2010 Direct Data Submission Guide

(2009 Dates of Service)

Measures:

Optimal Diabetes Care

Optimal Vascular Care

October 16, 2009

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***Measurement Specifications**: Separate documents for the Optimal Diabetes Care and Optimal Vascular Care measurement specifications were distributed along with this guide and can be downloaded from the MNCM Data Portal, or contact support@mncm.org.*

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Mission and Vision of MN Community Measurement (MNCM)

The mission of MN Community Measurement is to accelerate the improvement of health by publicly reporting health care information. MN Community Measurement's vision is to

- be the trusted source for performance measurement and public reporting of quality data across the spectrum of health care that
- drive change towards more safe, effective, patient centered, timely, efficient, and equitable care
- be a resource used by providers to improve care and patients to make better decisions
- catalyze our community to work together on health care measurement to reduce administrative costs and maximize value.

Impact of Diabetes and Ischemic Vascular Disease

According to the MN Department of Health, diabetes is a high impact clinical condition in Minnesota. One in four Minnesotans either have diabetes or are at high risk of developing it. Each year more than 27,000 Minnesotans are newly diagnosed with diabetes. Diabetes is the sixth leading cause of death in Minnesota and is a significant risk factor in developing cardiovascular disease and stroke, non-traumatic lower extremity amputations, blindness, and end-stage renal disease. Diabetes costs Minnesota $2.7 billion annually, including medical care, lost productivity and premature mortality. According to the American Diabetes Association, an estimated 23.6 million American children and adults have diabetes. Most people with diabetes have other risk factors, such as high blood pressure and cholesterol that increase the risk for heart disease and stroke. In fact, more than 65% of people with diabetes die from these complications.

According to the MN Department of Health, vascular disease is a high impact clinical condition in Minnesota. Over 20% of all deaths in Minnesota are due to heart disease and over 7% are due to stroke, making them the second and third leading causes of death, respectively, in the state behind cancer. Inpatient hospitalization charges incurred in Minnesota were $1.7 billion for heart disease patients and $318 million for stroke patients in 2007. Risk factors reported by adults in Minnesota include elevated cholesterol (32%), hypertension (21%), tobacco use (17.5%), and being overweight (62%). According to the American Heart Association, an estimated 80 million American adults have one or more types of cardiovascular disease. In every year since 1900 (except the 1918 influenza pandemic), cardiovascular disease accounted for more deaths than any other single cause or group of causes of death in the United States. In 2005, cardiovascular disease claimed 1 of every 2.8 deaths in the United States.

Because of the health impact of diabetes and cardiovascular disease, national and regional organizations have brought together physicians to develop best practices to improve treatment and patient outcomes. By working with MN Community Measurement to collect and measure these outcomes, your medical group can contribute to information that can help to ultimately improve the health of patients and our communities.

The term Ischemic Vascular Disease is used in this guide to define cardiovascular disease. Ischemic Vascular Disease, or IVD, includes atherosclerotic disease of coronary, peripheral, renal and cerebral arteries. Please refer to the Optimal Vascular Care measure specifications for the ICD-9 codes used to determine patient populations.

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Optimal Care Measures

The Optimal Diabetes Care (ODC) and Optimal Vascular Care (OVC) measures are considered "composite" or "all-or-none" measures in which ALL components of the measures must be met for the patient to be considered optimally managed. The components of these measures include:

	Measures	
Components	*Optimal Diabetes Care*	*Optimal Vascular Care*
1. **Blood Sugar Control**: Most recent HbA1c test completed in the past 12 months with a value of less than 8.0 percent	✓	n/a
2. **Blood Pressure Control**: Most recent blood pressure taken in the past 12 months with values of less than 130/80 mm Hg	✓	✓
3. **Cholesterol Control**: Most recent low-density lipoprotein (LDL) cholesterol test completed in the past 12 months (ODC) or 15 months (OVC) with a value of less than 100 mg/dL	✓	✓
4. **Daily aspirin use or a documented contraindication** (41 and older only for the ODC measure)	✓	✓
5. **Tobacco free status**	✓	✓

Direct Data Submission

The goal of Direct Data Submission (DDS) is to collect data from medical groups on specific health care conditions and publically report comparable rates of health care quality at the clinic site level. All medical groups follow the same instructions for population identification and data collection. MNCM certifies methodologies prior to data collection. Then, each medical group submits data to MNCM via a secure, online data portal. As an independent auditor, MNCM validates the data for accuracy, calculates rates from the validated data, and publicly reports the data on the MNCM Web site www.mnhealthscores.org.

There are benefits to medical groups for submitting data through the DDS process. First, DDS rates represent the clinic patient population. Using the DDS process allows clinic-level reporting, and results are available five to six months earlier than health plan results. DDS also fulfills participation requirements for health plan pay-for-performance programs as well as Minnesota Bridges to Excellence. And, DDS results can be used by medical groups for quality improvement purposes.

Purpose and Function of this Guide

This guide is intended to be a comprehensive instruction for DDS. Please contact MNCM with any questions or feedback. Our e-mail address is support@mncm.org.

Thank you… MNCM appreciates your participation in DDS. Medical groups' efforts to submit data via DDS allows MNCM to report comparable health care quality rates in Minnesota and communities that border Minnesota.

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Important Information for 2010 Reporting

Reporting requirements for the Minnesota Department of Health's Quality Reporting, Bridges to Excellence, and other health plan pay-for-performance programs: By completing the registration process in the MNCM Data Portal and by completing the Direct Data Submission process outlined in this guide, a medical group will fulfill the new MDH requirements and qualify for the Bridges to Excellence and other health plan pay-for-performance programs (e.g., Recognizing Excellence, etc.).

Total population submission for medical groups using an electronic medical record: Medical groups that have implemented and have been using an electronic medical record (EMR) as of January 1, 2009 must submit data using total population for each measure. Medical groups that do not have an EMR are encouraged to submit data using total population but may also submit data from a sample. If some clinics within a medical group are using an EMR and others are not yet using an EMR, only those clinics using an EMR must submit data using total population; clinics not using an EMR may submit data using total population or a sample.

For the ODC measure, the HbA1c target changed from less than 7.0 percent to less than 8.0 percent. MNCM's Reporting Advisory Committee changed the target due to changes in the medical evidence that patients with certain risk factors may be better controlled with an HbA1c target of less than 8.0. For more information, please see the ICSI guideline for *Diagnosis and Management of Type 2 Diabetes Mellitus in Adults*, www.icsi.org.

Elimination of the 648.0x codes diabetes mellitus complicating pregnancy (not gestational): Diabetic patients who are also pregnant during the measurement time frame may have different management goals and targets for A1c and LDL control. Management to targets is impacted by the inability to utilize some medications because of the risk of fetal harm versus maternal benefit (e.g., statins are contraindicated in pregnancy with an FDA pregnancy category X, some oral diabetic medications are also questionable in terms of safety during pregnancy). Because of these safety concerns, the 648.0x codes were eliminated from the diabetes specifications for identifying the patient population (denominator).

