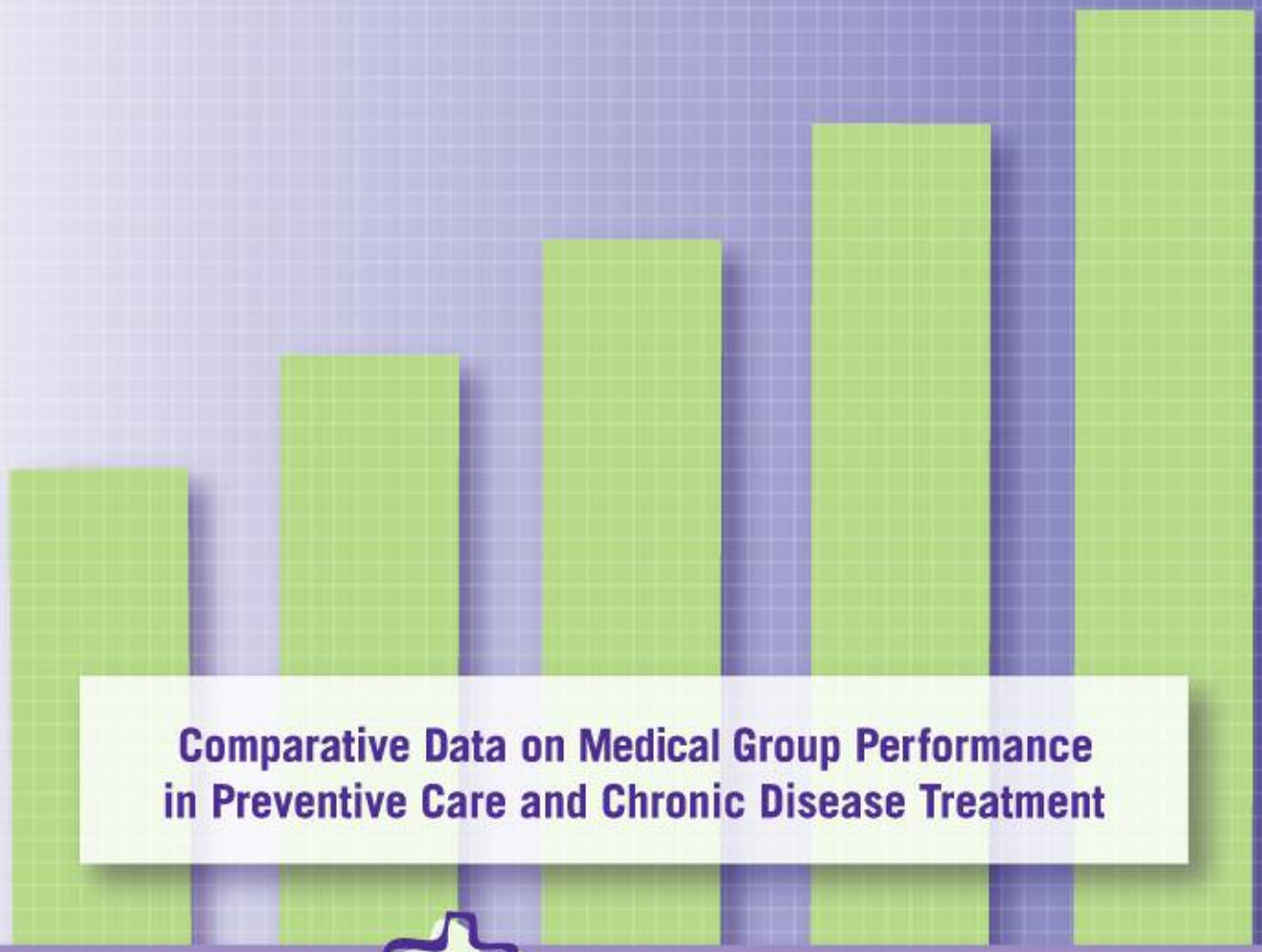
2007
HEALTH CARE QUALITY REPORT



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

MN Community MEASUREMENT
Measure Up To Better Health

www.mnhealthcare.org

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December 2007

We at MN Community Measurement (MNCM) are pleased to release our *2007 Health Care Quality Report* – the fourth in our series of annual reports on the quality of health care in Minnesota. We are encouraged by the growth we have seen in this time, through increasing rates for many of the measures and involvement by providers in innovative approaches to quality measurement, reporting and improvement.

While the core of the report continues to be based on health plan data, a new direct data submission (DDS) process to collect clinical data directly from medical groups was piloted for the first time this year. As a result, two measures – Optimal Diabetes Care and Optimal Coronary Artery Disease (CAD) Care – now include findings by clinic site. Data submitted by medical groups directly to MNCM has been a significant addition to our transparency efforts. We also are able to report results sooner to providers on their quality improvement efforts. At the same time, clinic-level information is more relevant to consumers – a need we heard strongly in our recent focus group study. More DDS measures are soon to follow. Our vision is that results from this efficient, statewide clinical data collection process can be used not only by medical groups, but also health plans, employers, consumers and even Medicare for various quality improvement, regulatory, accreditation and performance payment purposes. Our thanks go to all of the medical groups that participated in this process.

MN Community Measurement continues to align with other quality improvement efforts taking place in the community. An example is our involvement in the Institute for Clinical Systems Improvement's (ICSI) new DIAMOND (Depression Improvement Across Minnesota – Offering a New Direction) project. Medical groups will submit data directly to MNCM for reporting outcomes of depression care at each clinic site. We foresee reporting depression response and remission rates as measured by the Patient Health Questionnaire (PHQ-9), a new tool that will help clinicians assess the severity of a patient's depression and changes over time. The combination of ICSI working with medical groups to redesign depression care, health plans restructuring how they pay for it and MNCM measuring and reporting the results will demonstrate how collaboration across the health system can lead to real and lasting improvement. In addition, our Optimal Diabetes Care and Optimal CAD Care measures are being used by both health plans and purchasers in pay-for-performance programs that recognize medical groups for their quality of care.

We plan to develop new measures to align with new clinical guidelines for asthma and well child care. And while we continue to refine our measures of ambulatory care effectiveness, we are venturing into another of the Institute of Medicine's six aims for improving health care: patient-centeredness. We are currently developing two measures. One will measure how medical groups use health information technology to care for and communicate with patients.

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Medical groups are involved on a committee to shape this work. We anticipate that we will report capabilities and processes such as e-prescribing, medication reconciliation, and patient use of personal health records (PHR). The second measure will assess patients' perceptions about their care experiences. We have met with several medical groups to explore methods of incorporating standardized questions into their current patient experience survey processes. Using the Consumer Assessment of Healthcare Providers and Systems – Clinician and Group Survey (CG-CAHPS), a survey recently endorsed by the National Quality Forum, MNCM will report a measure for which patients themselves are the best sources of data and which is of great interest to them.

Our ultimate goal is to achieve the best possible value in our health care. This can only be met when the care that is delivered is of the highest quality at an appropriate cost. Valid and timely measurement and reporting of care outcomes and cost information is critical to this effort. We are committed to continuing our partnership with others in the community to achieve this goal.

As always, we welcome your feedback and insights as we move forward.

Sincerely,

Brian Anderson, MD, Board Chair
MN Community Measurement

Jim Chase, Executive Director
MN Community Measurement

MN Community Measurement 2007 Health Care Quality Report

(For care delivered in 2006)

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2007 Health Care Quality Report

Executive Summary

2007 Health Care Quality Report

We are pleased to present the *2007 Health Care Quality Report*, the fourth-annual review of comparative provider group performance on key clinical measures produced by MN Community Measurement (MNCM). The report includes 13 clinical measures:

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Use of Appropriate Medications for People with Asthma
- Breast Cancer Screening
- Cancer Screening Combined
- Cervical Cancer Screening
- Childhood Immunization (Combo 3)
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Optimal Coronary Artery Disease Care
- Optimal Diabetes Care
- Optimal Vascular Care

The purpose of this report is to share comparative quality information on clinics and medical groups for use by the public in health care decision-making and by health care professionals in quality improvement efforts. The *2007 Health Care Quality Report* provides at-a-glance ratings on the quality of health care delivered at 90 primary care groups – an increase over the 73 groups reported last year. These medical groups include more than 700 clinics in Minnesota and bordering counties. The report also includes information on cardiology, endocrinology, obstetrics/gynecology and urgent/convenience care clinics.

Key Findings

Key findings of the report include:

- **Statewide results are holding steady for most measures.**
- **A few medical groups now have the highest rates across several measures.**
- **Other medical groups have shown significant improvement from past years.**
- **Practice variation between medical groups continues so opportunities for improvement exist.**

Direct Data Submission

With each release of the annual *Health Care Quality Report* we refine our methodology, expand our measurement categories and improve our public presentation of the data. A new innovation in data collection enabled MNCM to report findings at the clinic-site level for the first time. Whereas historically all measures were based on health-plan-generated data reported at the medical group level, a new direct data submission (DDS) process now is providing more timely and representative data directly from medical groups, which can then be reported by individual clinic site. As with all of our data, these results undergo an external audit to ensure accuracy. Our first piloted DDS measure was our signature Optimal Diabetes Care all-or-none measure. This measure is now reported on the MNCM Web site for 191 clinic sites, in addition to the medical group level findings collected through the traditional health plan method. A second pilot measure was the

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Executive Summary

2007 Health Care Quality Report

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Optimal Coronary Artery Disease (CAD) Care all-or-none measure, which we expect to report on the Web site in December 2007.

Consumer Focus Group Findings

While MN Community Measurement continues to see increasing interest in this information among health care providers and purchasers, one of our most critical challenges is to increase use of health care quality information by consumers. We have made improvements to our Web site to better accommodate consumer needs, including an online demonstration of how to use the site, more patient education about the conditions being measured, and multiple searching options. However, recent focus groups have made it clear that the display of information on our current web site is not meeting consumers' needs – most markedly, by not providing data at a level that is relevant. Consumers expressed a need for more granular data, such as clinic-level, or even physician-level findings.

Focus group participants also emphasized that they value a provider's "soft skills" – how well providers communicate and motivate – so we are building momentum with medical groups to implement a comparable patient experience survey process in 2008. Adding this new domain will broaden our dashboard of information that can be used to improve health care quality.

Looking Forward

In the four years since its first report, MNCM has had an important impact on our community. Medical groups across the state are engaged in improvement efforts related to MNCM measures. We have gained acceptance of our measures and shown the importance of transparency in improving the health care system. MNCN is one of the first organizations to demonstrate the use of all-or-none measures and comparisons of providers in a consumer-friendly format. MNCM has grown to be a statewide collaboration that includes consumers, employers, health plans and providers, and has helped align efforts across payers to minimize the administrative cost of data collection and focus the provider improvement effort.

For a second year, MNCM contributed to a statewide pay-for-performance effort that rewarded medical groups financially for excellence in care delivery. Two of our measures were used for the 2007 Minnesota Bridges to Excellence (BTE) program, sponsored by the Buyers Health Care Action Group (BHCAG). BHCAG is already working to expand the program to include new depression measures in 2008 and we look forward to continuing our role in that process.

Our vision is to be the trusted source for performance measurement and public reporting of quality data across the spectrum of health care. Our efforts aim to drive change by serving as a resource for providers to improve care and for patients in making decisions about their care. We are working to catalyze our community to work together on health care measurement to reduce costs and maximize value.

Introduction

Until four years ago, patients had few sources of information on the quality of their health care, while today they can compare the quality of care delivered by most of the medical groups in Minnesota and surrounding communities with a few clicks of a mouse. Minnesota's health plans, in collaboration with the Minnesota Medical Association (MMA), brought about this dramatic change by creating a non-profit organization called MN Community Measurement to publish comparative quality information for use by the public in health care decision-making and by providers in quality improvement efforts.

Our aim is to improve the level of care that all patients receive by making more and more important quality data available. Each year, our report expands by including more measures on more medical groups. Our *2007 Health Care Quality Report* presents 13 comparable measures of medical group and clinic performance. We believe this information will ultimately drive improvements in care.

Many employers advise their employees to review our quality ratings during benefits open enrollment. For the last two years, the Minnesota Department of Employee Relations included links to our Web site in its online provider directory during benefits open enrollment for more than 50,000 employees.

More and more medical groups and clinics are engaged in this work and using this information for their own quality improvement efforts. This is evident by their high interest in serving on our advisory committees, voluntarily submitting their data, and their representation at our first Measurement Forum in February 2007.

Visitors to our Web site, www.mnhealthcare.org, can search for the newest quality ratings by medical group or clinic, by measure or by geographic area. We continue to provide information on the diseases and preventive care services that are measured, plus an overview of the doctor's role and the patient's role in caring for the patient's condition. We also use a "star system" so visitors to the Web site can see whether a medical group's performance on a particular measure was above, within or below the average range. We recorded more than 16,000 visits to our site in the month after the data were posted last year.

Today we are coming into our own. We've had numerous opportunities to learn from experience as we've grown and to implement our own cycle of improvement. This report is an excellent example of this process in action.

Key Findings

A few medical groups now have the highest rates across several measures while other medical groups have shown significant improvement over past years.

1. **Results for the Optimal Diabetes Care measure show slight improvement.**
   Achieving only slight improvements could be due to a change in the measurement specifications. The A1c level target tightened from less than or equal to 7 to less than 7 and the LDL less than 100 level had to be performed during the measure ment year only. Fairview Health Services set the Minnesota benchmark of 20 percent of diabetes patients in full compliance with all five components included in this all-or-none measure. Five medical groups had rates and confidence intervals that were fully above the medical group average:
   - Fairview Health Services
   - Neighborhood Health Care Network
   - Park Nicollet Health Services
   - Family HealthServices Minnesota
   - HealthPartners Medical Group

2. **Results for the Childhood Immunization (Combo 3) measure are up.**
   Combo 3 includes the pneumococcal conjugate vaccine. Last year, Combo 2 was reported instead of Combo 3 since this vaccine had just been added to the practice guidelines. Stillwater Medical Group set the top Minnesota benchmark of 91 percent of children under age two being up-to-date with all recommended immunizations. Eight medical groups had rates and confidence intervals that were fully above the medical group average:
   - Stillwater Medical Group
   - Aspen Medical Group
   - Park Nicollet Health Services
   - Mankato Clinic
   - CentraCare Health System
   - HealthPartners Medical Group
   - Affiliated Community Medical Centers
   - Children's Physician Network

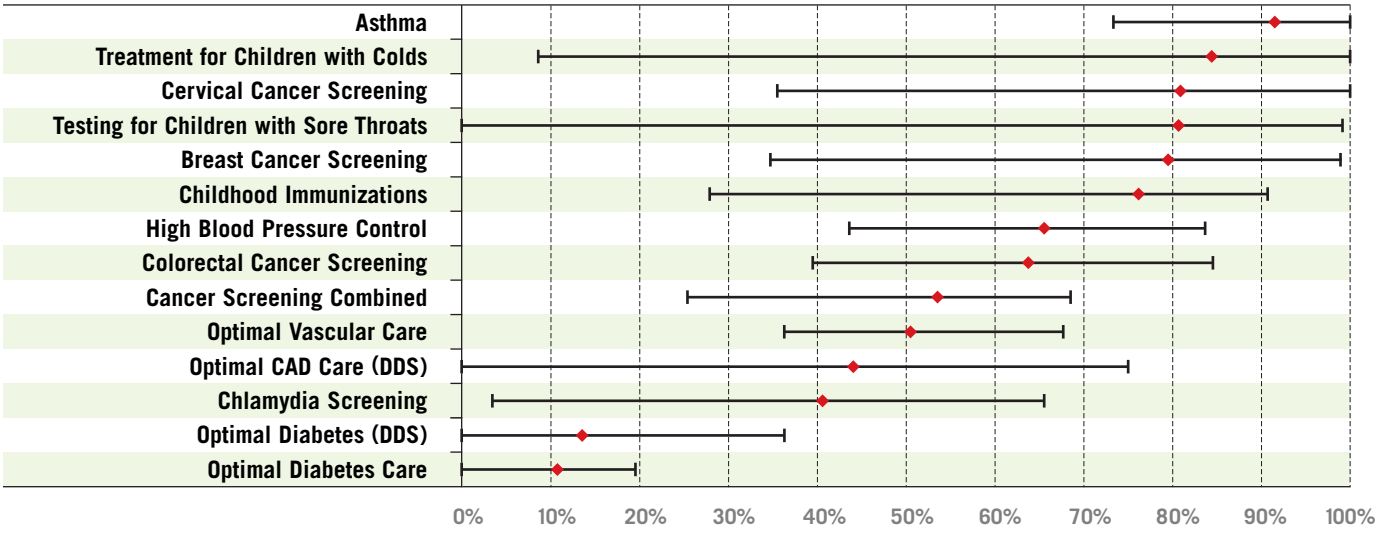
3. **Results for the Cancer Screening Combined measure are up slightly statewide.**
   HealthPartners Central Minnesota Clinics established the Minnesota benchmark of 69 percent of patients compliant with all three cancer screenings (breast, cervical and colorectal). Four medical groups had rates and confidence intervals that were fully above the medical group average:
   - HealthPartners Central Minnesota Clinics
   - Park Nicollet Health Services
   - HealthPartners Medical Group
   - Hennepin County

