Jim Chase, President, Minnesota Community Measurement (MNCM)

An Interview with The Civic Caucus

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Notes of the Discussion

Present : Jim Chase, Janis Clay (phone), Audrey Clay (phone), Paul Gilje (coordinator), Verne Johnson (chair, phone), Ted Kolderie, Dan Loritz (vice chair), Walt McClure, Tim McDonald, Dana Schroeder, Clarence Shallbetter.

Summary of Discussion: Quality, cost and patient experience are important ways to evaluate health care, according to Jim Chase. He asserts that the health care system is not a good value for most people in the United States. The goals of Minnesota Community Measurement (MNCM) are to give people the right tools and incentives to make good health decisions and to give clinicians information so they can use it to improve quality and cost. Chase argues that the biggest challenges in developing measures to assess quality, cost and patient experience are access to data and the need to stay focused on a few good measures. According to Chase, cost and quality measures could help in making health-care capacity decisions. Minnesota's health-care exchange is planning to use MNCM's measurement tools for quality and he hopes people will soon agree to a standardized cost measure the exchange would be willing to use.

Background.

Jim Chase is president of Minnesota Community Measurement (MNCM), a nonprofit organization whose mission is to improve the health of the community by publicly reporting information on health care quality. Chase is past chair of the Network of Regional Healthcare Improvement, a group of leading regional health initiatives working to improve the quality and value of health in their communities. He also serves on the boards of the Institute of Clinical Systems Improvement and Apple Tree Dental.

Chase has over 20 years of experience in the health care field and has had a strong commitment to improving the health of the people of Minnesota. Prior to his work at MNCM, he spent nine years as director of health-care purchasing with the Minnesota Department of Human Services. He has also held positions with Health Risk Management, Inc., United Health Care and Fairview Hospitals.

Chase has a master's degree in hospital administration from the University of Minnesota and a bachelor's degree from Washington University in St. Louis. Since 1989, he has been a faculty member for managed care with the ISP Health Administration program at the University of Minnesota. He also served on the State Pharmaceutical Assistance Transition Commission that advised Congress on the impact of the new Medicare drug benefit on state pharmacy assistance programs.

Minnesota Community Measurement (MNCM) started about eight years ago, Jim Chase began. At that time, health plans were sharing some data with medical groups that they had at the health plan level. "We realized we shouldn't just be a health plan entity," he said. "We needed to work across multiple stakeholders in the community to get information out there." If only health plans were sharing information, physicians wouldn't trust it. If only physicians were sharing information, it wouldn't be trusted by the health plans. "There needed to be some balance there and I think that's something we've been able to strike," he said.

"Our goal has always been to have information that will improve health in the community," Chase explained. "We started with some clinical measures health plans were doing and reallocated that data from a health plan level to a medical group level. A big step was getting clinical data from physicians."

While MNCM was only doing samples, physicians had information across all their population, he said. They were willing to give his group the data out of their medical records. Some could give electronic data; others got the information from paper records. Right away, 80 percent of the primary-care providers in the state starting sharing this information. Providers started using this information for improvement in health practices and health plans started using it in their contracting.

MNCM started with quality initiatives, but realized if it were going to have an impact, it needed to look at more than just the quality of care, Chase said. It needed to include patient experience and cost, as well.

The Problem.
The health care system is not a good value for most people in the United States. We're not competitive internationally. "Often people are talking about affordability of care, but affordability and cost must go hand in hand," Chase said. "In the past we sort of ignored cost and said as long as we can subsidize people, it must be OK. But the relative cost of health care is so high we can't just subsidize any more to make care affordable."

MNCM's role is around transparency, he said. The problem of the value equation is that the system just does not have enough information at all levels to make it work. There aren't the right incentives and there's not enough information for people to do the right thing.

Chase said a good example is smoking. We know clinically it's a bad idea to smoke. He noted that some clinicians are better at reducing smoking than others. "How often do you get asked? How do you get asked? There are differences," he said.

If we're going to have a system that has better incentives for physicians to deliver more quality at a lower cost and a better patient experience we need information to get the system to work.

The Goals.

1. Give people the right tools and incentives to do the right thing. That has been a challenge, Chase said. "This is really hard work. We hear you can't measure quality, but we believe you can measure aspects of it." The standard often held up in research is that you need a 95 percent statistical confidence level in any findings before you can act, but he doesn't necessarily agree with that. He asserted that the public has so little information on health care cost and quality, that we need a different standard. The perfect should not be the enemy of the good.