Elimination of the "transferred care" and "diabetes managed by other provider" exclusions: The decision to no longer allow these exclusions was made by MNCM's Reporting Advisory Committee (RAC) earlier this year. This decision was based on an analysis of our diabetes population (n=114,285) and the volume and type of exclusions that were being used by the medical groups, specifically focusing on "diabetes managed elsewhere" and "transferred care." An internal analysis demonstrated rates of less than 1% for both of these exclusions and a very unequal distribution of medical groups who were utilizing these exclusions. Also, review of five national measurement programs revealed that no exclusions like these were used. The RAC decided that based on the promotion of medical home and coordination of care that the exclusion for "diabetes managed elsewhere" was to be eliminated and that for "transferred care." If the patient meets the visit criteria (two or more face-to-face visits for diabetes in the last 2 years and at least one visit for any reason in the last 18 months) that it is acceptable to include this patient for measurement purposes. Patients that transfer care will eventually fall out of the denominator as not meeting the visit criteria.

Collection and submission of Race, Ethnicity, Primary Language (REL) data: MNCM is asking medical groups to begin collecting and submitting patient REL data this year. It will be voluntary to submit these data elements in the 2010 report year (2009 dates of service) and REL data will not be publically reported in 2010. Groups will be required to submit this data in the 2011 report year. MNCM recognizes that it will take time to capture these data elements on 100% of patients. In both reporting years,

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MNCM requests clinics submit all the data available to date. All of these data elements will eventually be used by MNCM for risk adjustment.

Collection and submission of Gender and Patient Zip Code: Medical groups are required to submit Gender and Patient Zip Code with the clinical data this year. This information will also be used for risk adjustment.

For the ODC measure, aspirin use will be measured in patients age 41 and older (rather than 40 and older). For the purposes of measurement, MNCM decided that it would be more reasonable to allow a window of time (one year) for patients with diabetes who are just turning age 40 to begin taking aspirin (unless contraindicated).

Medical groups are required to submit the patient's insurance coverage and member ID. MNCM shares this information with the corresponding health plan who then maps the member ID to the appropriate insurance product category (e.g., Commercial, Medicaid, Medicare). MNCM will also be able to identify patients without insurance. Please pay close attention to the list of codes in the measurement specifications.

MNCM Data Portal improvements: MNCM continues to make improvements to the MNCM Data Portal https://data.mncm.org to make it a functional and easy-to-use site. Because the MNCM Data Portal is undergoing changes upon the release of this guide, instructions in this guide are written in general terms. We have made every attempt to make the instructions in this guide clear, easy to understand and applicable when using the MNCM Data Portal.

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DDS Participation Requirements

To participate in the DDS process, medical groups must agree to:

- Follow the MNCM timeline outlined in this guide
- Accept and agree to MNCM's *Site Terms of Use Agreement* (electronically signed in MNCM Data Portal)
- Submit data for ALL clinic sites
- Submit data in required format (.csv)
- Participate in the data validation processes as required by MNCM
- Have results publicly reported on www.mnhealthscores.org and in the annual *Health Care Quality Report*.

Confidentiality and HIPAA

Our legal firm, Lindquist & Vennum P.L.L.P., has assured us that direct data submission fits within the scope of lawful compliance with HIPAA and MN statute as long as we have a signed Business Associate Agreement (BAA) with the medical group. This document can be electronically signed on the MNCM Data Portal, or MNCM would be open to signing a medical group's standard BAA document version. The BAA is signed annually and remains in effect for all direct data submissions for the year.

Health Insurance Portability and Accountability Act (HIPAA) Law:

- This activity is considered within the scope of "health care operations" associated with the medical group quality improvement efforts.
- The federal HIPAA law specifically allows release of individually identifiable health information - without the consent or authorization of the individual - for treatment, payment and health care operations of, or for, the provider.

Minnesota Statute:

- The primary governing Minnesota statute is MN Stat. Section 144.335.
- Subd. 3a. entitled "Patient consent to release of records; liability" states: (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law.
- However, the statute does not restrict release (without patient authorization) to only those circumstances authorized by state law.
- Legal opinion assures us that it is reasonable to conclude that the HIPAA privacy regulation does specifically address authorization for release of such information. The appropriate method for a covered entity to allow such release and to make sure the release is for a certain, narrow purpose, is either via a data confidentiality agreement or, if the auditor or other entity to whom the information is released will be maintaining any individually identifiable health information, a business associate agreement.

American Recovery and Reinvestment Act of 2009:
At the release of this guide, MNCM is reviewing policies, procedures, and practices to ensure HIPAA compliance with the new ARRA provisions.

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Overview of Steps for Direct Data Submission
ODC and OVC Measures

1. **Register medical group, clinics, providers and contacts on the MNCM Data Portal at https://data.mncm.org starting November 2, 2009. Instructions will be sent to medical groups.**
   - Determine clinic designations, board certified specialties, and a list of providers.
   - For new medical groups and clinics, MNCM will assign new unique ID numbers for the medical group and for individual clinics.
   - Select all board certified specialties offered by medical group.
   - Upload a file of all clinic providers (MD, DO, PA, NP).
   - Verify all information.
   - Electronically sign the *Site Terms of Use Agreement* and *Business Associate Agreement*.

2. **Read the DDS guide and measurement specifications.**

3. **Determine how to identify patient populations (denominators) based on established patient criteria outlined in the measure specifications.**
   - Download and complete a document outlining process used to identify patient populations for each measure, and upload this file on the MNCM Data Portal.
   - Include ages/birth date ranges, ICD-9 codes, visit counts, how patients will be attributed to a provider/clinic, provider specialties, how exclusions will be handled, if total population or a sample will be submitted and how a sample will be generated.
   - Upload document on MNCM Data Portal for certification.
   - MNCM will send an e-mail when denominator process has been certified (within 2-3 business days).
   - Do not start collecting data until denominator is certified and billing cycle and patient records are complete for 2009 dates of service.

4. **In January 2010, begin collecting clinical data.**
   - Refer to the guide for field specifications and definitions.
   - Keep a “crosswalk” of the patient list for the validation audit (match the patient ID that is submitted to MNCM with the ID and method for locating the patient record).
     - Have the ability to locate patients to pull records or look up in the EMR.
     - Complete the Exclusions Template and upload this file onto the MNCM Data Portal; save this file for the validation audit.
   - Enter clinical data to Excel template that can be downloaded from the MNCM Data Portal.
   - Complete internal quality checks of data in Excel file; look for missing or incorrect data.

5. **Finalize file and upload data to the MNCM Data Portal.**
   - Using the Excel file, save a new file (CSV format) to upload on the MNCM Data Portal.
   - When ready, click “Submit to MNCM” button to complete data submission.

