2006 Health Care Quality Report

Comparative Data on Provider Group Performance
in Preventive Care and Chronic Disease Treatment

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Measure Up To Better Health

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April, 2007

MN Community Measurement has experienced tremendous growth this year and the commitment to health care transparency in our community has never been stronger. You'll see evidence of our growth with the inclusion of new provider groups and new clinical quality measures in our *2006 Health Care Quality Report*. This year, MN Community Measurement expanded its reporting from 54 to 73 primary care provider groups, plus included new types of providers: endocrinology, nephrology, obstetrics/gynecology and urgent/convenience care. Inside, you'll also find four new measures of clinical quality: colorectal cancer screening; a cancer screening composite; appropriate testing for children with sore throats; and appropriate treatment for children with colds.

We also see more provider groups taking actions to improve their delivery of care. The findings in this report show that quality is increasing in our state due to these efforts. But we are not closing the gaps in care as rapidly as we should and our challenge in the coming months will be to identify new ways to leverage our efforts to improve the health care system.

Fortunately, we've had a number of recent opportunities to increase the reach and impact of our health care quality information.

We are pleased to announce our involvement in two new national pilot projects that will help us continue to improve our reporting efforts:

- The first, a Robert Wood Johnson Foundation initiative called Aligning Forces for Quality, will not only help us to further expand our measures, but also understand how to best present the data to engage consumers in managing their health care.
- The second pilot, Better Quality Information (for Medicare Beneficiaries), will enable us to include Medicare fee-for-service claims in our data which will help us expand the scope of our measures. This initiative is funded by the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality.

Next, MN Community Measurement received national exposure this past August when both President George W. Bush and U.S. Health and Human Services Secretary Michael Leavitt paid separate visits to Minnesota to highlight their shared vision to improve the U.S. health care system by bringing greater transparency to health care quality and costs. During their visits, both leaders recognized MN Community Measurement as a key player in shaping this national agenda.

Finally, MN Community Measurement has been selected to provide measures for two important regional health care quality improvement initiatives. Governor Pawlenty has announced that his administration's new QCare initiative will rely on measures from MN Community Measurement to reward health care quality in the state. In addition, our measures were selected this year for

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Minnesota's Bridges to Excellence program, sponsored by the Buyers Health Care Action Group, as the basis for rewarding provider groups for excellence in diabetes care.

We believe that the next significant leap in health care quality will come when consumers take a more active role in their care. Our focus in 2007 will be to provide consumers with information that will help them make better choices about their care. We are grateful for the commitment, dedication and support of the community as we continue to build momentum around public reporting and health care quality improvement. As always, we welcome your insights and feedback.

Thank you,

John Frederick, MD, Board Chair
MN Community Measurement

Jim Chase, Executive Director
MN Community Measurement

MN Community Measurement 2006 Health Care Quality Report

2005 Dates of Service

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2006 Health Care Quality Report

We are pleased to present the *2006 Health Care Quality Report*, the third-annual review of comparative provider group performance on key clinical measures produced by MN Community Measurement. This report expands upon the baseline data first established in our 2004 report. We now report on 13 clinical measures: treatment of asthma, depression, diabetes and high blood pressure; appropriate treatment for children with colds and appropriate testing of children with sore throats; screening for breast, cervical and colorectal cancer, and for all three cancer screenings combined; screening for chlamydia infection; and childhood immunizations and well child visits.

The purpose of this report is to provide valid and reliable information to help consumers make informed decisions about their health care, and to help health care providers improve patient care. The *2006 Health Care Quality Report,* provides at-a-glance ratings on the quality of health care delivered by 73 primary care groups – an increase over the 54 groups reported last year. These 73 provider groups include more than 700 clinics in Minnesota and counties that border Minnesota. Also this year, we report on specialty groups including endocrinology, nephrology, obstetrics/gynecology and urgent/convenience care.

The MN Community Measurement Web Site

MN Community Measurement is also proud to unveil its new Web site design as of November 2006. The new design is intended to make it even easier for consumers and providers to access and evaluate health care quality information. At www.mnhealthcare.org, you'll find accurate, comparative details on the quality of care delivered by Minnesota's provider groups.

Looking Forward

MN Community Measurement is already preparing for its *2007 Health Care Quality Report,* which will further expand the number of measures and provider groups. We will also explore new modes of data collection such as direct data submission from provider groups. As a pilot site for the Better Quality Information initiative, funded by the Centers for Medicaid and Medicare Services and the Agency for Healthcare Research and Quality, we will have the ability to include Medicare fee-for-service data next year for selected measures. And as a grant recipient of the Aligning Forces for Quality Initiative, funded by the Robert Wood Johnson Foundation, we look forward to learning more about effective strategies to translate health care quality information in the most meaningful, useful way to better engage consumers.

This year, MN Community Measurement was an important contributor to a statewide pay-for-performance effort that rewarded provider groups financially for excellence in care delivery. Our measures were used for the 2006 Minnesota Bridges to Excellence program, sponsored by the Buyers Health Care Action Group (BHCAG). BHCAG is already working to expand the program with additional measures and employers for 2007 and we look forward to playing an important ongoing role in that process.

Key Findings

- **Statewide results are up for most measures;**
- **Practice variation between provider groups continues to occur, but no single provider group has the highest or the lowest rates across all measures; and**
- **Opportunities for improvement exist.**

Introduction

Our nation's health care crisis is inextricably tied to the complexity of information that exists within our health care system. Movements toward new information technology, such as electronic medical records, are a step in the right direction to manage the massive amount of information involved in the delivery and financing of health care. A related movement is transparency – the unveiling of previously unseen data on how well providers perform in the delivery of care. We live in the age of the Internet, where access to information seems boundless. Yet, until recently, only very limited data about the quality of our health care was available publicly.

MN Community Measurement's aim is to improve the level of care that all Minnesotans receive by making more and more of this important quality data available. Each year, our report expands by including more measures on more providers. Our *2006 Health Care Quality Report* includes thirteen broad clinical areas of provider performance and presents the data so that it is comparable across provider groups. We believe that this information will assist consumers in making decisions about their healthcare and ultimately drive improvements in care.

When providers know how their performance ranks among their peers, they have clear benchmarks on which to set their improvement goals. By participating in public reporting of their performance, provider groups make themselves accountable to their patients and show their commitment to providing a high level of care.

When consumers have information about their health care provider's performance, they are empowered to talk with their providers to ensure they are receiving the best care for their needs. With comparative quality information, consumers have a tool by which to be more active participants in the process of making health care decisions.

Key Findings

Quality is Improving

Many statewide results have improved over last year. Specifically:

1. The results for the Optimal Diabetes Care composite measure (NEW Targets) show improvement. Rates on this stringent, patient-centered measure have increased from four percent in 2004 to six percent in 2005 to ten percent in 2006. In 2006, Camden Physicians proved possible a Minnesota benchmark of 23 percent of diabetes patients in full compliance with all five components included in this composite measure. This high mark will challenge all Minnesota provider groups to evaluate the care they provide and improve to the highest possible standard. In 2006, six provider groups had rates and confidence intervals that were fully above the provider group average of ten percent, including:
   - Camden Physicians
   - Winona Clinic
   - HealthPartners Central Minnesota Clinics
   - St. Cloud Medical Group
   - Fairview Health Services
   - HealthPartners Medical Group

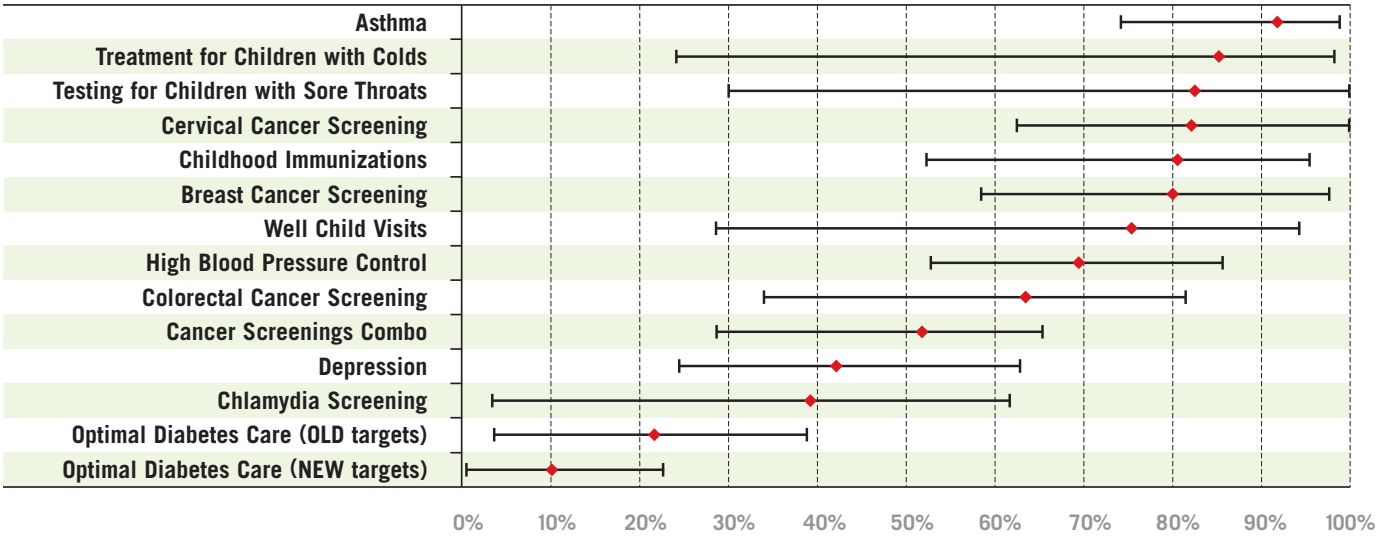
2. Rates on the Childhood Immunization measure are up statewide. In 2006, Mayo Clinic set the top Minnesota benchmark of 95 percent of children under the age of two being up-to-date with all recommend immunizations. Five provider groups had rates and confidence intervals that were fully above the provider group average of 81 percent, including:
   - Mayo Clinic
   - HealthPartners Medical Group
   - CentraCare Health System
   - Park Nicollet Health Services
   - Children's Physician Network

3. Rates for the High Blood Pressure Control measure are also up statewide. In 2006, Mayo Clinic established the achievable Minnesota benchmark of 86 percent of patients with diagnosed hypertension having blood pressure equal to or less than 140/90. Six provider groups had rates and confidence intervals that were fully above the provider group average of 69 percent, including:
   - Mayo Clinic
   - Mankato Clinic
   - Altru Health System
   - Park Nicollet Health Services
   - Quello Clinic
   - HealthPartners Medical Group

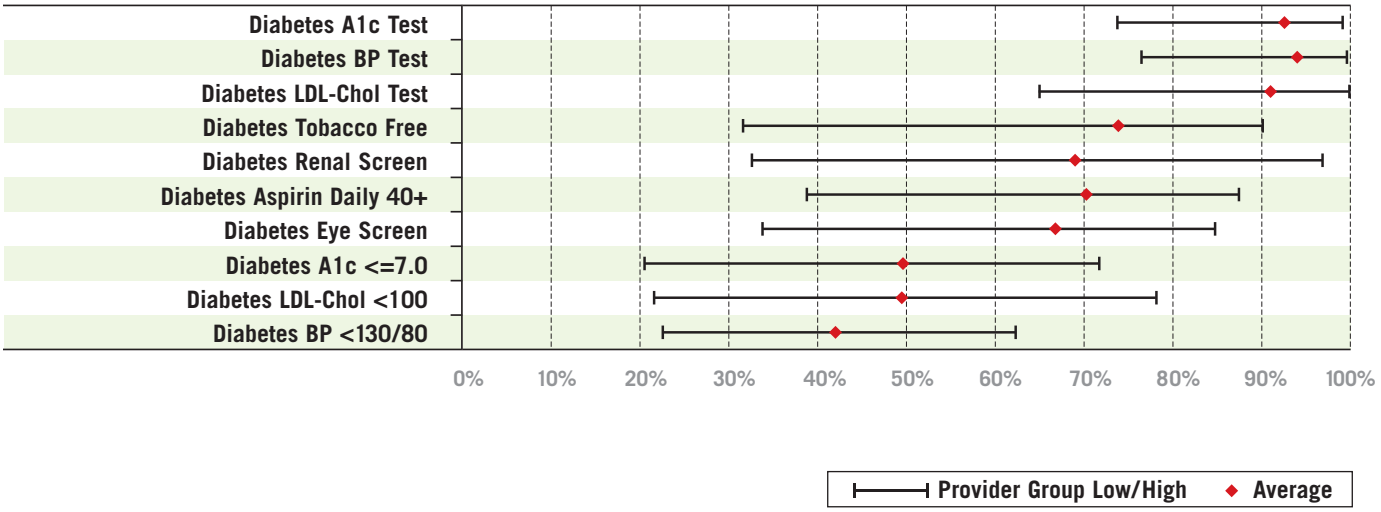
Practice Variation Continues

We continue to observe significant practice variation across provider groups for all measures. This means that the quality of health care varies between provider groups and opportunities for improvement exist. It is important to note that no single provider group has the highest or the lowest rate across all measures.

All Measures - Practice Variation



Diabetes Care - Practice Variation



Changes in the 2006 Report

There were several changes made to enhance this years report:

- New categorization of clinical measures into three broad categories: Living with Illness, Getting Better and Staying Healthy.
- More detailed information on data sources, data collection, sampling methodology, and measures for improved transparency of processes.
- Additional steps incorporated into the member/patient attribution process.
- New data sources from PrimeWest Health System and Sioux Valley Health Plan
- Non-equal interval confidence intervals (CIs) calculated. The updated calculations result in a more accurate approximation of the range of possible values for confidence intervals.
- Introduction of four new measures (including one new composite measure) and the discontinuation of the adolescent immunization measure.
- New types of providers; one nephrology clinic, two endocrinology clinics, seven urgent/convenience care sites, and 18 obstetrics/gynecology clinics.
- Optimal Diabetes Care: the focus of this measure shifted to new targets to align with Institute for Clinical Systems Improvement (ICSI) guidelines. Old targets are still included for trending purposes.
- Asthma Medication Management: The methodology to determine the eligible population was modified and now focuses on chronic asthma. This change decreased the measure denominator, which contributed to the significant increase in the reported rate.
- Well Child Visits: Previous reports displayed the percentage of children who received six or more visits in the first 15 months of life. The 2006 measure reflects five or more visits in the first 15 months of life.
- Chlamydia Screening in Women: Technical coding issues were identified for seven groups, so their rates were suppressed in 2006.
- Improved Web site navigation and design at www.mnhealthcare.org.

Data Sources and Data Collection

The data used for this report were derived from administrative billing data from health plans, with some measures requiring additional medical record review. The data set reflects patients enrolled in managed care plans. Eight health plans and two county-based purchasers provided data from the following products:

- Commercial HMO/POS,
- Medicare Cost and Risk,
- Minnesota Public Health Care Programs (Prepaid Medical Assistance Program, MinnesotaCare and General Medical Assistance Care), and
- MSHO (Minnesota Senior Health Options).

The data do not include uninsured patients who pay out-of-pocket, or patients covered by Medicaid / Medicare fee-for-service. However, MN Community Measurement plans to add Medicare fee-for-service data for some measures in 2007.

Data for this report were collected by the health plans in a standard way using the Health Plan Employer Data and Information Set (HEDIS) 2006 Technical Specifications. The following organizations made a significant commitment of resources to integrate their data for purposes of public reporting at the provider group level:

Minnesota Health Plans:

- Blue Cross and Blue Shield of Minnesota
- First Plan of Minnesota
- HealthPartners
- Medica
- Metropolitan Health Plan
- PreferredOne
- Sioux Valley Health Plan
- UCare Minnesota

County-based Purchasing Organizations:

- PrimeWest Health System
- South Country Health Alliance

The reporting cycle is annual, consistent with building upon the HEDIS reporting and data collection cycle. HEDIS is produced and maintained by the National Committee for Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality. HEDIS data specifications include the continuous enrollment criteria that MN Community Measurement also incorporates into the sample selection process.

The resources required to collect and report accurate measures were extensive. Rigorous validity check processes were incorporated into the data gathering and aggregation before publishing. All organizations were subject to audit by a certified HEDIS auditor.

During the provider review period, several medical groups alerted MN Community Measurement to concerns about their results. A pattern was identified and linked to one of the data collection vendors. This report was delayed to accommodate the correction of the problem. To ensure the quality of the data going forward, validity check processes will be tightened and the provider review period will be extended.

Measures

The *2006 Health Care Quality Report* relied on existing HEDIS measures that aligned with practitioner guidelines established by Minnesota's own Institute for Clinical Systems Improvement (ICSI). HEDIS is a national set of standardized performance measures designed to ensure that purchasers and consumers can reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, asthma and diabetes. Although HEDIS measures were originally designed as a set of performance measures for the managed care industry, they have been adapted for use by MN Community Measurement as a way to measure and compare the performance of health care provider groups.

Although the *2006 Health Care Quality Report* does not address hospital or individual practitioner performance, these areas are being considered for future reports. The current measurement set addresses one of the four Institute of Medicine's dimensions of quality – effectiveness of care. Within this dimension, thirteen clinical condition areas are presented. Future reports will expand to include the remaining dimensions of quality: safety, timeliness and patient experience.

Methodology

As in previous years, NCQA was selected to conduct the sampling process for MN Community Measurement's "hybrid measures" – those that require medical record review. MN Community Measurement (MNCM) supplemented HEDIS samples for selected measures with an additional sample – called the MNCM sample – for reporting medical group performance.

For 2006 a two-stage, random sample was drawn. This strategy was designed with NCQA statisticians to ensure reporting for the maximum number of medical groups while minimizing the impact of sample weighting on the results. The sampling procedure started with the HEDIS sample selected by the plans and added a supplemental sample for medical groups that did not meet a minimum target number for reporting based on HEDIS sampling alone. Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

The stratified, random sampling approach was applied to the hybrid measures; each was sampled independently. The hybrid measures included: Optimal Diabetes Care, Childhood Immunizations, High Blood Pressure Control, Colorectal Cancer Screening, and Cancer Screening Combined for ages 50-80. For each hybrid measure, a target was set for the total sample size per group (i.e., the sum of the HEDIS and the MNCM samples) ranging from 63 to 69 patients, depending upon the measure.

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Health plans provided NCQA with a data file containing a record for each individual patient included in the eligible population for each measure. The data indicated the provider group to which the patient was attributed and whether that person had been selected for the plan's HEDIS sample. Health plans attributed patients to a provider group using a patient attribution logic.

In the next step, the MNCM sample was allocated across the oganization/product/provider group strata to meet the target sample sizes per provider group for those groups where the total HEDIS sample across all plans fell short of the MNCM target per group. Next, the actual MNCM sample was selected randomly with the SAS SURVEYSELECT procedure, using the sample sizes for each strata determined in the previous step. Patients in a health plan's HEDIS sample were not eligible for the MNCM sample.

Results were weighted to get accurate rates. This allowed for aggregation and unbiased reporting by provider group. Weighting is a cost-saving measure that allows MN Community Measurement to draw a smaller sample from which to estimate provider group and statewide rates. Weighting does not affect results; it is intended to efficiently utilize health plan resources to collect data.

Regardless of the sampling scheme used from one year to the next, there can be fluctuation in rates due to natural variation and/or changes to the delivery system. The weight was calculated for each sampling stratum (i.e. each oganization/product/provider group combination) and was equal to the total eligible population for that stratum divided by the total sample size (i.e. HEDIS plus MNCM samples) for that stratum. During analysis, for any population where a rate was desired (e.g., a provider group or the MNCM population as a whole), the denominator is the sum of the weights for all individuals in that population. The numerator was the sum of the weights for the individuals in the population that met the numerator criteria.

Rates and 95 percent confidence bounds were calculated for each measure for any provider group with 60 or more observations in the sample. A minimum threshold of at least 60 patients per provider group was established for public reporting of the hybrid measures. A minimum threshold of 30 patients per provider group was established for public reporting of the measures calculated using administrative data only.

An improvement in the confidence interval calculations was introduced in 2006. A normal approximation method was used prior to 2006. That method was a fairly good approximation for large samples but produced estimates that could be extremely biased for small sample sizes and/or instances when the rate in question was close to zero or one.

The updated calculations result in a more accurate approximation of the range of possible values for confidence intervals. Computation of upper and lower confidence bounds result in unbiased, asymmetrical estimates around the rates. It is appropriate for MN Community Measurement to use this method because the bias, as compared to the normal approximation, has been minimized, leading to improved star ratings.