4. **The new Optimal Vascular Care measure showed that, statewide, more than 39 percent of patients with vascular disease received optimal care.**
   Quello Clinic established the Minnesota benchmark of 68 percent of patients with vascular disease achieving all four components included in this all-or-none measure. A total of four medical groups had rates and confidence intervals that were fully above the medical group average:
   - Quello
   - HealthPartners Medical Group
   - St. Paul Heart Clinic
   - Fairview Health Services
   - Park Nicollet Health Services

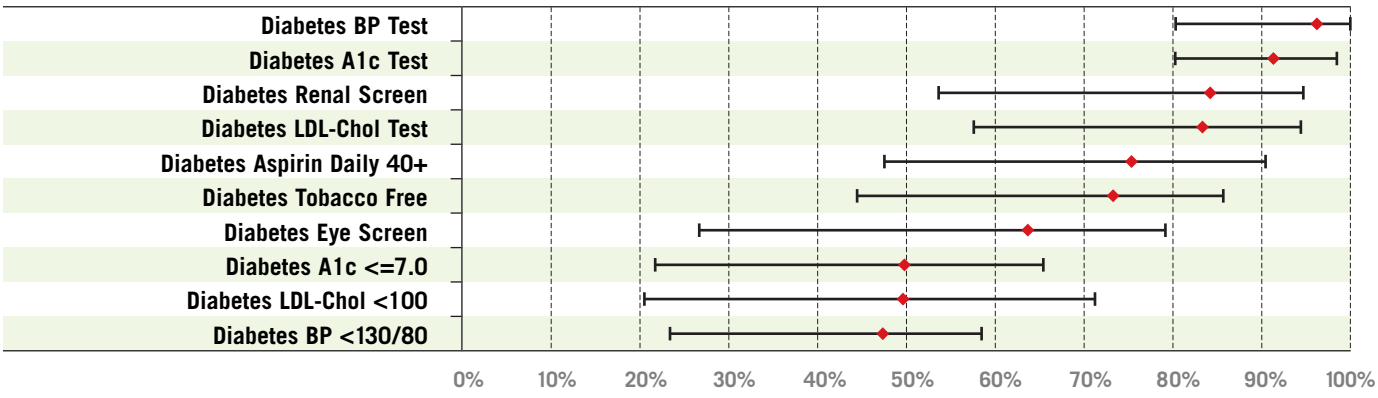
Practice Variation Continues

We continue to observe significant practice variation across medical groups for all measures. This variation in quality signals numerous opportunities for improvement applicable across the entire healthcare community.

All Measures - Practice Variation



Diabetes Care - Practice Variation



Medical Group Low/High ◆ Average

Changes in the 2007 report and Web site

There were several changes from last year's report:

- Two new measures were introduced: Optimal Coronary Artery Disease (CAD) Care and Optimal Vascular Care.
- A new process was piloted for medical groups to submit data directly to MNCM, allowing for timely clinic level reporting. This process was voluntary and was applied to two measures in 2007: Optimal Diabetes Care and Optimal CAD Care.
- Twenty three medical groups – representing more than 191 clinics – participated in the direct data submission process for the Optimal Diabetes Care measure; twenty eight medical groups – representing 160 clinics – were reported for the Optimal CAD Care measure.
- More medical groups were reported: 90 primary care groups; 20 obstetrics/gynecology clinics; 13 urgent care/convenience care clinics; 3 cardiology groups and 2 endocrinology clinics. A total of 128 groups participated in this year's report, up from 103 in 2006.
- Cardiology clinics were included in the report for the first time for the Optimal Vascular Care and Optimal CAD Care measures.
- The patient attribution process was revised for the Optimal Diabetes Care measure to better align with the Reporting Advisory Committee's recommendation to assign responsibility for coordination of diabetes care to the primary care clinics; although in some cases, a specialist (endocrinologist) may be responsible for the care. The goal is to attribute as many patients as possible to the appropriate entity.
- The measures for Well Child Visits and Depression Care were retired in order to focus more on outcomes measures.
- The adequately controlled A1c level for the Optimal Diabetes Care measure changed from less than or equal to 7 to less than 7 to align with guidelines.
- Within the Optimal Diabetes Care measure, the LDL less than 100 component had to be performed during the measurement year only. In past years, it could be performed in the measurement year or in the year prior.
- Reporting of the Childhood Immunization Combo 2 was discontinued. Combo 3, which is now reported to align with guidelines, includes the pneumococcal conjugate vaccine.
- Reporting of the old targets for the Optimal Diabetes Care measure was discontinued to align with guidelines.
- Reporting of the Controlling High Blood Pressure measure of less than or equal to 140/90 was discontinued and less than 140/90 is reported as a new measure since the age parameters were lowered to 18-85 (formerly 46-85).
- For the Chlamydia Screening in Women measure, technical coding issues continued for some medical groups so their rates were suppressed again for 2007.
- Navigation and design improvements were made to the MNCM Web site, www.mnhealthcare.org.
- A new micro Web site – www.theD5.org – was launched October 1. It focuses solely on the clinic-level Optimal Diabetes Care results and responds to consumer feedback by targeting diabetes information to patients with diabetes.

Data Sources and Data Collection

Health plan data sources and data collection process

The majority of data used for this report are derived from administrative billing data from health plans and/or medical record review. The data set reflects patients enrolled in managed care plans including commercial HMO/POS/PPO products, Medicare (cost and risk products), and Minnesota Public Health Care Programs (Prepaid Medical Assistance, MinnesotaCare and General Medical Assistance Care products) from 10 reporting health plans and county-based purchasing organizations. The data does not include the uninsured, patients who pay out-of-pocket, or patients covered by Medicaid/Medicare fee-for-service products. However, we may add Medicare fee-for-service data for relevant measures in the future.

These data are collected by the health plans in a standard way using the Health Plan Employer Data and Information Set (HEDIS) *2007 Technical Specifications*. Our reporting cycle is annual, consistent with the HEDIS data collection and reporting cycle. HEDIS is produced and maintained by the National Committee of Quality Assurance (NCQA), a private, non-profit organization dedicated to improving health care quality. The following organizations made a significant commitment of resources to collect and aggregate their data for purposes of public reporting:

- Blue Cross and Blue Shield of Minnesota
- FirstPlan of Minnesota
- HealthPartners
- Medica
- Metropolitan Health Plan
- PreferredOne
- Sanford Health Plan
- PrimeWest Health System
- South Country Health Alliance
- UCare

The resources required to collect, aggregate and report accurate measures are significant. Validation processes are part of the data collection, aggregation and reporting phases, which occur before results are published. All organizations are audited by a certified HEDIS auditor.

Medical group data sources and data collection process

In 2007, MNCM piloted a direct data submission (DDS) process with medical groups for two measures – Optimal Diabetes Care and Optimal Coronary Artery Disease (CAD) Care. In February 2007, medical groups were invited to submit data directly to MNCM for the Optimal Diabetes Care measure. Twenty-three medical groups – representing 191 clinics – voluntarily participated in this pilot. The benefits of this new DDS process include the following:

- **Performance results represent a clinic's complete population of patients.** Medical groups identified either a representative sample of patients with diabetes on their current panel of patients or they sent data on their entire population of patients with diabetes.

- **Reporting by clinic site.** We can now report the Optimal Diabetes Care measure on 191 individual clinic sites of the participating medical groups.

- **Reporting is faster.** This process allowed earlier reporting – more than three months earlier – than the health plan data collection process. We expect to shorten the reporting cycle time even further next year.

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Data Sources and Data Collection

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After data were submitted, site visits were conducted by medical groups to validate results. In July, we released the new direct data submission (DDS) Optimal Diabetes Care results on our Web site. With the successful completion of the DDS process for the Optimal Diabetes Care measure, we moved forward with a second measure – Optimal Coronary Artery Disease (CAD) Care. We introduced the specifications for this new measure to medical groups with a Learning Summit in June 2007.

The Optimal CAD Care results also represent 2006 dates of service. Like Optimal Diabetes Care, it is an all-or-none measure adapted from a measure endorsed by the National Quality Forum (NQF). The numerator components are: LDL level <100; blood pressure <140/90; daily aspirin use; and documented tobacco free. In the 2008 reporting year on care delivered in 2007, the blood pressure component will be aligned with the ICSI guideline at <130/80.

The Optimal CAD Care measure was also the first to be collected through MN Community Measurement's Internet portal. Once again, MNCM encouraged medical groups to submit data for their entire CAD population, even if their entire patient population per clinic was less than 60. Otherwise, if medical groups chose to submit a sample of their patient population, they had to submit a minimum sample of 60 patient records for each clinic site.

We intend to build upon this DDS process with the medical groups in 2008 and beyond. We have invested in an Internet portal for data submission and tested it with the CAD measure. We are currently working on our third measure for DDS – depression care – with medical group submission in 2008.

Measures

The *2007 Health Care Quality Report* relies primarily on HEDIS measures that are aligned with clinical guidelines established by Minnesota's own Institute for Clinical Systems Improvement (ICSI). HEDIS is a national set of standardized performance measures originally designed for the managed care industry. The measures have been adapted for use by MN Community Measurement as a way to track the performance of medical groups.

The 2007 measures were set with the advice of our Reporting Advisory Committee. Table 1 *(page 14)* lists the measures that are continuing from previous years, new for our 2007 reporting cycle, retired since last year or coming in the future. Two measures – High Blood Pressure Control and Childhood Immunizations (Combo 3) – were included in the past but are reported as new measures because of significant specification changes.

We retired the Well Child Visits and Depression Care measures in order to focus more on outcomes measures. We retired Optimal Diabetes Care (Old Targets) to provide focus on the diabetes measure that is aligned with current guidelines. We added two cardiovascular care all-or-none measures. Rates for the new Optimal Vascular Care measure were calculated using data collected from the health plan process. Rates for the new Optimal CAD Care measure were calculated using data submitted directly from medical groups. In 2008, the Optimal CAD Care (DDS) measure denominator will broaden and it will be renamed Optimal Vascular Care.

In 2008, we will begin collecting outcome-based depression measures through our direct data submission process. These measures are based on the PHQ-9 patient survey, a tool that helps clinicians assess the severity of a patient's depression and changes over time. Such a measure will more closely reflect the treatment goals that both patients and their physicians have for this condition. This new measure will also enable us to align with the improvement efforts for depression care that are being developed over the next two years as a collaboration among the Institute for Clinical Systems Improvement (ICSI), the health plans, the Minnesota Department of Human Services and several medical groups in Minnesota.

Although this report does not address hospital, nursing home or other settings of care, these areas are being considered for future reports. Our vision is to be the trusted source for performance measurement and public reporting of quality data across all settings of health care.

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Continuing for 2007:

- Asthma
- Cancer Screening:
  - Breast
  - Cervical
  - Colorectal
  - Cancer Screening Combined *(Ages 50–80)*
- Childhood Immunization *(Combo 3)*
- Chlamydia Screening
- Controlling High Blood Pressure *(new target)*
- Optimal Diabetes Care*
- Pharyngitis *(sore throats)*
- Upper Respiratory Infection *(URI)*

New in 2007:

- Optimal Vascular Care
- Optimal Coronary Artery Disease (CAD) Care**

Recently Retired:

- Childhood Immunization *(Combo 2)*
- Depression Medication Management
- High Blood Pressure – *(old target)*
- Optimal Diabetes Care *(old targets)*
- Well Child Visits

Coming in 2008:

- Depression** *(2008)*
- Patient Experience*** *(2008)*
- Health Information Technology** *(2008)*

Future:

- CAD re-named Optimal Vascular Care**
- Asthma all-or-none measure**
- Specialty measure
- Cost of care/resource use
- Other care settings

Rates calculated using either claims data alone or medical record review data collected by health plans, with the following exceptions:

* Rates calculated using medical record review data collected by health plans AND data submitted directly from medical groups.

** Rates calculated using data submitted directly from medical groups.

*** Rates calculated using survey data.

Methodology

Health plan methodology

HEDIS measures are calculated using either an administrative method or a hybrid method. Administrative methodology requires health plans to identify the denominator and numerator using their administrative databases. The denominator includes all eligible patients as defined by criteria for each measure. Rates are calculated based on all patients who meet the denominator criteria and who are found through administrative data to have received the service identified in the numerator criteria. A minimum threshold of 30 patients per group was established for public reporting of the measures. These measures include:

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with URI
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Use of Appropriate Medications for People with Asthma

Hybrid methodology requires health plans to identify the numerator through both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Rates are calculated based on all patients in the sample who are found through either administrative or medical record data to have received the service identified in the numerator. For each hybrid measure, a target of 60 patients per medical group was set as the minimum sample size.

The hybrid measures include:

- Cancer Screening Combined for Ages 50–80
- Childhood Immunizations
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Optimal Diabetes Care
- Optimal Vascular Care

Again in 2007, a two-stage, random sample was drawn. This strategy was designed with statisticians to ensure reporting for the maximum number of medical groups while minimizing the impact of weighting on the results. As in previous years, NCQA conducted the sampling process for all hybrid measures. The data indicated the medical group to which the patient was attributed and whether that person had been selected for the health plan's HEDIS sample.

Health plans assigned patients to a medical group using logic based on Evaluation and Management codes. These codes identified the frequency of patient visits to a certain medical group. A patient was attributed to the medical group they had visited most frequently during the measurement year. If a patient visited two or more groups with the same frequency, they were attributed to the medical group visited most recently. The patient attribution process was revised for the Optimal Diabetes Care measure to better align with the Reporting Advisory Committee's recommendation to assign responsibility for coordination of diabetes care to the primary care clinics; although in some cases, a specialist (endocrinologist) may be responsible for the care. The goal was to attribute as many patients as possible to the appropriate entity.

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Methodology

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The sampling procedure started with the health plans providing NCQA with a data file containing a record for each eligible patient for each hybrid measure. The file identified eligible patients who were included in the HEDIS sample selected by the plans.

Next, the HEDIS sample was supplemented with an additional sample for medical groups that did not meet 60 patients with the HEDIS sample alone. The supplemental sample was allocated across the health plan/health plan product/medical group strata to attain at least 60 observations per medical group for those groups where the total HEDIS sample across all plans fell short. The supplemental sample was selected randomly with the SAS SURVEYSELECT procedure, using the sample sizes for each stratum determined in the previous step. Patients who were included in a health plan's HEDIS sample were not eligible for the supplemental sample.

Results were weighted to get accurate rates. This allowed for aggregation and unbiased reporting by medical group. Weighting is a cost-saving measure that allowed us to draw a sample from which to estimate medical group and statewide rates. Weighting does not affect results; it was applied to efficiently utilize health plan resources for data collection. The weight was calculated for each sampling stratum (i.e. health plan/health plan product/medical group combination) and was equal to the total eligible population for that stratum divided by the total sample size (i.e. HEDIS sample plus supplemental sample) for that stratum. During analysis, for any population that a rate is desired – for example, a medical group or statewide – the denominator is the sum of the weights for all patients in that population. The numerator is the sum of the weights for patients in the population that meet the numerator criteria. Rates and 95 percent asymmetrical confidence intervals were calculated for each measure for all medical groups.

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. 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.

Medical group methodology

For the direct data submission pilot process, MNCM gave medical groups guidelines for both measures (Optimal Diabetes Care and Optimal CAD Care) to identify the measure denominators for consistency from group to group. The guidelines included directions on the look back timeframe to identify current patient panels, number of visits needed in the measurement timeframe, and ICD-9 codes to pull from their business practice management systems or electronic health records (EHR).

Medical groups were required to report data to MNCM for each clinic site where care was provided for their patient panel. Medical groups attributed patients to physicians and physicians to clinic. Each medical group's attribution method was reviewed by MNCM as part of the field validation process.

Medical groups could decide whether to send full population data or a sample. For medical groups that wished to submit a sample, data submission guidelines were given on the accepted methodologies to select a systematic or a random sample. For the Optimal Diabetes Care measure, the minimum sample size per clinic site was

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Methodology

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100 observations (or their entire population if the clinic had fewer than 100 patients) and for CAD the minimum sample size per clinic site was 60 observations (or full population if fewer than 60 patients were identified per clinic).

Most medical groups that submitted full population data for all of their clinics had either a clinical registry or an EHR with data spanning the measurement timeframe. MNCM provided an Excel worksheet for the medical groups to submit data in a standard file format.

Performance results were calculated and are reported on the MNCM Web site at the clinic level. For the Optimal Diabetes Care pilot, a 95 percent confidence level was calculated only for clinic sites that submitted a sample and no minimum population size was established for the public reporting of the clinic site level results. For the Optimal CAD Care measure, a 95 percent confidence level was calculated for clinic sites that submitted a sample or full population data, and a minimum population size of 30 was established for public reporting. Confidence intervals provide the range into which a rate would fall 95 percent of the time based on normal approximation.