6. **MNCM will contact the medical group regarding the validation audit.**

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Timeline for Direct Data Submission

Process Step	Timelines/Deadlines
Registration *Medical groups can register their clinics and providers on the MNCM Data Portal at https://data.mncm.org/login.*	• Registration begins November 2, 2009 • Deadline: February 10, 2010
Population Identification (Denominator) *Medical groups must submit a document for each measure (ODC and OVC) outlining the method for determining patient populations (denominators) to the MNCM Data Portal. MNCM reviews and approves the denominator methods.* *MNCM highly recommends that medical groups submit these documents prior to December 11, 2009 so that the methods can be certified and data collection can begin in January 2010.*	• Denominator document submissions can begin after registration • MNCM recommends submitting documents prior to December 11, 2009 • MNCM responds within 2-3 business days
Data Collection and Submission *Medical groups collect clinical data and prepare files for each measure to upload to the MNCM Data Portal.* *Data collection begins after the 2009 billing cycle is completed and after the patient record updates are made for 2009 dates of service.*	• MNCM Data Portal opens January 18, 2010 • File submission deadline: February 15, 2010 (for both measures, ODC and OVC)
Data Validation *A MNCM auditor performs the validation audit to verify that the submitted data matches the source data in the medical record.*	After the data file is successfully uploaded onto the MNCM Data Portal, a MNCM auditor will contact the medical group to schedule the validation audit.
Data Results *After the successful submission and validation of the clinical data, MNCM will post the results on www.mnhealthscores.org.*	May 2010

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Clinic Definition

MNCM requires that all the clinics within a medical group are listed on the portal and data is submitted for every clinic site. We have created the following clinic site definition:

> *A Clinic Site is a functional unit that is easily understood by patients/consumers. The goal of reporting by Clinic Site is to provide patients/consumers with information about the entity with which they are most familiar – their clinic – and to provide information to clinics that is actionable for quality improvement purposes. A single Clinic Site is first defined as a building, separate space or an entity with a separate address. Large, multi-specialty clinic sites may further define themselves (i.e., by department or "call group") as long as all the data are included. Additionally, large clinic sites that desire further departmental granularity need to have a significant number of prescribing providers in the department or call group at that site. Prescribing providers include physicians, nurse practitioners, and physician assistants.*

Medical groups may also have small clinic locations that are affiliated with a larger, main clinic site. These "satellite" or "outreach" locations may be staffed by providers who are affiliated with the larger clinic site, and these locations may have limited days/hours of operation (for example, open one or two days a week). Patients seen at these locations would have their records (paper or electronic) and billing data included in the larger clinic's system. MNCM recommends that patients seen at satellite locations be "rolled up" along with the patients at the larger, affiliated clinic site.

With the provider detail submitted by medical groups during the registration process, MNCM will be able to determine if an additional departmental designation is appropriate. Please e-mail support@mncm.org with questions about specific clinic and provider designations.

If a medical group opened or acquired a new clinic in the last year, the new clinic must register with the medical group and must submit data with the medical group. If the new clinic uses a different practice management system, billing system or EMR, they would follow the same DDS instructions and measure specifications to collect the data, and the medical group would include the new clinic's data in the file that is submitted to MNCM.

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Step 1: Registration on the MNCM Data Portal

Important: Please do not login in to the portal until November 2009.

The MNCM Data Portal is under construction. A new registration process is being developed and will be implemented in the portal in November. Medical groups will receive an e-mail notice and further instructions once the portal is ready for medical groups to register. Please stay tuned.

The MNCM Data Portal site's URL is https://data.mncm.org/login. Please check back in November.

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Step 2: Identifying the Patient Population

The denominator is the total number of patients eligible for each measure. The eligible patient population is identified for each measure using a practice management system, billing system, or electronic medical record (EMR).

An established patient who meets each of the following criteria is included in the population (denominator):

Optimal Diabetes Care Measure	Optimal Vascular Care Measure
• Patient was age 18 to 75 during the measurement period (date of birth was 01/01/1934 to 12/31/1991). • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the last 2 years (01/01/2008 to 12/31/2009) with visits coded with a diabetes ICD-9 code (any position, not only primary). Use this date of service range when querying the practice management or EMR system to allow a count of the visits within the time frame. • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the last 18 months (07/01/2008 to 12/31/2009) for any reason. This may or may not include one of the face-to-face diabetes visits. ***Eligible specialties***: *Family Medicine, Internal Medicine, Geriatric Medicine, Endocrinology.* ***Eligible providers***: *Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).* ***Diabetes ICD-9 codes***: *250—250.93*	• Patient was age 18 to 75 during the measurement period (date of birth was 01/01/1934 to 12/31/1991). • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the last 2 years (01/01/2008 to 12/31/2009) with visits coded with an ischemic vascular disease ICD-9 code (any position, not only primary). Use this date of service range when querying the practice management or EMR system to allow a count of the visits within the time frame. • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the last 18 months (07/01/2008 to 12/31/2009) for any reason. This may or may not include one of the face-to-face ischemic vascular disease visits. ***Eligible specialties***: *Family Medicine, Internal Medicine, Geriatric Medicine, Cardiology.* ***Eligible providers***: *Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).* ***Ischemic Vascular Disease ICD-9 codes***: *Please see the measurement specifications for a complete list of codes.*

For purposes of determining if a patient is established to a practice, medical groups will count the number of face-to-face visits during a two-year timeframe. Groups may have different ways of defining or classifying visit types within a practice, but the intent is to count visits where there is face-to-face evaluation of the patient by an MD, DO, PA or NP. Face-to-face visits include the following visit types: office visit, physical exam, annual visits, and pre-op visits. Lab-only visits or visits just for a BP check would not be included for the purposes of this count, however, these visits would be a source for collection of the most recent labs or blood pressure.

"Inactive" patients: Patients designated as "inactive" in a practice management system, billing system or electronic medical record must be included in the patient population if they meet the established patient criteria noted above.

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Helpful Information for Identifying the Patient Population:

Evaluation & Management CPT Codes (optional)

The following list of codes may be helpful in determining what types of visits to include for identifying the patient population (denominator). E & M codes do **not** need to be used when querying a practice management system to determine visit counts, however, they have been included here to help further define what is meant by a "face-to-face" visit with a provider. Please refer to a CPT coding manual for more details.

Description	CPT Codes
E & M Codes	*99201 – 99205, 99211 – 99215,*
Preventive Codes	*99384- 99397*
Office Consultation	*99241-99245*
Individual Counseling	*99401-99404*
Group Counseling	*99411-99412*
Other Preventive Medicine Services	*99420, 99429*
Unlisted E & M Codes	*99499*

Visit Scenarios (to help define visit criteria)

Below are examples to show appropriate application of the visit criteria (assuming all other denominator components are met):

Visit scenario	Include patient in population?
Patient was seen face-to-face by a provider in January 2008 and April 2008 for diabetes; patient was also seen in December 2008 for sore throat (not diabetes).	*Yes. This patient meets the diabetes visit criteria (2 visits in measurement period or year prior), and patient also has seen a provider face-to-face on or after 7/1/08.*
Patient was seen face-to-face by a provider in January 2008 and April 2008 for diabetes; patient also came in for labs (only) in December 2009 and a subsequent face-to-face visit with the provider in December 2009.	*Yes. This patient meets the diabetes visit criteria and was seen by a provider face-to-face on or after 7/1/08. (Note: If the face-to-face visit had not occurred in December 2009 and the patient only came in for labs, the patient would not be included in the population.)*
Patient was seen face-to-face by a provider in January 2008 and April 2008 for diabetes; patient also came in for a blood pressure check in November 2009 with a subsequent face-to-face visit with the provider to address high blood pressure and diabetes in December 2009.	*Yes. This patient meets the diabetes visit criteria and was seen by a provider face-to-face on or after 7/1/08. (Note: If the face-to-face visit had not occurred in December 2009 and the patient only came in for a BP check, the patient would not be included in the population.)*
Patient was seen face-to-face by a provider in January 2008 and April 2008 for diabetes; patient has not been in clinic since for any reason.	*No. This patient meets the diabetes visit criteria, however the patient has not been seen by a provider on or after 7/1/08.*
Patient was seen face-to-face by a provider in April 2008 and April 2009 for diabetes; patient was not seen for any other visit.	*Yes. This patient meets the diabetes visit criteria, and the second diabetes visit was on or after 7/1/08.*