MN Community Measurement 2006 Summary of Statewide Results

2005 Dates of Services

Quality Measure	Statewide Average	95% CI	Eligible Population	Page
Living with Illness Measures				
Asthma Care				14
Ages 5-56 (all ages)	91.3%	90.8% - 91.8%	13,584	15
Ages 5-17 (children)	94.8%	94.1% - 95.4%	4,560	16
Ages 18-56 (adults)	89.6%	88.9% - 90.2%	9,024	17
Depression Treatment				18
Acute Phase – 84 Days	60.1%	59.1% - 61.0%	10,161	18
Continuation Phase – 180 Days	41.6%	40.7% - 42.6%	10,161	19
Optimal Diabetes Care (all 5 cardiovascular risks at NEW targets)	9.5%*	8.9% - 10.2%	41,831	20
A1c <=7.0	48.1%*	47.0% - 49.1%	41,831	23
Blood Pressure <130/80	40.7%*	39.6% - 41.7%	41,831	25
LDL-C <100	48.1%*	47.0% - 49.1%	41,831	27
Daily Aspirin Use	67.8%*	66.7% - 68.8%	41,831	29
Documented Tobacco Free	71.9%*	70.9% - 72.8%	41,831	31
Optimal Diabetes Care (all 5 cardiovascular risks at OLD targets)	20.4%*	19.6% - 21.3%	41,831	32
A1c <=8.0	67.7%*	66.7% - 68.7%	41,831	35
Blood Pressure <130/85	49.1%*	48.0% - 50.1%	41,831	37
LDL-C <130	68.7%*	67.7% - 69.7%	41,831	39
Daily Aspirin Use	67.8%*	66.7% - 68.8%	41,831	29
Documented Tobacco Free	71.9%*	70.9% - 72.8%	41,831	31
High Blood Pressure Control	69.0%*	67.9% - 70.0%	69,726	42
Getting Better Measures				
Appropriate Treatment for Children with Colds	85.7%	85.3% - 86.0%	32,053	44
Appropriate Testing for Children with Sore Throats	81.8%	81.3% - 82.4%	17,692	48
Staying Healthy Measures				
Breast Cancer Screening (Mammograms)	74.3%	74.0% - 74.6%	89,576	52
Cervical Cancer Screening (Pap Tests)	77.3%	77.1% - 77.4%	246,291	56
Colorectal Cancer Screening	58.3%*	56.9% - 59.7%	208,323	60
Cancer Screening Combined – Ages 50-80 (breast, cervical, colorectal)	47.6%*	46.2% - 49.1%	208,323	62
Chlamydia Screening – Ages 16-25	35.9%	35.4% - 36.3%	45,415	64
Childhood Immunizations	78.4%*	77.3% - 79.5%	19,527	68
Well Child Visits – 5 or more in first 15 months of life	73.8%	73.2% - 74.5%	17,846	70

* These statewide averages are weighted.

Living with Illness

Asthma

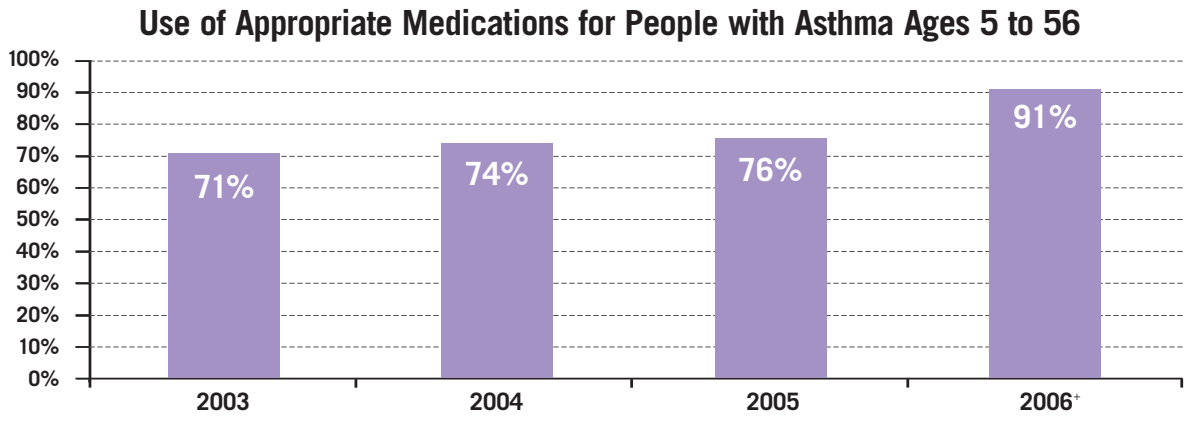
Use of Appropriate Medications for People with Asthma – Ages 5 to 56

This measures the percentage of patients from ages 5 to 56 years with persistent asthma who were continuously enrolled in their health plan during the measurement year (2005 dates of service) and were appropriately prescribed medication during the measurement year. While there are a number of acceptable therapies for people with persistent asthma, the best available evidence indicates that inhaled corticosteroids are the preferred primary therapy. For people with moderate-to-severe asthma, inhaled corticosteroids are the only recommended primary therapy. Preferred therapy includes cromolyn sodium, inhaled corticosteroids, nedocromil, leukotriene modifiers and methylxanthines. While long acting beta-agonists are a preferred adjunct for long-term control of moderate-to-severe asthma, their recommended use is in addition to inhaled corticosteroids. If prescribed alone (without inhaled corticosteroids) they do not count toward this measure.

For more details on how to manage medications for people with asthma, see the NAEPP Expert Panel Report 2, Guidelines for the Diagnosis and Management of Asthma, which can be accessed at ***www.nhlbi.nih.gov***.

The data for this measure are collected from health plan claims.

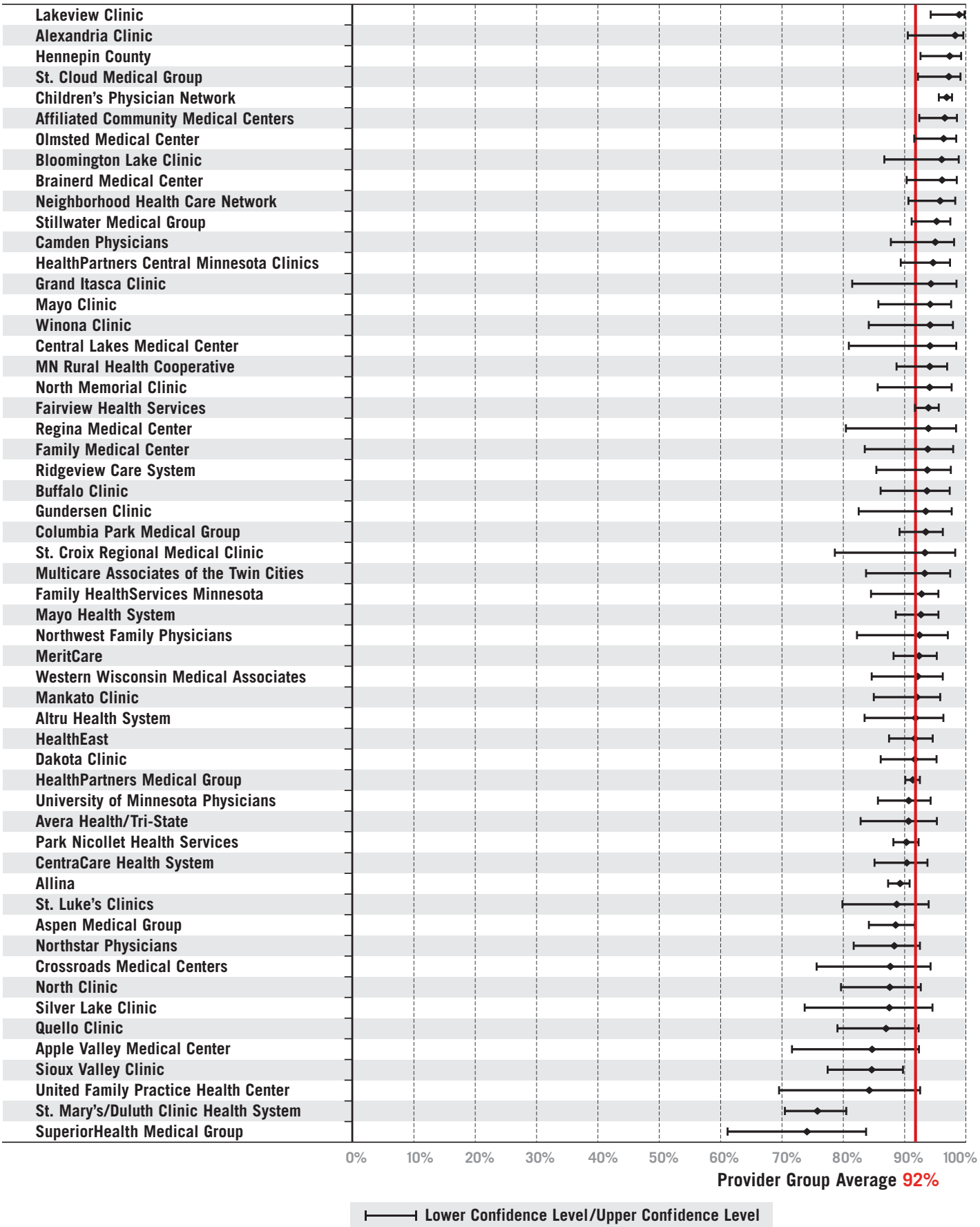
Use of Appropriate Medications for People with Asthma	Statewide Average*	95% CI	Numerator	Denominator
All Ages (5 - 56)	91.3%	90.8% - 91.8%	12,404	13,584
Ages 5 - 17	94.8%	94.1% - 95.4%	4,323	4,560
Ages 18 - 56	89.6%	88.9% - 90.1%	8,081	9,024



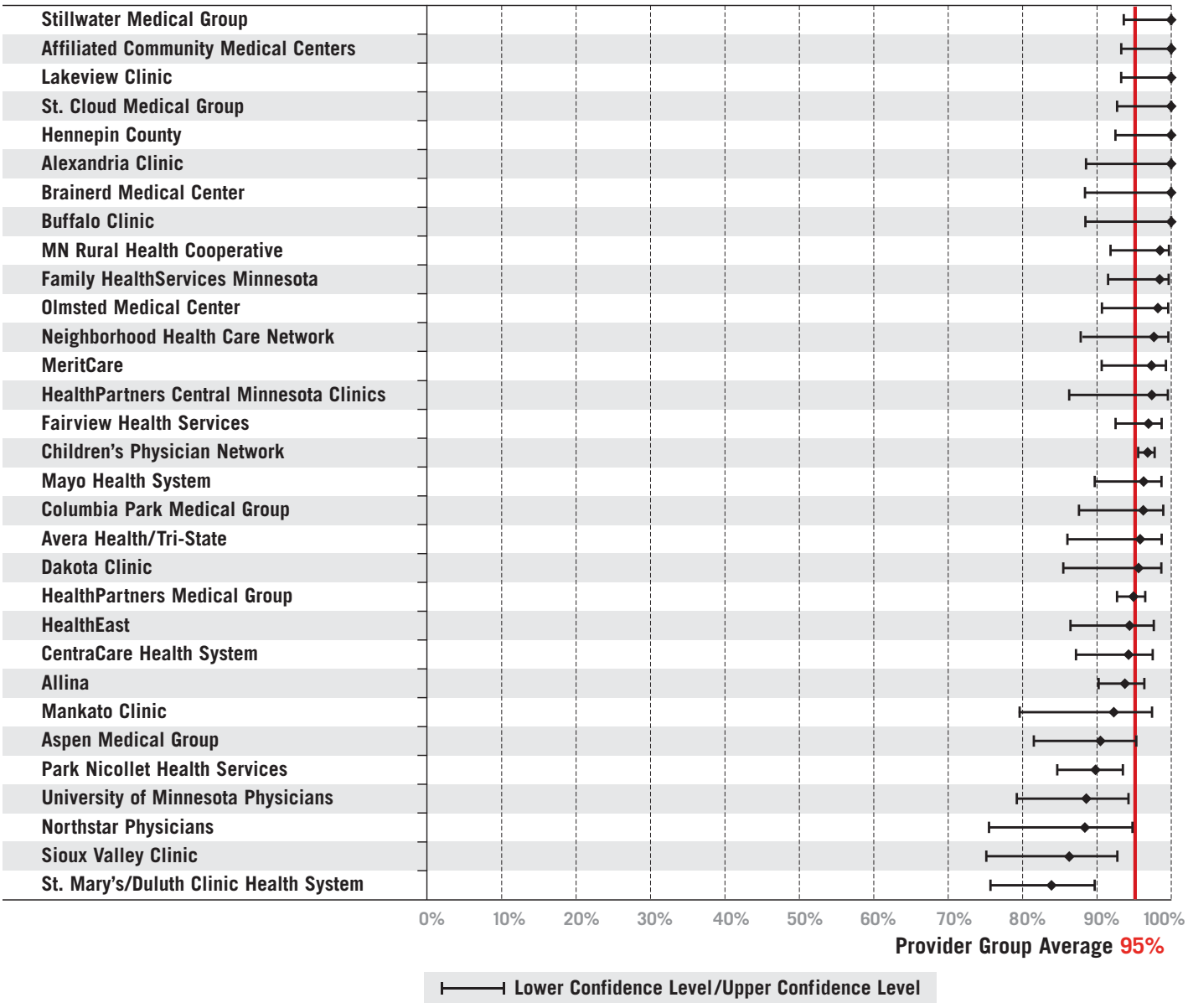
*Statewide averages include both health plan members who were attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who were attributed to a provider group. Therefore, these averages may sometimes differ.

+Note: Caution is needed when comparing 2006 data to previous years. In 2006, the methodology to determine the eligible population was modified. This change decreased the measure denominator, which contributed to the significant increase in the reported rate.

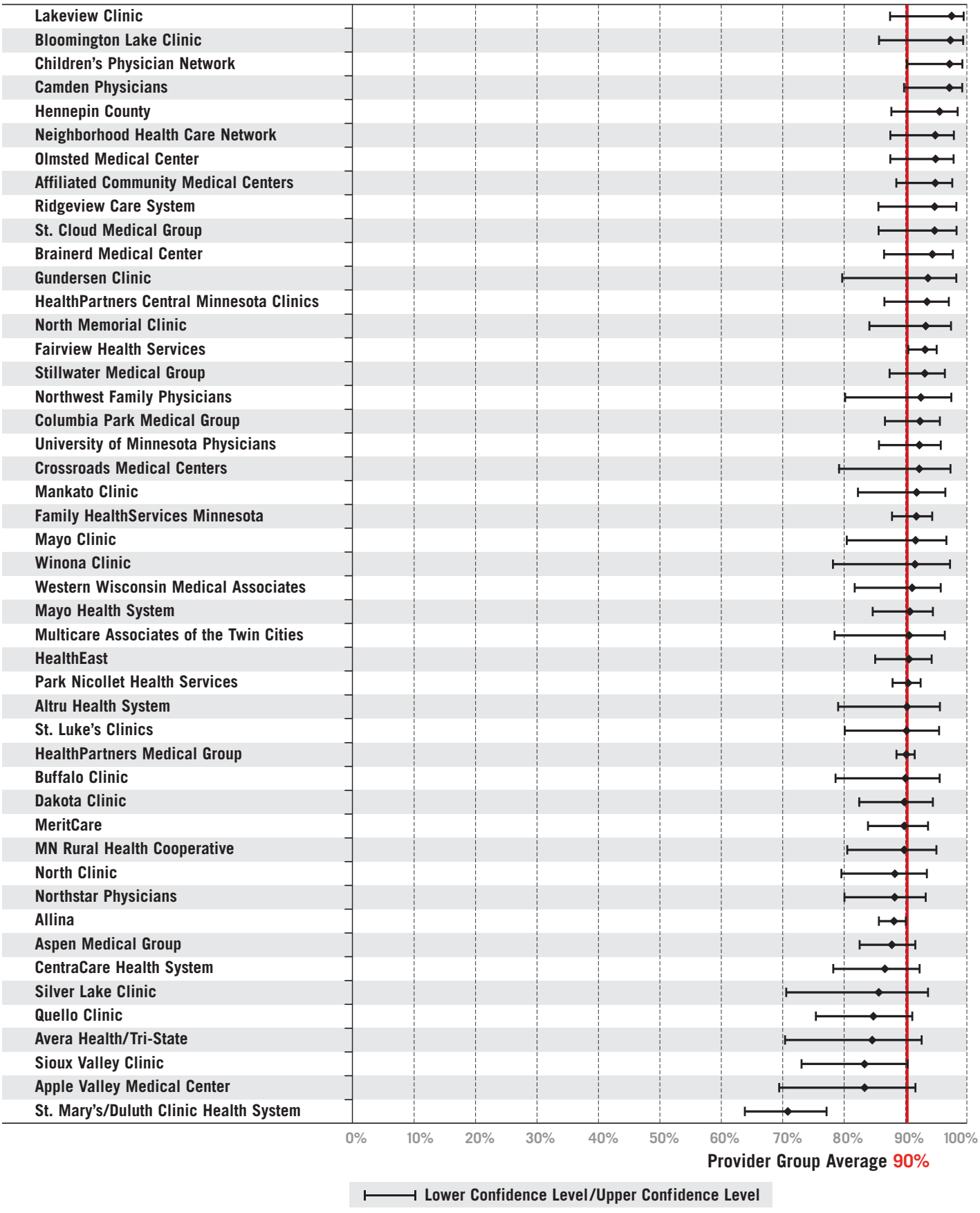
Use of Appropriate Medications for People with Asthma - Ages 5 to 56



Use of Appropriate Medications for Children with Asthma - Ages 5 to 17



Use of Appropriate Medications for Adults with Asthma - Ages 18 to 56



Living with Illness

Depression

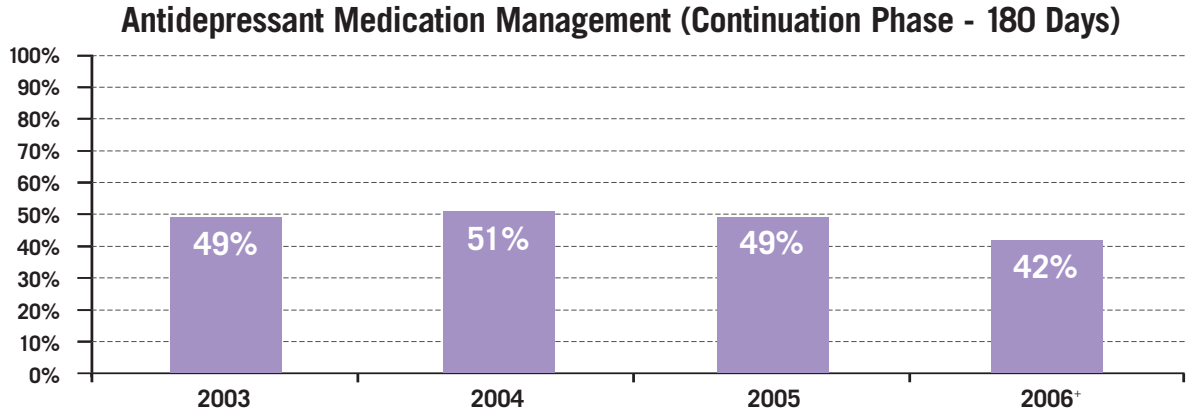
Depression: Antidepressant Medication Management

This measures the percentage of patients age 18 years or older as of April 30 of the measurement year (2005 dates of service), who were continuously enrolled in their health plan from 120 days prior to and 245 days following the diagnosis of a new episode of major depression, who were treated with antidepressant medication, and had at least three follow-up contacts with a practitioner that were coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase and 180-day Effective Continuation Treatment Phase.

1. Acute Treatment Phase is defined as the percentage of patients who remained on antidepressant medication for the entire 12-week (84 days) acute treatment phase. This intermediate outcome measure assesses the percentage of adult patients initiated on an antidepressant drug who received a continuous trial of medication treatment during the acute phase of their disease.
2. Effective Continuation Treatment Phase is defined as the percentage of patients who remained on antidepressant medication for at least six months (180 days). This intermediate outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen, by determining whether patients completed the period of Continuation Phase Treatment adequately for defining a recovery (as defined by Agency for Healthcare Research and Quality – AHRQ, Depression in Primary Care)[1].

The data for this measure are collected from health plan claims.

Antidepressant Medication Management	Statewide Average*	95% CI	Numerator	Denominator
Acute Phase Treatment - 84 days	60.1%	59.1% - 61.0%	6,106	10,161
Continuation Phase Treatment -180 days	41.6%	40.7% - 42.6%	4,227	10,161



[1] Depression in Primary Care, Volume 2. Treatment of Major Depression, Clinical Practice Guideline, Number 5.