MN Community Measurement 2007 Summary of Statewide Results

2006 Dates of Services

Quality Measure	Statewide Average	95% CI	Eligible Population	Page
Calculated Using Direct Data Submission by Medical Groups				
Optimal Diabetes Care	13.5%*	13.3% - 13.8%	85,225	19
Optimal Coronary Artery Disease (CAD) Care	45.1%*	44.4% - 45.9%	27,787	24
Calculated Using Data Collected by Health Plans				
"Living with Illness" measures				
Asthma Care				
Ages 5-56 (all ages)	91.3%	90.9% - 91.8%	14,722	29
Ages 5-17 (children)	94.6%	94.0% - 95.2%	4,962	30
Ages 18-56 (adults)	89.7%	89.0% - 90.3%	9,760	31
Optimal Diabetes Care	10.5%*	9.9% - 11.1%	50,037	33
A1c <7.0	51.3%*	50.4% - 52.3%	50,037	34
Blood Pressure <130/80	45.9%*	45.0% - 46.9%	50,037	35
LDL-C <100	48.1%*	47.1% - 49.0%	50,037	36
Daily Aspirin Use – Ages 41-75	73.9%*	73.0% - 74.7%	44,839	37
Documented Tobacco Free	71.7%*	70.9% - 72.6%	50,037	38
High Blood Pressure Control	65.5%*	64.5% - 66.4%	101,902	41
Optimal Vascular Care	38.9%*	37.5% - 40.3%	11,740	43
LDL-C < 100	63.9%*	62.5% - 65.3%	11,740	44
Blood Pressure <130/85	73.5%*	72.2% - 74.7%	11,740	45
Daily Aspirin Use	89.4%*	88.5% - 90.3%	11,740	46
Documented Tobacco Free	75.8%*	74.5% - 77.0%	11,740	47
"Getting Better" measures				
Appropriate Treatment for Children with URI	84.4%	84.0% - 84.7%	45,409	50
Appropriate Testing for Children with Pharyngitis	80.7%	80.2% - 81.1%	33,312	54
"Staying Healthy" measures				
Breast Cancer Screening (Mammograms)	75.5%	75.3% - 75.8%	99,295	58
Cervical Cancer Screening (Pap Tests)	77.6%	77.4% - 77.8%	243,056	62
Colorectal Cancer Screening	59.7%*	58.6% - 60.8%	234,131	65
Cancer Screening Combined – Ages 50-80 (breast, cervical, colorectal)	49.3%*	48.1% - 50.4%	234,131	67
Chlamydia Screening – Ages 16-25	40.8%	40.3% - 41.2%	45,212	70
Childhood Immunizations	74.4%*	73.2% - 75.5%	20,434	73

* These statewide averages are weighted.

Results by Measure (Clinic Level)

Optimal Diabetes Care

Optimal Diabetes Care (direct data submission by medical groups)

This measures the percentage of patients with diabetes (Type I and Type II) ages 18–75 who reached **all** of the following five treatment goals to reduce cardiovascular risk:

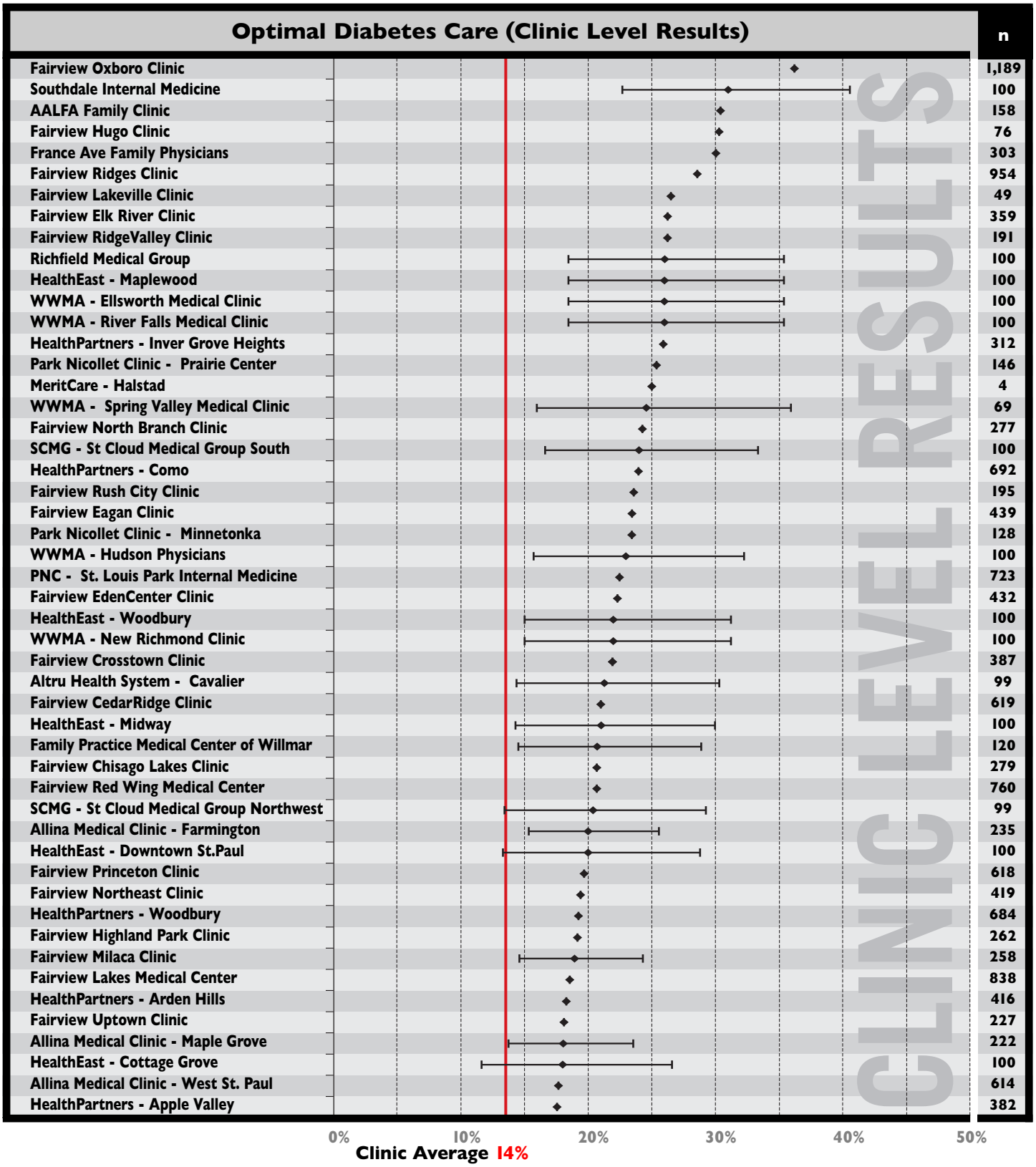
- Hemoglobin A1c (HBA1c) less than 7
- Blood pressure less than 130/80 mmHg
- LDL-cholesterol less than 100 mg/dl
- Daily aspirin use, ages 41–75
- Documented tobacco-free status

*This rate is calculated using an all-or-none method. Credit was given for achieving this measure when **all** five components were met for each patient. As a pilot project, confidence intervals were calculated only for clinics that submitted a sample. Confidence intervals provide the range of where a rate would fall 95 percent of the time base on normal approximation. In the future, confidence intervals will be calculated even for full population data because patient populations are dynamic, not static. The data for this measure are collected from medical groups and clinics.*

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal Diabetes Care	13.5%	13.3%- 13.8%	8,297	58,911	85,225

No trend chart – first year measure using data submitted directly from medical groups.

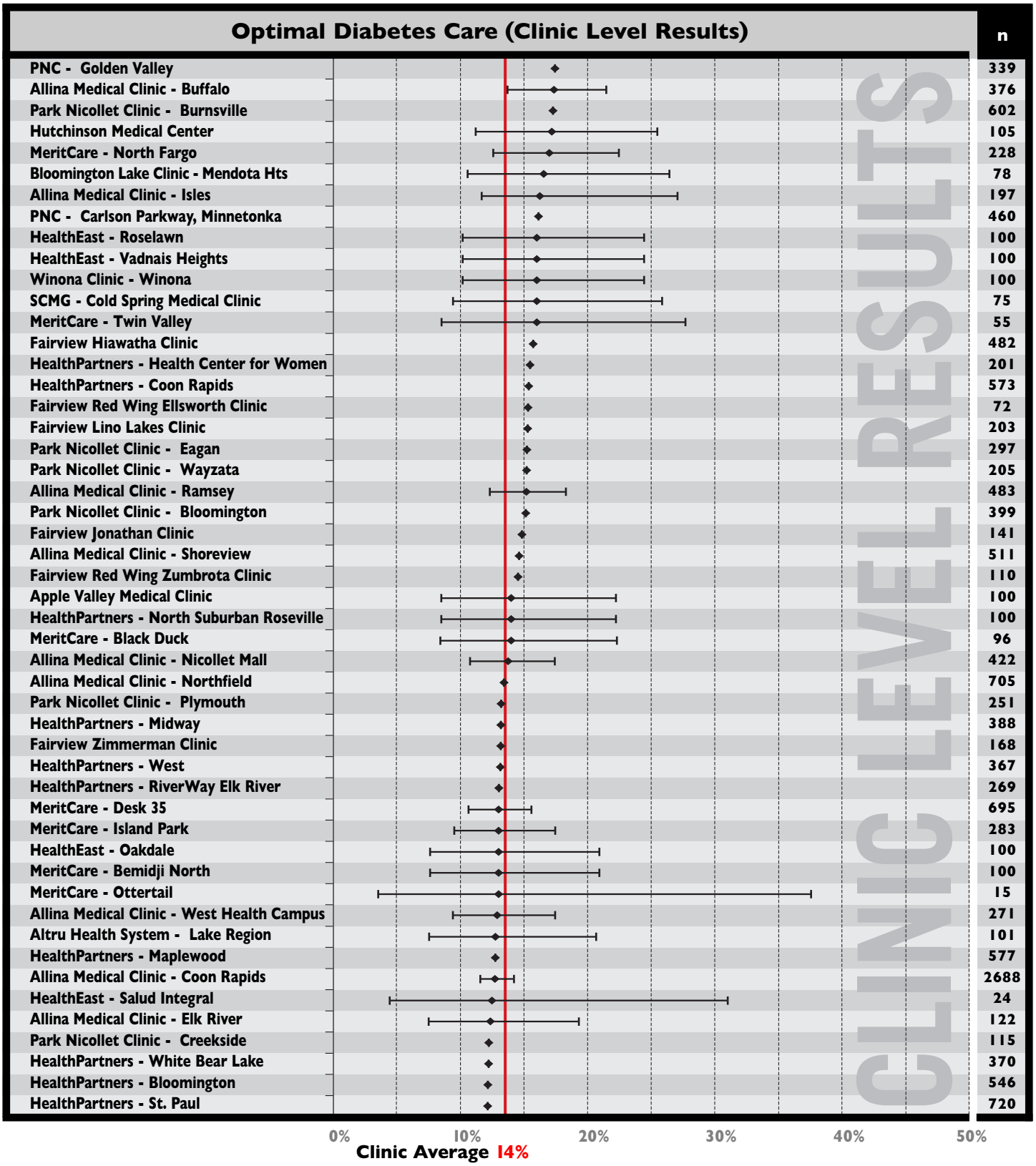
*Statewide averages include both health plan members who were attributed to a provider group AND health plan members who could not be attributed to a provider group. Provider group averages include only health plan members who were attributed to a provider group. Therefore, these averages may sometimes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



AMC - Allina Medical Clinic
AHS - Altru Health System
CPMG - Columbia Park Medical Group
FMC - Family Medical Center
HP - HealthPartners
PNC - Park Nicollet Clinic
SCMG - St. Cloud Med Group
WWMA - Western Wisconsin Medical Associates

Lower Confidence Level / Upper Confidence Level

Optimal Diabetes Care (Clinic Level Results)



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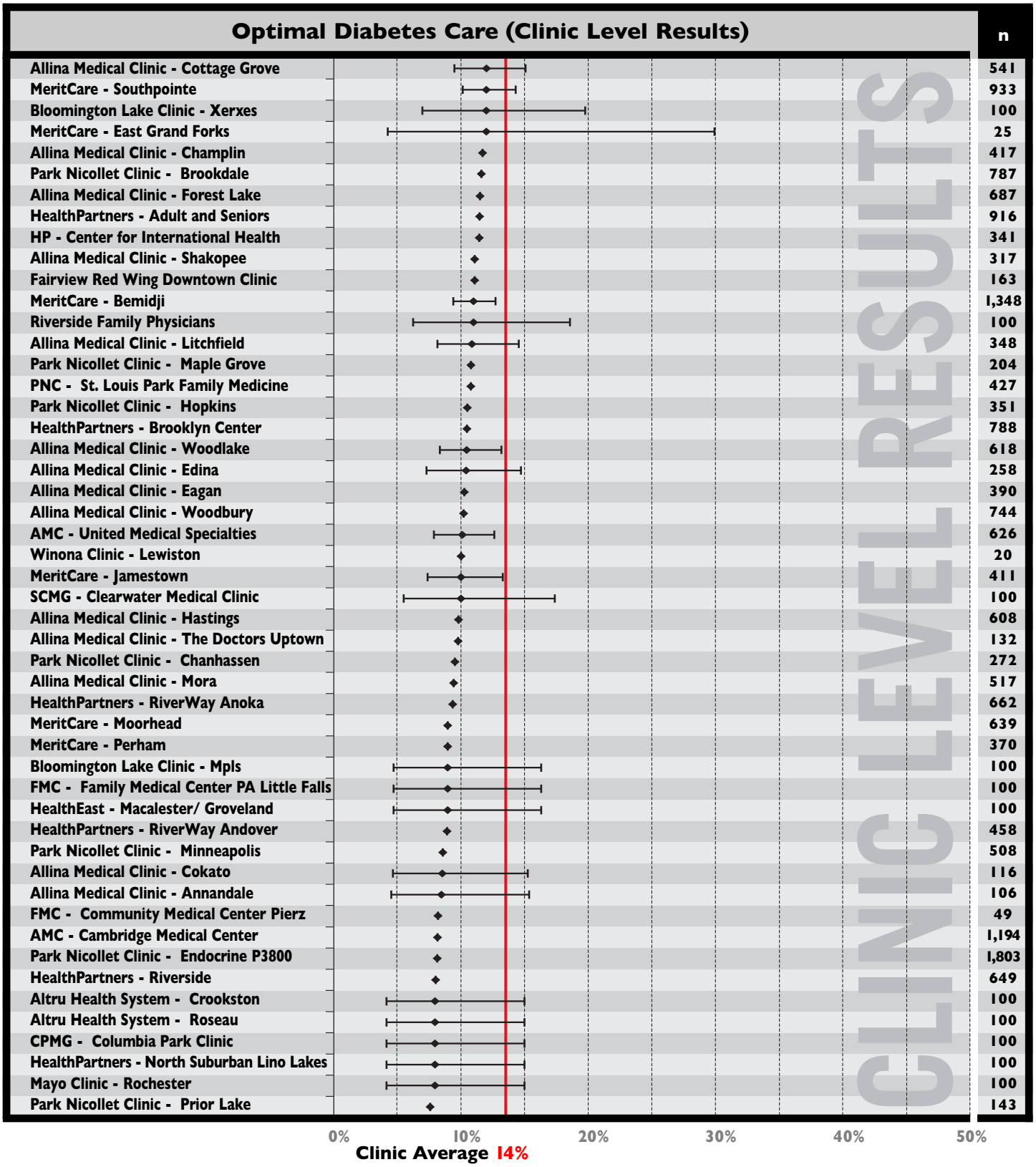
Lower Confidence Level / Upper Confidence Level

Optimal Diabetes Care (Clinic Level Results)