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Allowable Exclusion Reasons for Removing a Patient from the Population

Exclusion reasons have been kept to a minimum. If a patient meets the established patient criteria for the population, the patient must be included. Below are the allowable exclusions:

- **Patient was a permanent nursing home resident during the measurement period**
- **Patient was in hospice at any time during the measurement period**
- **Patient died prior to the end of the measurement period**
- **Documentation that the diagnosis code was used in error (patient does not have the condition)**

Other information about exclusions:

- Please remember to keep track of excluded patients found during data collection for validation purposes:
    - ***Exclusions Template****: A template will be available on the MNCM Portal to use for tracking excluded patients. This document will need to be uploaded to the MNCM Data Portal when the clinical data file is submitted. MNCM will review this list and validate a selection of records during the validation audit. Please read more about the Exclusions Template in the Data File Creation and Data Submission step in this guide.*
    - *If a* ***sample*** *of patients will be submitted and a patient that meets one of the exclusion reasons above is found, document this reason and on the original patient list or data collection form, and enter this patient in the Exclusions Template.*
    - *If the* ***total population*** *will be submitted using an EMR extraction of data, it is okay upload a different Excel file of excluded patients that are removed from the population. Using the Exclusions Template is not necessary, although it must be clear to MNCM what the exclusion reason is for each patient.*
- Do not enter patients that did not meet the initial established patient criteria (e.g., not ages 18-75, did not meet the visit criteria, etc.).

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Helpful data elements that can be included in the system query:

- *Clinic or facility (this information must be substituted with the Clinic ID as noted in the MNCM Data Portal in the data file that is submitted to MNCM)*
- *Patient ID number (this information can be a medical record number or account number, but the medical group must later substitute the number with an new ID for the purposes of DDS; keep a "crosswalk" of this information for the validation audit)*
- *Patient Date of Birth (DOB)*
- *Provider name or ID number (this number should match the provider ID entered in the registration process)*
- *Provider type/specialty code (this information must be substituted with the MNCM-assigned specialty code in the data file that is submitted to MNCM)*
- *Insurance information (this information must be substituted with the MNCM-assigned insurance code in the data file that is submitted to MNCM)*
- *Insurance member ID number (format field as TEXT as it is in the Excel template)*
- *Date of last visit in the measurement period (not necessary, but helpful for auditors to find the most recent values required on the data collection form)*
- ***New patient data elements**: race, ethnicity, language, gender, and zip code*

Keep a "Crosswalk":

It is very important to keep a "crosswalk" between the unique identifier and the patient's name and DOB, so that records can be located by clinic staff at the time of validation by MNCM.

If a medical group opened or acquired a new clinic in the last year, the new clinic must register with the medical group and must submit data with the medical group. If the new clinic uses a different practice management system, billing system or EMR, they would follow the same DDS instructions and measure specifications to collect the data, and the medical group would include the new clinic's data in the file that is submitted to MNCM.

For medical groups that implemented a new practice management system or EMR in the last two years: Please consider how to generate the patient population using both systems. Two queries or patient lists may be necessary. The lists should then be combined and a common identifier(s) selected to de-duplicate the list. Please contact MNCM with any questions.

Finalizing the patient population list:

1. **Sort the list by the clinic site (where the patient is attributed)**.
2. **De-duplicate the list and include only one record for each patient**. If a patient is listed more than one time within a clinic or within the entire medical group, determine which provider or clinic the patient will be attributed to and delete the other patient record/row. *Tip: The Excel PivotTable function can show counts of patients. Use the patient medical record number, account number or other unique ID as the common identifier.*
3. **Perform this quality check**: Is the total number of patients in the population similar to last year? If the totals are significantly different, does the difference make sense? Maybe a clinic opened/closed, or maybe a clinic's overall patient population increased/decreased this year, etc. Does a correction in the methodology or query need to be made?

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Certifying the Patient Population (Denominator)

To avoid the need for medical groups to resubmit data because the wrong patient population is inadvertently pulled, MNCM completes an upfront review of the source code or methodology used to produce a clinic's patient population (denominator). **MNCM must certify the method before medical groups generate patient population lists or collect/submit data.** Please see the DDS Timeline outlined in this guide for the suggested submission date associated with this process step. MNCM can also do a preliminary review of the method upon request.

Denominator Template Form

This template is provided to ensure all pertinent information is submitted to MNCM.

1. Login to the MNCM Data Portal and download the form.
2. Complete the form and save.
3. Login to the MNCM Data Portal and follow the process for uploading the form.
4. MNCM will review the method and respond within 2-3 business days. MNCM will either (1) contact the medical group if more clarification is needed, in which case the medical group will need to make the necessary revisions and re-upload the form, or (2) certify the method in the MNCM Data Portal; an automatically generated e-mail will notify the medical group that the method is certified.

Details for the Denominator Method

It is necessary to include certain information for the denominator method. The following elements are included on the denominator template form mentioned above, and MNCM should be able to identify:

- *Birth date ranges used*
- *ICD-9-CM codes included*
- *Visit date range and visit count details that ensures established patient criteria were followed*
- *Description of how patients will be attributed (assigned) to one provider and one clinic*
- *Board certified specialties offered by the medical group that ensures the appropriate specialties for each measure were included*
- *Whether exclusions will be taken and how exclusions will be handled*
    - *EMR groups can list which accepted exclusions will be filtered through the query process*
    - *Medical groups that will manually abstract data can describe that exclusions will be identified and documented during record review*
- *Whether total population or a sample of the patient population will be submitted; if a sample, the process for generating a sample (including an oversample)*
- *Source code or "screen shots" can be included also*

Do not include patient lists or protected health information (PHI) in the denominator method.

Patient attribution:

It is important to decide how to attribute a patient to one provider and one clinic site if the patient was seen by multiple providers or at multiple clinics. Some options for patient attribution include:

- An assigned primary care provider to the patient
- A provider who saw the patient most often in the measurement period
- A provider who saw the patient most recently in the measurement period

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Submission Size: Total Population versus Sample

Medical groups that have implemented and have been using an electronic medical record (EMR) as of January 1, 2009 must submit data using total population for each measure. Medical groups that do not have an EMR are encouraged to submit data using total population but may also submit data from a sample. If some clinics within a medical group are using an EMR and others are not yet using an EMR, only those clinics using an EMR must submit data using total population; clinics not using an EMR may submit data using total population or a sample.

