark was trying to do to the providers, now we hear comments like “we should have always practiced this way” and “by working with Wellmark we have been able to significantly improve quality”.