OPTIMIZING THE USE OF A VALUABLE COMMUNITY ASSET: HEALTH CARE DATA

July 27, 2017
Today’s Agenda

- Welcome
- Point of View: Data as a Community Asset
- Perspectives from Minnesota Experts
  - Stefan Gildemeister, Minnesota Department of Health
  - Julie Sonier, Minnesota Community Measurement
- Employer Perspective
  - Jon Born, SUPERVALU
  - Nance Lee Mosquera, City of Saint Paul
- How Individual Preferences Impact Value Ratings
  - Jim Andrianos, Calculated Risk
- Discussion
- Closing comments
Point of View
Data as a community asset

- Measurement & reporting can be a foundation to drive significant value, including:
  - Consensus around priorities and standards
  - Transparency for patients and providers
  - Quality improvement at the clinic and system level
  - Infrastructure changes that move the market forward
  - Better health outcomes for patients
  - Cost efficiency for patients and purchasers

- Perspectives on measurement & reporting can vary by stakeholder groups (e.g. policymakers, patients and purchasers may want more measurement/transparency; whereas providers may be concerned about burden)
Point of View
Data as a community asset

- Measures can be focused on process, outcome, or cost
- Sophisticated measurement & reporting requires a significant investment, including:
  - Infrastructure/technology
  - Process
  - Oversight
- Minnesota is a leader in measurement & reporting, with national, state, and nonprofit organization sources
- Measurement & reporting is a community asset that must:
  - Reflect the priorities of the community
  - Evolve to reflect the changing landscape of health care
  - Be *used* to realize optimal value
Stefan Gildemeister
MN All Payer Claims Database (MN APCD): Developing Analytics of Practical Value to MN Employers

Stefan Gildemeister | Director, Health Economics Program

July 2017
• Context about the MN APCD
• Uses of the data to date
• Work w/employers in 2017
What is the MN APCD?

• Large-scale database that systematically collects and integrates health care claims data from most MN payers
  • De-identified enrollment information
  • Medical & pharmacy claims
  • Actual transaction prices
• Longitudinal and geographically rich detail on
  • Diagnosed health conditions
  • Delivered health care services
  • Settings of care delivery
**MN APCD: Origin & Path**

**Phase I**
- Development
- **2007**
  - Health Reform Discussions
- **2008**
  - Legislation (included formation of an APCD)

**Phase II**
- Provider Transparency
- **2008 to 2009**
  - Develop data system and intake processes
- **2011 to 2014**
  - Work on methods & reports re: provider value
- **2014**
  - Suspension of transparency effort/start research

**Phase III**
- Health Policy Research
- **2015**
  - Authorization to develop Public Use Files from MN APCD
- **2016**
  - MDH Authority Extended Through 2019

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**Legislative Focus**
- Provider transparency
- Public Health
- Quality measurement
- Delivery system reform
- Payment reform
Legislatively Permitted Uses of the MN APCD, Starting in 2014

- Access limited to MDH for specific, but broad authorized uses
- Data granularity is limited
  - Protecting provider identity
- Public Use File process begun in 2016
  - Three initial files
  - Evolving set of content and vintages of data
Uses of the MN APCD to Date

Ongoing Work

- Pediatric outcomes
- Concentration in health care spending
- Health care use and cost for cancer care
- Drivers of commercial health care spending
- Trends in use of services and cost associated with Hep-C
- Potential of telemedicine on...
Engage Minnesota employers to:

• Help design reports and analytic products that are of value to employers as they purchase health care

• Build awareness of the MN APCD as an important resource for health information in Minnesota – support its integrity

This project is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.
Project Components

• Key informant interviews/environmental scan

• Discussions with employers on
  • What content matters to employers
  • What analytic tools/products are of highest priority
  • How to make the data most valuable to purchasers of services

• Feedback on
  • Usability of an initial set of displays
  • Effectiveness of key messages and communication tools
Price Variation: High Level

- Focuses on common, high cost inpatient treatments that regularly occur in specialties such as general surgery, cardiology, obstetrics, etc.