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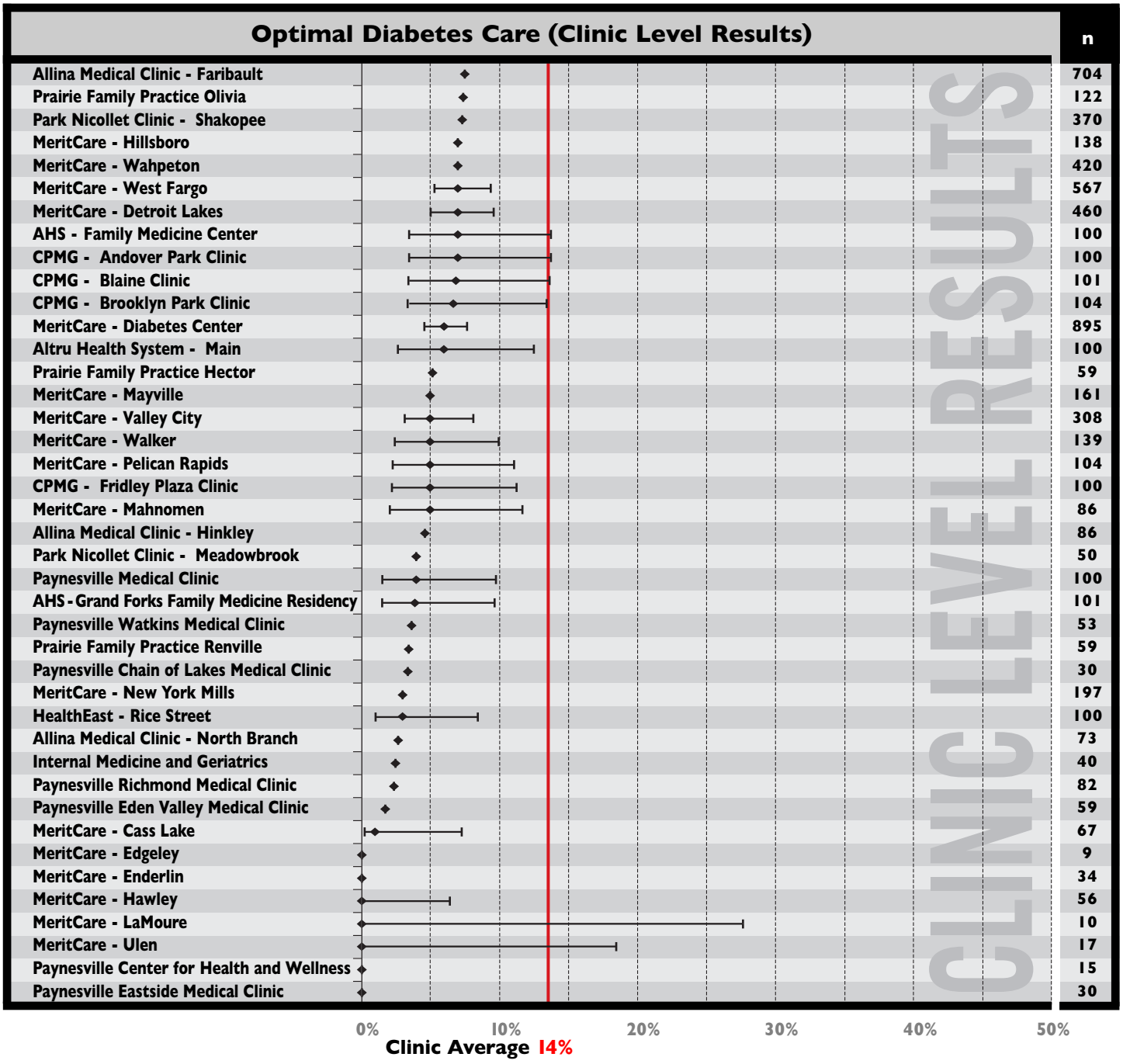
Lower Confidence Level / Upper Confidence Level



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Lower Confidence Level / Upper Confidence Level

Results by Measure (Clinic Level)

Coronary Artery Disease (CAD) Care

Optimal Coronary Artery Disease (CAD) Care (direct data submission by medical groups)

The percentage of patients, ages 18–75, with coronary artery disease who reached **all** of the following four treatment goals to reduce cardiovascular risk:

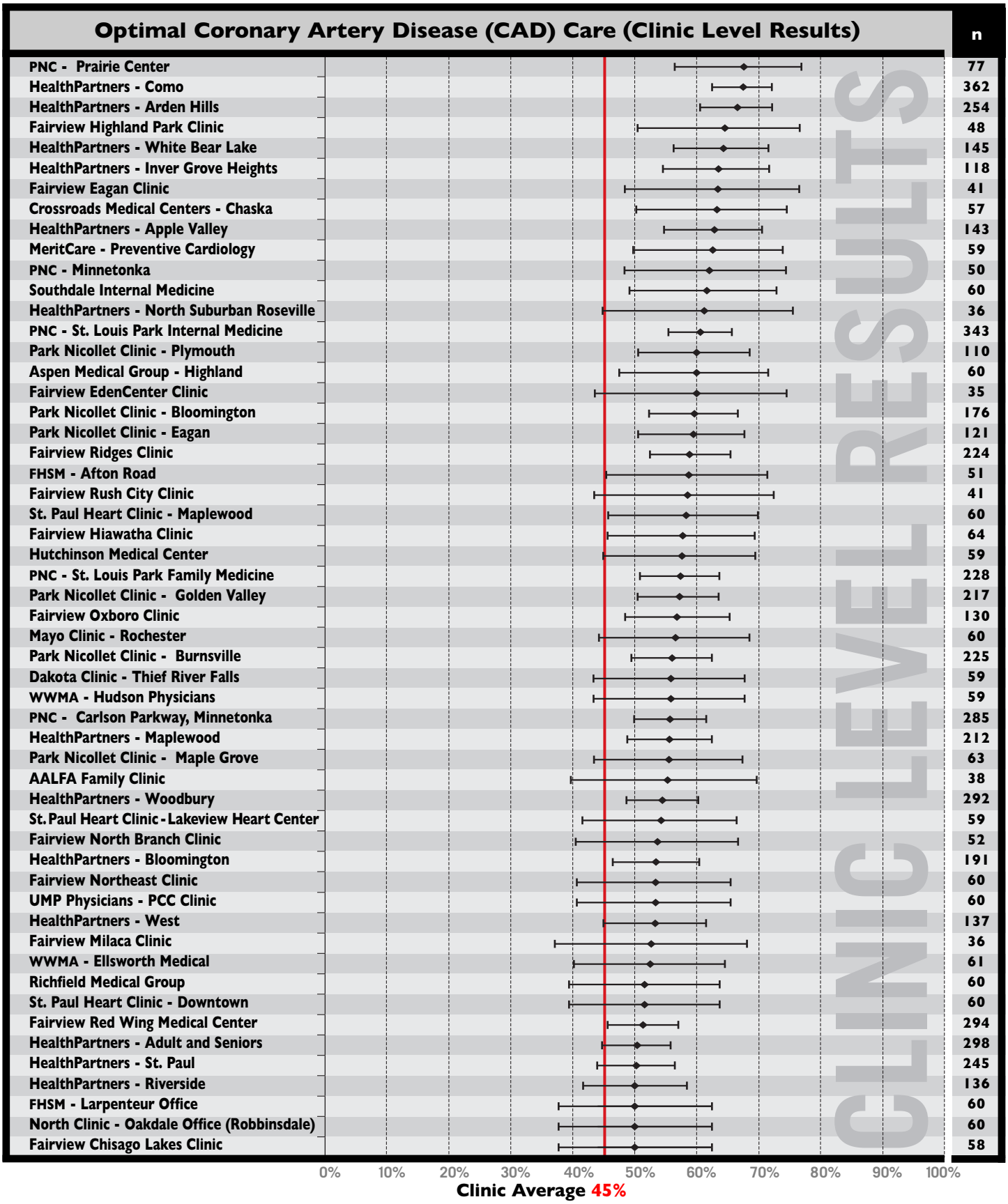
- Blood pressure less than 140/90 mmHg
- LDL-C less than 100 mg/dl
- Daily aspirin use
- Documented tobacco-free status

*This rate is calculated using an all-or-none method. Credit was given for achieving this measure when **all** four components were met for each patient. Confidence intervals were calculated for clinics that submitted a sample or full population data. Confidence intervals provide the range of where a rate would fall 95 percent of the time base on normal approximation. The data for this measure are collected from medical groups and clinics.*

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal CAD Care	45.1%	44.4%-45.9%	6,736	13,852	27,787

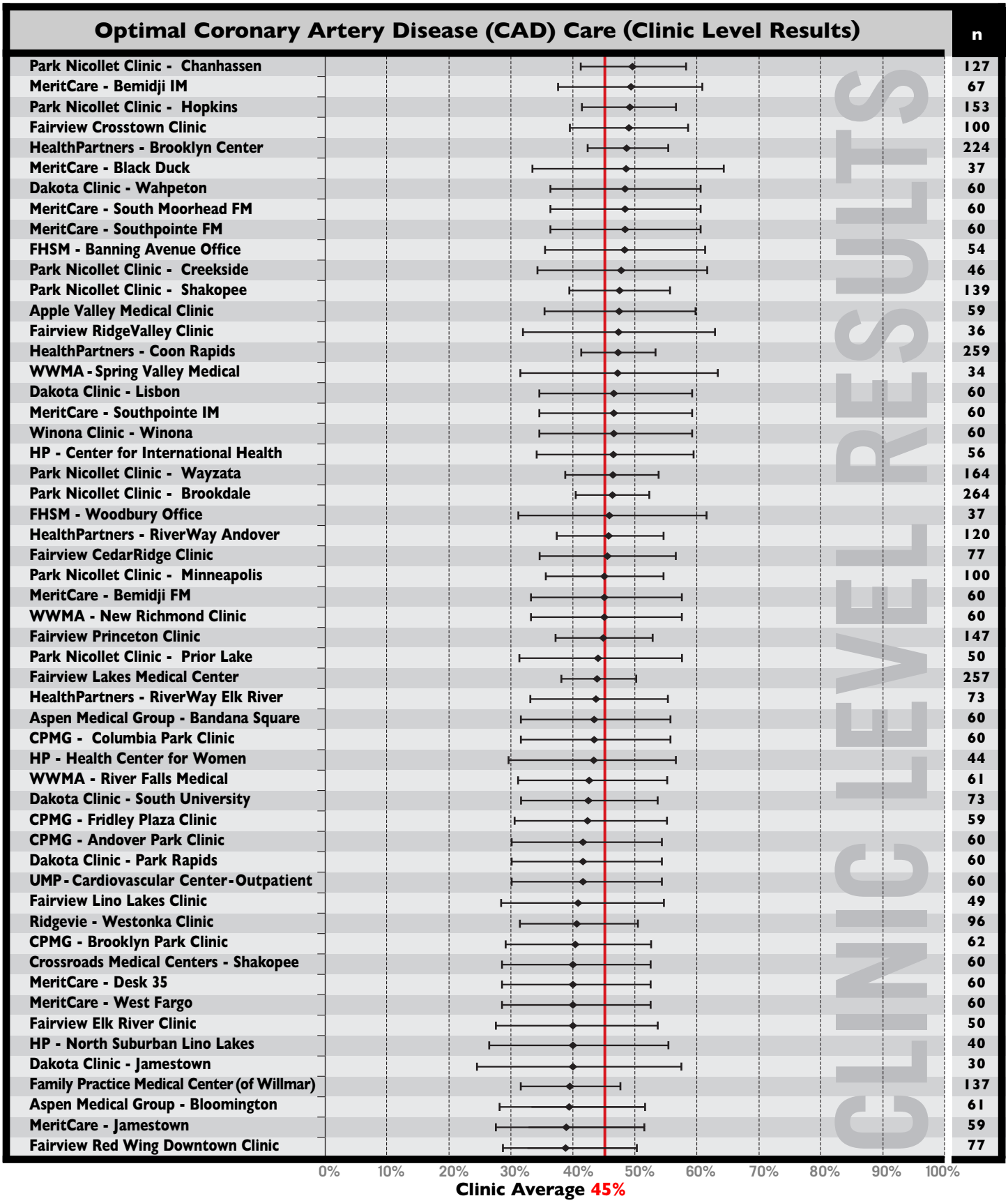
No trend chart – first year measure using data submitted directly from medical groups. Data audit will occur in October. Participating medical groups will view their results prior to reporting. A medical group comparison chart will be inserted after audit is completed.

*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.

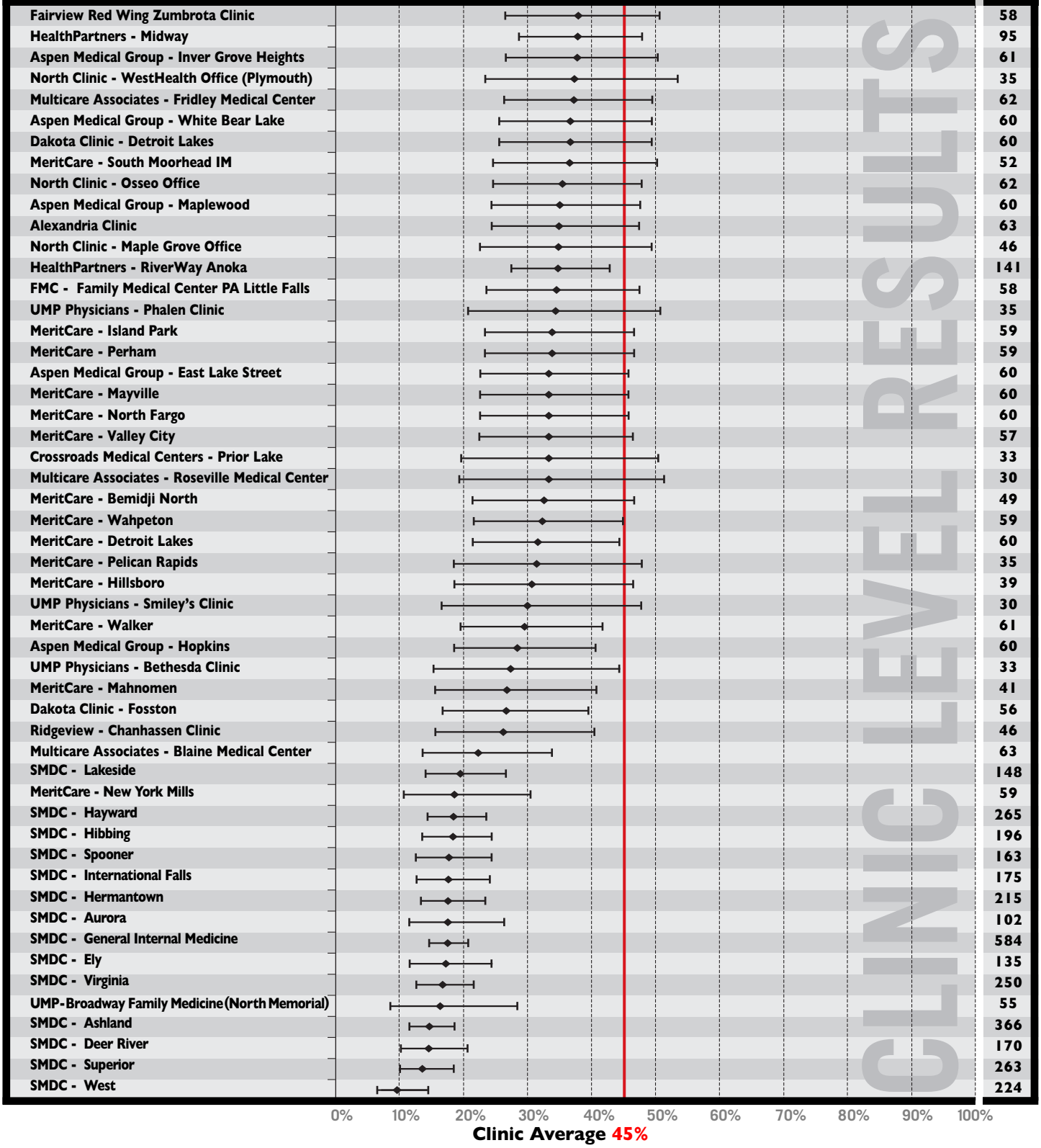


AMC - Allina Medical Clinic
AHS - Altru Health System
CPMG - Columbia Park Medical Group
FHSM - Family HealthServices Minnesota
FMC - Family Medical Center
HP - HealthPartners
PNC - Park Nicollet Clinic
SCMG - St. Cloud Med Group
SMDC - St. Mary's/Duluth Clinic
UMP - University of Minnesota Physicians
WWMA - Western Wisconsin Medical Associates

Lower Confidence Level / Upper Confidence Level



Optimal Coronary Artery Disease (CAD) Care (Clinic Level Results)



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Lower Confidence Level / Upper Confidence Level

Results by Measure (Medical Group Level)

"Living with Illness" measures

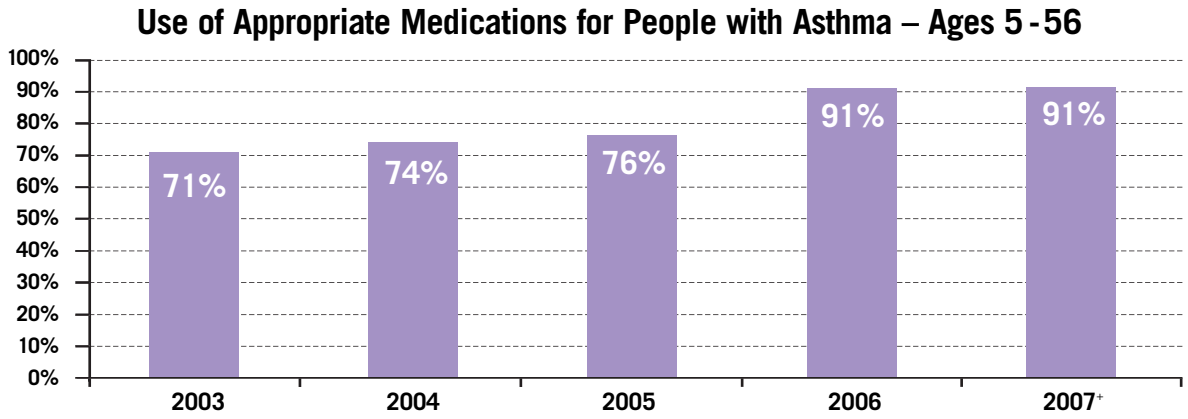
Asthma

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

This measures the percentage of patients ages 5–56 who were identified as having persistent asthma and who were appropriately prescribed medication.