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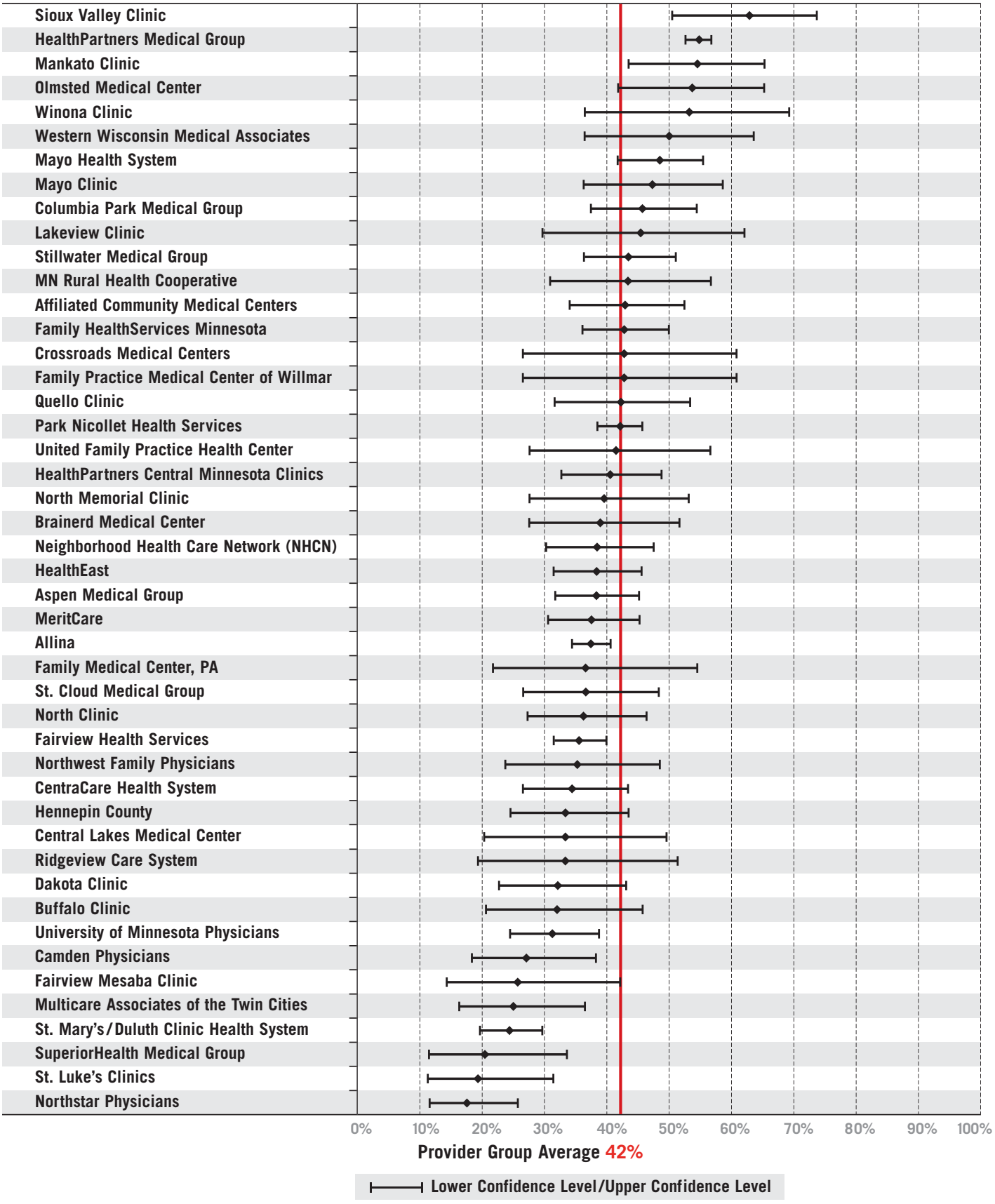
Antidepressant Medication Management (Continuation Phase - 180 Days)



Living with Illness

Diabetes

Optimal Diabetes Care Composite (NEW Targets)

This measures the percentage of patients with diabetes (Type I and Type II), age 18-75, who were continuously enrolled in their health plan during the measurement year (2005 date of service) and reached **all** of the following five treatment goals:

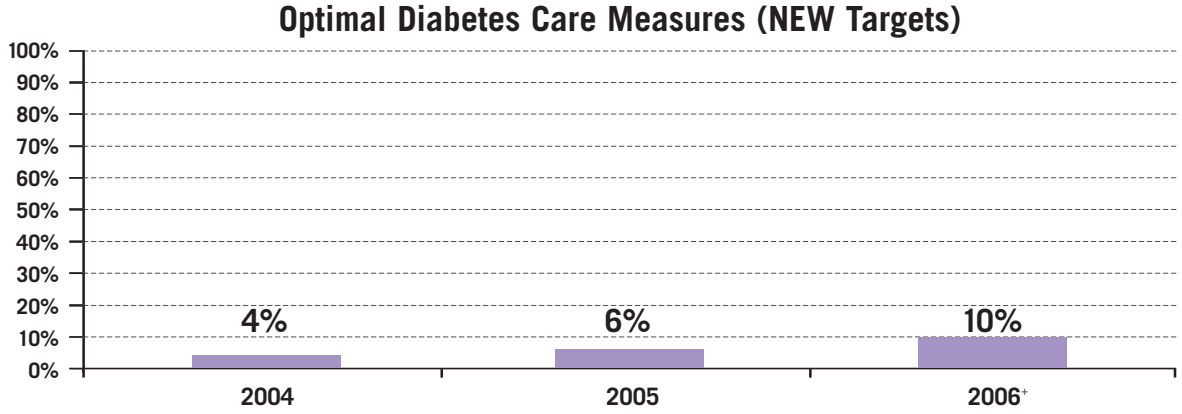
- Hemoglobin A1c less than or equal to 7.0%
- Blood pressure less than 130/80 mmHg
- LDL-C less than 100 mg/dl
- Daily aspirin use, ages 41-75
- Documented tobacco-free status

The composite simultaneously focuses improvement on four intermediate outcomes (A1c, BP, LDL and documented tobacco-free status) and one process measure (aspirin prophylaxis).

In addition to calculating a rate for each of the components listed above, a composite rate is calculated using an all-or-none method. All-or-none is defined as credit given for achieving this measure when all five components are met. No partial credit is given, such as if only four of the five components are met.

The data for this measure are collected from health plan claims and medical record review.

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal Diabetes Care (NEW Targets)	9.5%	8.9% - 10.2%	798	8,401	41,831
A1c <=7.0	48.1%	47.0% - 49.1%	4,041	8,401	41,831
BP<130/80mmHg	40.7%	39.6% - 41.7%	3,419	8,401	41,831
LDL-C <100mg/dl	48.1%	47.0% - 49.1%	4,041	8,401	41,831
Aspirin Use	67.8%	66.7% - 68.8%	5,696	8,401	41,831
Documented Tobacco Free	71.9%	70.9% - 72.8%	6,040	8,401	41,831



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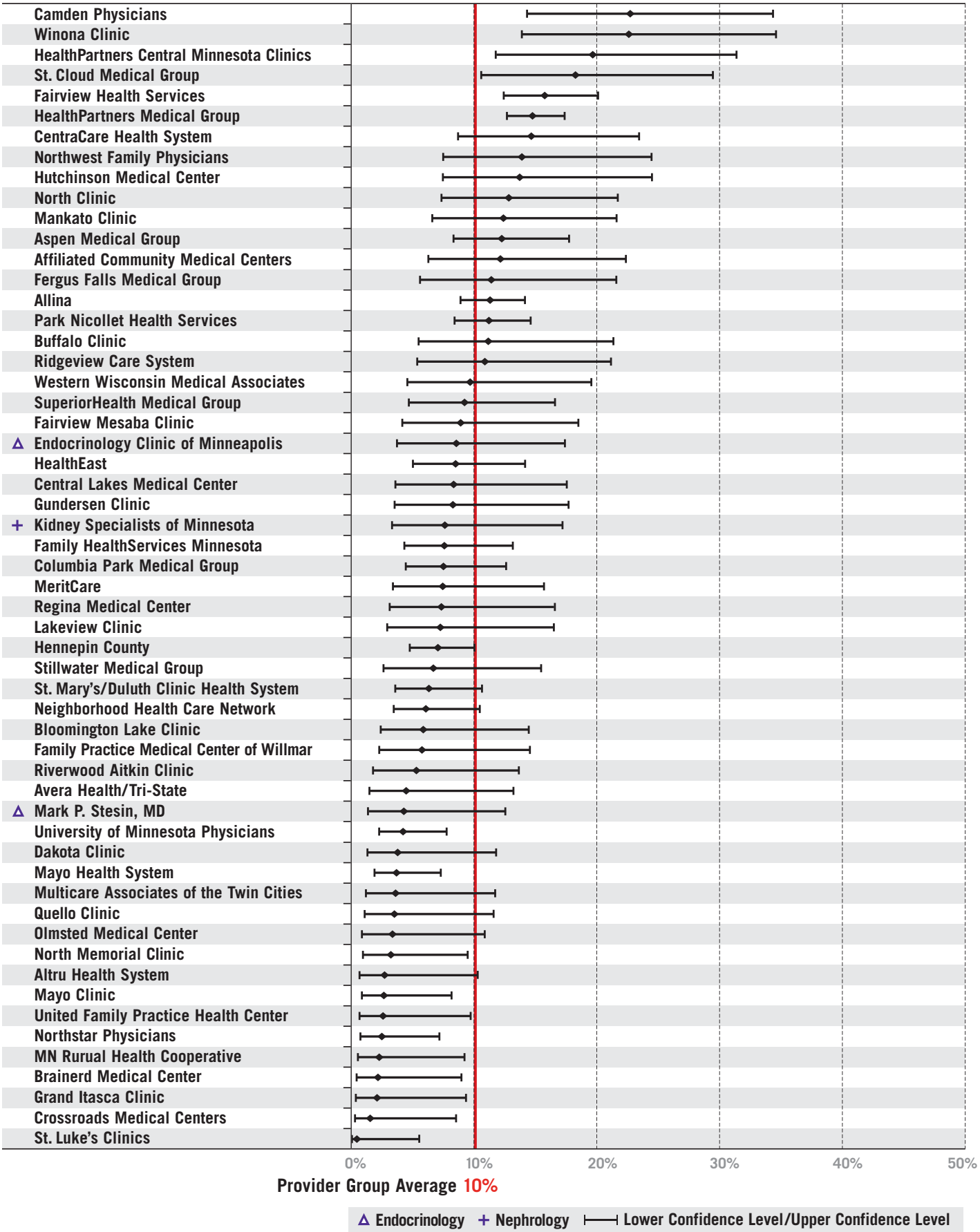
Optimal Diabetes Care (NEW Targets)



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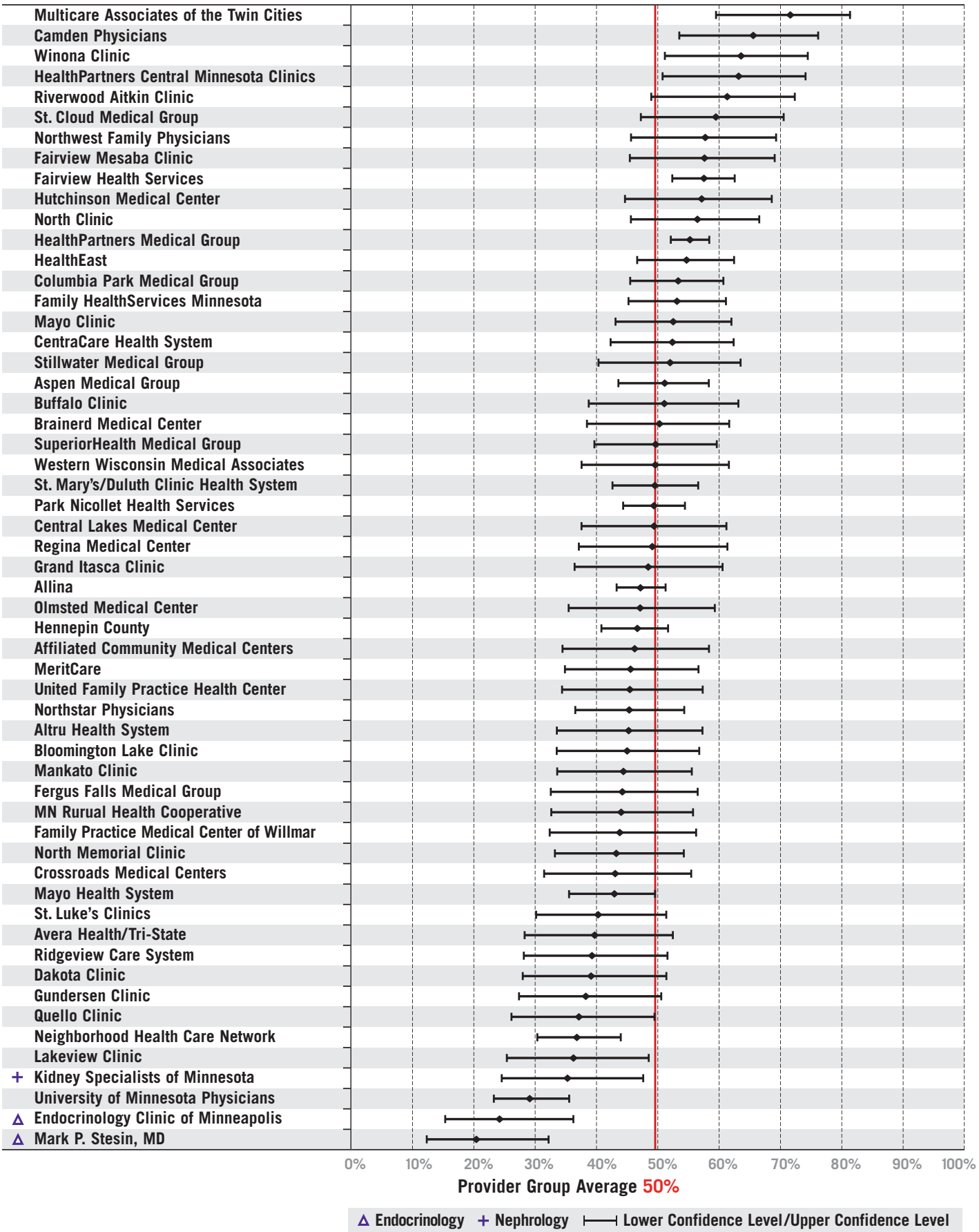
Diabetes: A1c<=7% (NEW Target)



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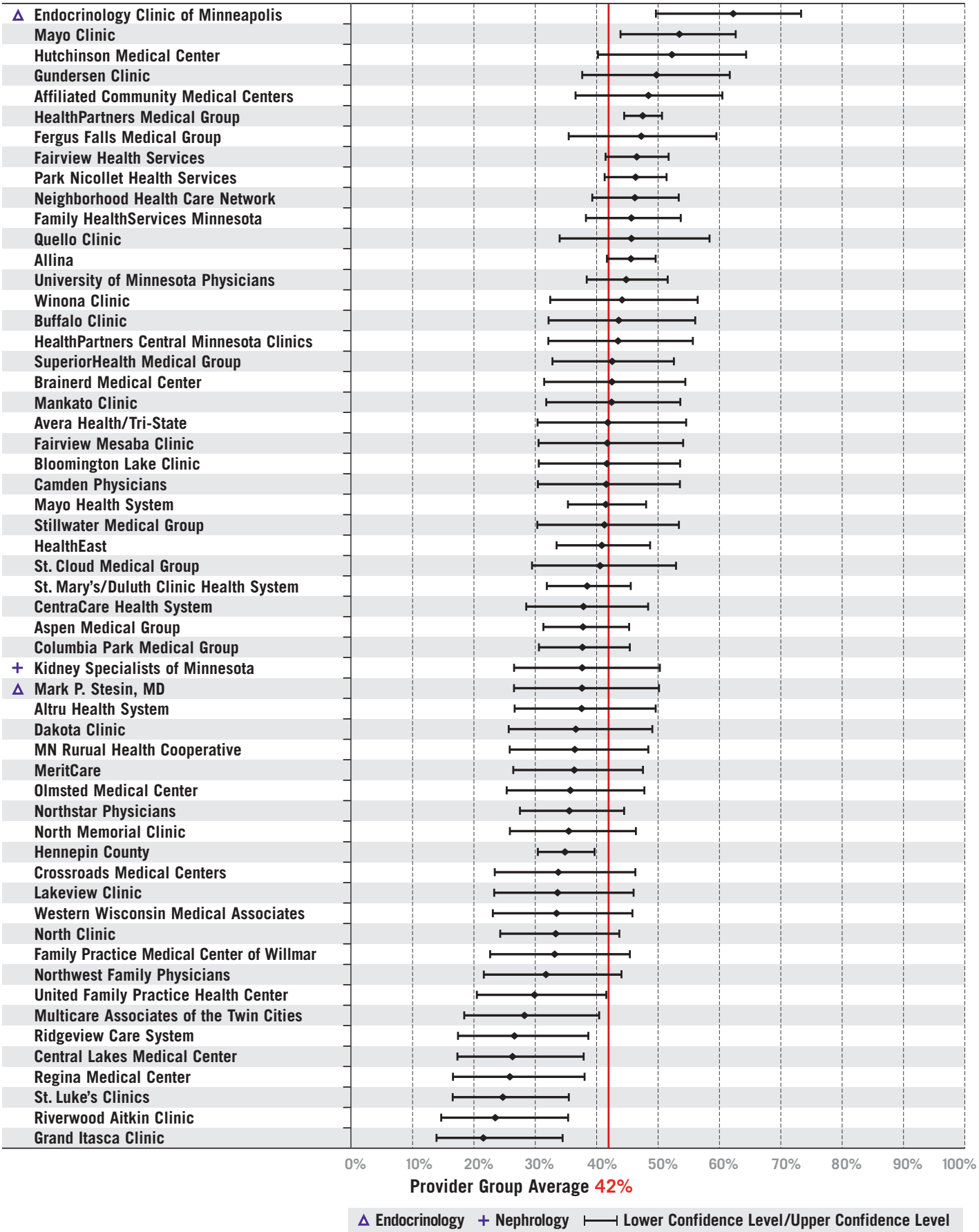
Diabetes: Blood Pressure Below 130/80 (NEW Target)



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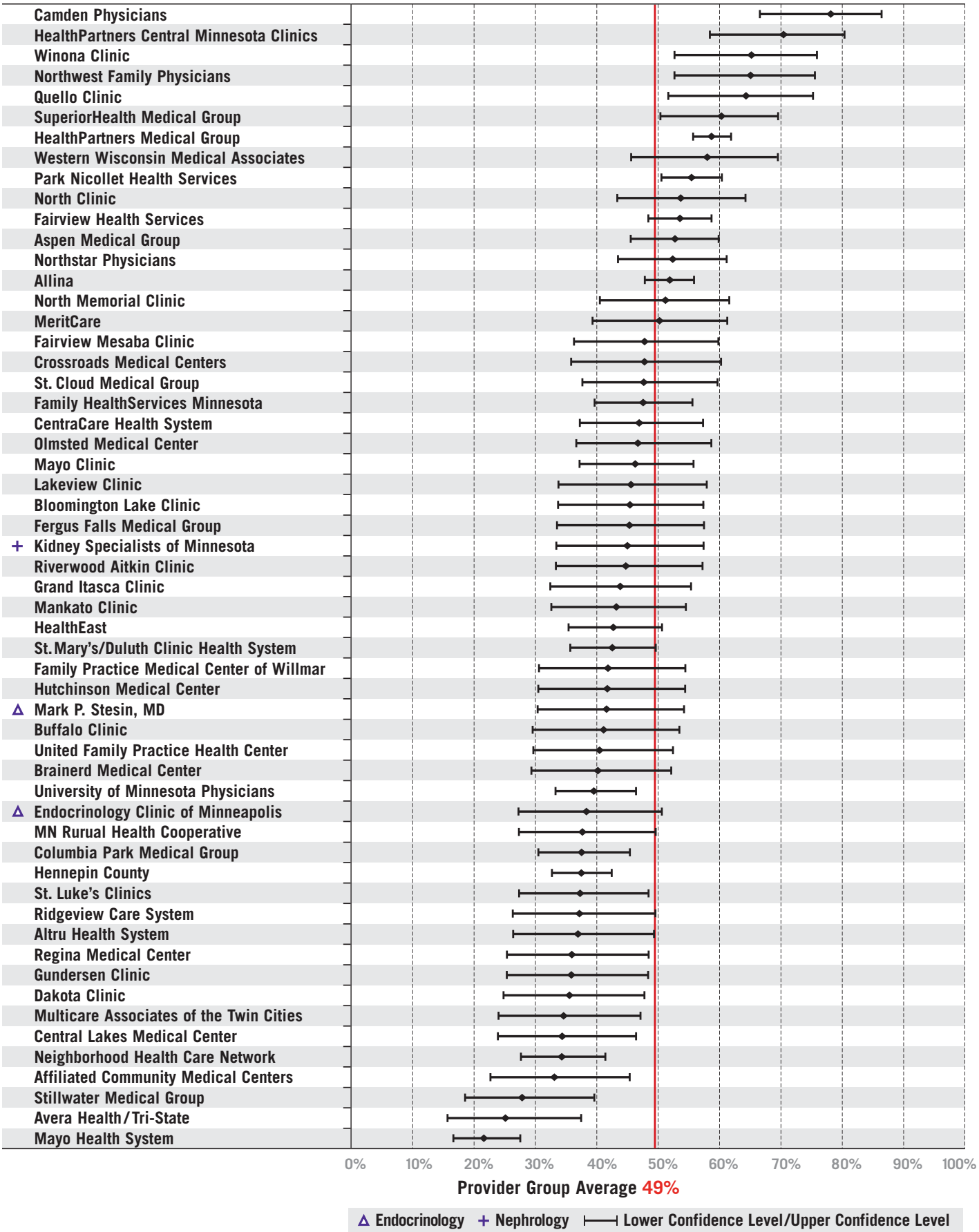
Diabetes: LDL Below 100 (NEW Target)