"It's better to know a little bit, so you have something a little better than random," he said. "Health care is just a roulette wheel for most people." People think quality is good everywhere, but there is often a great variation in quality, cost and patient experience.

2. Give clinicians the information, so they can use it to improve quality and cost. "There's been a big transition in this community over the last eight years, especially on using quality information," Chase asserted. "Now we're seeing a great transition, as well, around cost. There's a recognition that the clinicians need to be responsible for the cost of care." Now patients are going to ask how much it's going to cost them. He said MNCM wants to focus on actual cost, not what people are charged. How much does the system cost all of us?

Comparative cost data is controversial. In response to a question, Chase said that for any given provider, plans might be paying a lot more or a lot less than to other providers. But consumers don't see that. It doesn't matter to them, but it matters to the total cost.

There was great pushback when MNCM said it wanted to compare across medical groups throughout the state what they got paid for 100 common procedures-not what the charges were, but what they actually were paid by the four biggest health plans.

MNCM put the data out and the groups said it must be wrong. The charges depend on the different levels of physician visits, which the physicians record as different codes. "The relative amounts paid don't make sense anymore," Chase said. "It didn't used to matter, because the customers didn't pay attention to that." They only paid attention to their copay or the total amount they had to pay.

Walt McClure commented, "There are a ton of doctors who want to have quality and efficiency. They're punished. They've got to make money."

Systems want to grow, Chase responded. "If we can reduce hospital readmissions, which Medicare is really pushing for, it'd be a great thing. But if we don't do anything, the system is just there to find ways to get other people admitted. You've got a system that's designed for that. It's not really going to save us money."

Measurement data could help with health-care capacity decisions. An interviewer commented that there has been an explosion in the provision of expensive hospital care for children in this region. "We're building capacity and specialization for, presumably, the same number of kids."

Chase offered a different example. He said Minnesota does a lot of orthopedic surgeries, but there's not a lot of data available to patients about when it's effective and when it isn't. It's similar to asking if

we put more kids in the hospital, are they better off? "We're never going to solve the problem without the data to be able to say we can give people the same outcomes or better without building another hospital or without adding in all these new procedures," he said.

Chase said he often is asked whether people will choose their doctors based on the measures. "That isn't the driver here. There is enough threat of people moving to another doctor to make everybody improve their product. You're not going to put people out of business, because there's always an undersupply of health care providers."

An interviewer responded that he has heard that we do want to downsize the industry by driving a substantial fraction of hospitals and medical providers out of the industry-the ones that are lowest quality and highest cost. Chase said that some areas do have an overcapacity. An operational measurement system-developed as fast as we can-will drive change.

The Challenges.

Chase argued that the biggest challenges in developing measures to assess the quality, cost and patient experience in health care are access to data and the need to stay focused on key measures.

1. Access to data. MNCM has solved a huge problem now on getting clinical data from providers, Chase said. "There are pushbacks on data privacy, but I think a lot of it is specious. We don't need to look at individual patient data; we can look at population data. It solves a lot of those problems. We must get used to building in safeguards." But patient privacy doesn't need to be a barrier around looking at some of these clinical data.

There are huge barriers still around health plans being willing to share the cost data, he said. "We're lucky in this community that we can get our plans to do it. I don't know nationally how that's going to work without some real public outcry that the plans don't get to own this data."

2. The need to be focused. Nationally, there are over 700 measures being endorsed by the National Quality Forum. "What's made us work better is getting some focus around what's important," Chase explained. "You don't need 700 measures; you need to focus on a handful of things and they need to be higher level. We've been successful about getting buy-in from physicians."

Minnesota's health-care exchange is planning to use MNCM's quality measures ; **Chase hopes the exchange will also use his group's developing cost measures.** A questioner asked how the state's health-care exchange fits into MNCM's work. Chase responded that the people working on the exchange are interested in MNCM's measures and data. The first thing the exchange needs to do is to give data on health-plan choices that people have to make. He'd like to have the exchange eventually include physician-practice cost and quality data and patient experience data.

He said the exchange is working with MNCM on quality. Because his organization works so hard on quality measures, it has data on about 600 sites of care across the state. "The catch is on cost data. Lots of people are doing different things. We need to get people to align around similar metrics."