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

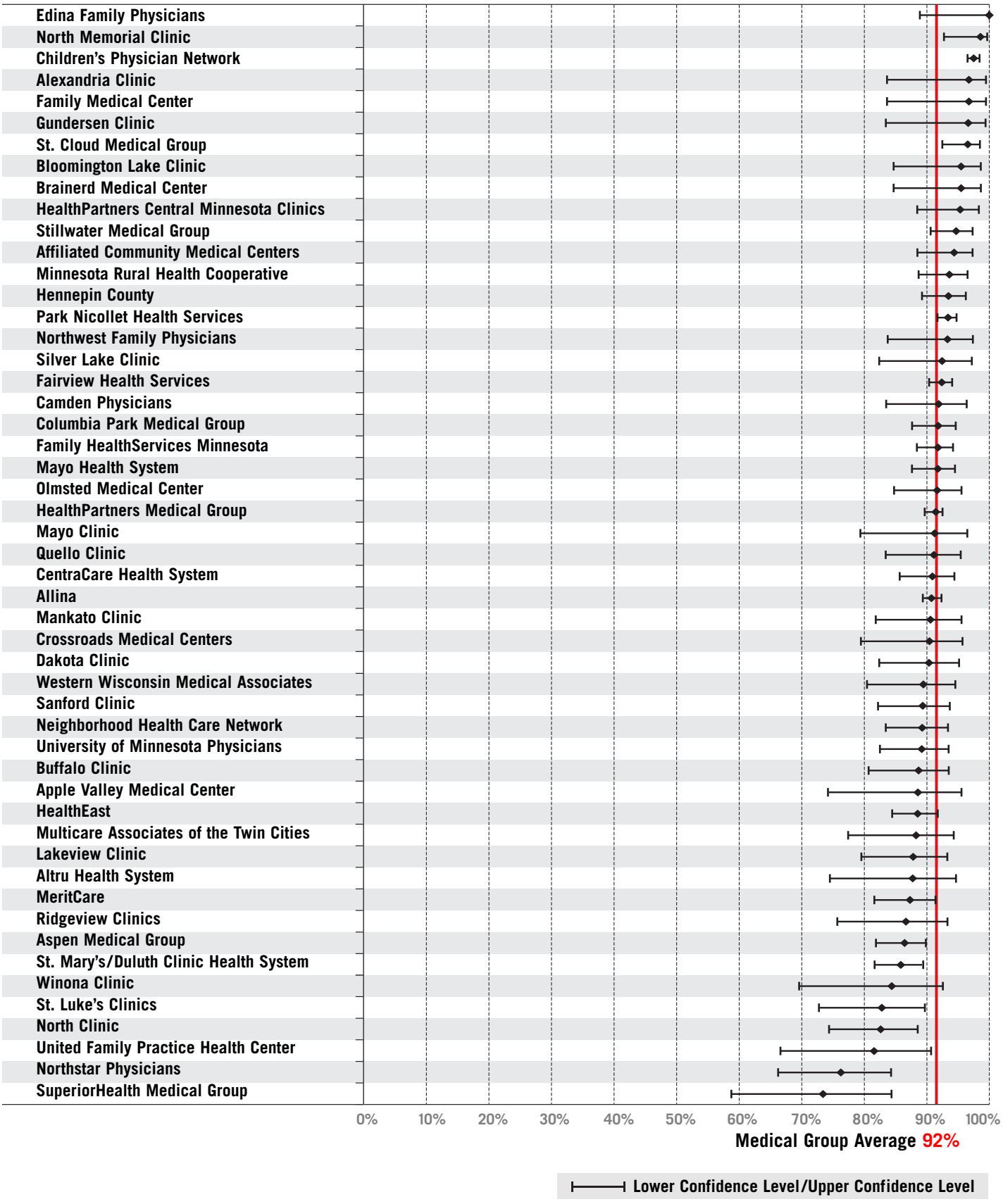
Use of Appropriate Medications for People with Asthma	Statewide Average*	95% CI	Numerator	Denominator
All Ages (5-56)	91.3%	90.9% - 91.8%	13,446	14,722
Ages 5-17	94.6%	94.0% - 95.2%	4,695	4,962
Ages 18-56	89.7%	89.0% - 90.3%	8,751	9,760



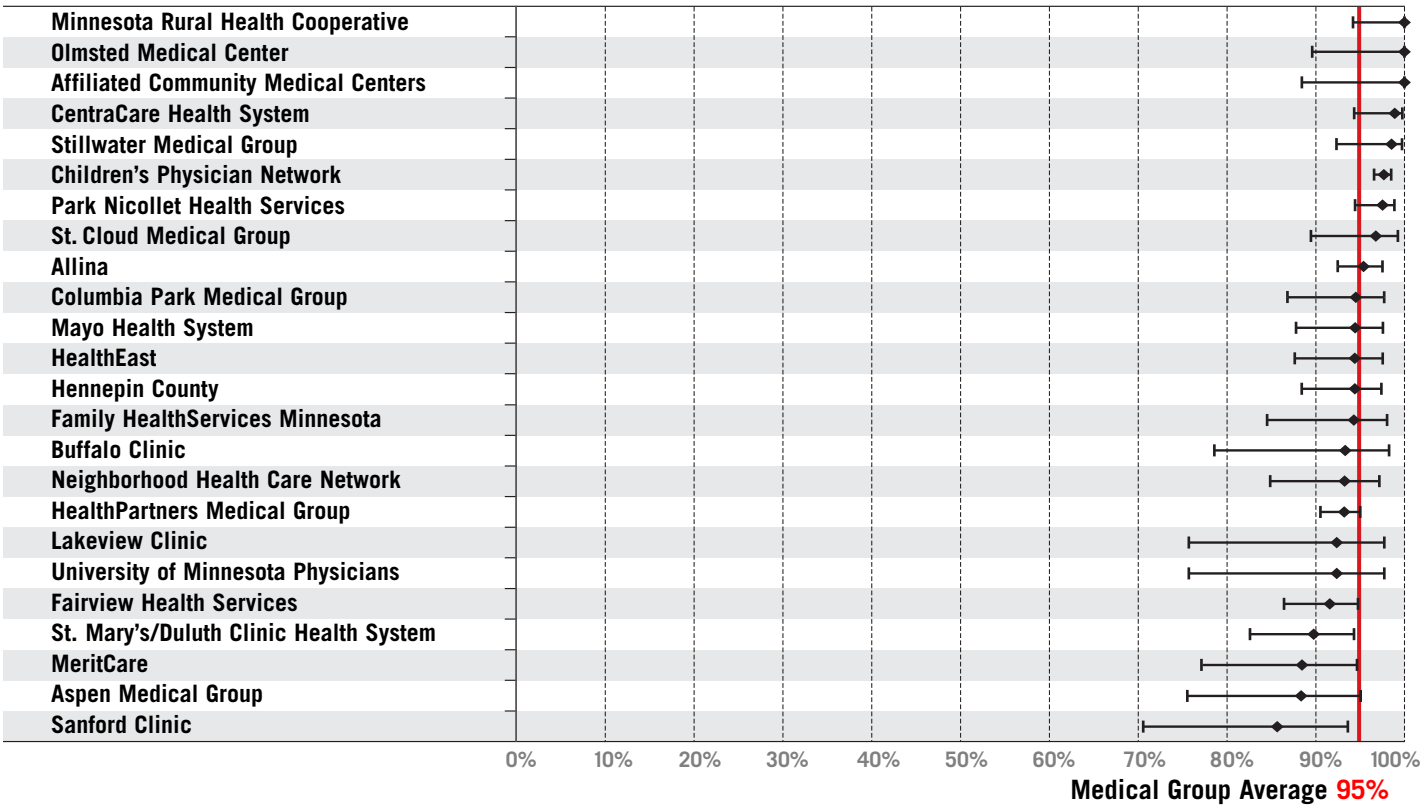
*Statewide averages (above) include both health plan members who were attributed to a medical group AND those who could not be attributed to a medical group. Medical group averages (located on the following pages) include ONLY health plan members who were attributed to a medical group. Therefore, these averages may differ.

+Note: Caution is needed when comparing 2007 rates 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.

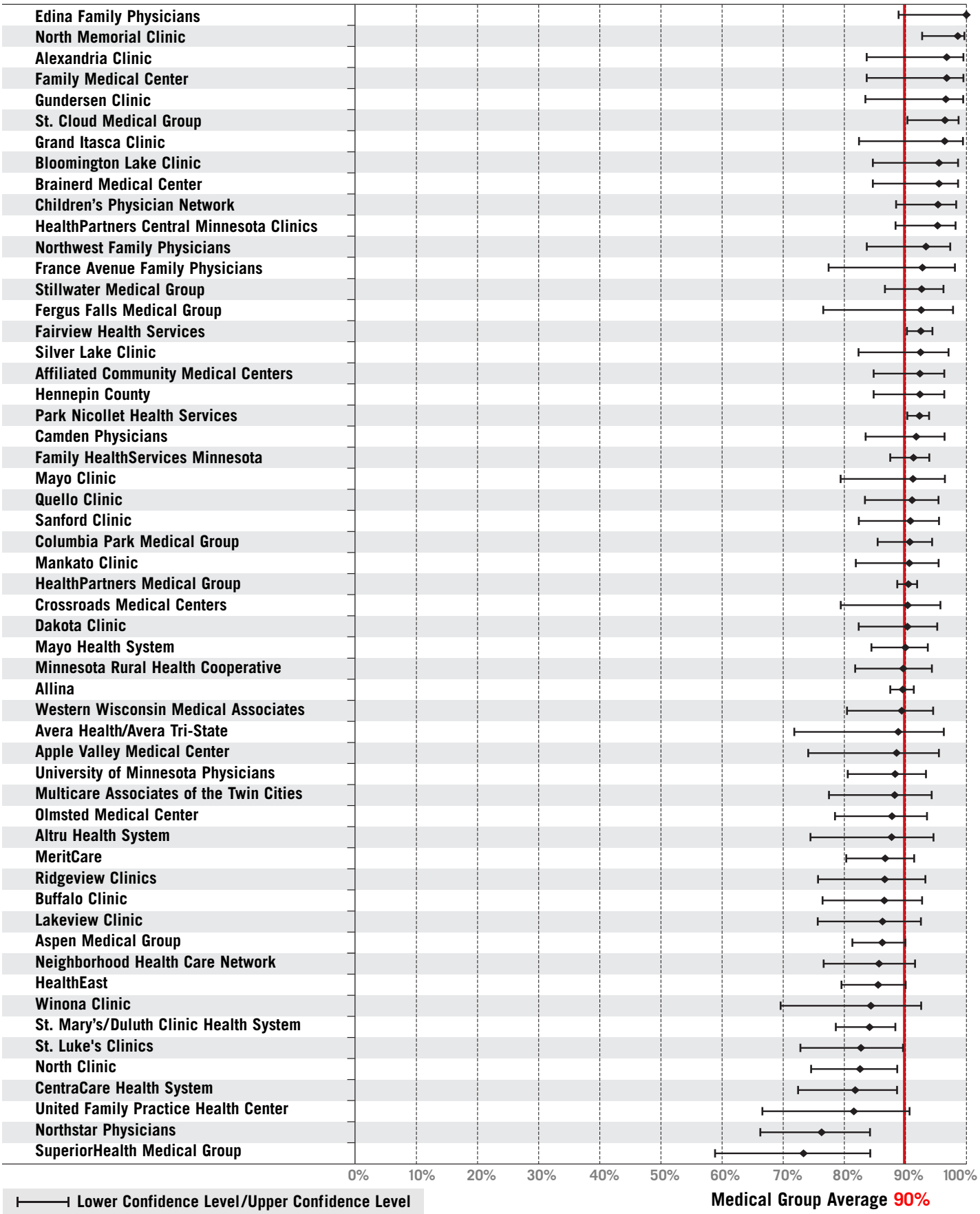
Use of Appropriate Medications for People with Asthma (Ages 5 - 56)



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



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



"Living with Illness" measures

Optimal Diabetes Care

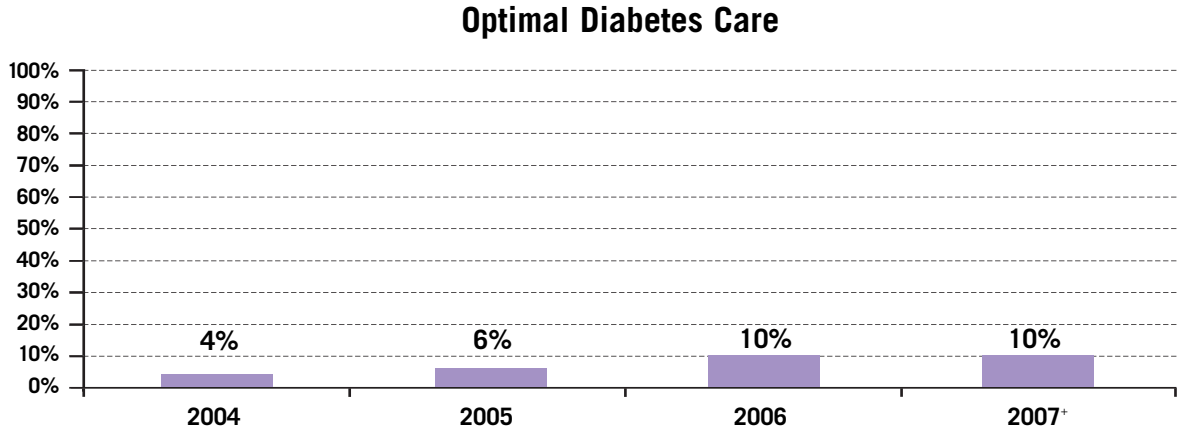
Optimal Diabetes Care

This measures the percentage of patients with diabetes (Type I and Type II) ages 18–75 who reached **all** of the following five treatment goals to reduce the risk of cardiovascular diseases:

- Hemoglobin A1c (A1c) less than 7
- Blood pressure less than 130/80 mmHg
- LDL-C less than 100 mg/dl
- Daily aspirin use, ages 41–75
- Documented tobacco-free status

*This rate is calculated using an all-or-none method. Credit is given for achieving this measure when **all** five components are met. The data collected for this measure are from health plan claims and medical record review.*

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal Diabetes Care	10.5%	9.9%-11.1%	950	10,440	50,037
A1c < 7	48.7%	47.7%-49.6%	8,848	10,440	50,037
BP <130/80	45.9%	45.0%-46.9%	6,702	10,440	50,037
LDL-C <100	48.1%	47.1%-49.0%	7,585	10,440	50,037
Daily Aspirin Use	73.9%	73.0%-74.7%	9,721	9,325	44,839
Documented Tobacco Free	71.7%	70.9%-72.6%	7,079	10,440	50,037



*Statewide averages (above) include both health plan members who were attributed to a medical group AND those who could not be attributed to a medical group. Medical group averages (chart pages) include ONLY health plan members who were attributed to a medical group. Therefore, these averages may differ.