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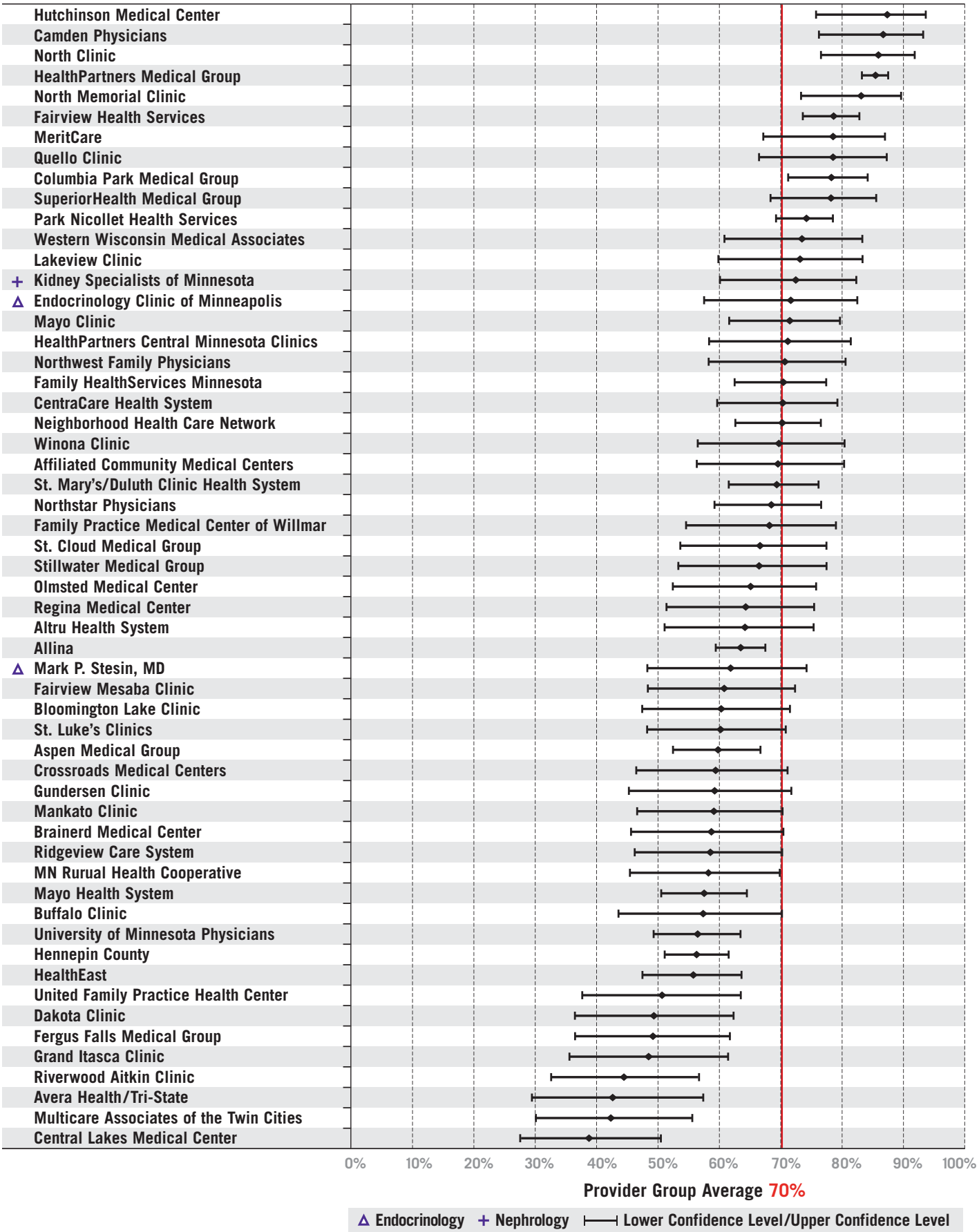
Diabetes: Daily Aspirin Use



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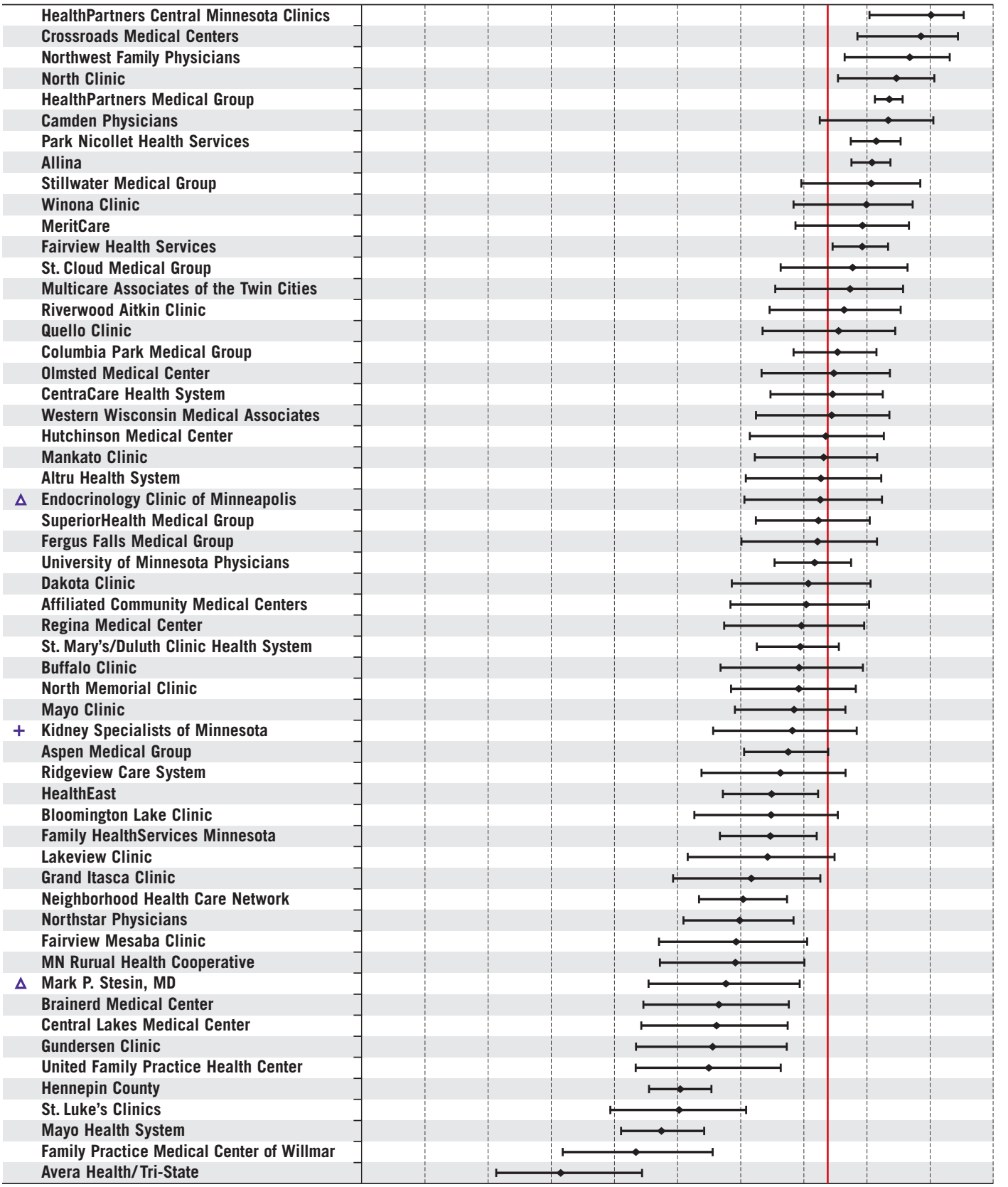
Diabetes: Tobacco Free



Living with Illness

Diabetes

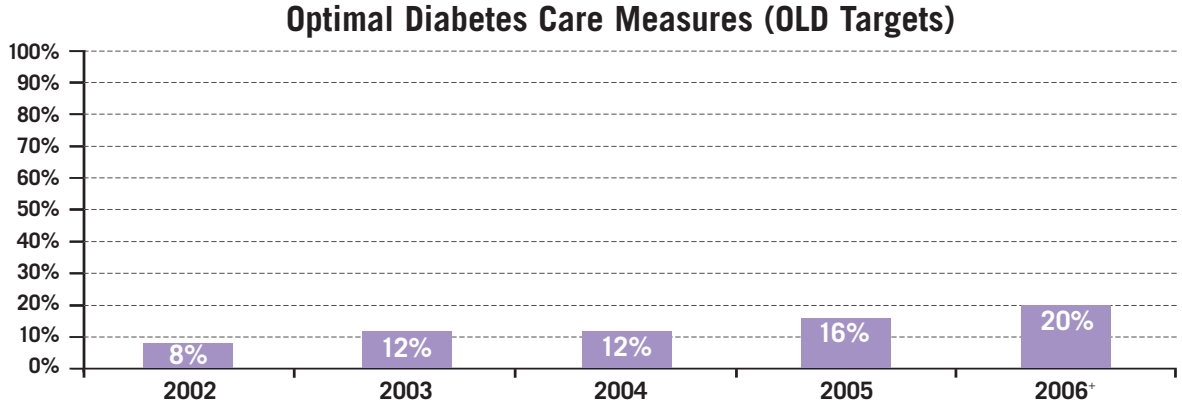
Optimal Diabetes Care Composite (OLD Targets)

This measures the percentage of patients with diabetes (Type I and Type II), age 18 - 75, who were continuously enrolled in their health plan during the measurement year (2005 dates of service) and reached **all** of the following five treatment goals:

- A1c less than or equal to 8.0%
- Blood pressure less than 130/85 mmHg
- LDL-C less than 130 mg/dl
- Daily aspirin use, age 41-75
- Documented tobacco-free status

The data for this measure are collected from health plan claims and medical record review.

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal Diabetes Care (OLD Targets)	20.4%	19.6%-21.3%	1,714	8,401	41,831
A1c <= 8.0	67.7%	66.7%-68.7%	5,687	8,401	41,831
BP <130/85 mmHg	49.1%	48.0%-50.1%	4,125	8,401	41,831
LDL-C <130 mg/dl	68.7%	67.7%-69.7%	5,771	8,401	41,831
Aspirin Use	67.8%	66.7%-68.8%	5,696	8,401	41,831
Documented Tobacco Free	71.9%	70.9%-72.8%	6,040	8,401	41,831



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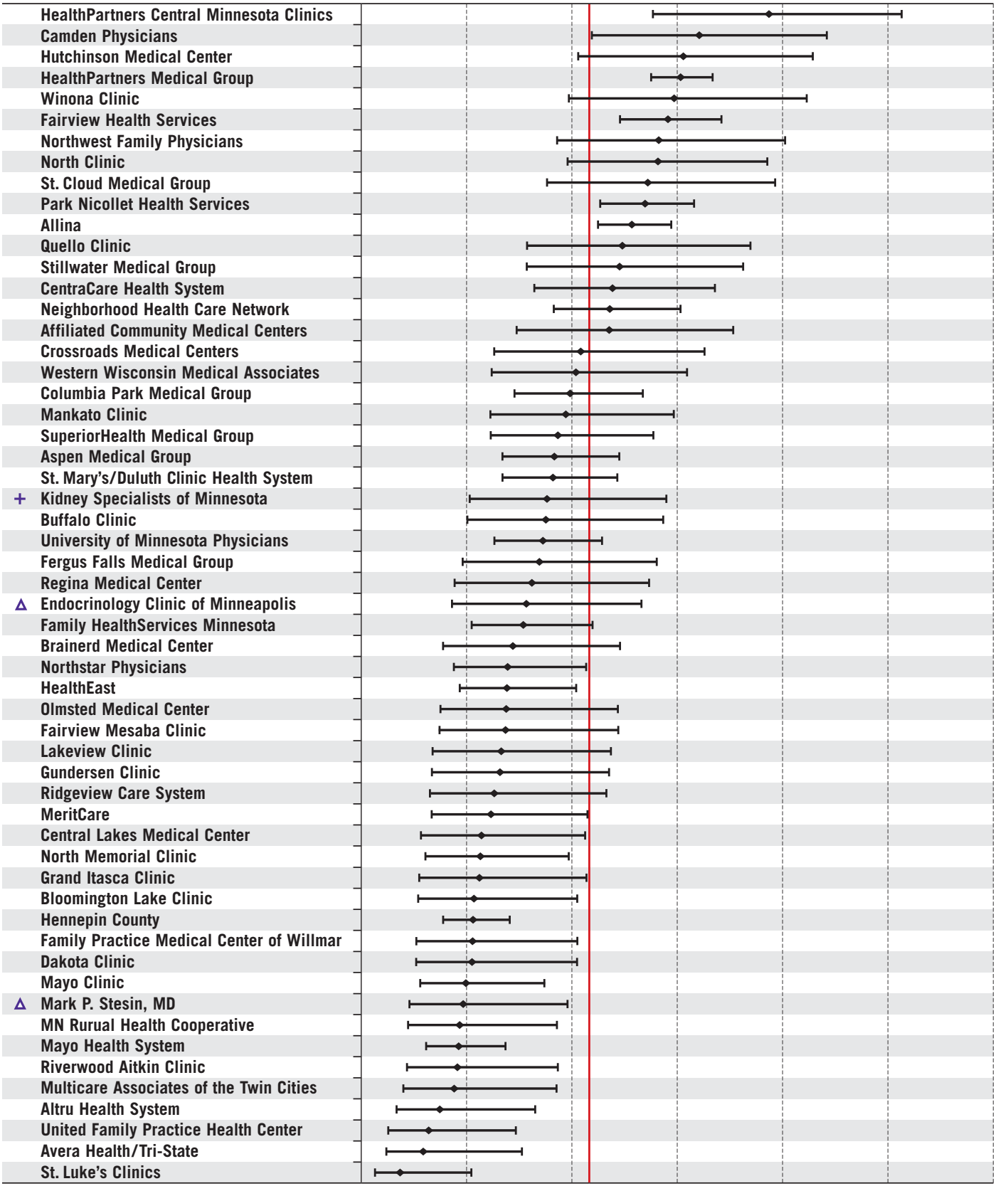
Optimal Diabetes Care (OLD Targets)



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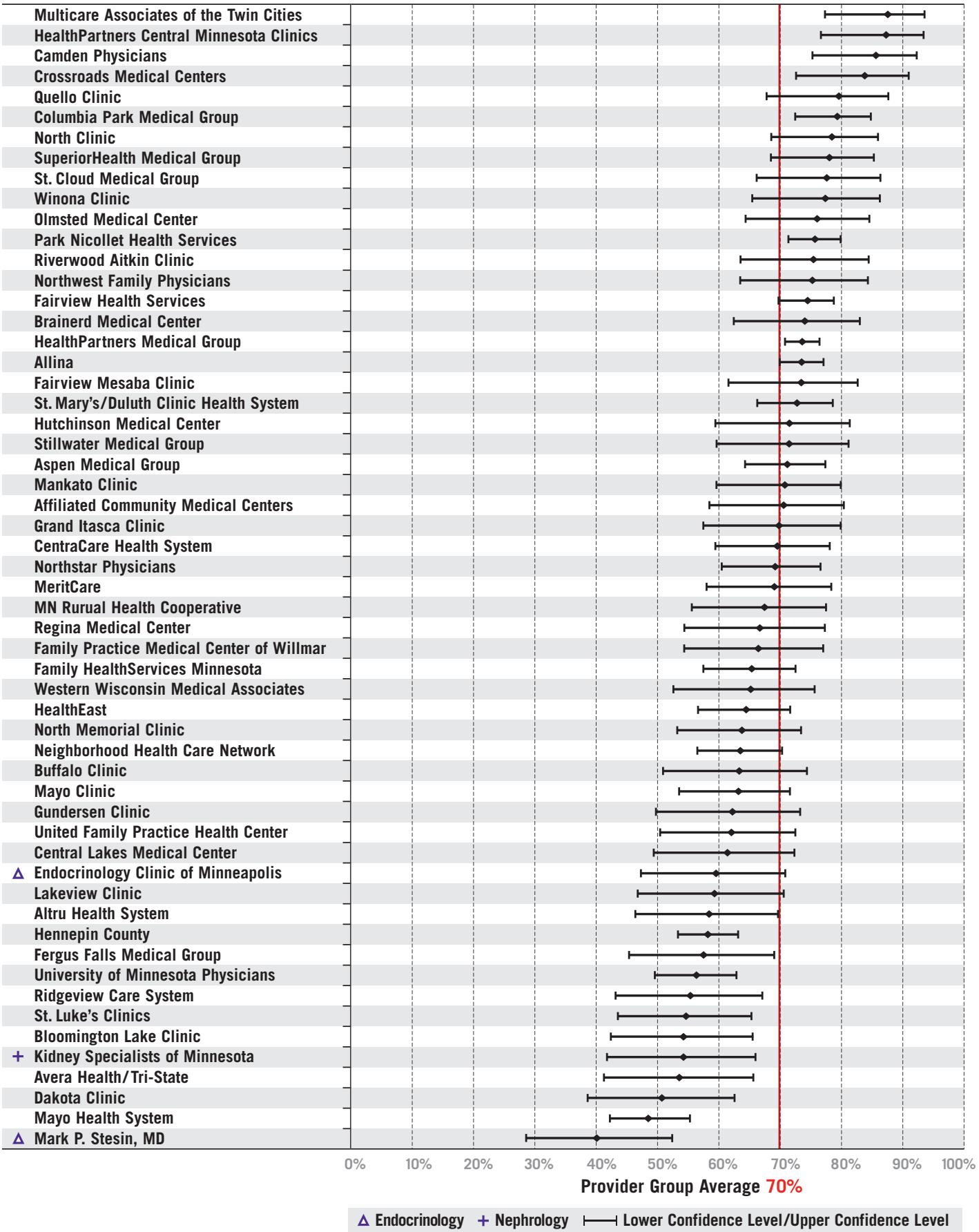
Diabetes: Alc<=8 (OLD Target)



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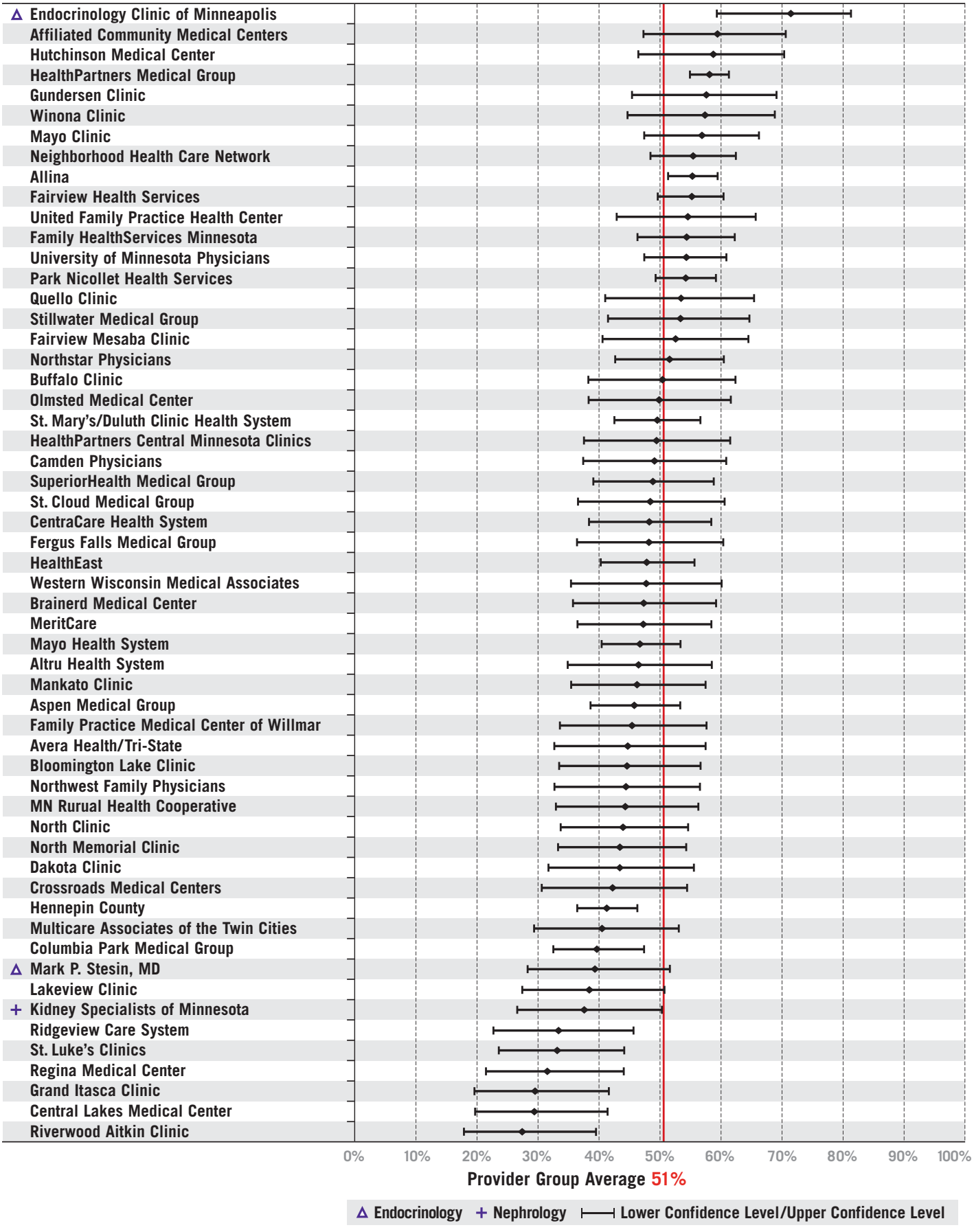
Diabetes: Blood Pressure Below 130/85 (OLD Target)