By submitting total population, the confidence interval around the rate narrows, indicating a higher likelihood that the rate accurately reflects the clinic's performance. In the annual *Health Care Quality Report*, MNCM uses the confidence interval when designating High Performers. Clinics with a rate and confidence interval that are fully above average are highlighted as High Performers. If the confidence interval was wide due to a smaller sample size, and crosses the clinic average, that clinic is not highlighted as a High Performer.

For clinics that are not using an EMR and that will submit data from a sample, the following is an online tool for determining sample size: http://www.surveysystem.com/sscalc.htm. Different sampling options can be calculated by entering confidence level, confidence interval, population and sample size values.

The minimum required sample size for clinics not using an EMR is 60 patients per clinic site, per measure. Each clinic must also oversample by at least 20 patients to account for possible exclusions. If a clinic site has fewer than 60 patients in their total population for the measure, the entire population must be submitted. Also, please note the special requirements for Blue Cross Blue Shield of Minnesota on this page.

Sampling Requirements for BCBS Recognizing Excellence:

Clinics with both Family Medicine and Internal Medicine specialties that are participating in Blue Cross and Blue Shield of Minnesota's Recognizing Excellence program must submit a minimum of 60 Family Medicine patients and a minimum of 60 Internal Medicine patients. Keep in mind though that the sample must also be **representative of the clinic** in order to meet MNCM's requirement. Oversampling will be necessary to accomplish both the BCBSM and the MNCM requirements.

Sampling options:

The easiest way to meet both BCBSM and MNCM sample requirements is to use an Excel list and generate a random list of patients using the RAND function (see instructions on the next page). Work through the patient list row by row (do not skip rows) from the top down until at least the minimum required records are reviewed for each specialty. One specialty will likely have more patients included, and this is okay because this will still represent the clinic population; how varied the number of patients for each specialty depends on how disproportionate the numbers are of patients seen by FM or IM.

Another way to generate a sample to meet both BCBSM and MNCM requirements is to determine a sample size using the following process (example provided in italics):

1. Determine the total number of patients in the population (diabetes or IVD).
2. Determine the percentage of patients that are in each specialty.
    a. *For example, a population of 1000 diabetes patients might have 600 patients seen by a FM provider (60%) and 400 patients seen by an IM provider (40%).*
3. Divide the percentage values.
    a. *Using the example above, divide 60/40 = 1.5*
4. Determine the sample size (minimum required is 60). The specialty with the smaller number of patients would submit this sample size.
    a. *Using the same example, the IM specialty (250 patients) would submit 60 patients.*
5. Determine the number of patients to submit for the specialty with the larger number of patients by multiplying the sample size by the number reached in Step 3.
    a. *Using the same example, multiple 60 by 1.5 = 90. In other words, 90 patients must be submitted for the FM specialty in this example.*

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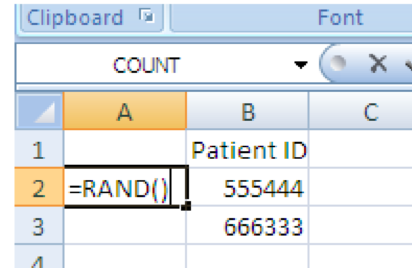
Options for Selecting a Sample

Excel Random Number Generator:
For patient lists generated in Excel, use the "RAND" function to assign a random number to each record (please also see Microsoft Excel Help, topic RAND for more information):

1. Insert a blank column on the leftmost side of the spreadsheet
2. Label new column "RAND"
3. Place cursor in the first blank cell (A2) and type *=RAND()*
4. Press enter (a number like 0.793958 will appear)
5. Place the cursor back into this cell; resting over the corner to have the pointer change to a black cross, double click or drag the formula down to the last row/patient
6. Highlight the whole column and click *Edit, Copy, Paste Special = Values* to freeze the random number (otherwise it will change with every click on the spreadsheet)
7. Sort entire patient population by this new random number
8. Work down the list row by row, starting with row 1 until the number of records in the sample is met for submission (**at least 60 patients per clinic, per measure**)
9. If a patient meets one of the accepted exclusions, keep working down the list and use oversamples that are after the number of records in the sample. For example, if 100 records will be submitted and 2 exclusions were found, include patient rows 101 and 102 to replace the excluded records.



Paper List Sample Selection:
For paper-generated lists, complete the following steps:

1. Start with a list that has patients sorted by some unique patient related variable.
   a. *Identifying number like a medical record number [MRN] or chart number is ideal.*
   b. *Sorting alphabetically is the least desirable in terms of randomness, however, this may be used when there is no other alternative.*
2. Select every Nth patient for the number of patients that will be reported (**at least 60 patients, plus at least 20 oversamples = 80 patients per clinic, per measure**).
   a. *N should equal the clinic site's total population divided by the number of patients that will be submitted (if needed, round down to the nearest whole number). **Review ALL randomly selected records and oversamples to exhaust the entire patient list**. Highlight or mark every Nth patient on the list. This is the sample.*
   b. *Example: If a clinic site has 800 diabetes patients and 80 patients will be submitted, divide 800/80 = 10. Select every 10th patient on the list.*

Missing records: *If a record in the sample list is not available or "missing," do NOT exclude this record. Missing records must still be included in the sample.*

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Step 3: Data Collection

Medical groups can collect clinical data from medical records by either 1) extracting the data from an electronic medical record through a data query, or 2) abstracting the data from the medical record (paper record or EMR). Data collection occurs after:

1. The clinic's billing and medical record updates are complete for the measurement period,
2. The denominator method is certified by MNCM, and
3. The patient population is pulled and sample is selected according to the measure specifications and sampling instructions.

Tools for Data Collection and Data Entry

Data Collection Forms

The data collection forms were created for medical groups that manually collect data from an EMR or paper record. The necessary data elements are on the form. These forms can also be used to note where certain data elements were found in the medical record. Data collected on these forms must also be entered into the Excel file mentioned below. Please download these forms from the MNCM Data Portal.

Excel Template

The Excel template was created to ensure all necessary data elements are collected for DDS. This file contains all of the necessary fields as well as the correct column formatting according to the measure specifications. Please download the Excel template from the MNCM Data Portal.

Field Formatting in the Excel File:

Prior to entering data in the Excel file it is important that the field formats follow the measure specifications in this guide. Pay special attention to field formatting (e.g., dates look like dates, etc.). Do not use "General" formatting in Excel. The Excel template provided on the MNCM Data Portal will provide the correct formatting.

Pay particular attention to the formatting of the insurance member IDs. This field must be formatted as "Text" to account for IDs that contain leading zeros or that are alpha/numeric.

Using Multiple Data Collectors and *Inter-Rater Reliability (IRR)*

Ideally, one data collector or data collection process is preferred because it ensures that the data is collected in one consistent way. If, however, more than one person will collect data, we recommend improving IRR by conducting an internal training and discussing the process with all persons who will collect data. This ensures that the measurement specifications are interpreted consistently and that the data is collected in a uniform way.