- Sheds light on how prices vary

- Assists employers to evaluate the market implications of price variation
# Price Variation: Detail

**Commercial Price Variation for High Volume Inpatient Treatments**

Display of minor severity treatments with the largest total spending.

<table>
<thead>
<tr>
<th>Inpatient grouping software: AFR DRGs (336)</th>
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## Key:
- **Total Spending**
- **Median Case Price**
- **Lower & Upper Medians**

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**For Discussion Purposes Only (not real data)**

**INPATIENT CASE COMPOSITION**

- What services are required?
- Hospital Inpatient
- Outpatient
treatment?
- MD/Surgeon/Anesthesiologist
- Ancillary Services: (PT/OT, etc)
- Drug
Some (Abbreviated) Early Lessons

• Employers see value in having an All Payer Claims Database in MN
  • They are interested in existing reports, and surprised to learn the richness and depth of the MN APCD
  • Too few know about this resource

• They would like to see the information made available to themselves and their brokers

• They were supportive of the need to continue submitting data

• They feel some of the limitations the legislature has placed on the data constraints the usefulness of the data
Additional Resources

- MN APCD Background Information: http://www.health.state.mn.us/healthreform/allpayer/index.html
- Public Use Files derived from the MN APCD: http://www.health.state.mn.us/healthreform/allpayer/publicusefiles/index.html
- Publications that rely on the MN APCD http://www.health.state.mn.us/healthreform/allpayer/publications.html
- Health Economics Program Homepage http://ww.state.mn.us/healtheconomics
Thank you!

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Julie Sonier
Health Care Measurement and Reporting: Where Are We Now, and Where Are We Headed?

Julie Sonier
President
MN Community Measurement

Minnesota Health Action Group Member Meeting
July 26, 2017
MN Community Measurement

• Accelerating the improvement of health through public reporting

• Our vision:
  • To be the primary trusted source for health data sharing and measurement
  • To drive change that improves health, patient experience, cost and equity of care for everyone in our community
  • To be a resource used by providers and patients to improve care
  • To partner with others to use our information to catalyze significant improvements in health
What is Being Measured?

- **Quality**
  - Publicly report quality measures on clinics and hospitals
- **Patient Experience**
  - Reported nation’s first statewide patient experience survey in 2013
- **Cost**
  - Costs for 90+ common procedures
  - Total cost of care
- **Equity of Care**
Public Reporting

Compare ratings on the quality and cost of healthcare in Minnesota and neighboring areas.

Get started by selecting one of the following categories:

- Clinic Quality and Patient Experience
- Medical Group Quality and Total Cost
- Hospital Quality and Patient Experience
- Cost of Services and Procedures

Clinic Quality and Patient Experience
Use our clinic quality and patient experience ratings and resources to improve your health and health care.

View all Clinic Quality of Care Ratings
View all Clinic Patient Experience Ratings
Public Reporting

Public reporting display on MNHealthScores.org – Cost and quality side-by-side
Where Should We Go Next?

• Encourage/leverage better use of the data we have now
  • Employers/consumers – plan design, comparing costs/quality
  • Health plans and providers – quality improvement, payment reform
  • Government – e.g., reducing disparities
  • Research

• Alignment of measures and reducing reporting burden are key concerns
  • But need to be careful not to let go of the progress we have made
  • Employers need to be engaged – what is most meaningful for commercially insured population?

• Measures that are meaningful, actionable, and timely
Contact

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sonier@mncm.org

Connect with us!