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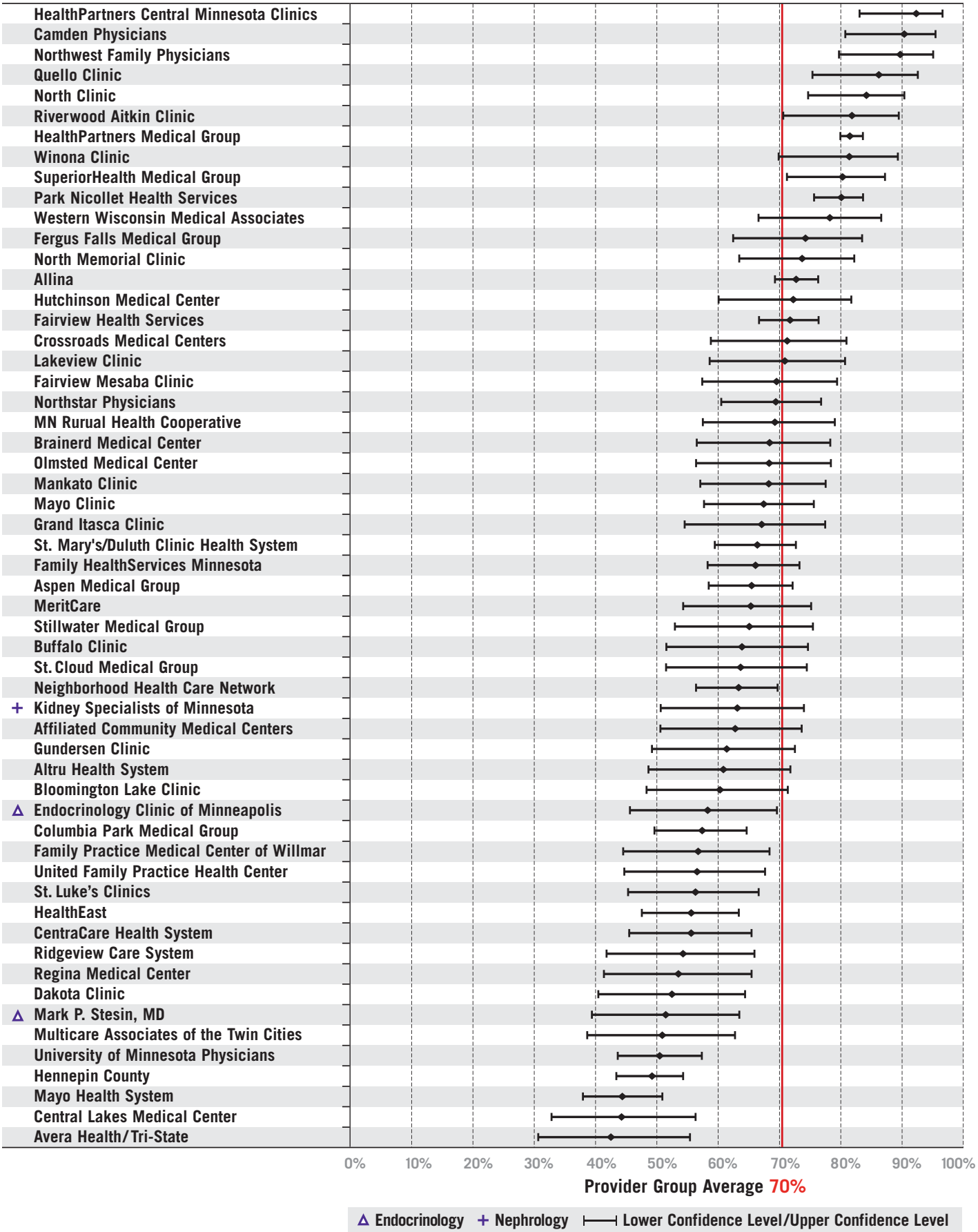
Diabetes: LDL Below 130 (OLD Target)



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Living with Illness

Diabetes
(Individual Measures)

A1c Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
A1c screening	90.5%	89.9% - 91.1%	7,603	8,401	41,831
A1c <= 6.0	15.2%	14.4% - 15.9%	1,277	8,401	41,831
A1c <= 7.0	48.1%	47.0% - 49.1%	4,041	8,401	41,831
A1c <= 8.0	67.7%	66.7% - 68.7%	5,687	8,401	41,831
A1c <= 9.0	74.8%	73.9% - 75.8%	6,284	8,401	41,831
A1c > 9.0	25.2%	24.3% - 26.1%	2,117	8,401	41,831
A1c untested	9.5%		798	8,401	41,831

BP Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
BP documented	91.0%	90.3% - 91.6%	7,645	8,401	41,831
<130/85	49.1%	48.0% - 50.1%	4,125	8,401	41,831
<130/80	40.7%	39.6% - 41.7%	3,419	8,401	41,831
BP untested	9.0%		893	8,401	41,831

LDL Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
LDL screening	89.8%	89.1% - 90.4%	7,544	8,401	41,831
<100	48.1%	47.0% - 49.1%	4,041	8,401	41,831
<130	68.7%	67.7% - 69.7%	5,771	8,401	41,831
LDL untested	10.2%		857	8,401	41,831

2006 Average	HbA1c	LDL	Systolic BP	Diastolic BP	Patients Sampled
2006 Average Weighted Levels	7.2	94.6	127.4	73.7	8,401

*Statewide averages include both health plan members who were attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who were attributed to a provider group. Therefore, these averages may sometimes differ.

Living with Illness

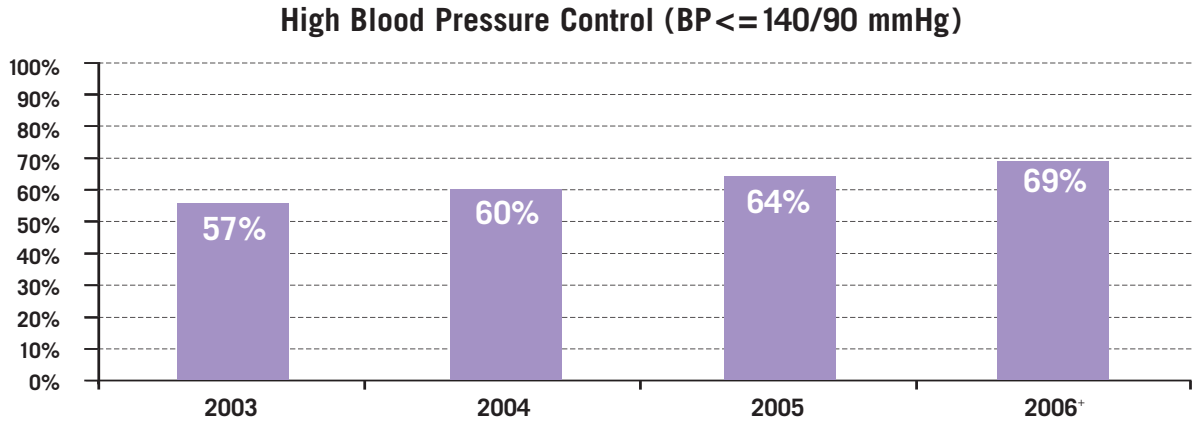
High Blood Pressure

High Blood Pressure Control

This measures the percentage of patients, age 46 - 85, with a diagnosis of hypertension (high blood pressure) who were continuously enrolled in their health plan during the measurement year (2005 dates of service) and whose blood pressure was determined to be less than or equal to 140/90. This intermediate outcome measure assesses whether blood pressure was controlled among adults diagnosed with hypertension.

The data for this measure are collected from health plan claims and medical record review.

High Blood Pressure Control	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
BP <= 140/90 mmHg	69.0%	67.9% - 70.0%	6,439	7,157	69,726



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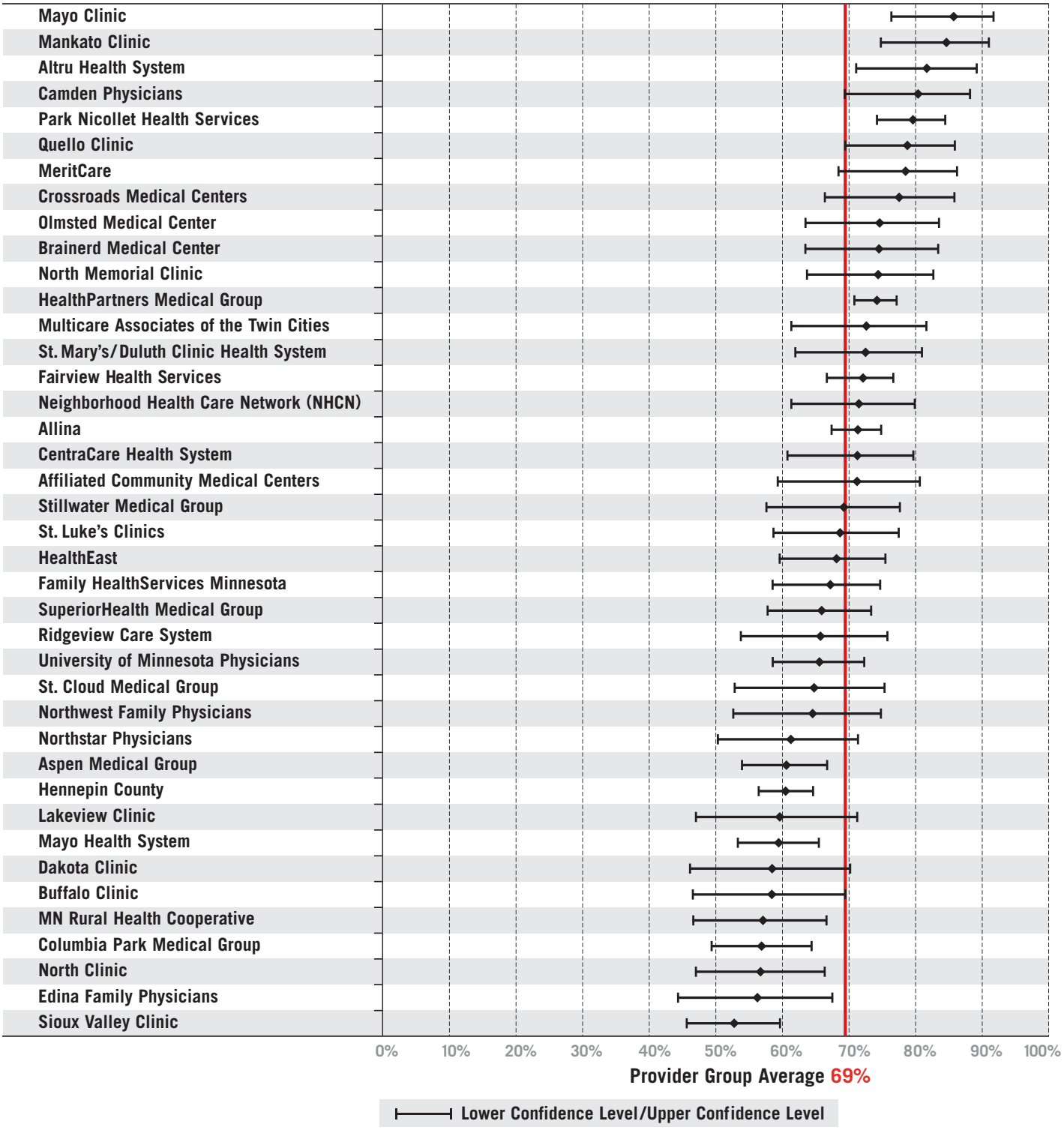
+Note: Caution is needed when comparing 2006 data to previous years. In 2006, the methodology to determine the eligible population was modified. This change decreased the measure denominator, which contributed to the significant increase in the reported rate.

High Blood Pressure Control (BP<=140/90 mmHg)



Getting Better

Children with Colds

Appropriate Treatment for Children with Colds

This measures the percentage of children, ages three months to 18 years, who were given a diagnosis of upper respiratory infection (URI) during the measurement year (2005 dates of service) and were not dispensed an antibiotic prescription on or within three days after the episode date. (Note: A higher percentage indicates better performance – the proportion of patients for whom antibiotics were not prescribed).

The data for this measure are collected from health plan claims.

	Statewide Average*	95% CI	Numerator	Denominator
Appropriate Treatment for Children with Colds	85.7%	85.3% - 86.0%	27,455	32,053

First year measure.
No historical trend graph

*Statewide averages include both health plan members who are attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who are attributed to a provider group. Therefore, these two averages may sometimes differ.

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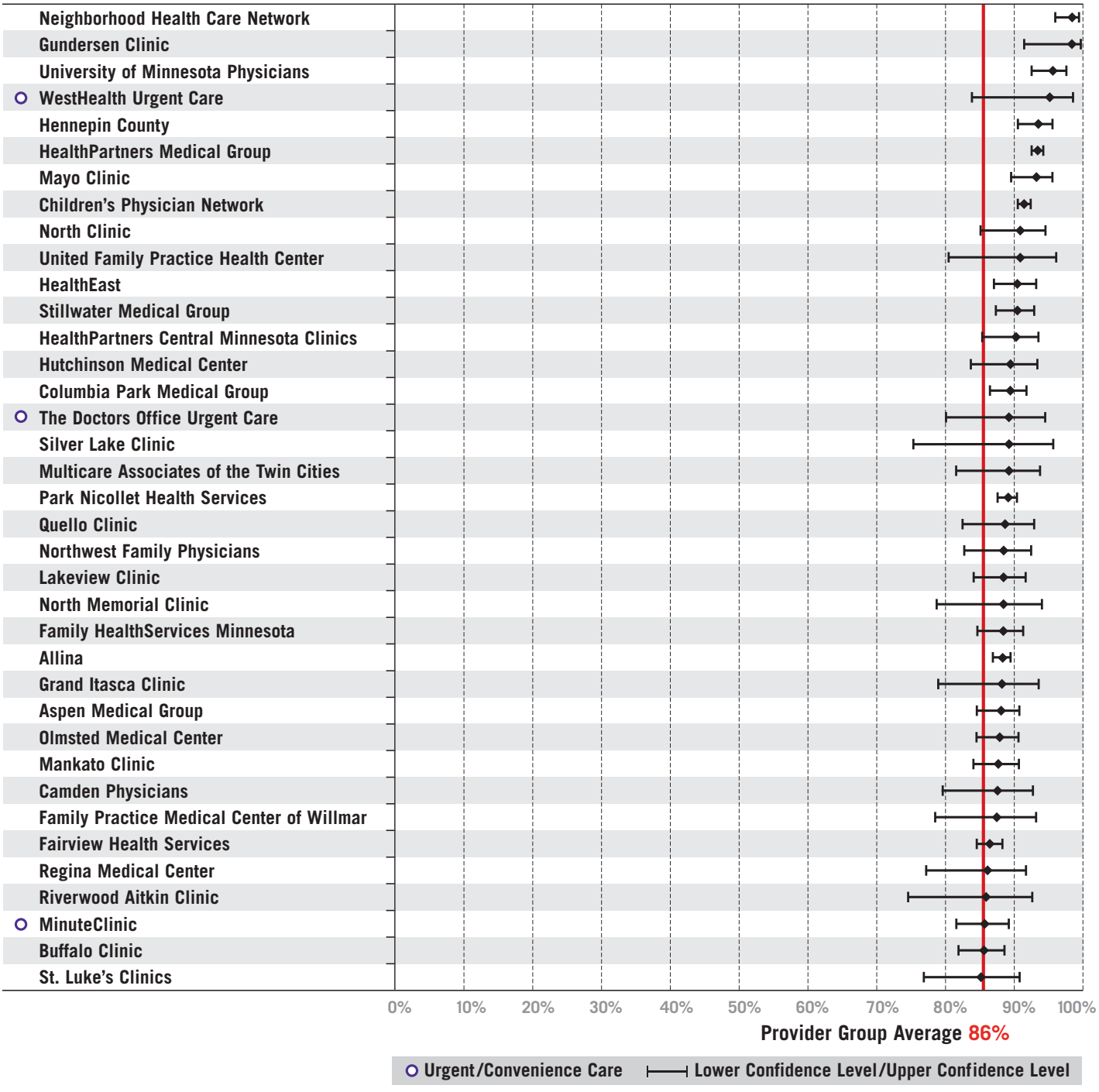
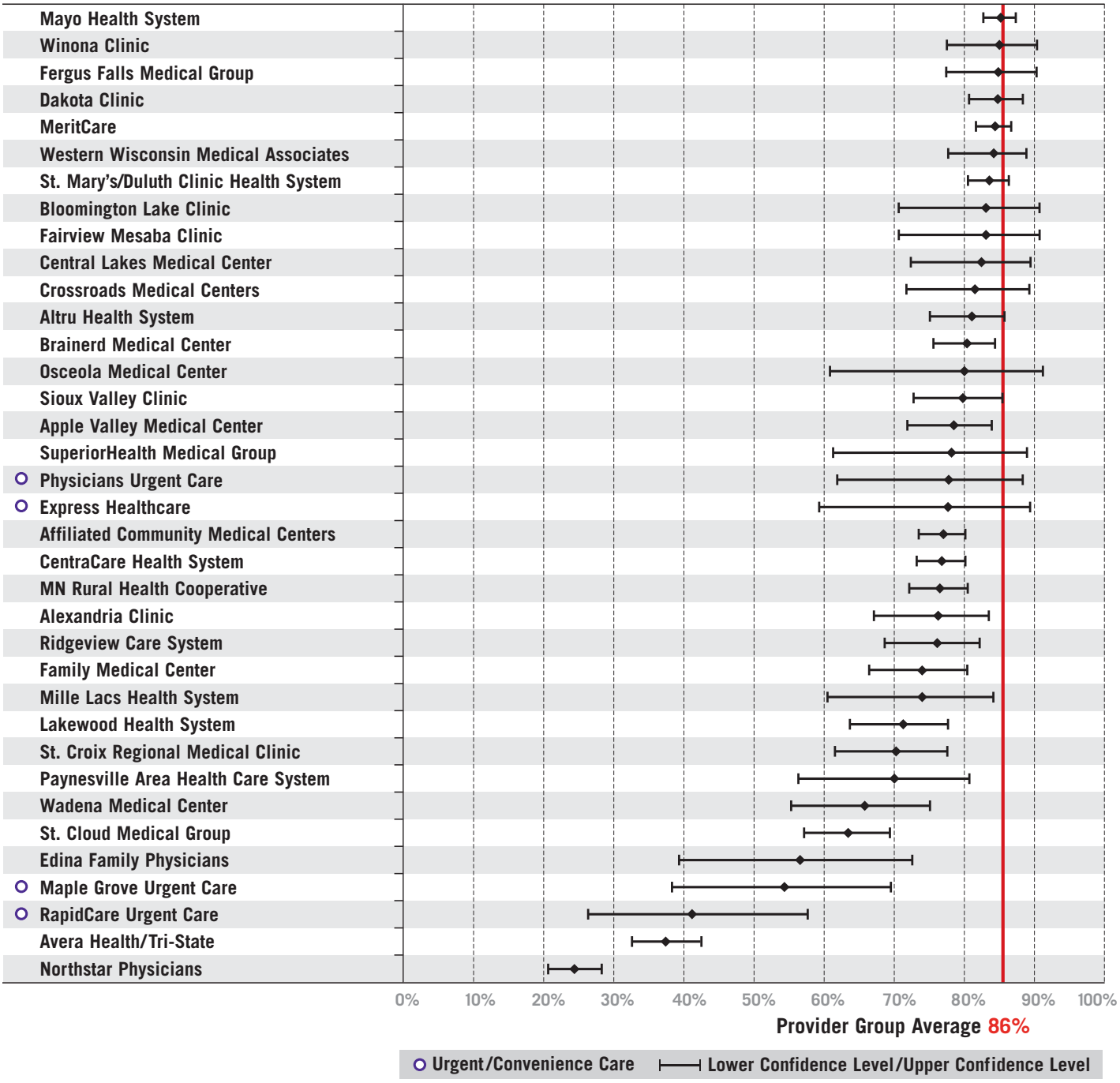
Appropriate Treatment for Children with Colds



Appropriate Treatment for Children with Colds – *continued*



Getting Better

Getting Better

Children with Sore Throats

Appropriate Testing for Children with Sore Throats

This measures the percentage of children, ages 2 - 18 years, who were diagnosed with pharyngitis (2005 dates of service), prescribed an antibiotic on or within three days after the episode date, and received a group A streptococcus (strep) test during the period from three days prior to three days after the episode date. (Note: A higher percentage indicates better performance – appropriate testing).

The data for this measure are collected from health plan claims.