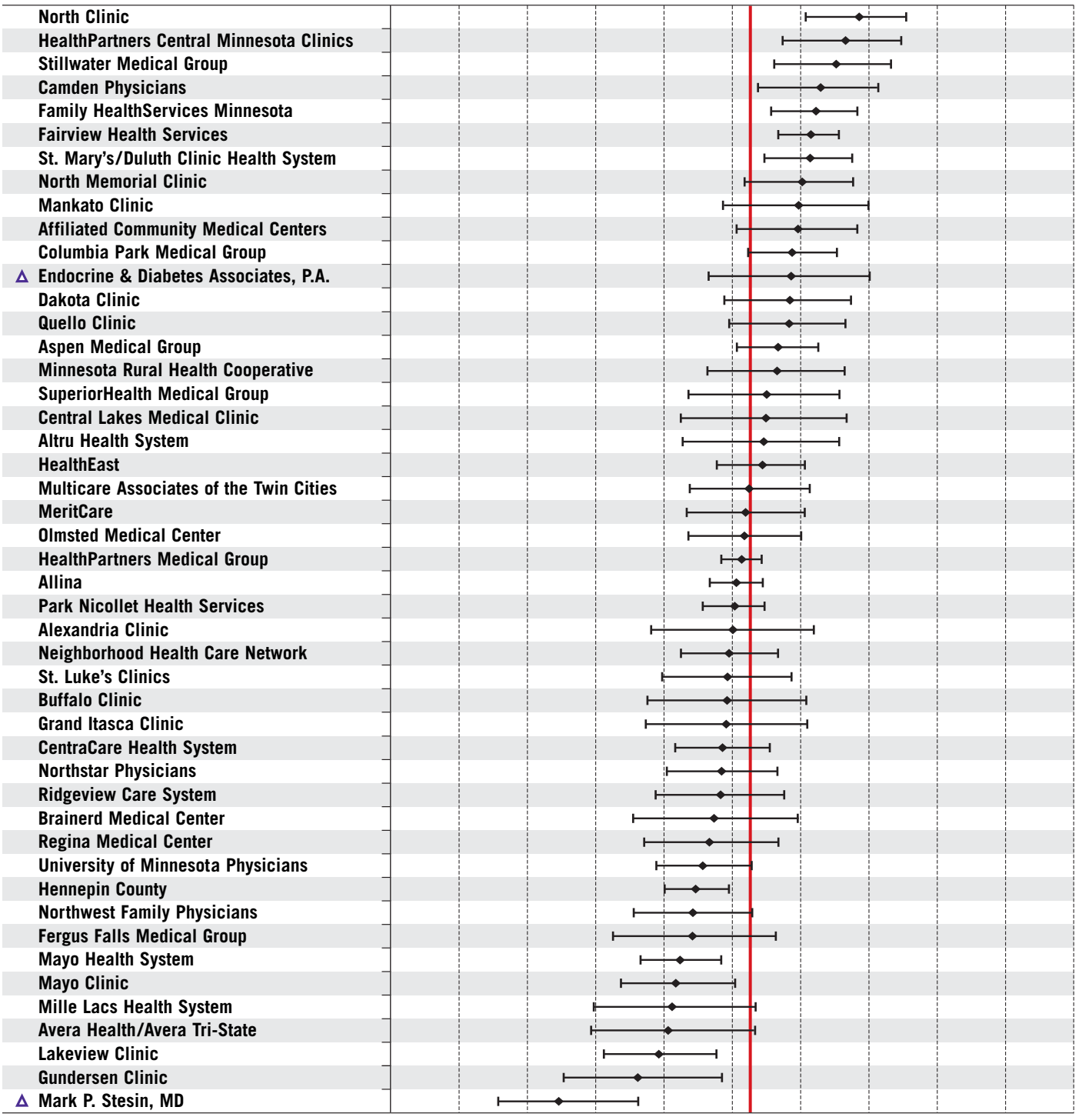
+Note: Caution is needed when comparing 2007 rates to previous years. In 2007, the measurement specifications changed for some of the individual components of the Optimal Diabetes Care composite measure.

Optimal Diabetes Care

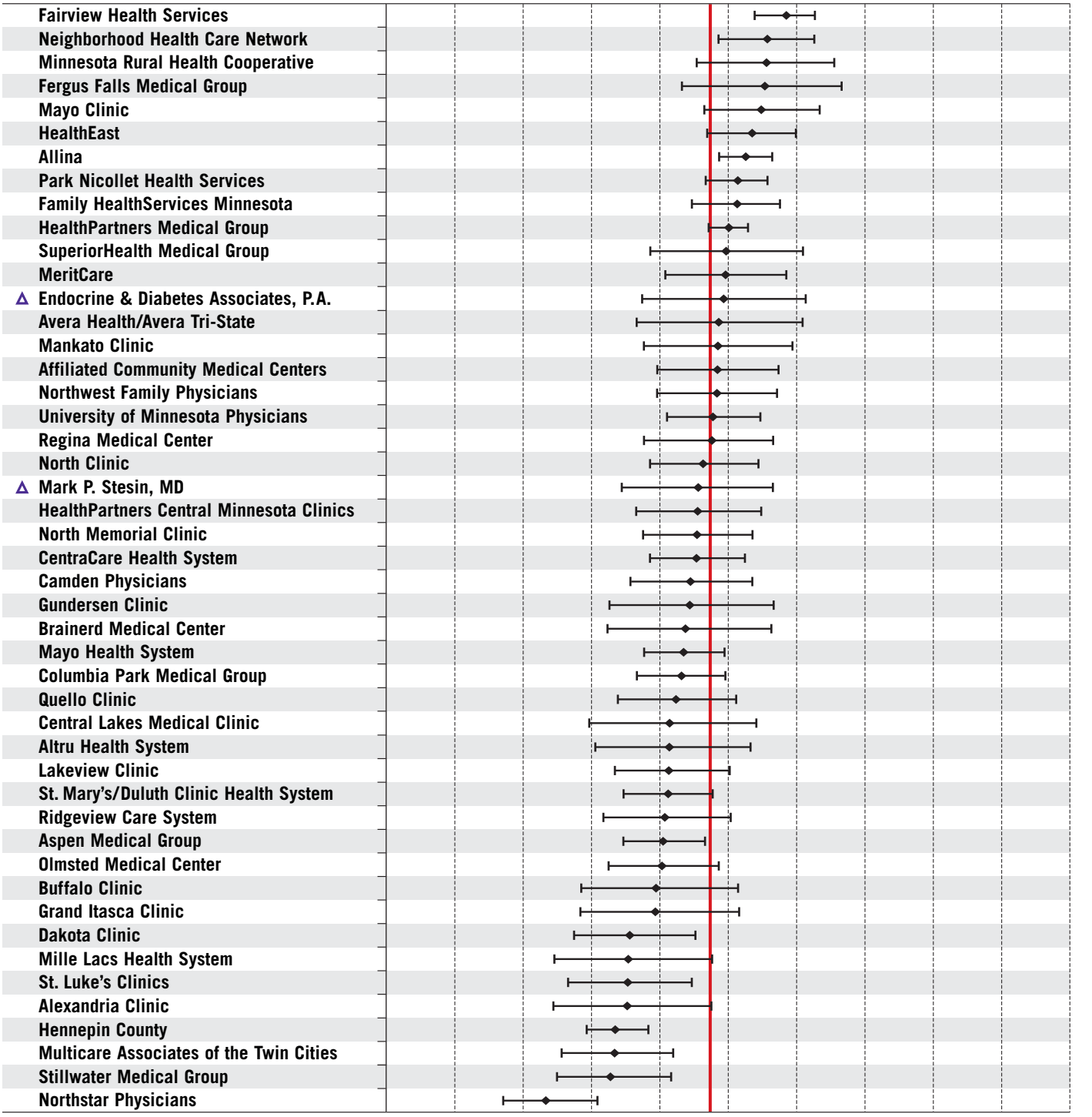
Medical Group Average 11%

△ Endocrinology — Lower Confidence Level/Upper Confidence Level

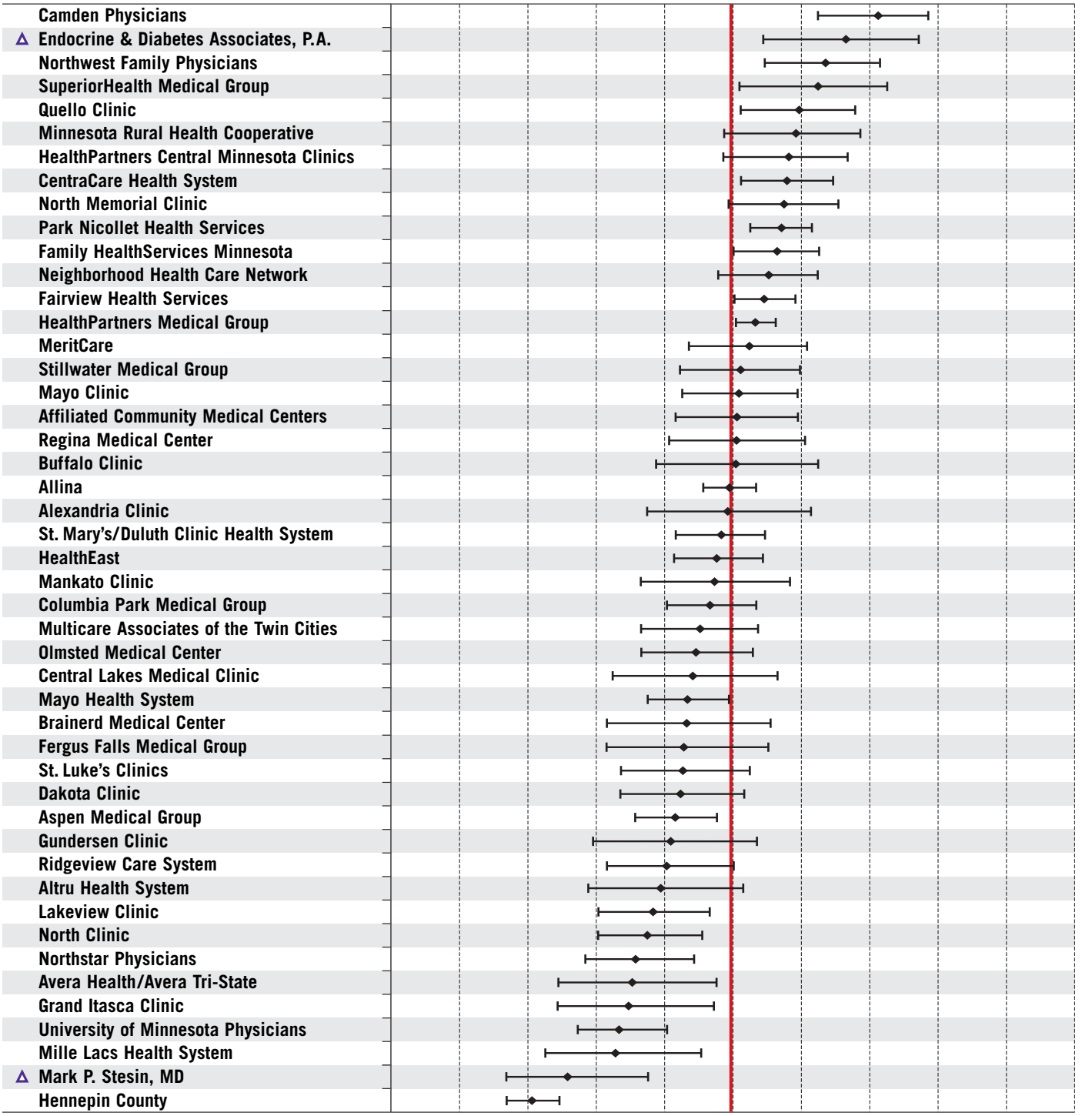
Diabetes: A1c < 7%



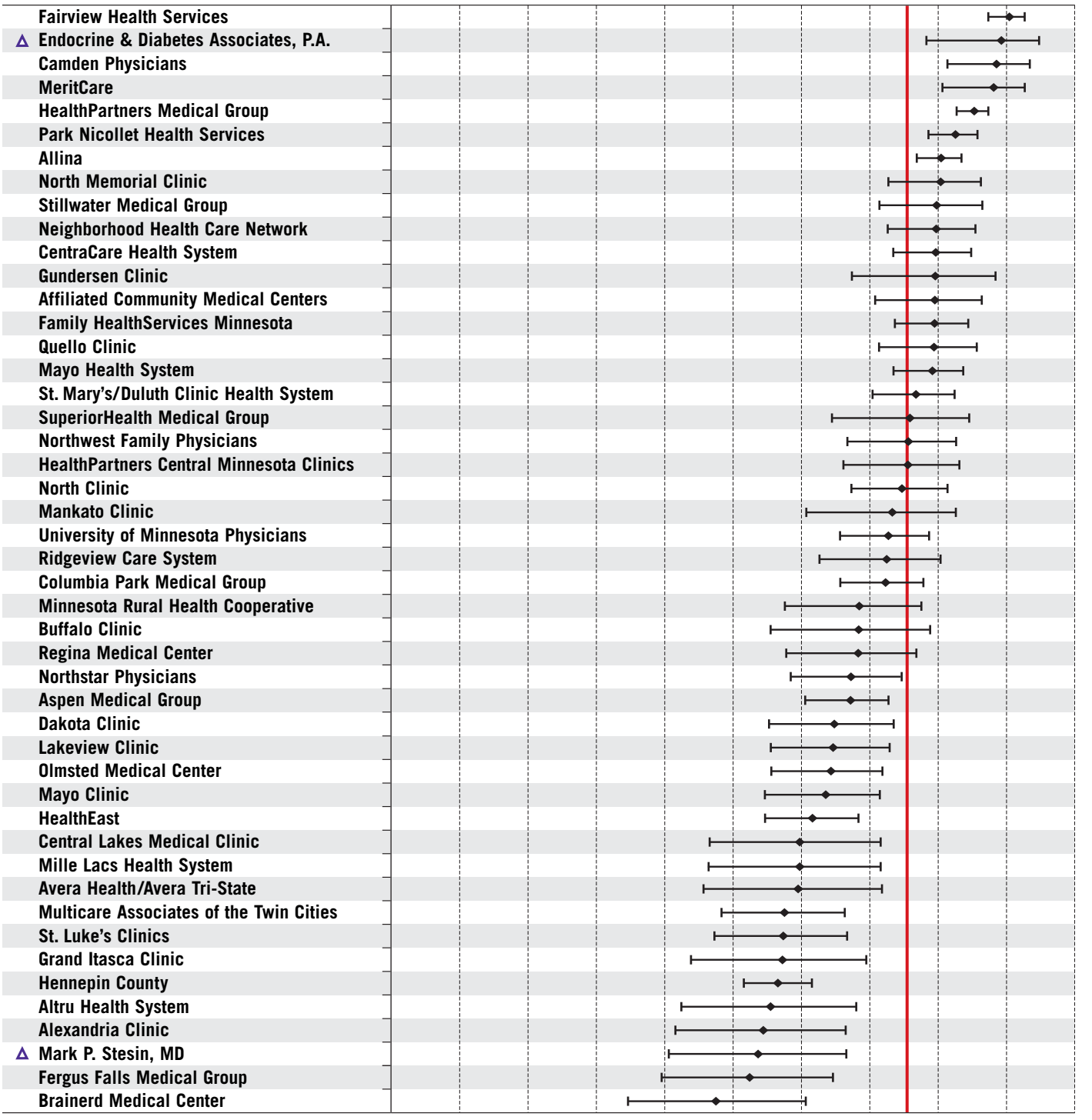
Diabetes: Blood Pressure <130/80



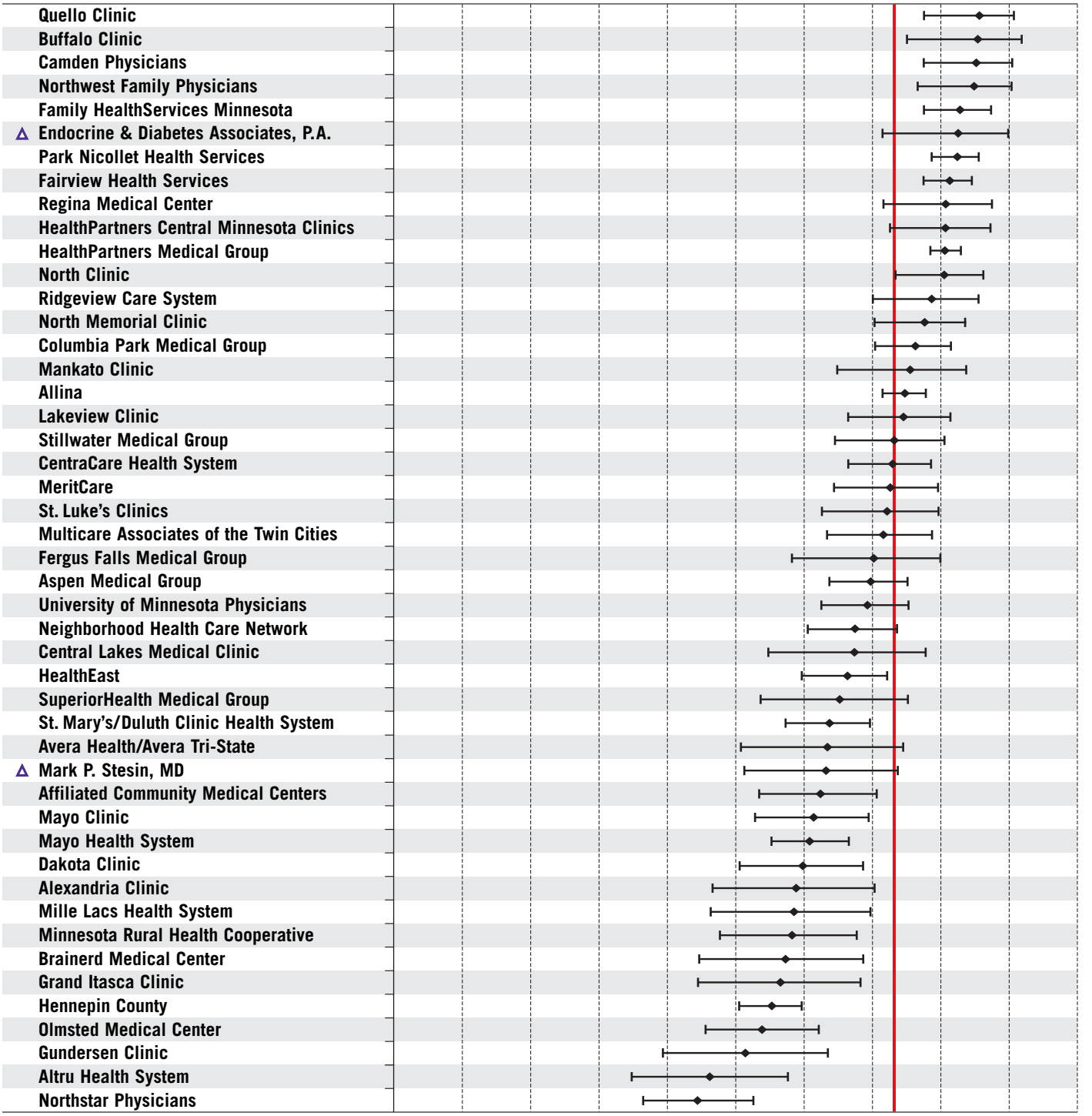
Diabetes: LDL-C <100



Daily Aspirin Use



Diabetes: Tobacco Free



"Living with Illness" measures

Diabetes Care (Individual Measures)