On the web
MNCM.org
MNHealthScores.org

On social media
@mnhealthscores
facebook.com/mnhealthscores
Linkedin.com/company/mn-community-measurement
Employer Perspective
Jim Andrianos
BUILDING ON YOUR COMMUNITY DATA ASSETS

SUMMARIZING PERFORMANCE WITH VALUE RATINGS

(abridged)

proprietary
THE CHALLENGE AND NEED

- **MEASURE PROLIFERATION**
  - There are 620 NQF-endorsed measures (as of last month)
  - As more measures come online, the cognitive burden on users becomes increasingly overwhelming

- **NEED FOR A COMPOSITE SCORE**
  - Composites can simplify evaluation as the number of measures grow
  - For years, employers have called for rolled-up scores that summarize measure results for primary care, disease care, etc.

- **SATISFACTORY WAY TO CONSTRUCT VALUE RATINGS**
  - A Value Rating is a special kind of composite score that blends performance for quality, price, patient experience...and more

Calculated Risk, Inc. 2017
Weight every measure EQUALLY
- “Everything is important at some level to someone; we won’t judge”
- BUT: Is patient satisfaction just as important as mortality?

Ask EXPERTS to assign weights to measures
- “Doctors ought to know what the weights should be”
- BUT: What if some types of performance don’t apply to me/us?

Lesson: One-size-fits-all weighting systems won’t do

Good news: this dilemma was addressed a decade ago by an national multi-stakeholder body
In 2006, the Ambulatory Quality Alliance\(^1\) established the following definition - which still stands today - for measures addressing Value of Care:

A Value of Care Measure is:

“A measure of a specific stakeholder’s preference-weighted assessment of a particular combination of quality and cost of care performance.”

In other words:

Do not adopt a single weighting scheme for everyone

BUT: how can we ascertain a stakeholder’s “preference weights”?

\(^1\) More than 100 organizations; founded by AAFP, ACP, AHIP, and AHRQ
Imagine two people in the market for a new car. Suppose the performance attributes they care about are:

- Ride Quality
- Purchase Price
- Crash Safety
- Warranty

Naturally, each user’s personal circumstances will color the relative importance of each attribute.

We can guide or ‘curate’ each user through an econometric process to reveal his or her own Preference Profile...
Using an interactive survey to reveal your Preference Profile for different product attributes
NO SURPRISE: PREFERENCES DIFFER BY USER

- User #1 weights Crash Safety heavily, 3x more than Purchase Price

**USER #1: Preference Profile**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Weight</th>
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<tbody>
<tr>
<td>RIDE QUALITY</td>
<td>5%</td>
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<tr>
<td>PURCHASE PRICE</td>
<td>20%</td>
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<tr>
<td>CRASH SAFETY</td>
<td>62%</td>
</tr>
<tr>
<td>WARRANTY</td>
<td>13%</td>
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</table>

- User #2 prefers Ride Quality over Purchase Price by a factor of 7

**USER #2: Preference Profile**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Weight</th>
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<tbody>
<tr>
<td>RIDE QUALITY</td>
<td>42%</td>
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<tr>
<td>PURCHASE PRICE</td>
<td>6%</td>
</tr>
<tr>
<td>CRASH SAFETY</td>
<td>40%</td>
</tr>
<tr>
<td>WARRANTY</td>
<td>12%</td>
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</table>

Each consumer will choose a different car even though they refer to the same performance data

Calculated Risk, Inc. 2017
A demonstration to show how preferences matter

Four popular measure families from public reporting:

- Prevention
- Disease Care
- Wise Use of Services
- Patient Experience of Care

This demonstration uses real data but excludes price data. The subsequent demonstration includes price data, illustrating a true VALUE RATING
A comparison of two users: **ALICE & BOB**

<table>
<thead>
<tr>
<th>ALICE</th>
<th>BOB</th>
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<tbody>
<tr>
<td>She places a premium on surveillance and treatment</td>
<td>He wants a lighter touch in his healthcare – thinks less can be more</td>
</tr>
<tr>
<td>Her plan covers most everything; little cost-sharing</td>
<td>Has <strong>significant cost sharing</strong> obligations with his plan</td>
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<tr>
<td>She is <strong>not concerned about overtreatment</strong></td>
<td>He <strong>worries about overuse and avoidable harm</strong></td>
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<tr>
<td>Alice <strong>trusts patient surveys</strong></td>
<td>Bob has <strong>some doubts about patient surveys</strong></td>
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Using the interactive survey to reveal your