"I'm not one who wants to put all my chips on everybody going through the exchange in four or five years," Chase said. It'll be helpful for a certain population, but there are still large employers and Medicare. "We want consistent data to be used in all those formats and to be effective." He said that won't be ready by 2014, when the exchange is supposed to be up and running.

"We want to help get people to use the stuff we're doing," he said. "I'm hopeful our tools get used in the exchange. They're planning to use our quality stuff. I'm hoping we end up with a standardized cost measure they would be willing to use, as well."

He said the 2013 Legislature would have to determine which measures the exchange is going to use if it's going to be ready in 2014.

A questioner asked who will be using the exchange and Chase stated, "It's not predictable at this point. We might see the exchange being the best thing or we might see it fizzle."

Walt McClure argues that it's urgent to get a measurement system operating now. Walt McClure, of the Center for Policy Studies, commented that the data do not have to be tied to the progress of the exchange. He'd like to see the cost information HealthPartners uses developed for everybody. "The only thing that's going to protect the state and get us driving to what we want is an operational system now as fast as we can," he urged.

McClure continued. "Let's get a system up with adequate measures as fast as possible to show the public what's possible, to show doctors what's possible, to show the plans what's possible and, mainly, to show the feds what's possible. If we don't have an operating system, it's all talk. We have a window of opportunity to lead the country, to show them how to do things. We must get an operational system to protect us and move the whole country forward. We want to use anything that's adequate."

According to McClure, the Center for Policy Studies is advocating "to everyone who will listen" getting an operational system up that can give information to patients, as well as to providers and plans. Then patients can know who's better for less. He said the job should be delegated to MNCM. "The window is limited. We need an operational system up in two to three years or we're going to lose our advantage and other people are going to be making decisions which get terribly in our way."

Minnesota Community Measurement's funding is diverse. An interviewer asked how MNCM can be impartial if it gets paid by the very health plans it's evaluating. Chase answered that his group doesn't get paid by providers. The bulk of its money comes from health plans, some from the state and some from grant-makers.

"We have enough diversity in revenues that I think we're not perceived as cow-towing to any one organization," he said. "You won't get good measures by giving us a chunk of money. You're going to get good measures by making us be hungry, as a small organization, to get measures used to improve care. People will stop funding us if we don't develop good measures next year. National organizations have built lots of measures that nobody wants to use. We're only going to survive if we build stuff that is useful for this system going forward."

Quality and cost measures can drive competition. An interviewer asked whether use of the measures drives competition among providers and plans. Chase responded that it does, because it's a

reputational issue among systems. "That's been a culture change. Now in board meetings they're talking quality. We hope they will talk about costs when we have those measures. How is our performance comparing to others?" He said one provider group asked if they could use their quality measure scores to recruit physicians.

MNCM hopes to report cost data across health plans within the next year. In response to a question, Chase said there will be a wide variation in costs among providers. "It's driven by two major factors: how much people get paid and how much stuff do they do. "

When asked how cost is measured, Chase replied that the measure is population-based. For any one medical group, his group looks at the actual total amount they were paid, not what they charged. We add up everything that was paid for each patient and divide it by the number of patients."

McClure said you can use the measure to show which providers are really efficient and which aren't. Then you look at the outcomes. The cost is the thing you're interested in when you want to steer people to providers who are efficient.

"We didn't have a cost measure. Now we do," he said, referring to a cost measure that HealthPartners is using on its own that has been endorsed nationally. "The potency on this doesn't come when we just get this information to the providers, it comes when patients start shifting providers on the basis of this information."

Chase responded that his group has been making great progress in taking the nationally endorsed cost measure and trying to get other plans to use it. "Technology has changed. It's much simpler now," he said. "We've set a goal that within the next year, we're going to be able to report this cost data across payers. Let's get a standardized methodology among plans."

Medicare looks at standardized pricing, not total costs. In response to a question, Chase said Medicare doesn't use the total costs measure. They look at what they're going to pay for any certain procedure, which they've standardized across the country. They haven't figured out how to measure how many various tests and procedures are done by individual providers.

"They've been pretty good about standardizing pricing," Chase said of Medicare. "They've been pretty bad about relative pricing. They're affected by politics. So specialists get more than others. They're focusing on each unit, not on how many units are used for the same outcomes. But the data can show that one section of the country does more procedures for the same outcome."