Internal training could include a review of the DDS guide and data collection forms. It would also be important to provide instructions for locating information in the clinic's medical record or EMR. Also, recall data collection errors made in previous submission cycles, make plans to improve the data collection process, and perform quality checks of the data.

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Locating Data Elements in the Patient Record

The primary source of data is the clinic's documentation in the medical record (e.g., flowsheets, progress notes, lab reports, etc.). Data collectors may also choose to review the outside correspondence in the clinic's medical record that documents more recent data within the measurement period, but this is optional. If data is used from outside correspondence, please document this for the validation audit. Below are tips for locating data in the patient record. **Please follow the measure specifications for data collection.**

Lab Values (HbA1c and LDL-cholesterol)

- *Lab report/lab data that is part of the primary clinic's medical record*
- *Dated value in a note from a referring provider or specialist (e.g., consult)*
- *NOTE: Measurement periods for LDL are different for ODC (LDL in the last 12 months) and OVC (LDL in the last 15 months)*

Blood Pressure

- *Progress note or vital sign flowsheet that is part of the clinic's medical record*
- *Dated values in a note from a referring provider or specialist (e.g., consult)*
- *NOTE: a BP from an outside referring provider or specialist is acceptable if it is documented in the primary clinic's record; this reading may be used **only** if it is more recent than the primary clinic's reading*

Tobacco Status

- *Annual exam, progress note, health questionnaire, flowsheet, etc. that is part of the primary clinic's medical record*
- *Dated documentation in the primary clinic's medical record from outside correspondence (note from a referring provider or specialist such as a consult, hospital records or emergency room visits)*
- *NOTE: tobacco status from an outside referring provider or specialist is acceptable if it is documented in the primary clinic's record; this status may be used **only** if it is more recent than the primary clinic's documented status*

Aspirin or Contraindication to Aspirin

- *Medication list, progress note, or condition-specific flowsheet that is part of the primary clinic's medical record*
- *Dated documentation in the primary clinic's medical record from outside correspondence (note from a referring provider or specialist such as a consult, hospital records or emergency room visits)*
- *NOTE: Aspirin requirements are different for ODC (age 41 and older) and OVC (all patients age 18-75)*

Validation Audit and Outside Correspondence in the Patient Record:

If the most recent data from the primary clinic's medical record is used, the MNCM auditor will NOT do a more extensive review of outside correspondence during the validation audit.

Data Collection Tips:

- When manually collecting data using an EMR, highlight the row, column or cell that contains the data needed. This reduces the chance of looking at the wrong row, column or cell.
- Watch for TYPOS when entering data (number transpositions, etc.).

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Tracking Where Data is Located in the Patient Record

It's important to keep track of where data is located in the patient record. For example, if data is used from an outside specialist or provider note (that is within the primary clinic's record), document the source on the data collection form or Excel spreadsheet. If you are collecting data directly in the Excel spreadsheet, create a "NOTES" column and enter the source details in this column. After you have completed data collection, SAVE A COPY of the Excel file and remove the "NOTES" column in the file that will be used for submitting to MNCM.

Patient Registries:

A patient registry is an important tool to help clinics track patient progress and to use for quality improvement purposes. However, MNCM cautions the use of a patient registry for identifying patients in the population or for the collection of clinical data. Many registries give a "snapshot" of patients at a given time and would therefore not include all patients for the MNCM measure according to established patient criteria or may not reflect the most recent clinical data (e.g., most recent blood pressure or labs). Registries that are programmed to update the patient population and clinical results on a continual basis (24/7) could possibly be used, however, please discuss this with MNCM.

During the validation audit, the MNCM auditor will review the *patient record* for validation and not the patient registry. If a clinic uses data from a patient registry, the auditor may find a more recent date/value in the medical record and this would be counted as a validation error.

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Step 4: Data Quality Checks

MNCM recommends completing several internal quality checks of the data before submitting the data. Performing quality checks ensures that the data is accurate and able to be validated by a MNCM auditor. If corrections are needed, make these **in the Excel file**.

Excel's AutoFilter

Use the Filter function in Excel to look for incorrect or missing data:

- Click inside any data cell and activate the AutoFilter by doing the following:
    - In Excel 2003, click the **Data** menu, point to **Filter**, and then click **AutoFilter**.
    - In Excel 2007, click the **Data** tab and in the **Sort & Filter** area click **Filter**.
- The AutoFilter arrows now appear to the right of each column heading.
- Click on the drop-down boxes of any column and scan for incorrect, "out-of-range" or missing data (e.g., an A1c value entered as 68 instead of 6.8).
- To display all data again, click on the same drop-down box and select **(All).**
- Remove the Filter option by doing the following:
    - In Excel 2003, click **Data, Filter, and AutoFilter** again
    - In Excel 2007, click the **Filter** option again in the **Sort & Filter** area

Example Quality Check:

Verify that every A1c date has an associated A1c value entered by clicking the A1c Value drop-down menu to see a list of values and other selections; scroll through to find the ***(Blank)*** *selection; click* ***(Blank)*** *to see which record(s) had a missing value; verify the data in the medical record and make changes in the Excel file.*

Please see next page for a list of quality checks to complete.

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Quality Checks to Complete in Excel File

MNCM recommends completing the following quality checks **in the Excel file** prior to submitting the data to find potential errors that would normally be found when the file is scanned during the file upload process in the MNCM Data Portal.

- ❒ Check again for duplicate patients.
  Tip: Use the Excel PivotTable to do counts by patient insurance member ID. If a patient is found more than one time in the same clinic or within the entire medical group, determine which provider/clinic the patient should be attributed to and remove the patient row that is not needed. Keep in mind that the duplicate record may need to be replaced by another record in order to meet sample requirements.
- ❒ Check that there are no 2010 dates of service (or later) in any of the date fields.
- ❒ Check for blank cells that must have data (clinic ID, patient ID, date of birth, etc.)
- ❒ Check that patient insurance member ID is included for all applicable insurance payers.
- ❒ Check that patient insurance member ID is formatted as TEXT (leading zeros will show); check for any IDs that appear like "scientific notations" or start with "E+." Make corrections as necessary.
- ❒ Check that patient dates of birth are within range for each measure.
- ❒ Check that all clinic IDs match the number listed in the MNCM Data Portal.
- ❒ Check that data codes were entered correctly (specialty, insurance, tobacco status, etc.).
- ❒ Remove any patient records that were taken as exclusions (patient died, was in hospice, etc. – see list of accepted exclusions).
- ❒ Check that lab dates have an associated value (exception: if the LDL is "too high to calculate," the LDL value field should be blank, etc.)
- ❒ Check that the A1c values have a decimal point when necessary ("6.8" versus "68").
- ❒ Check that the ASA dates accurately reflect ASA **use** in the measurement period (med *review* date versus the med *start* date).
- ❒ Check that the Excel file does not have any blank rows at the bottom of the spreadsheet. This can slow the file upload process.
  *Tip: Press **Ctrl/End** at the same time to go to the bottom most cell in the spreadsheet. If there are several blank rows, remove them by highlighting the BLANK rows, right-clicking in the left margin, and select **Delete** (this deletes the rows and not only the text within the cells).*

Optional Quality Check: Complete an Audit of Clinical Data

Another option is to select a random sample of several records (about 30) and audit those records to see if the data matches what was collected from the patient record. If errors are found, make the corrections in the Excel file, however also consider if the errors were isolated cases or indicative of a larger data collection problem. (*Examples of a larger data collection problem: In an EMR query of the data, the ASA date may be the date ASA was started, but not the date ASA was documented in the measurement period. Or, the EMR query did not capture the most recent lab values.*)

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Step 5: Data File Creation and Data Submission

Final Steps to Complete in the Excel File:

Before proceeding with the next steps, it is extremely important to finalize the data collection, data entry and quality checks discussed previously in this guide. Once this is complete, proceed with the following steps.