Preference Profile

for different kinds of performance by

Medical Groups
PERFORMANCE DATA ARE STANDARDIZED BEFORE APPLYING PREFERENCE WEIGHTS

Standardization component of the methodology adjusts for:

1. Sample size
2. Measure-specific variance
3. Differing “degree of difficulty” (e.g., results that are clustered or dispersed)

26 measure results from the Washington Health Alliance

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<table>
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<tr>
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<th>WELL CARE</th>
<th>MAMMOGRAPHY</th>
<th>CERVICAL CANCER</th>
<th>CHLAMYDIA</th>
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<td>Medical Group 12</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Calculated Risk, Inc. 2017
### ALICE has a “Surveillance and Treatment” profile

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>28%</td>
</tr>
<tr>
<td>Disease Care</td>
<td>16%</td>
</tr>
<tr>
<td>Wise Use of Services</td>
<td>5%</td>
</tr>
<tr>
<td>Experience of Care</td>
<td>52%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>Value Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group M</td>
<td>91.5%</td>
</tr>
<tr>
<td>2</td>
<td>Group G</td>
<td>86.6%</td>
</tr>
<tr>
<td>3</td>
<td>Group J</td>
<td>82.5%</td>
</tr>
<tr>
<td>4</td>
<td>Group P</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

### BOB has a “Less is More” profile

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Disease Care</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Wise Use of Services</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Experience of Care</td>
<td>23%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>Value Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group M</td>
<td>94.9%</td>
</tr>
<tr>
<td>2</td>
<td>Group Q</td>
<td>80.0%</td>
</tr>
<tr>
<td>3</td>
<td>Group I</td>
<td>79.7%</td>
</tr>
<tr>
<td>4</td>
<td>Group G</td>
<td>78.9%</td>
</tr>
</tbody>
</table>

Calculated Risk, Inc. 2017
### Alice:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>Value Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>medical group M</td>
<td>91.5%</td>
</tr>
<tr>
<td>#2</td>
<td>medical group G</td>
<td>86.6%</td>
</tr>
<tr>
<td>#3</td>
<td>medical group J</td>
<td>82.5%</td>
</tr>
<tr>
<td>#4</td>
<td>medical group P</td>
<td>82.4%</td>
</tr>
<tr>
<td>#5</td>
<td>medical group I</td>
<td>74.3%</td>
</tr>
<tr>
<td>#6</td>
<td>medical group E</td>
<td>73.9%</td>
</tr>
<tr>
<td>#7</td>
<td>medical group L</td>
<td>70.6%</td>
</tr>
<tr>
<td>#8</td>
<td>medical group C</td>
<td>68.6%</td>
</tr>
<tr>
<td>#9</td>
<td>medical group B</td>
<td>65.5%</td>
</tr>
<tr>
<td>#10</td>
<td>medical group N</td>
<td>62.2%</td>
</tr>
<tr>
<td>#11</td>
<td><strong>medical group Q</strong></td>
<td><strong>58.7%</strong></td>
</tr>
<tr>
<td>#12</td>
<td>medical group F</td>
<td>57.6%</td>
</tr>
<tr>
<td>#13</td>
<td>medical group D</td>
<td>53.6%</td>
</tr>
<tr>
<td>#14</td>
<td>medical group K</td>
<td>47.9%</td>
</tr>
<tr>
<td>#15</td>
<td>medical group H</td>
<td>43.3%</td>
</tr>
<tr>
<td>#16</td>
<td>medical group A</td>
<td>22.9%</td>
</tr>
<tr>
<td>#17</td>
<td>medical group S</td>
<td>18.6%</td>
</tr>
<tr>
<td>#18</td>
<td>medical group R</td>
<td>15.6%</td>
</tr>
<tr>
<td>#19</td>
<td>medical group O</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

