



AMHERST H.
WILDER
FOUNDATION
ESTABLISHED 1906

WILDER RESEARCH
451 Lexington Parkway North
Saint Paul, MN 55104
651-280-2700
FAX 651-280-3700

www.wilderresearch.org

EXECUTIVE DIRECTOR
Paul Mattessich

MEMO

TO: Nathan Hunkins, Minnesota Community Measurement (MNCM)
FROM: Dan Swanson and Stephanie Kobbe
RE: Key findings from MNCM informant interviews
DATE: February 27, 2015

The following are key findings from the MNCM informant interviews.

- The most frequent responses from informants regarding the measurement and reporting experience were exclusively negative (33% of all responses), including comments that reporting is challenging, frustrating, and burdensome. There was a much smaller proportion of exclusively positive responses (18%): these included comments that the quality measurement process is generally good, that it is rewarding, and that there is value in the process. These viewpoints were not mutually exclusive; 31% of all responses had both positive and negative comments.

- *“In one word, [quality reporting is] very rewarding. In another word, very frustrating, as the burden increases. I see incredible value to doing the work; it’s necessary. But the other side is that it’s very challenging for providers.”* – Director of Quality at a large medical group

- Many respondents shared that the process of submitting a quality measure is time consuming or cumbersome and complex, with pieces that have to be done manually despite having electronic medical record (EMR) systems. On the positive side, respondents shared that the actual submission process to MNCM is easy and that MNCM provides helpful guidelines and customer care.

- Improved patient care emerged as the primary benefit of healthcare quality reporting as a whole. In addition to improved care, respondents indicated that quality reporting gives individual providers awareness of their own care, allows clinics and systems to benchmark their performance against peer organization, and gives structure to the changes they make as a whole.

- When asked about specific measures, depression came up most often as a burdensome measure to report (78%), and diabetes emerged as a beneficial measure for clinics to report (38%).

- Across all burdensome measures, manual abstraction (having to manually pull data in order to report) was indicated as a reason for the

burden (36%), along with the size of the population that needed to be pulled (16%).

- Many respondents indicated that all beneficial measures were such because they have improved patient outcomes and experiences (29%) and because they have increased awareness of quality benchmarks (31%).
- Almost half of all respondents (47%) indicated that they were self-taught on tracking and reporting quality measures, or did not receive training at all. Those who had been trained received training at a previous organization (16%), or had experience with reporting before public reporting became mandatory (13%).
 - Respondents at small- and medium-sized medical groups (99 providers or fewer) were more frequently self-trained or received no training (53%-54% of small and medium group responses); those at larger medical groups more frequently reported receiving on the job training (46% of large group responses).
- When asked about ways to make healthcare quality measurement less burdensome, respondents most frequently asked MNMCM and MDH to align measures between themselves and with federal guidelines. Respondents also asked MNMCM to consider the cost and limitations of new and existing measures, and to improve the notification process and timing for changes to measures.
- Most frequent suggestions for ways that MNMCM could make quality measurement more beneficial included providing education on quality measurement and report for providers and patients, and finding ways to share the best practices of top-performing clinics and systems.
- Respondents gave similar advice to other clinics who might seek to maximize benefits, and minimize burdens, related to reporting: to find an EMR system that works, to use that system to its fullest capabilities, to establish and standardize workflows for providers, and to use the results of reporting to improve on a regular basis.
- Most respondents had positive comments regarding their EMR system (51%).
 - There is slight variation in the frequency of positive comments by medical group size: respondents from large medical groups were more heavily weighted toward positive comments (62%), whereas comments from small medical groups are more evenly split (42% positive, 37% negative, 11% both positive and negative).
 - There is also variation based on the number of measures reported: responses from groups that report 5-8 measures were more heavily positive (57%), whereas groups that report 1-4 measures had more frequent negative (40%) or both positive and negative (20%) comments.
- Respondents were split on their opinion on provider support of the quality measures. Though respondents had more frequent positive impressions on how engaged providers

are (49%), many also felt that providers were frustrated or annoyed by the extra work involved in changing requirements, and that reporting gets in the way of patient care.

- Unlike other groups, respondents from large medical groups frequently indicated that providers want evidence that quality measurement data are correct or valid.
 - *“There’s always some skepticism until you prove the validity of the data, and the validity of data is twofold. Number one is the validity of the process of collection – are these numbers trusted? But also, do they have clinical meaning – is this measure valuable to me in improving the health of people, or healthcare delivery?”* – Director of Quality at a large medical group
- Many respondents shared that they have internal staff to track reporting program requirements (87%), and that the majority of tracking is done through emails or listservs (60%). Respondents also shared that keeping up with reporting requirements is challenging (24%), and that federal reporting requirements are more difficult to keep up with than others (22%).
- Just under half of respondents shared that they were not aware of any programs that their organization did not submit data for (47%).
 - Most respondents who shared that they intentionally did not report a particular measure come from small medical groups.
 - Of these, many shared that they did not have enough resources (such as time or staff) or a large enough/relevant population to report.