	Statewide Average*	95% CI	Numerator	Denominator
Appropriate Testing for Children with Sore Throats	81.8%	81.3% - 82.4%	14,480	17,692

First year measure.
No historical trend graph

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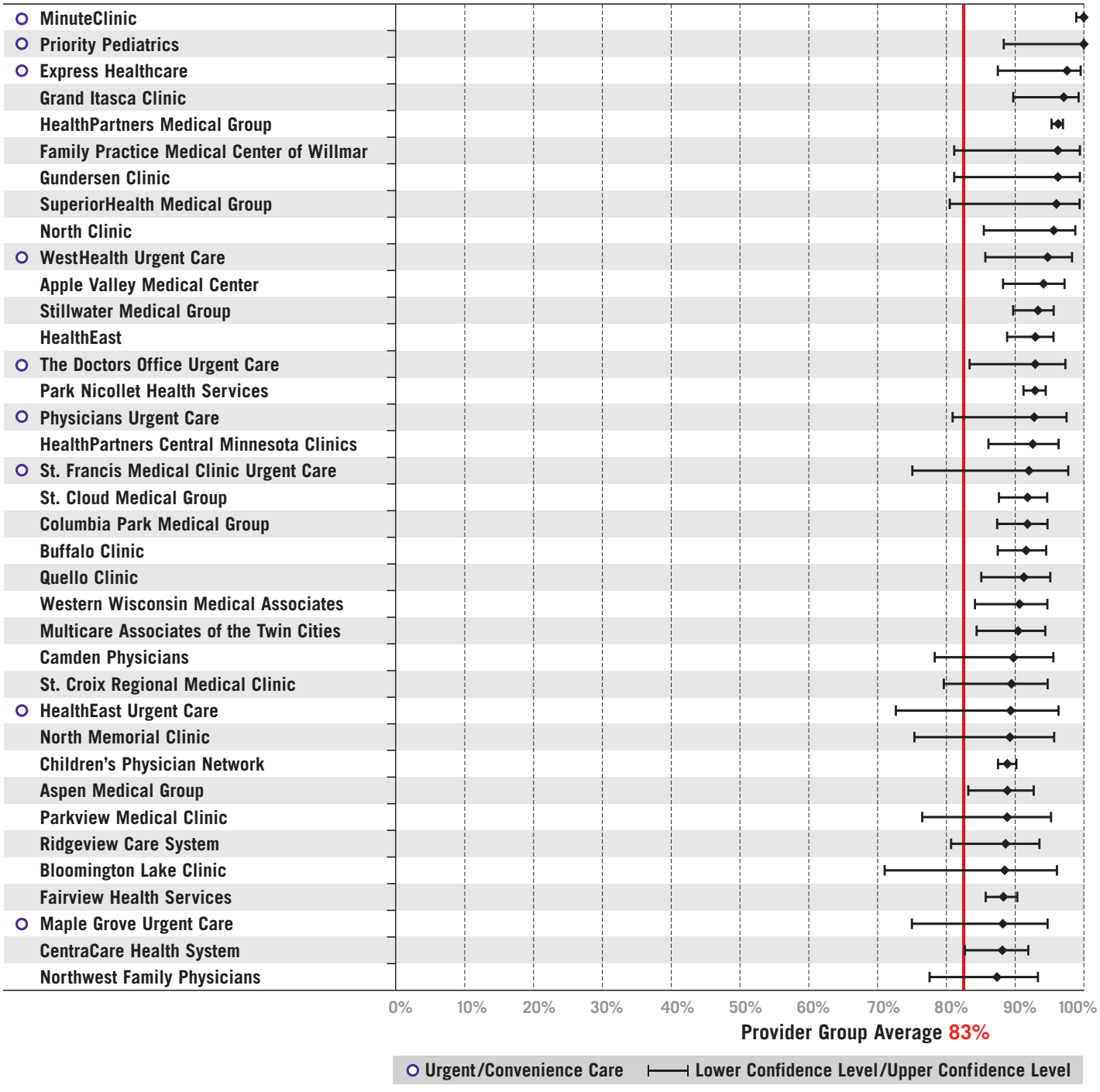
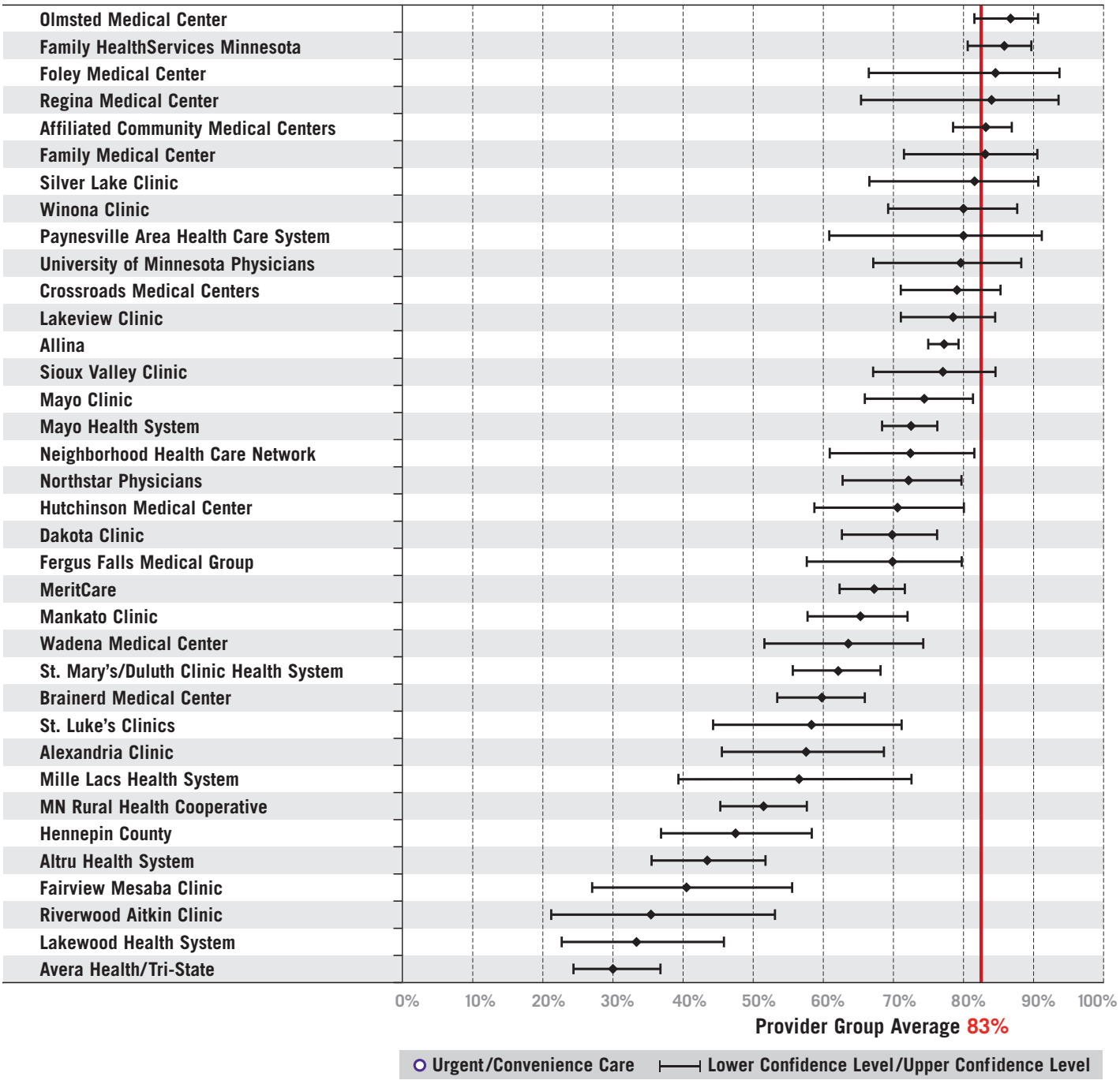
Appropriate Testing for Children with Sore Throats



Appropriate Testing for Children with Sore Throats – *continued*



Getting Better

Staying Healthy

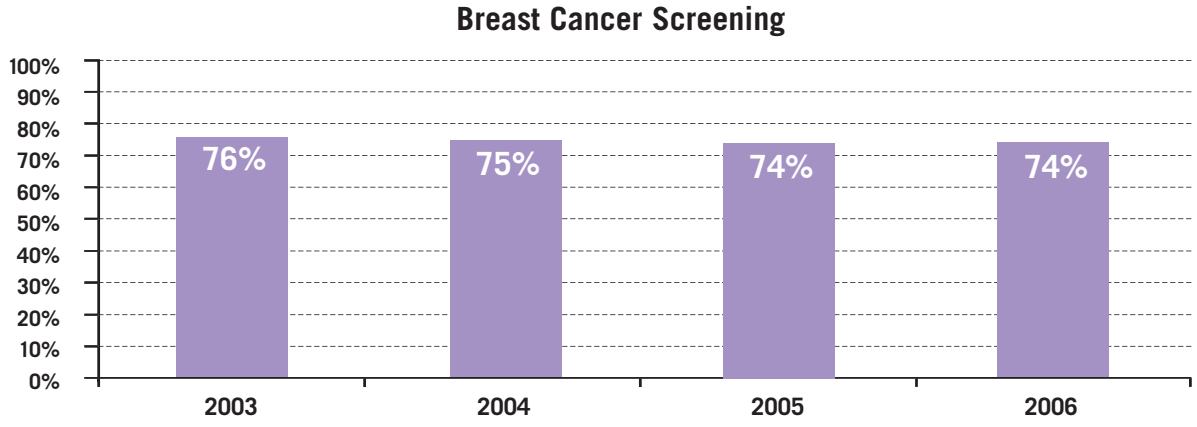
Breast Cancer Screening

Breast Cancer Screening (Mammograms)

This measures the percentage of women, ages 50 - 69, who were continuously enrolled in their health plan for the measurement year (2005 dates of service) and the year prior, and who had a mammogram during the measurement year or the previous year.

The data for this measure are collected from health plan claims.

	Statewide Average*	95% CI	Numerator	Denominator
Breast Cancer Screening	74.3%	74.0% - 74.6%	66,523	89,576



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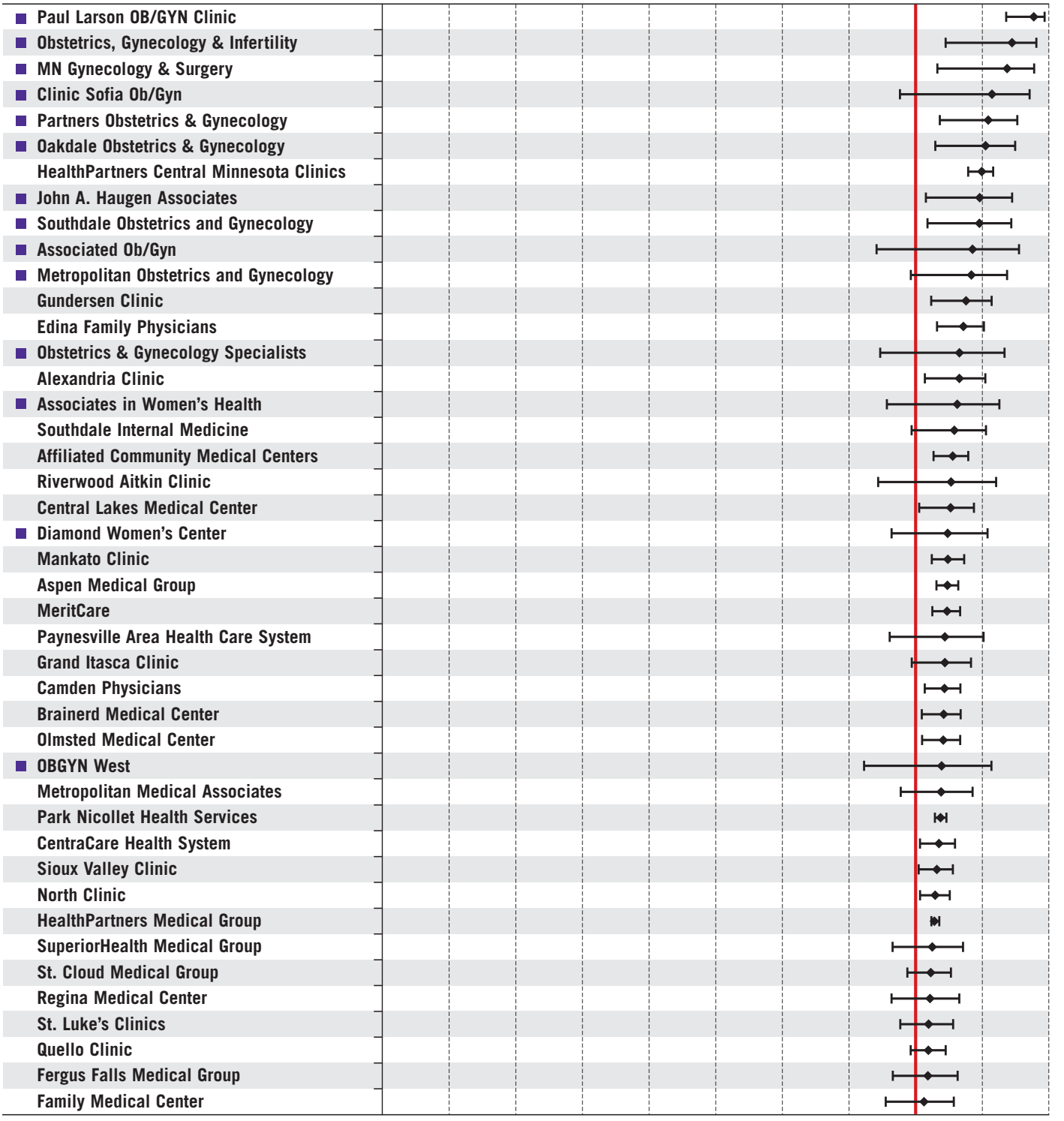
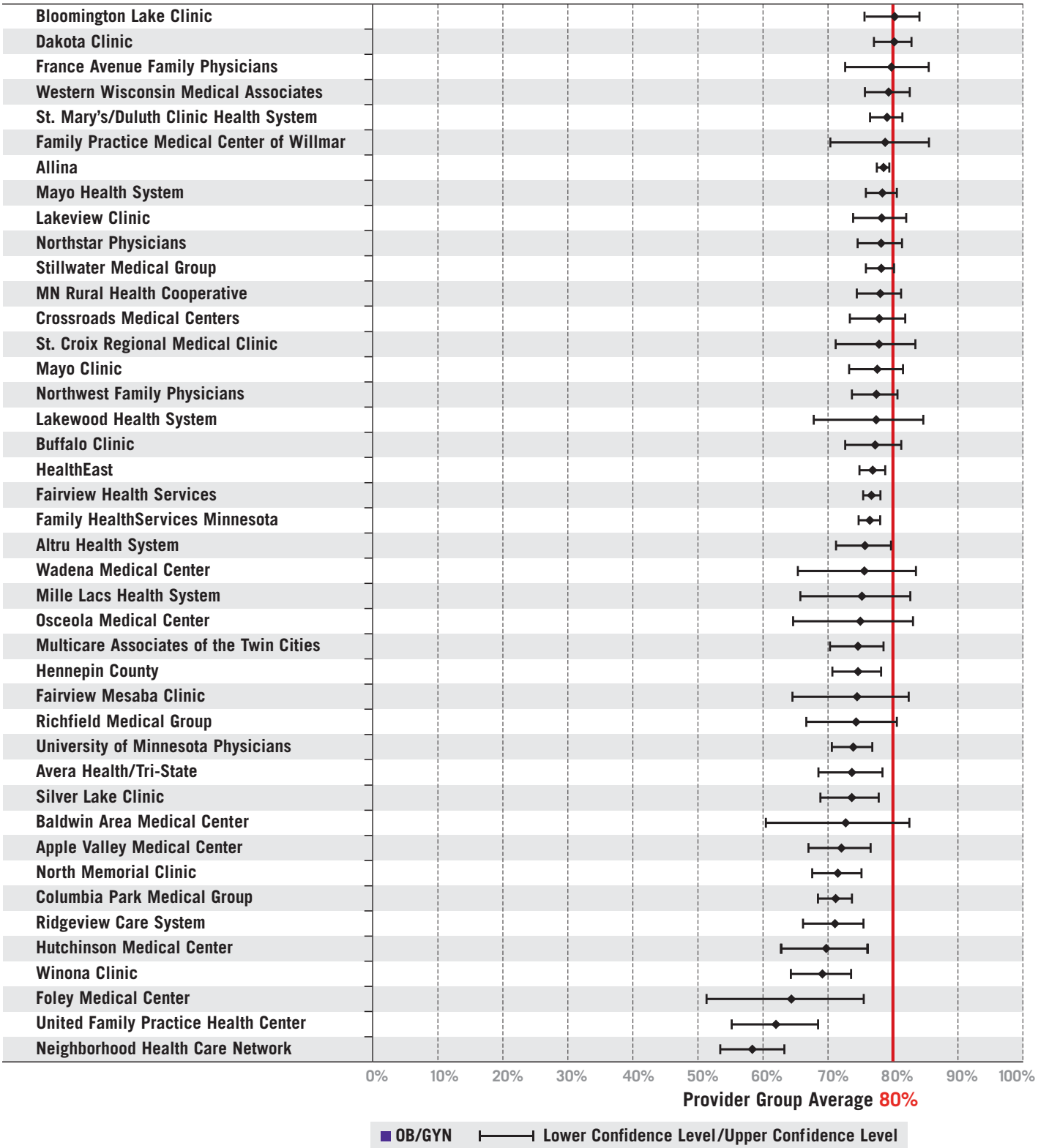
Breast Cancer Screening



Breast Cancer Screening – *continued*



Staying Healthy

Cervical Cancer Screening

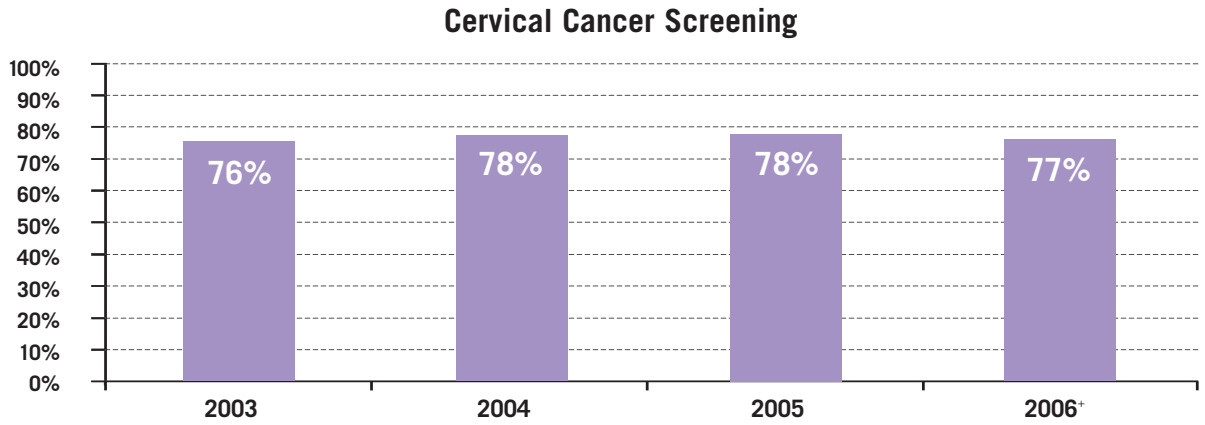
Cervical Cancer Screening (Pap Test)

This measures the percentage of women, ages 18-64, who were continuously enrolled in their health plan for three years[1] and who have received one or more Pap tests during the measurement year (2005 dates of service) or the previous two years.

The data for this measure are collected from health plan claims.