### Bob:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>Value Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>medical group M</td>
<td>94.9%</td>
</tr>
<tr>
<td>#2</td>
<td><strong>medical group Q</strong></td>
<td><strong>80.0%</strong></td>
</tr>
<tr>
<td>#3</td>
<td>medical group I</td>
<td>79.7%</td>
</tr>
<tr>
<td>#4</td>
<td>medical group G</td>
<td>78.9%</td>
</tr>
<tr>
<td>#5</td>
<td>medical group E</td>
<td>77.6%</td>
</tr>
<tr>
<td>#6</td>
<td>medical group P</td>
<td>73.2%</td>
</tr>
<tr>
<td>#7</td>
<td>medical group J</td>
<td>71.8%</td>
</tr>
<tr>
<td>#8</td>
<td>medical group N</td>
<td>69.4%</td>
</tr>
<tr>
<td>#9</td>
<td>medical group C</td>
<td>64.9%</td>
</tr>
<tr>
<td>#10</td>
<td>medical group K</td>
<td>59.9%</td>
</tr>
<tr>
<td>#11</td>
<td>medical group D</td>
<td>59.8%</td>
</tr>
<tr>
<td>#12</td>
<td>medical group S</td>
<td>45.7%</td>
</tr>
<tr>
<td>#13</td>
<td>medical group F</td>
<td>41.7%</td>
</tr>
<tr>
<td>#14</td>
<td>medical group L</td>
<td>40.0%</td>
</tr>
<tr>
<td>#15</td>
<td>medical group A</td>
<td>38.7%</td>
</tr>
<tr>
<td>#16</td>
<td>medical group R</td>
<td>38.4%</td>
</tr>
<tr>
<td>#17</td>
<td><strong>medical group B</strong></td>
<td><strong>37.8%</strong></td>
</tr>
<tr>
<td>#18</td>
<td>medical group H</td>
<td>26.0%</td>
</tr>
<tr>
<td>#19</td>
<td>medical group O</td>
<td>14.8%</td>
</tr>
</tbody>
</table>

Your preferences matter.
In effect, your preferences change the market you face
Higher value health care:

- **Right care**
  - Good infection control *(CDC)*

- **Right time**
  - Reliable post-discharge follow-up *(Dartmouth)*

- **Right amount**
  - Fewer discretionary services *(Dartmouth)*

- **Good effect**
  - Favorable mortality rates *(AHRQ)*

- **Fair price**
  - Lower ‘sticker’ prices *(CMS)*

- **Patient-centered**
  - Positive patient experience of care *(CMS)*
3rd Demonstration

Value Ratings for Hospitals
(using publicly available performance data)
SOCIO-POLITICAL ADVANTAGES OF VALUE RATINGS

1. Naturally Defensible
   - An objection to a poor Value Rating also questions your preferences

2. Enhanced Credibility
   - Value Ratings recognize that what suits one need not suit another
   - Dispels concerns about hidden motives while accentuating the rating organization’s goodwill and neutrality

3. Education and Discovery
   - Awareness of your Preference Profile can be clarifying, reassuring, and conducive to taking action

4. Compliant with AQA definition of Value of Care measure
   - A preference-weighted assessment of diverse performance results
THANK YOU

j.andrianos@calculatedriskinc.com
Thanks for Joining Us…

• A special thank you to today’s presenters!
• Check out: our website (enhancements to more clearly articulate who we are and what we do)
• Watch for: recap of member survey results and next steps
• Dates to remember:
  – **TOMORROW, July 27**: Minnesota Bridges to Excellence Recognition Reception, 5:30-7:00 p.m. at the Hilton MOA
  – **September 14**: Member Meeting, Employee Well-being: A Business Imperative
• Please take a minute to fill out the feedback form for today’s meeting