A1c Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
A1c test	89.0%	88.4% - 89.6%	8,848	10,440	50,037
A1c<6.0	13.5%	12.9% - 14.2%	1,413	10,440	50,037
A1c<7.0	51.3%	50.4% - 52.3%	5,080	10,440	50,037
A1c<8.0	68.3%	67.4% - 69.2%	7,127	10,440	50,037
A1c<9.0	76.8%	76.0% - 77.6%	8,018	10,440	50,037
A1c >=9.0	23.2%	22.4% - 24.0%	2,422	10,440	50,037
A1c untested	11.0%		1,152	10,440	50,037

BP Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
BP test	93.5%	93.0% - 93.9%	9,755	10,440	50,037
<130/85	54.9%	53.9% - 55.8%	5,726	10,440	50,037
<130/80	45.9%	45.0% - 46.9%	4,795	10,440	50,037
BP untested	6.6%		685	10,440	50,037

LDL Level	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
LDL test	81.0%	80.2% - 81.7%	8,455	10,440	50,037
<100	48.1%	47.1% - 49.0%	5,016	10,440	50,037
<130	65.9%	64.9% - 66.8%	6,874	10,440	50,037
LDL untested	19.0%		1,985	10,440	50,037

2006 Average	A1c	LDL-C	Systolic BP	Diastolic BP	Patients Sampled
2006 Average Weighted Levels	7.1	94.2	126.0	73.3	10,440

*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" measures

Controlling High Blood Pressure

Controlling High Blood Pressure

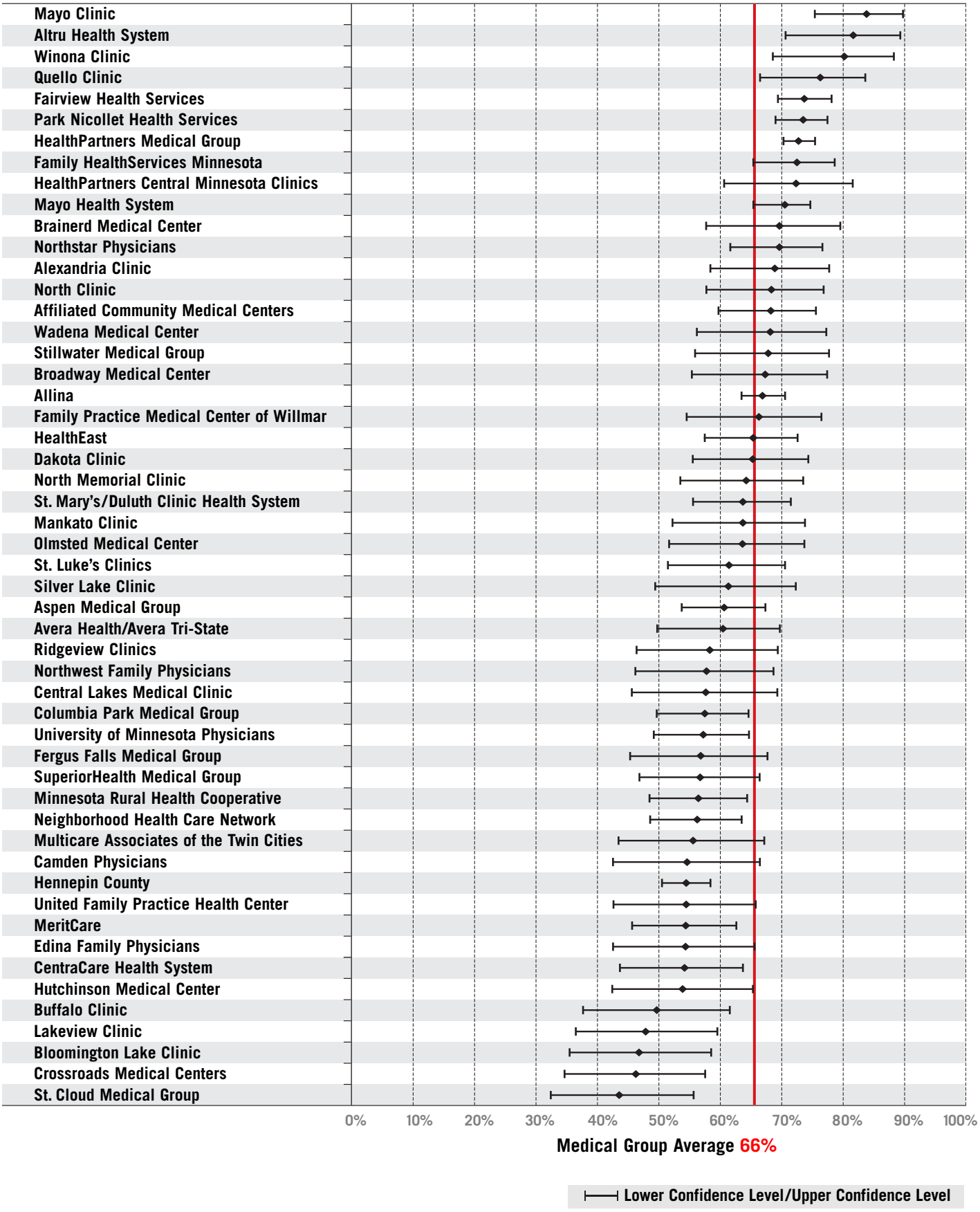
This measures the percentage of patients ages 18 – 85 with a diagnosis of hypertension (HTN) whose blood pressure was adequately controlled at less than 140/90 mmHg during the measurement year. The representative blood pressure is the most recent blood pressure reading during the measurement year (as long as the blood pressure occurred after the diagnosis of hypertension was made). *The data collected for this measure are 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	65.5%	64.5% - 66.4%	5,738	9,420	101,902

No trend chart since measurement specifications changed significantly from last year.

*Statewide averages (above) include both health plan members who were attributed to a medical group AND those who could not be attributed to a medical group. Medical group averages (chart pages) include ONLY health plan members who were attributed to a medical group. Therefore, these averages may differ.

High Blood Pressure Control



"Living with Illness" measures

Optimal Vascular Care

Optimal Vascular Care

This measures the percentage of patients ages 18–75 who have vascular disease and have reached **all** of the following four treatment goals to reduce the risk of cardiovascular diseases:

- Blood pressure less than 140/90 mmHg *(If diabetes co-morbidity, BP must be <130/80)*
- LDL-C less than 100 mg/dl
- Daily aspirin use, ages 41–75
- Documented tobacco-free status

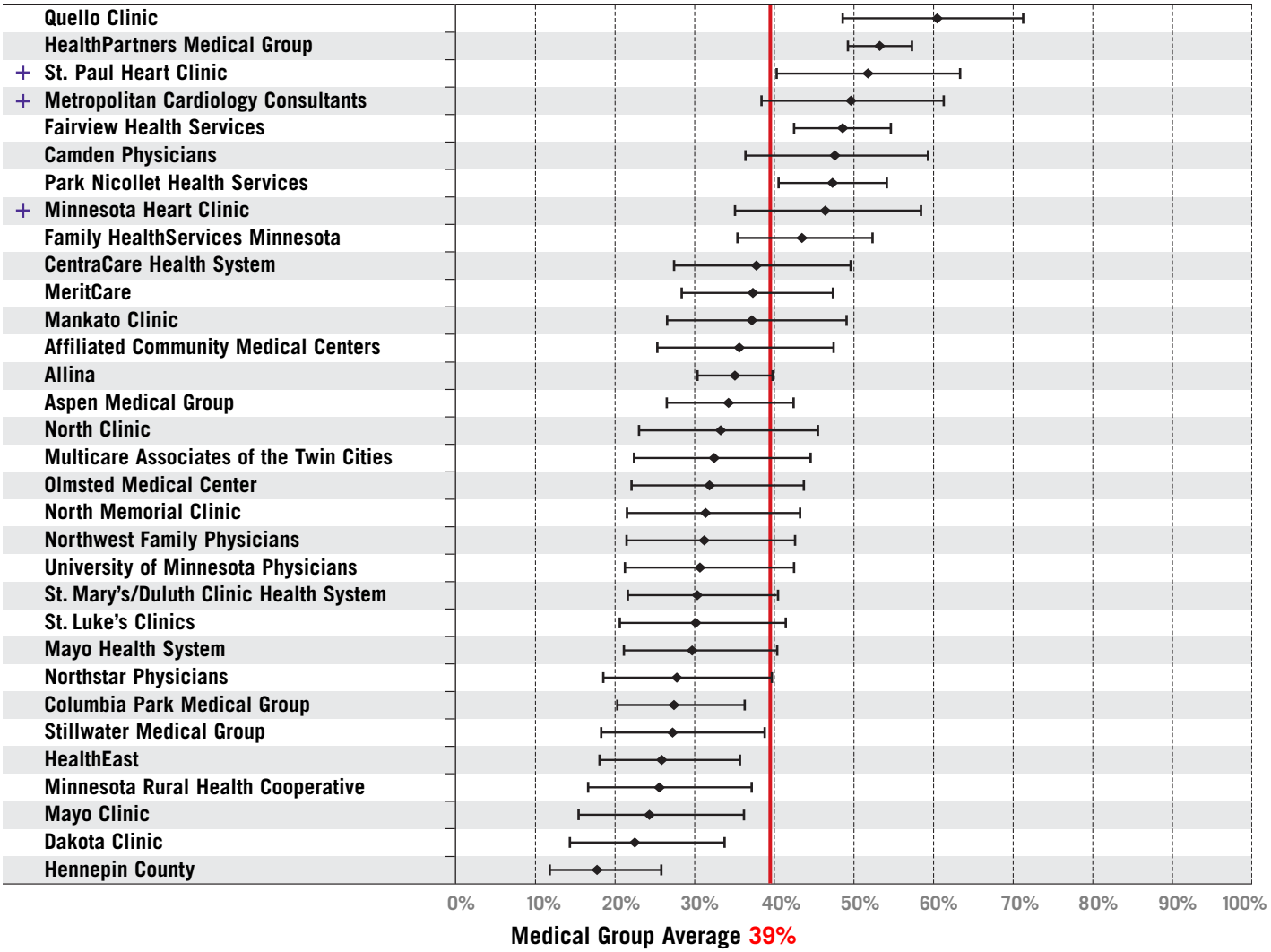
*This rate is calculated using an all-or-none method. Credit is given for achieving this measure when **all** four components are met. The data collected for this measure are from health plan claims and medical record review.*

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Optimal Vascular Care	38.9%	37.5% - 40.3%	1,595	4,662	11,740
LDL-C <100	63.9%	62.5% - 65.3%	3,783	4,662	11,740
BP <140/90 *(If diabetes co-morbidity, BP must be <130/80)*	73.5%	72.2% - 74.7%	4,456	4,662	11,740
Daily Aspirin Use	89.4%	88.5% - 90.3%	4,072	4,662	11,740
Documented Tobacco Free	75.8%	74.5% - 77.0%	3,341	4,662	11,740

No trend chart – first year measure

*Statewide averages (above) include both health plan members who were attributed to a medical group AND those who could not be attributed to a medical group. Medical group averages (chart pages) include ONLY health plan members who were attributed to a medical group. Therefore, these averages may differ.