[1] *For Medicaid members, the continuous enrollment requirement is one year.*

	Statewide Average*	95% CI	Numerator	Denominator
Cervical Cancer Screening	77.3%	77.1% - 77.4%	190,252	246,291



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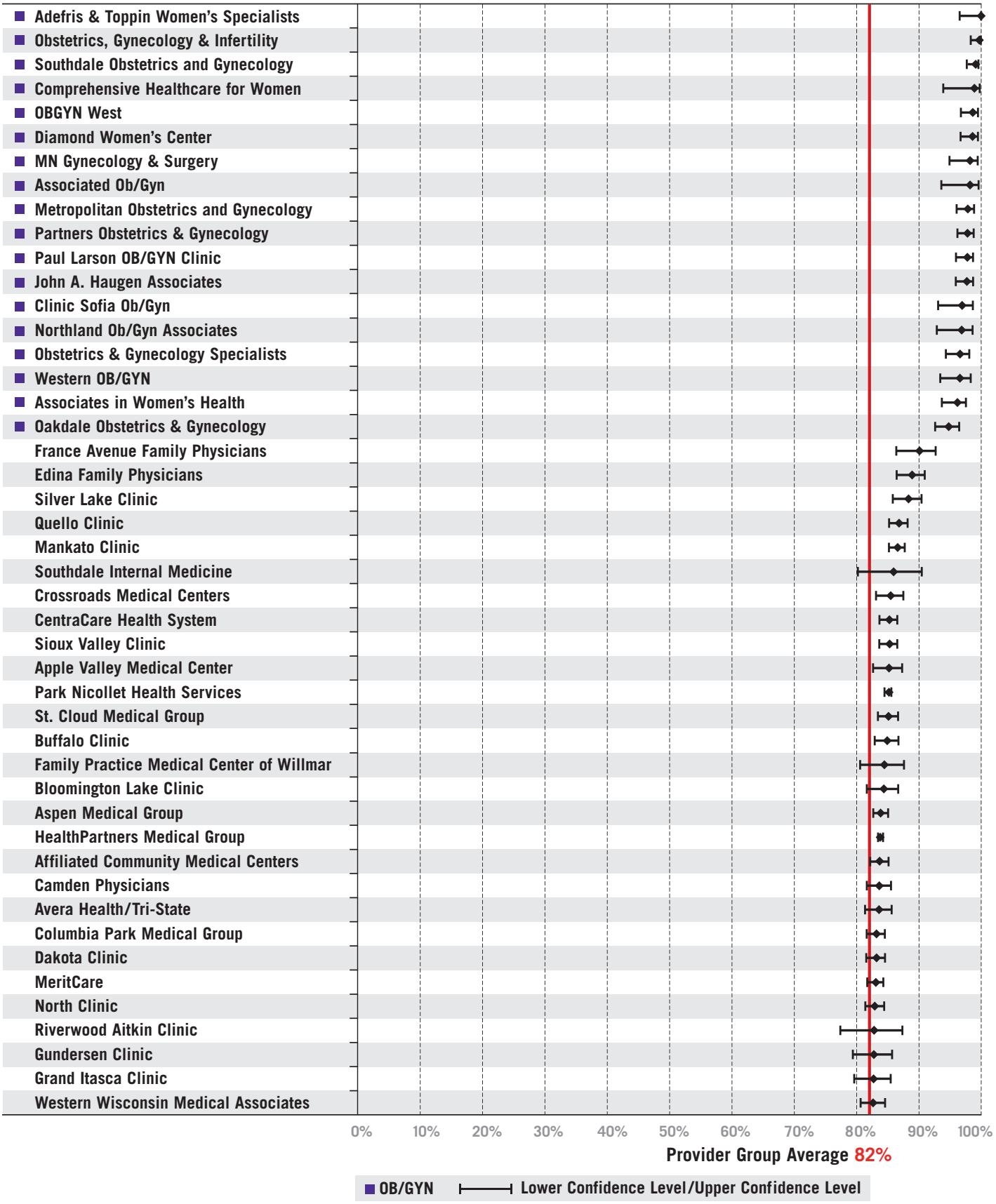
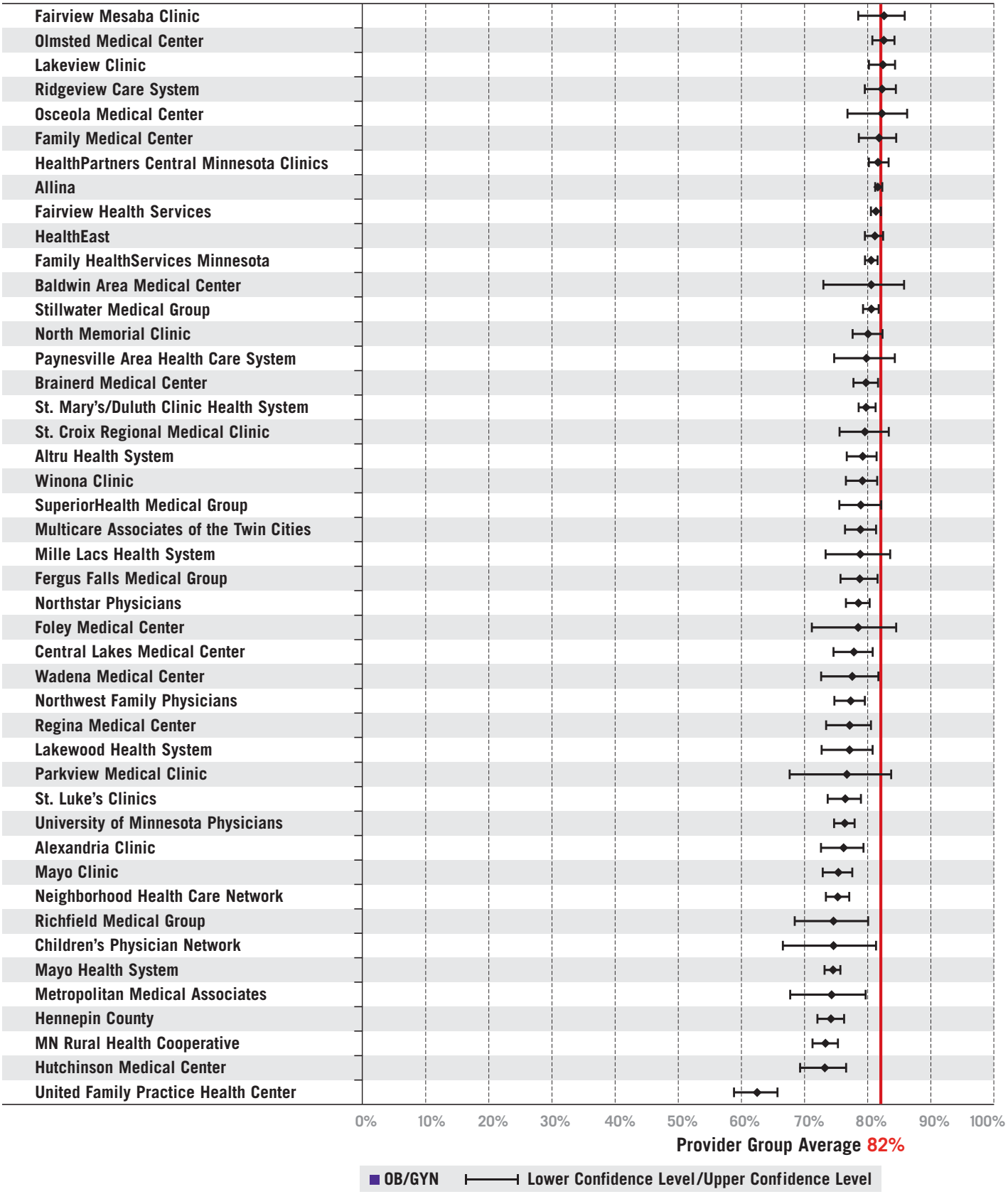
Cervical Cancer Screening



Cervical Cancer Screening – *continued*



Staying Healthy

Colorectal Cancer Screening

Colorectal Cancer Screening

This measures the percentage of adults, ages 50-80, who were continuously enrolled in their health plan for the measurement year (2005 dates of service) and the year prior and who had appropriate screening for colorectal cancer. Appropriate screenings are defined as one or more of the following: fecal occult blood test (FOBT) during the measurement year; flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year; double contrast barium enema (DCBE) during the measurement year of the four years prior to the measurement year; colonoscopy during the measurement year or the nine years prior to the measurement year.

The data for this measure are collected from both health plan claims and medical record review.

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Colorectal Cancer Screening	58.3%	56.9% - 59.7%	2,454	4,685	208,323

First year measure.
No historical trend graph

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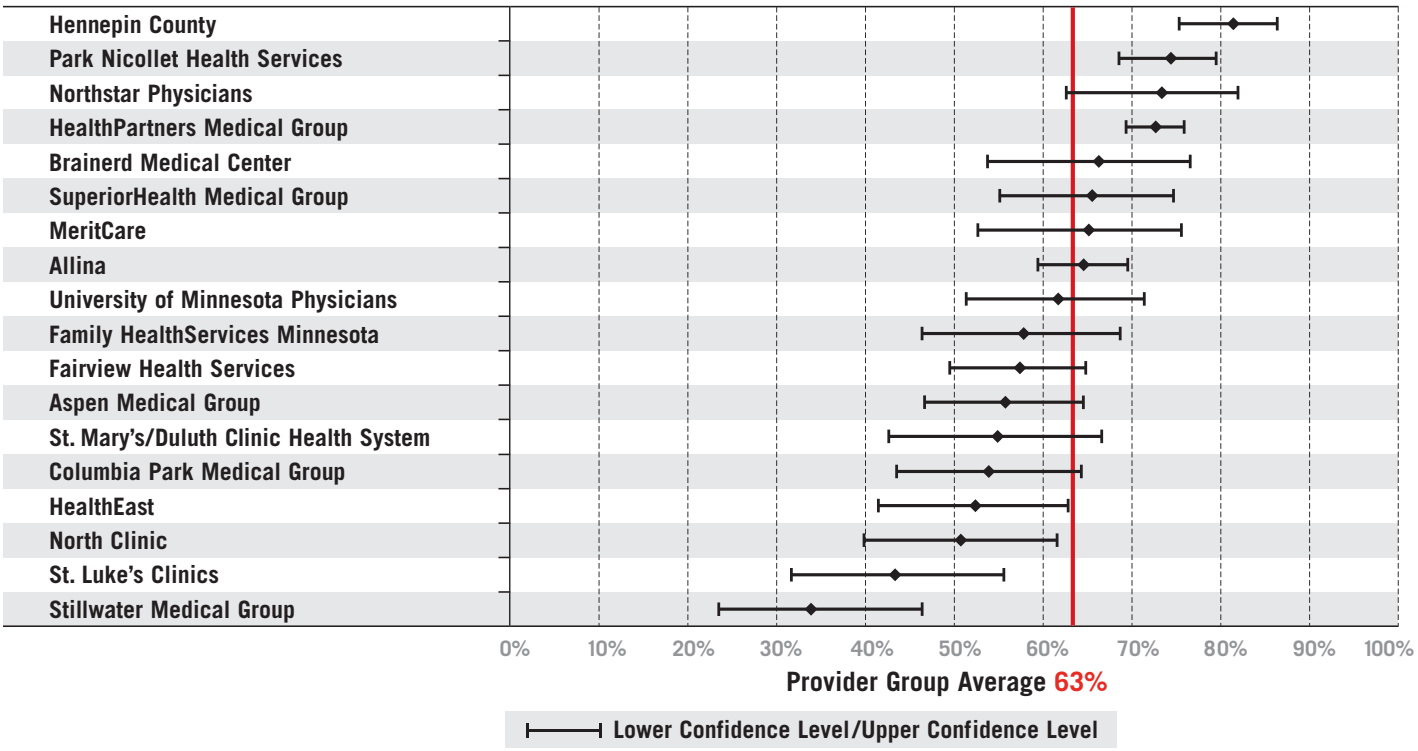
Colorectal Cancer Screening



Staying Healthy

Cancer Screening Combined

Cancer Screening Combined – Ages 50-80

This composite measures the percentage of adults, ages 50 - 80, who were continuously enrolled in their health plan during the measurement year (2005 dates of service) and one year prior and up-to-date for all appropriate cancer screening services (colorectal, breast, cervical). A patient must be up-to-date for ***all three components*** to be considered up-to-date for the cancer screening composite measure. In other words, this composite rate is calculated using an all-or-none method. All-or-none is defined as credit given for achieving this measure when all three components are met. No partial credit is given, such as if only two of the three components are met. (Note: Males are included in this measure, but countered for colorectal screening only.)

The data for this measure are collected from both health plan claims and medical record review.

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Cancer Screening Combined Ages 50-80	47.6%	46.2% - 49.1%	1,662	4,685	208,323

First year measure.
No historical trend graph

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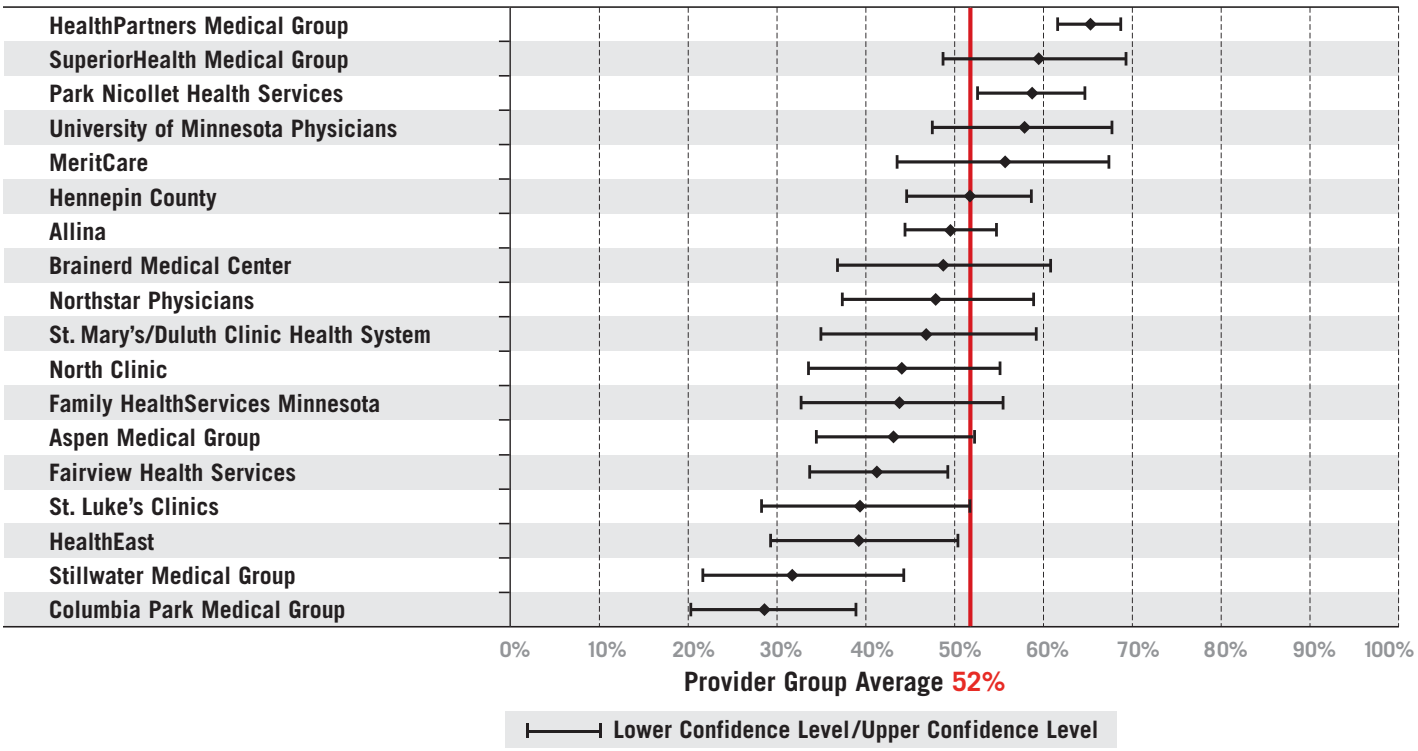
Cancer Screening Combined



Staying Healthy

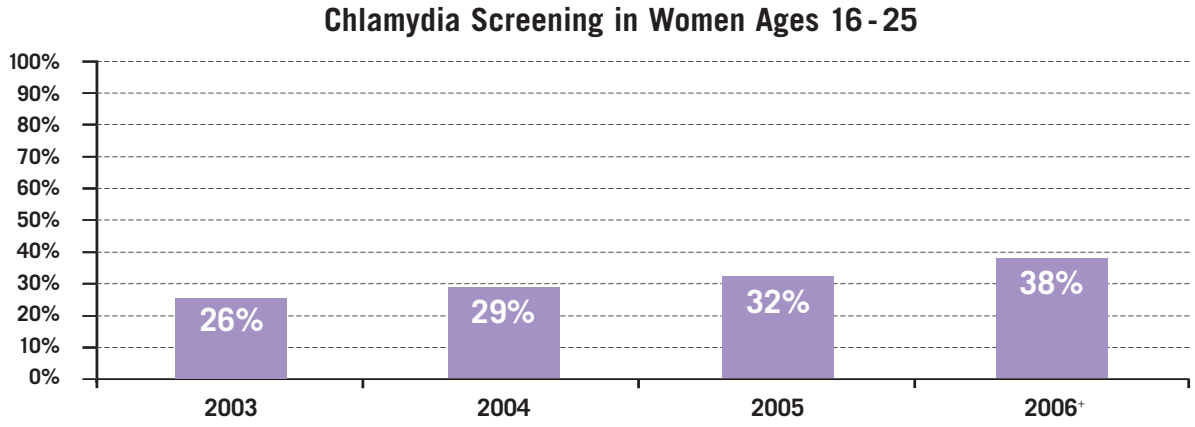
Chlamydia Screening in Women

Chlamydia Screening in Women

This measures the percentage of women, ages 16 - 25, who were continuously enrolled in their health plan during the measurement year (2005 dates of service), were identified as sexually active, and had at least one test for chlamydia.

The data for this measure are collected from health plan claims.

	Statewide Average*	95% CI	Numerator	Denominator
Chlamydia Screening in Women Ages 16 - 25	37.6%	37.1% - 38.0%	15,628	41,591



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+Note: Technical coding issues were identified for seven provider groups so their chlamydia screening rates were suppressed in 2006. Caution is needed when comparing 2006 data to previous years. In 2006, the methodology to determine the eligible population was modified. This change decreased the measure denominator, which contributed to the significant increase in the reported rate.

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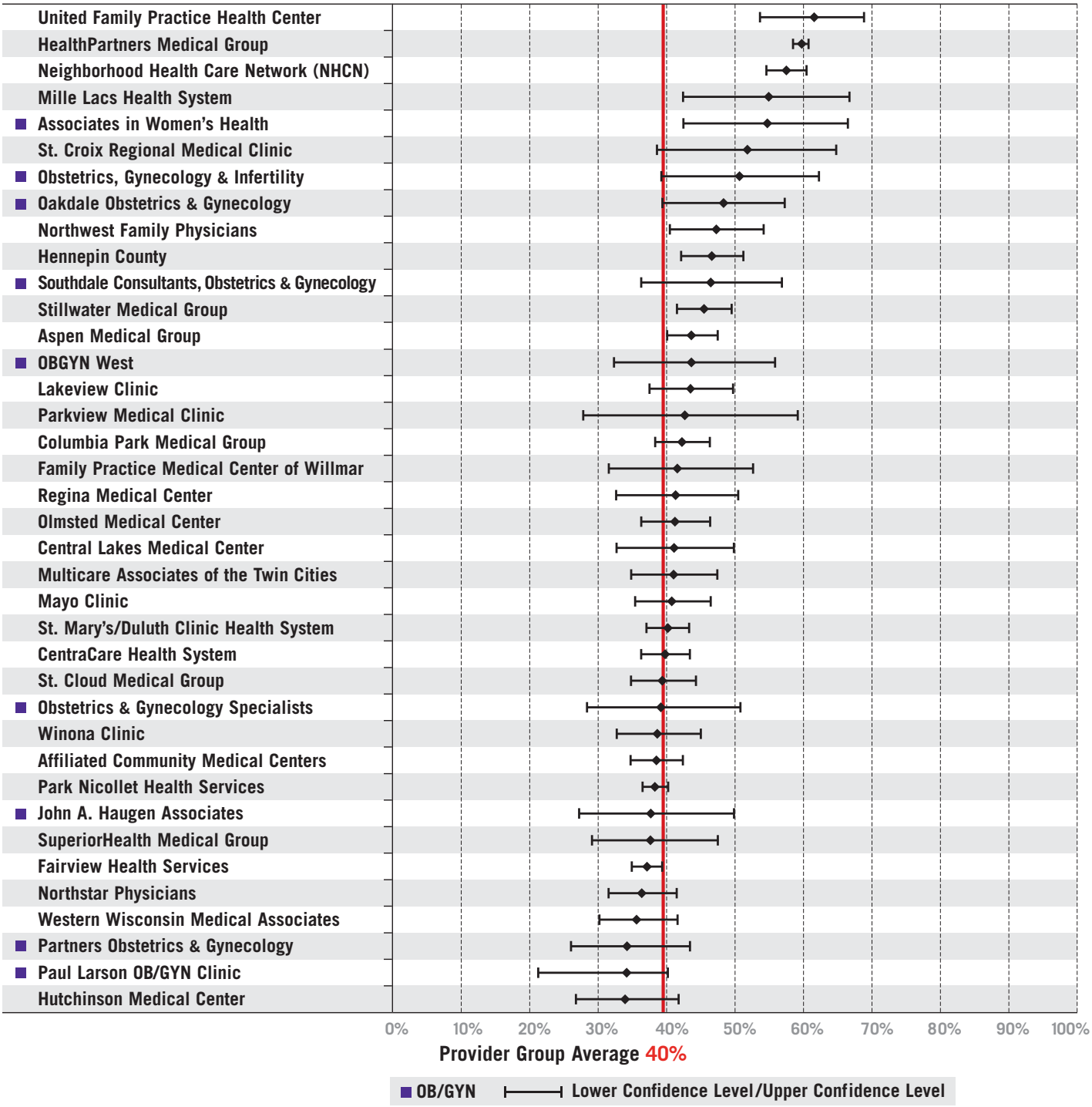
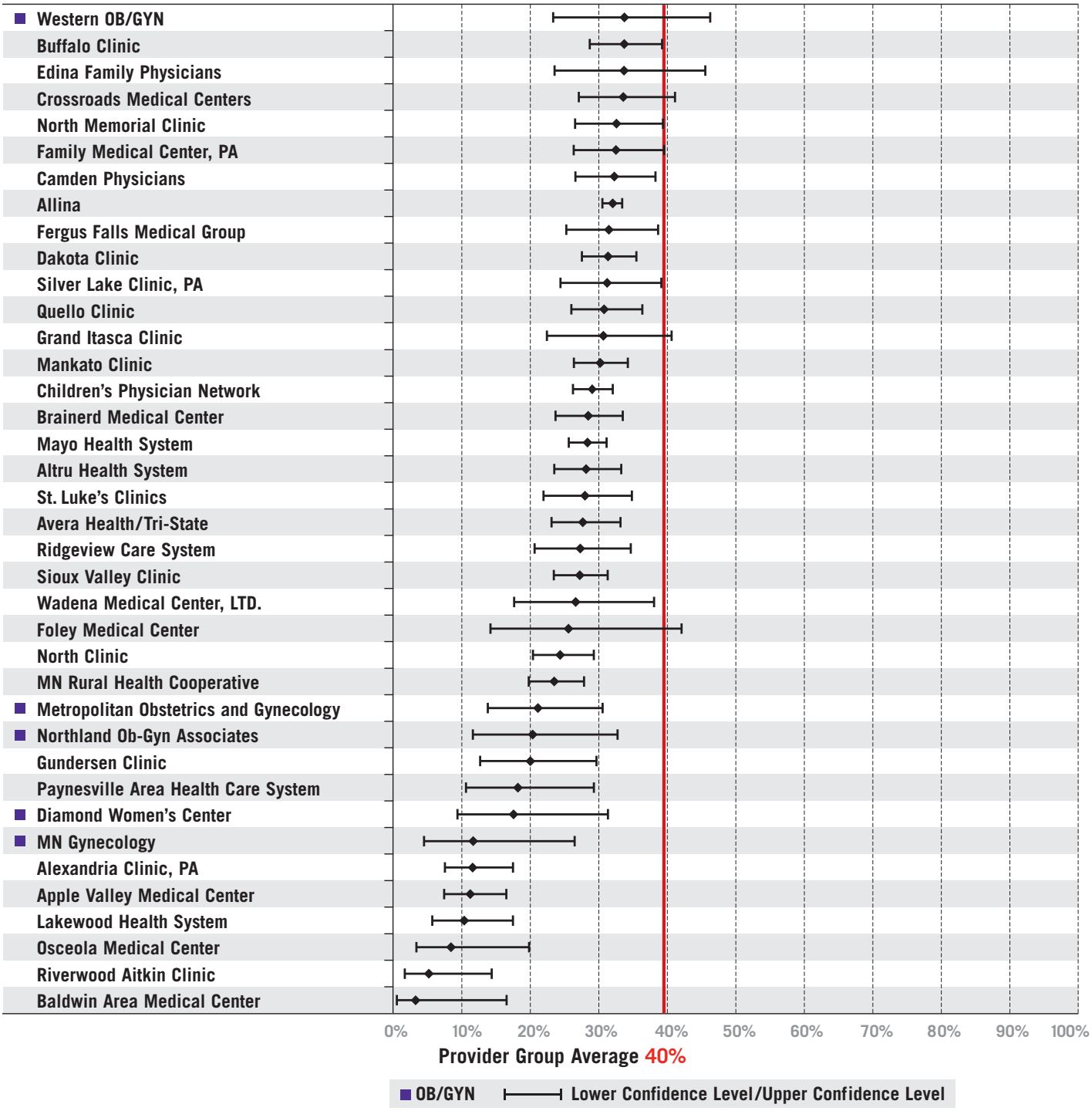
Chlamydia Screening in Women - Ages 16 to 25