Be sure to:

- Combine all clinic files into one spreadsheet. All clinics must be uploaded in one, single spreadsheet. The clinic identifier is the Clinic ID.
- Verify that each column is formatted according to measure specifications (TEXT, NUMBER, or DATE formatting). Columns can remain at any width.

If at any point in the process it is discovered that corrections to the data are needed, **make the necessary changes in the Excel file and save**.

Create CSV File for Data Submission

The next step is to create a CSV file that will be used for upload to the MNCM Data Portal. Below are steps for creating a CSV file (for Excel 2003 users or Excel 2007 users).

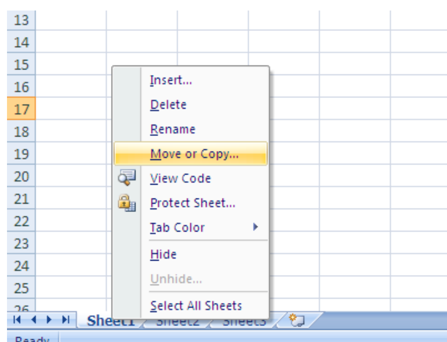
Important Message Regarding the CSV File:

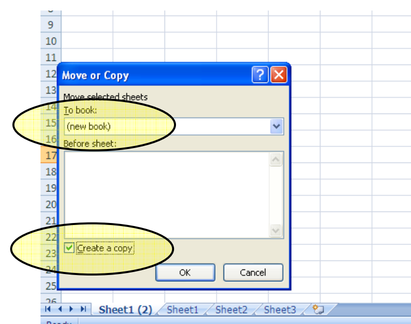
After creating the CSV file, do NOT open the CSV file in Excel. Opening the CSV file in Excel destroys the formatting and alters the data. **To view the data again, open the original Excel file**. If the CSV file is mistakenly opened in Excel, simply re-save a new CSV file from the original Excel file. Rename the old CSV file or delete it entirely.

What is a CSV file? Why is a CSV file needed for data submission? *CSV stands for "comma separated values." A CSV file is a common and simple format that is used to import /transport data between systems or software applications that are not directly related (e.g., from a spreadsheet to a database).*

If multiple tabs were created in the Excel spreadsheet, select the correct tab and proceed with the following steps (if spreadsheet has only one tab, start with step 6).

<table>
<tr><th>For Excel 2003 Users</th><th>For Excel 2007 Users</th></tr>
<tr><td colspan="2">1. Open the original Excel file (.xls) and do the following:</td></tr>
<tr><td>2. Click Edit or right-click the tab of the spreadsheet you wish to save (near the bottom of the screen)
3. Select Move or Copy Sheet
4. To book (new book) – this is a drop-down selection
5. Create Copy (check this box)
6. In this new book, click File, Save As</td><td>2. Right-click the tab of the spreadsheet you wish to save (near the bottom of the screen)
3. Select Move or Copy Sheet
4. To book (new book) – this is a drop-down selection
5. Create a Copy (check this box)
6. In this new book, click the Office Button (upper left-hand corner of screen); Select Save As</td></tr>
<tr><td colspan="2">7. Select the folder and file name of your choice.
8. At the very bottom you'll see Save as type; choose from the drop-down menu, CSV (comma delimited).
9. Click Save. When you save the CSV file, the following warning will appear: "…may contain features that are not compatible with CSV. Do you want to keep the workbook in this format?" Click Yes.
10. Now you can close the file; a message will appear: "Do you want to save this file...?" Click either yes or no. Your CSV file is now ready for upload to the MNCM Data Portal. Do NOT open the CSV file in Excel. If the file is mistakenly opened, simply resave a new CSV file.</td></tr>
</table>





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Upload CSV File to the MNCM Data Portal

The last step is to upload the CSV file to the MNCM Data Portal. Login to the MNCM Data Portal and go to the Home Page. Open the page for data submission and complete the next series of screens.

Step 1 Enter Denominator: Enter the following information for each clinic row:

- **Method Used for Data Collection**: Select one of the methods from the drop-down box:
  - *EMR extraction only*
  - *EMR extraction with manual data collection of some data elements*
  - *Manual data collection using EMR*
  - *Manual data collection using paper record*
  - *Manual data collection using both EMR and paper record*
- **Number of Patients That Meet Inclusion Criteria (Less Exclusions)**: Enter the number of patients who are eligible or met the inclusion criteria for the measure (based on diagnosis codes, age, visit criteria, etc.). Do NOT include patients who met an accepted exclusion (e.g., deceased, etc.). Including excluded patients in this count will decrease the final rate, so remember to subtract these patients from the total population.
- **Number of Patients Submitting**: Enter the number of patients in the clinic that are being submitted.
  - For total population submission, enter the same number as what was entered in the *Number of Patients That Meet Inclusion Criteria* category.
  - For a sample submission, enter the number of patients being submitted for the sample.
- **Not Reporting**: Check this box if a clinic is not reporting for this cycle of data collection. *Please be advised that MNCM's policy is that ALL clinic sites within a medical group submit their data through the DDS process. Likewise, this is a condition of participation for Bridges to Excellence (BTE) and other pay-for-performance programs.*
- **Messages**: If a sample is submitted, enter the reason for choosing to submit a sample rather than total population. If there was a significant change (increase or decrease) in the patient population or rate from DDS submission last year, enter the reason here.

Step 2 Review & Save: Verify the numbers entered and click ***Save and Continue***, or click ***Back to Step 1*** to re-enter.

Step 3 Upload Data: Click ***Browse*** to search for the CSV file and click ***Upload CSV and Continue***.

Step 4 Review & Submit: The portal will now scan the CSV file to identify possible errors. "Preliminary Rates" will also be listed for each clinic. Please review this information and determine if the file is ready to submit to MNCM. Follow these steps:

1. **Errors**: Corrections must be made and a new file uploaded (example: portal finds a date of birth that is out-of-range). Proceed to instructions 3 or 4 below.
2. **Warnings**: Review *possible* errors and decide whether corrections are needed (example: portal finds an A1c like *68* that should be *6.8*). If corrections are needed, proceed to instructions 3 or 4 below.
3. **Corrections to the data file**: Click ***Save as Draft***. This holds the file but does not submit the file to MNCM. **IMPORTANT: Make corrections in the original Excel file and save**; then save a new CSV file to upload. Do NOT make corrections in CSV file as this will destroy the format and alter the data. Go back to the portal submission page and click ***Re-Upload Data File***. Begin again with **Step 3 Upload Data**.
4. ***Clear & Start Over* button**: Only click this button to start the process completely over from **Step 1 Enter Denominator**. NOTE: all number entries and a new file upload will be necessary.