Chlamydia Screening in Women - Ages 16 to 25 – *continued*



Staying Healthy

Childhood Immunization

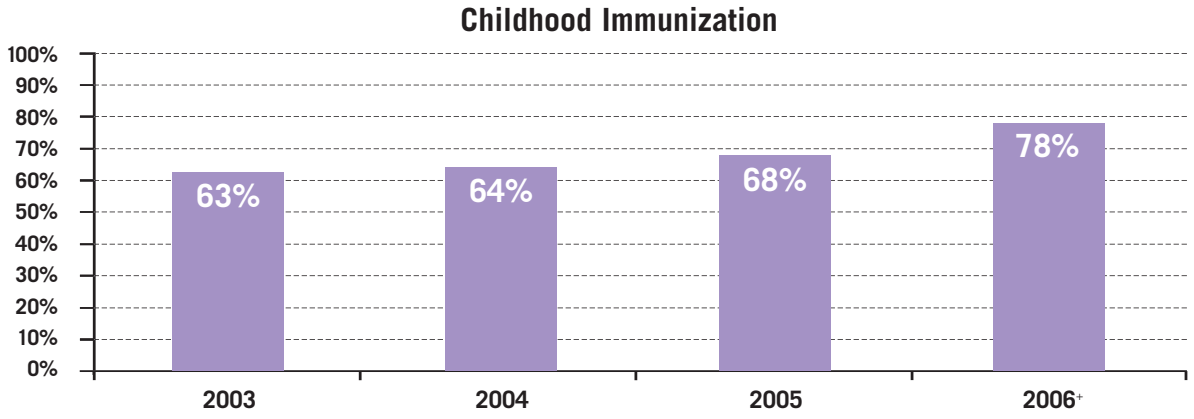
Childhood Immunization

This measures the percentage of children who turned two years old during the measurement year (2005 dates of service) and who were continuously enrolled in their health plan for 12 months immediately preceding their second birthday and who have received the following:

- **DTP or DTaP** – Four diphtheria-pertussis-tetanus vaccinations by the second birthday with at least one diphtheria and one tetanus vaccination falling on or between the child's first and second birthday. Any vaccination administered prior to 42 days after birth is not counted.
- **OPV or IPV** – At least three polio vaccinations with different dates of service on or before the second birthday. OPV/IPV administered before 42 days after birth cannot be counted.
- **MMR** – At least one measles-mumps-rubella vaccination falling on or before the second birthday.
- **HiB** – Three H influenza type B vaccinations with a different date of service on or before the second birthday. HiB administered before 42 days after birth cannot be counted.
- **Hepatitis B** – Three vaccinations with different dates of service on or before the second birthday.
- **VZV** – At least one chicken pox vaccination with a date of service falling on or before the second birthday.

The data for this measure are collected from both health plan claims and medical record review.

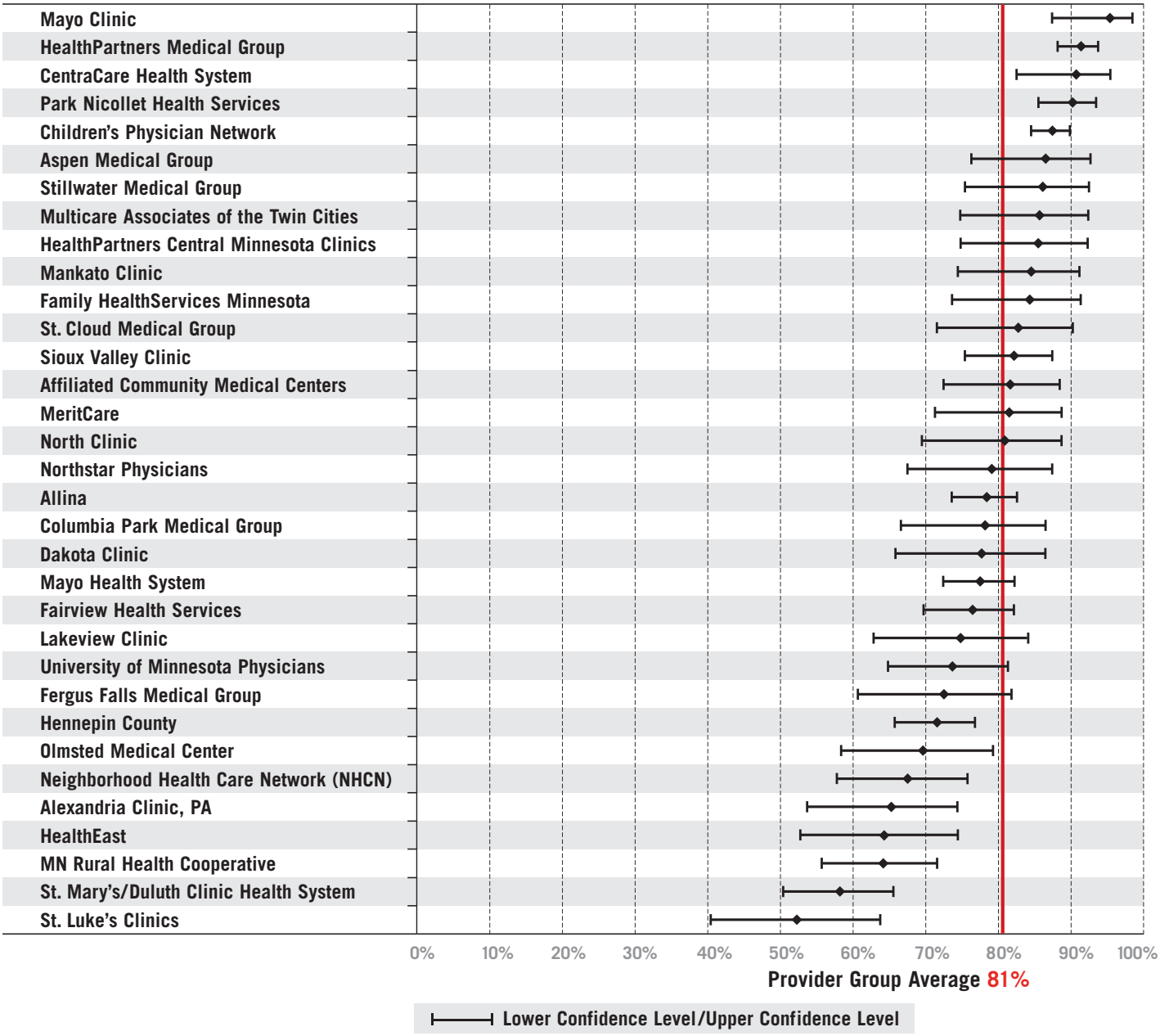
Childhood Immunization	Statewide Average* (Weighted)	95% CI	Total Fully Immunized	Denominator (Patients sampled)	Total Eligible
Children with all immunizations *including* chickenpox	78.4%	77.3%-79.0%	3,953	5,431	19,527



*Statewide averages include both health plan members who were attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who were attributed to a provider group. Therefore, these averages may sometimes differ.

+Note: Caution is needed when comparing 2006 data to previous years. In 2006, the methodology to determine the eligible population was modified. This change decreased the measure denominator, which contributed to the significant increase in the reported rate.

Childhood Immunization



Staying Healthy

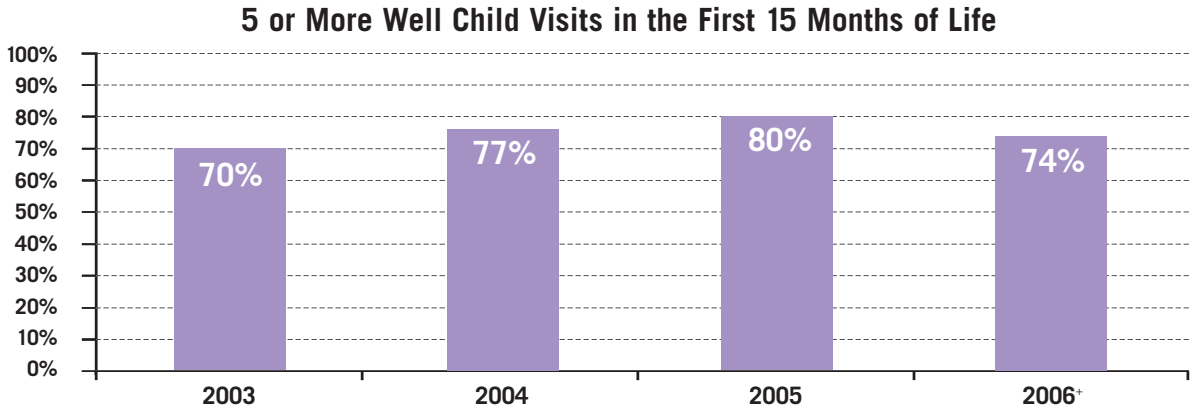
Well Child Visits

Well Child Visits

This measures the percentage of patients who turned 15 months old during the measurement year (2005 dates of service), who were continuously enrolled in their health plans from 31 days of age, and who received five or more well child visits with a primary care practitioner during their first 15 months of life.

The data for this measure are collected from health plan claims.

Well Child Visits in the First 15 months of life	Statewide Average*	95% CI	Numerator	Denominator
Five or more visits	73.8%	72.2% - 74.5%	13,174	17,846



*Statewide averages include both health plan members who were attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who were attributed to a provider group. Therefore, these averages may sometimes differ.

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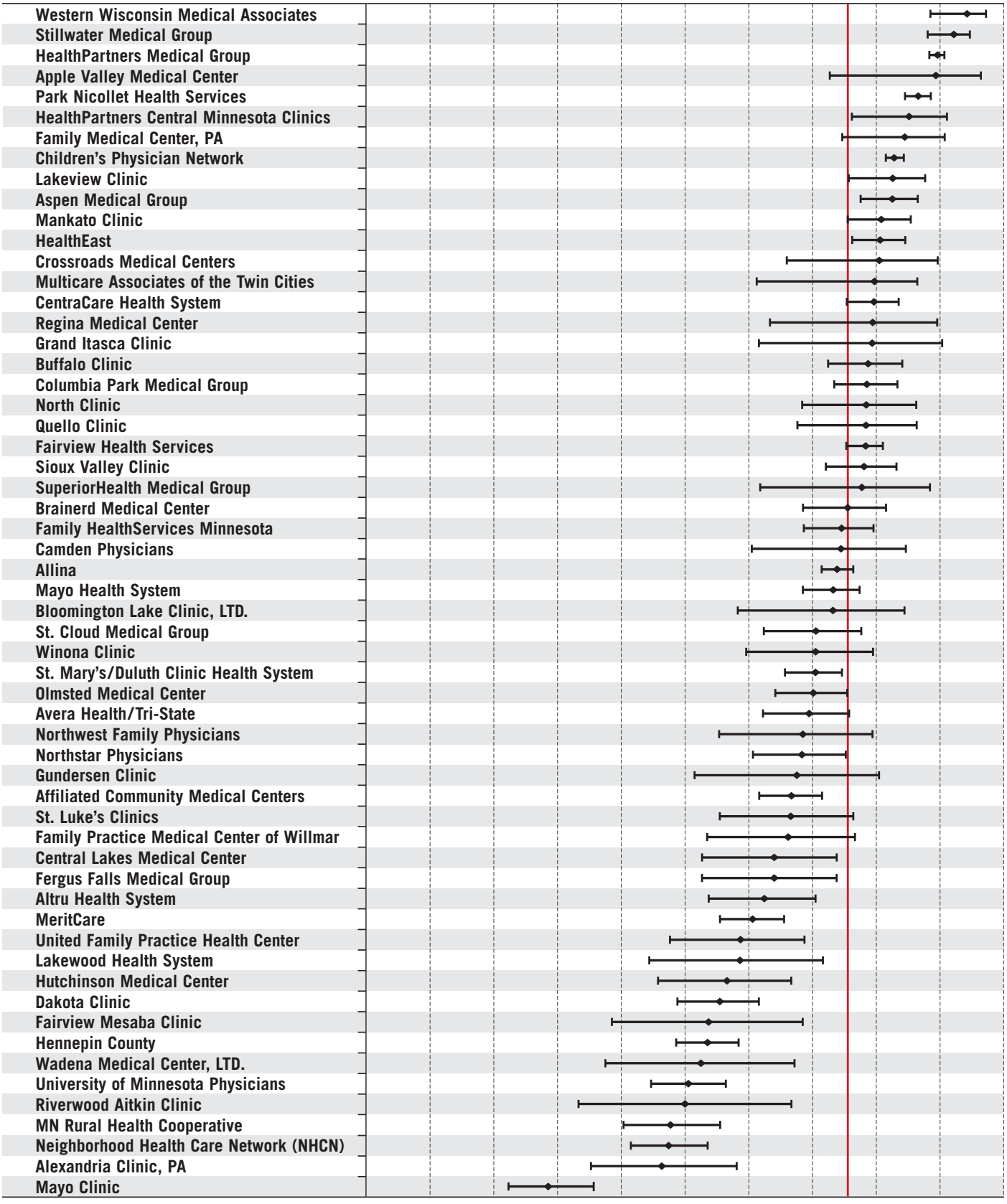
Well Child Visits - 5 or More Visits in the First 15 Months of Life



Future Plans

The national call to improve health care through better availability of quality information has never been clearer or stronger. From the publication of the Institute of Medicine's 2001 report[2] on redesigning our health care system to August 2006 visits paid to Minnesota by both President George W. Bush and U.S. Health and Human Services Secretary Michael Leavitt to discuss health care transparency, MN Community Measurement has heeded the call to collaboratively improve public reporting on healthcare quality.

In its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* the Institute of Medicine highlighted transparency in its "Ten Rules for Redesign" of the health care system by stating: "The system should make available to patients and their families information that enables them to make informed decisions when selecting a health plan, hospital, or clinic practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction."

To that end, MN Community Measurement's aim is to focus on the consumer's need to access and use health care information. In 2007, MN Community Measurement will introduce measures in a new dimension of quality: patience experience in the ambulatory care setting. More than a simple customer satisfaction report, this survey will measure multiple aspects involved during a patient/provider encounter that could have bearing on the patient's ultimate health outcomes.

To achieve greater efficiency in gathering quality data, MN Community Measurement is exploring new modes of data collection. One new mode we will test involves provider groups directly submitting data to MN Community Measurement, instead of via the health plans. This method of data collection will employ electronic medical records to reduce the cost and time involved in data gathering. While this process is being tested, we will move forward with aggregating Medicare fee-for-service data for some measures in 2007. This additional data will give a fuller picture of a provider group's practice population and aid them in assessing their performance.

Building on the first-time inclusion of specialty providers in the *2006 Health Care Quality Report,* MN Community Measurement will continue to expand the breadth of providers we measure. We also plan to expand our measurement set to include:

- Health Information Technology
- Optimal Vascular Care (composite measure)
- Patient Experience

MN Community Measurement will continue to provide results for the Minnesota Bridges to Excellence (BTE) program sponsored by the Buyers Health Care Action Group (BHCAG). Eight employers with nearly 200,000 employees and dependents combined were included in the analysis this year. Nine provider groups met the BTE thresholds for the 2005 Optimal Diabetes Care composite measure and were recognized in June 2006. BHCAG is already working to expand the program with additional measures and employers in 2007.

[2] *Crossing the Quality Chasm: A New Health System for the 21st Century*

Acknowledgements

The *2006 Health Care Quality Report* is an effort led by MN Community Measurement on behalf of the Minnesota health care community and the broader public. We would like to acknowledge the contributions of all of the organizations that shared their resources and the individuals who shared their time and expertise to make this report possible. We offer our sincere thanks to:

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Most importantly, we thank all of the provider groups, whose efforts are reflected in this report, for their continued commitment to quality improvement as a means to provide the best care possible for their patients.

List of Groups Reported in 2006

73 Primary Care Groups / Clinics

Affiliated Community Medical Centers
Alexandria Clinic
Allina
Altru Health System
Apple Valley Medical Center
Aspen Medical Group
Avera Health/Tri-State
Baldwin Area Medical Center
Bloomington Lake Clinic
Brainerd Medical Center
Buffalo Clinic
Camden Physicians
CentraCare Health System
Central Lakes Medical Center
Children's Physician Network
Columbia Park Medical Group
Crossroads Medical Centers
Dakota Clinic
Edina Family Physicians
Fairview Health Services
Fairview Mesaba Clinic
Family HealthServices Minnesota
Family Medical Center
Family Practice Medical Center of Willmar
Fergus Falls Medical Group
Foley Medical Center
France Avenue Family Physicians
Grand Itasca Clinic
Gundersen Clinic
HealthEast
HealthPartners Central Minnesota Clinics
HealthPartners Medical Group
Hennepin County
Hutchinson Medical Center
Lakeview Clinic
Lakewood Health System
Mankato Clinic
Mayo Clinic
Mayo Health System
Metropolitan Medical Associates
MeritCare
Mille Lacs Health System
MN Rural Health Cooperative
Multicare Associates of the Twin Cities
Neighborhood Health Care Network
North Clinic
North Memorial Clinic
Northstar Physicians
Northwest Family Physicians
Olmsted Medical Center
Osceola Medical Center
Park Nicollet Health Services
Parkview Medical Clinic
Paynesville Area Health Care System
Quello Clinic
Regina Medical Center
Richfield Medical Group
Ridgeview Care System
Riverwood Aitkin Clinic
Silver Lake Clinic
Sioux Valley Clinic
Southdale Internal Medicine
St. Cloud Medical Group
St. Croix Regional Medical Clinic
St. Luke's Clinics
St. Mary's/Duluth Clinic Health System
Stillwater Medical Group
SuperiorHealth Medical Group
United Family Practice Health Center
University of Minnesota Physicians
Wadena Medical Center
Western Wisconsin Medical Associates
Winona Clinic

List of Groups Reported in 2006

2 Endocrinology Clinics

Endocrinology Clinic of Minneapolis — Mark P. Stesin, MD

1 Nephrology Clinic

Kidney Specialists of Minnesota

18 Obstetrics/Gynecology Clinics

Adefris & Toppin Women's Specialists
Associated Ob/Gyn
Associates in Women's Health
Clinic Sofia Ob/Gyn
Comprehensive Healthcare for Women
Diamond Women's Center
John A. Haugen Associates
Metropolitan Obstetrics and Gynecology
MN Gynecology
Northland Ob-Gyn Associates
OBGYN West
Oakdale Obstetrics & Gynecology
Obstetrics, Gynecology & Infertility
Obstetrics & Gynecology Specialists
Partners Obstetrics & Gynecology
Paul Larson OB/GYN Clinic
Southdale Consultants, Obstetrics & Gynecology
Western OB/GYN

10 Urgent/Convenience Care Clinics

Express Healthcare
HealthEast Urgent Care
Maple Grove Urgent Care
MinuteClinic
Priority Pediatrics
Physicians Urgent Care
RapidCare Urgent Care
St. Francis Medical Clinic Urgent Care
The Doctors Office Urgent Care
WestHealth Urgent Care

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