When the data file is ready to submit to MNCM: Click ***Submit Data to MNCM*** and proceed to **Step 5 Done**.

Step 5 Done: The data file has been successfully submitted. MNCM will send an e-mail that the data has been received.

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Upload Excluded Patients File

For medical groups that manually collect data, any patient meeting an accepted exclusion must be tracked on the *Exclusions Template*. This template can be downloaded from the MNCM Data Portal.

***NOTE**: If the patient does not meet one of the accepted exclusions, the patient must be included in the patient population (denominator).*

Enter each excluded patient (patient ID, clinic ID, DOB) found during manual data collection in the spreadsheet. Enter “1” in the cell of the accepted exclusion. Enter any notes for future reference. See examples below.

***NOTE**: Do not add columns for other reasons that are not one of the accepted exclusions. Do not enter patients that did not meet the initial inclusion criteria (e.g., not ages 18 to 75, did not meet established patient visit criteria, etc.).*

This file does NOT need to be converted to CSV format; the Excel file can be uploaded. Before uploading the Excel file to the MNCM Data Portal, please do the following:

1. Sort the data by clinic site
2. Save and print the file for future reference

Diabetes Exclusions: Please upload this completed form on the MNCM Data Portal

Medical Group Name: *(enter your medical group name here)*

Patient ID	Clinic ID	Patient DOB	Nursing Home	Hospice	Deceased	Coded in error	NOTES:
Sample 1	9999a	12/31/1935	1				see 3/1/09 note
Sample 10	9999b	4/1/1960		1			see 2/1/09 note
Sample 50	9999c	5/5/1965				1	10/1/09 visit
Sample 76	9999e	1/3/1945			1		10/1/09 phone msg; patient died in Sept

IVD Exclusions: Please upload this completed form on the MNCM Data Portal

Medical Group Name: *(enter your medical group name here)*

Patient ID	Clinic ID	Patient DOB	Nursing Home	Hospice	Deceased	Coded in error	NOTES:
Sample 1	9999a	12/31/1935	1				see 3/1/09 note
Sample 10	9999b	4/1/1960		1			see 2/1/09 note
Sample 50	9999c	5/5/1965				1	10/1/09 visit
Sample 76	9999e	1/3/1945			1		10/1/09 phone msg; patient died in Sept

Step 6: MNCM Validation of Submitted Data

After the clinical data file is successfully uploaded to the MNCM Data Portal, MNCM will contact the medical group regarding the validation audit. The validation audit is conducted to verify that the submitted data matches the source data in the medical record. Below is more information about the validation process.

MNCM Validation Process

MNCM utilizes the NCQA (National Committee for Quality Assurance) "8 and 30" process for validation audits. The following method is used for each measure:

- MNCM randomly selects 33 records for each clinic site for validation. At most, 30 records for each clinic site will be reviewed. The additional three records requested are oversamples to ensure there will be 30 records available on the day of the review.
- MNCM auditor reviews the first 8 records of the clinic site's selected sample to verify that the submitted data matches the source data in the medical record.
- If **all** of the first 8 records reviewed are in perfect compliance (100%), the clinic site is determined to be in high compliance, and the MNCM auditor may determine that no further record review for that site is necessary.
- If the first clinic site is in high compliance and the data collection process for all clinic sites within the medical group is identical, further review may be abbreviated at the discretion of the MNCM auditor.
- If clinic sites are not in high compliance after review of the first 8 records, the MNCM auditor will continue to review the remaining 22 records. If after review of all 30 records the clinic site is not in high compliance on all factors (less than 90%), the MNCM auditor will review the results with the clinic representative and communicate the results with MNCM. MNCM will then contact the medical group to develop a mutually-agreed upon re-submission plan. (Re-submission plans will only be allowed for errors in the numerator portion.)
- Clinic sites that are not in high compliance or have not been in high compliance in a previous MNCM audit may be held to a more rigorous denominator certification and validation audit.

Validation Results: Once all clinics within a medical group have passed the MNCM validation process, MNCM will approve the data in the MNCM Data Portal which generates and automatic e-mail to the medical group's data contact that the data is verified and approved.

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Clinic Preparations for the Validation Audit

- All medical groups should plan for an validation audit.
- MNCM auditor will contact medical group to schedule the audit.
- MNCM will provide list of sample records to be audited.
- Medical group or clinic site representative must be available to participate in the entire audit process.
  - For validation audits using an EMR, a medical group or clinic representative will retrieve and display the selected records and various screens necessary to complete the validation.
- Records may have patient names or personal health information (PHI) "blinded," as long as it can be verified that the record belongs to the patient submitted for review. The MNCM auditor will also need to verify the patient's date of birth.
- Clinics must have the following available at the time of the validation audit:
  - ALL requested patient records
  - The "crosswalk" between the unique patient identifier and the patient's name and DOB, so that the record can be located by clinic staff at the time of validation audit
  - Data collection forms and other notes describing where various data elements were located in the patient record
  - List of patients that were excluded

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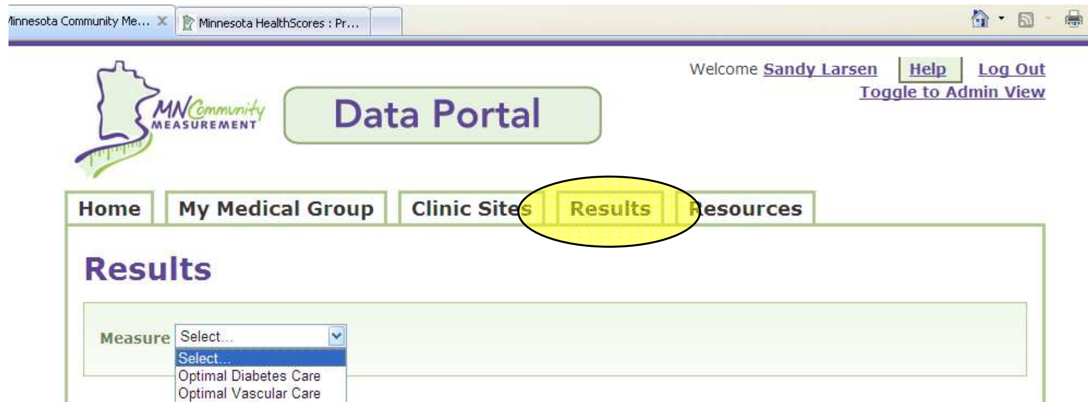
Step 7: DDS Results

Following the successful submission and validation of the clinical data, medical groups can expect to see results posted in May on the MN HealthScores Web site at www.mnhealthscores.org. Results will also be included in the annual *Health Care Quality Report* later in the year. DDS results can also be found on the "Results" tab on the MNCM Data Portal.



Pay-For-Performance Programs

Medical groups will also receive individual communications from health plans and MN Bridges to Excellence regarding their pay-for-performance programs that utilize DDS results.

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