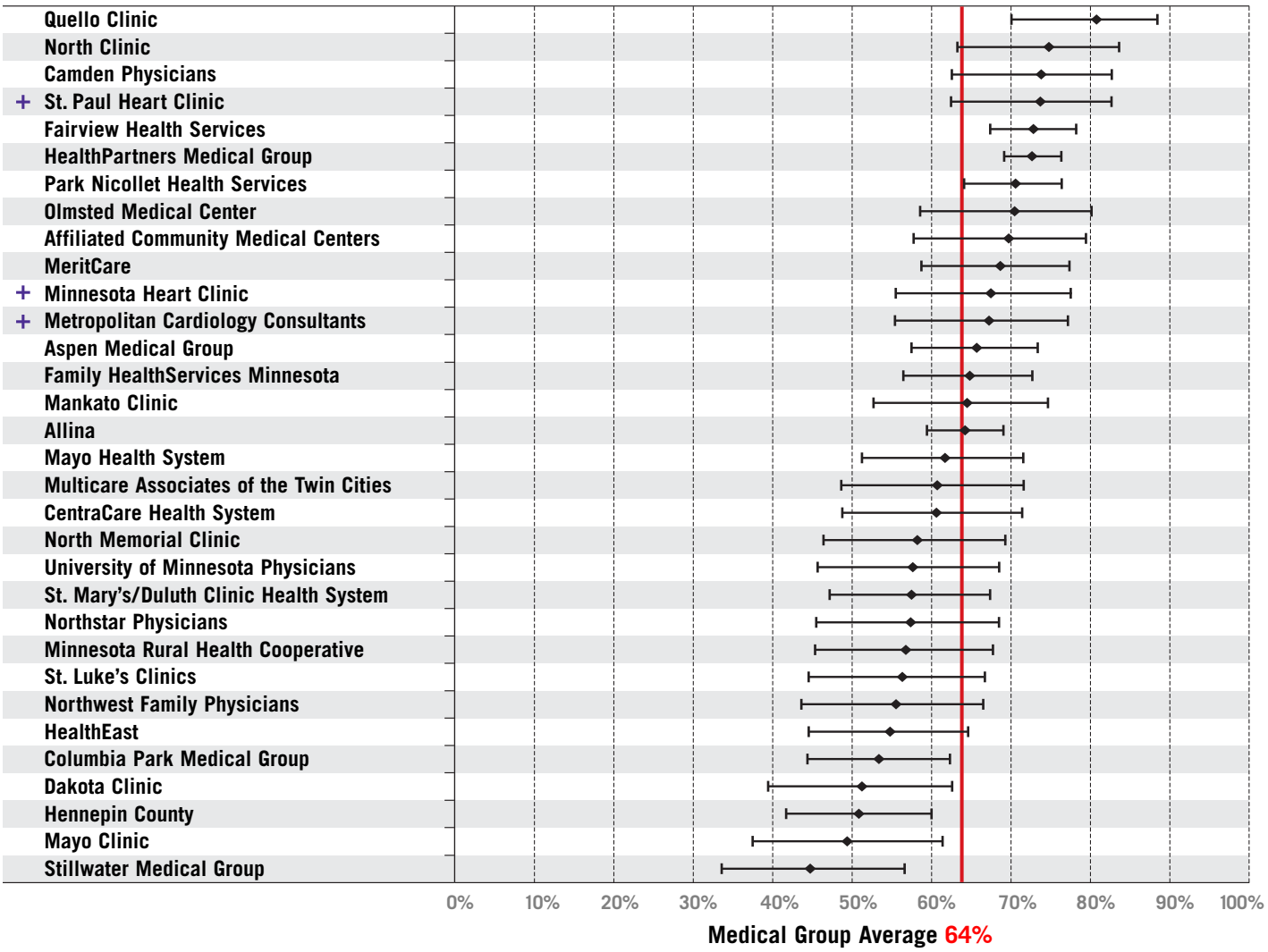
Optimal Vascular Care



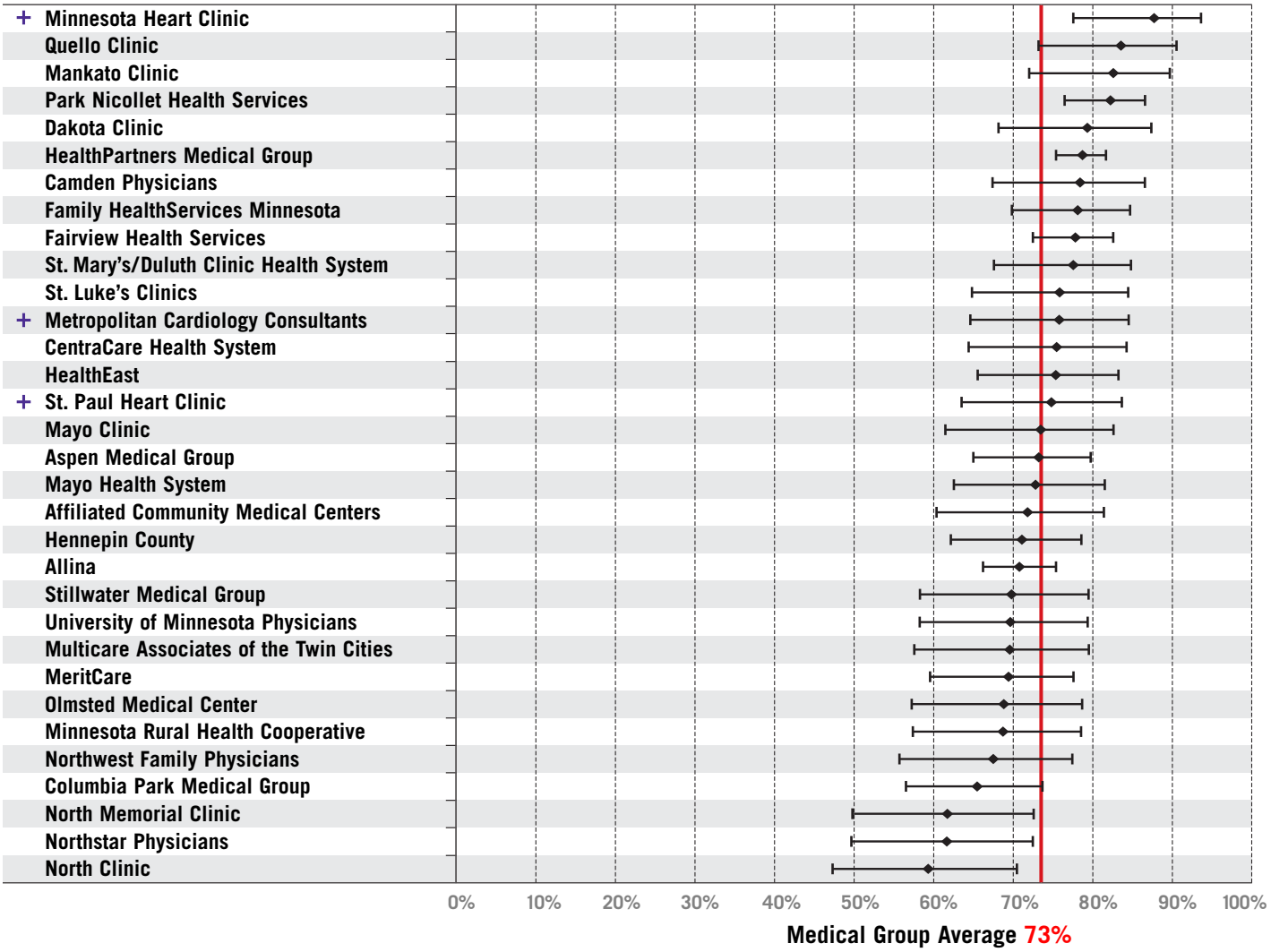
Medical Group Average 39%

\+ Cardiology — Lower Confidence Level/Upper Confidence Level

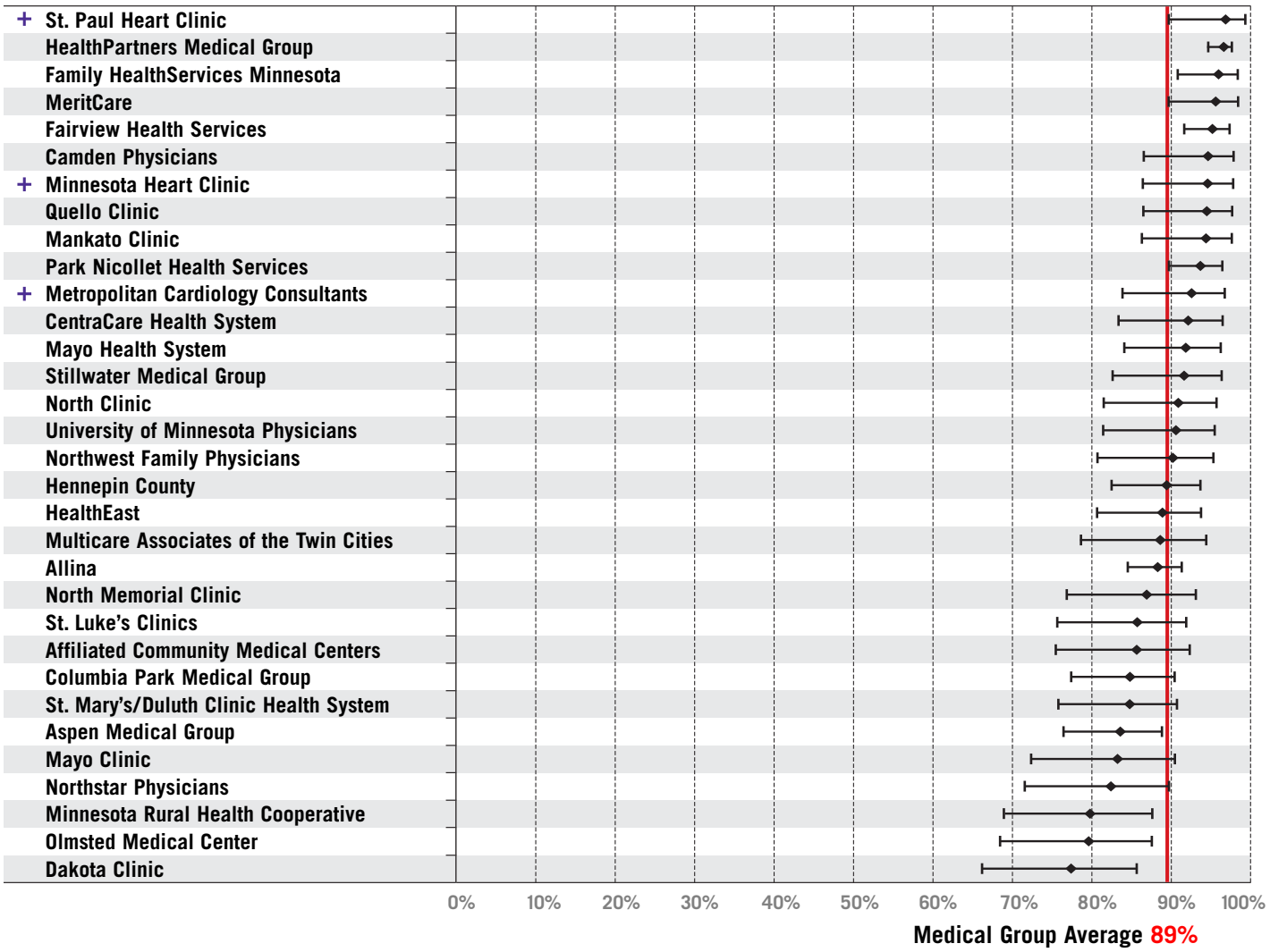
Optimal Vascular Care: LDL-C < 100



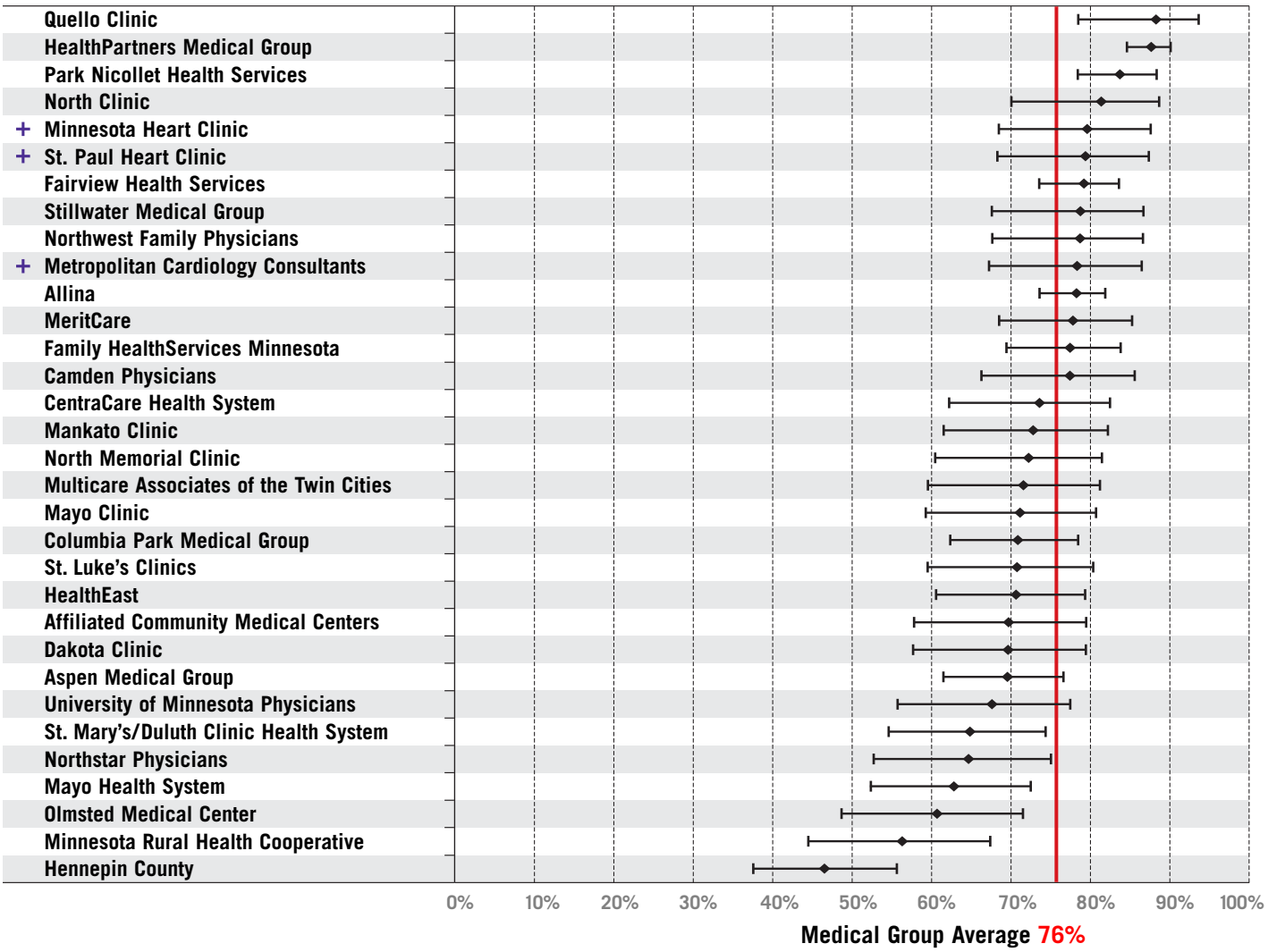
Optimal Vascular Care: Blood Pressure < 140/90



Optimal Vascular Care: Daily Aspirin Use



Optimal Vascular Care: Documented Tobacco Free



"Getting Better" measures

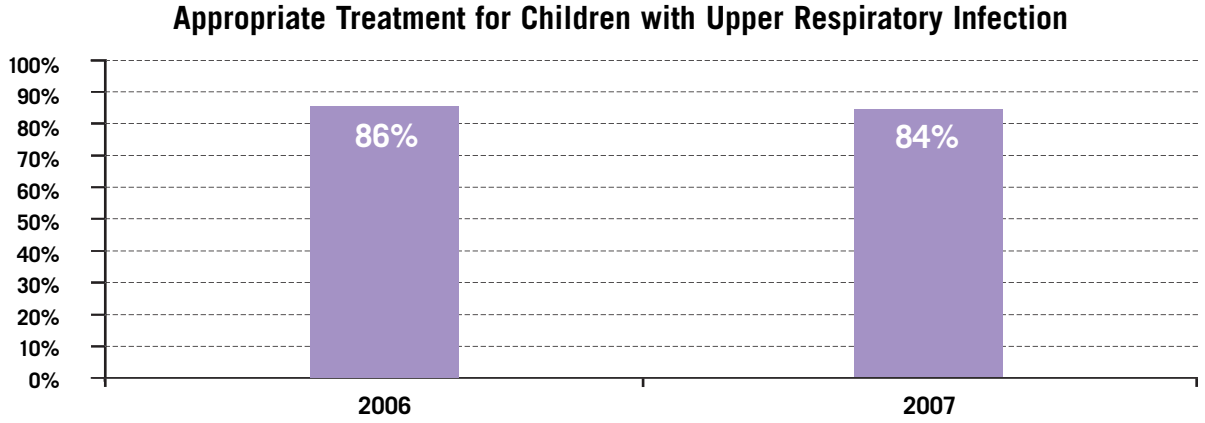
Appropriate Treatment for Children with Upper Respiratory Infection

Appropriate Treatment for Children with Upper Respiratory Infection

This measures the percentage of children ages three months to 18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on the episode date nor the three following days.

The data collected for this measure are from health plan claims. (Note: A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

	Statewide Average*	95% CI	Numerator	Denominator
Appropriate Treatment for Children with Upper Respiratory Infection	84.4%	84.0% - 84.7%	38,301	45,409



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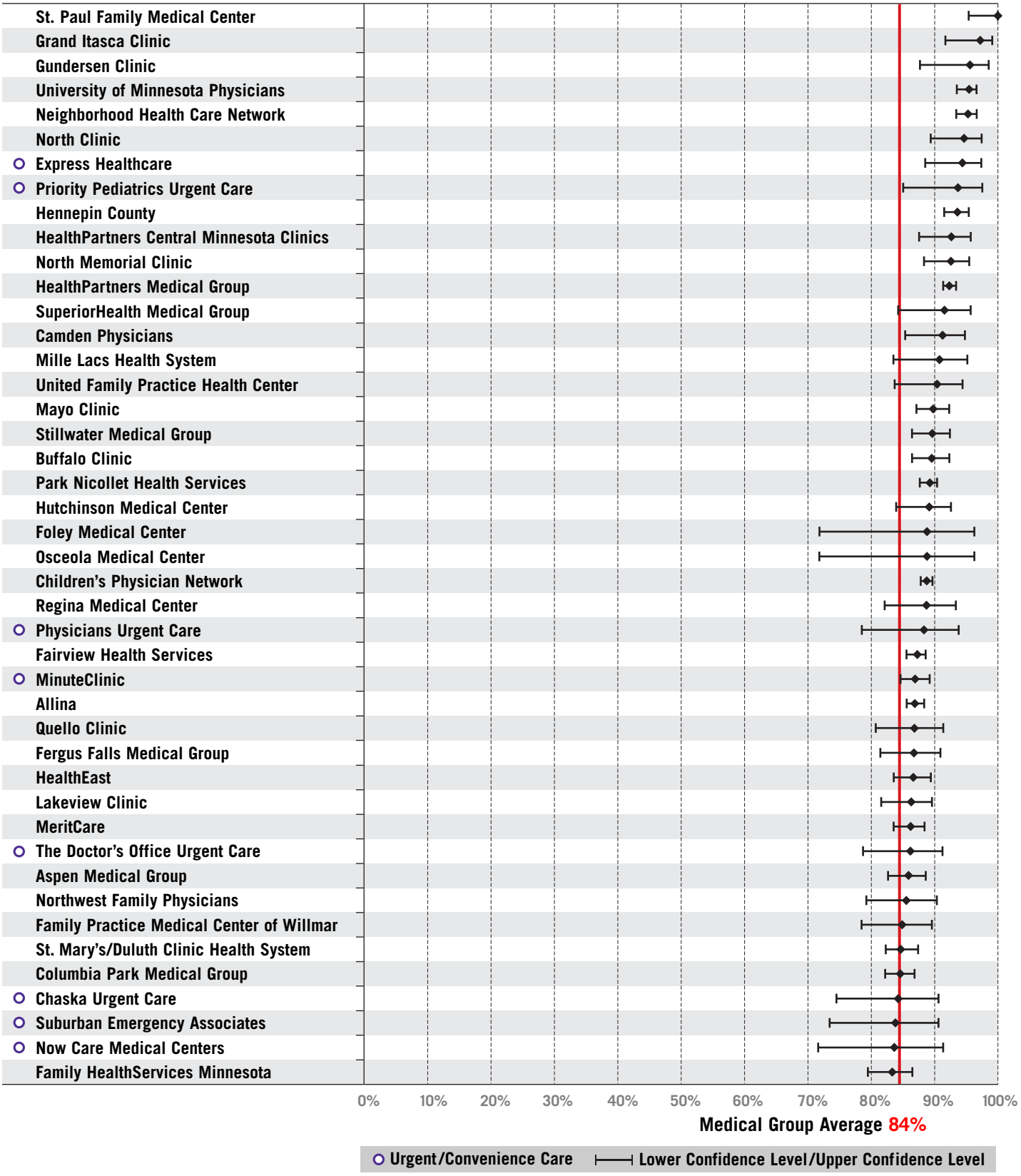
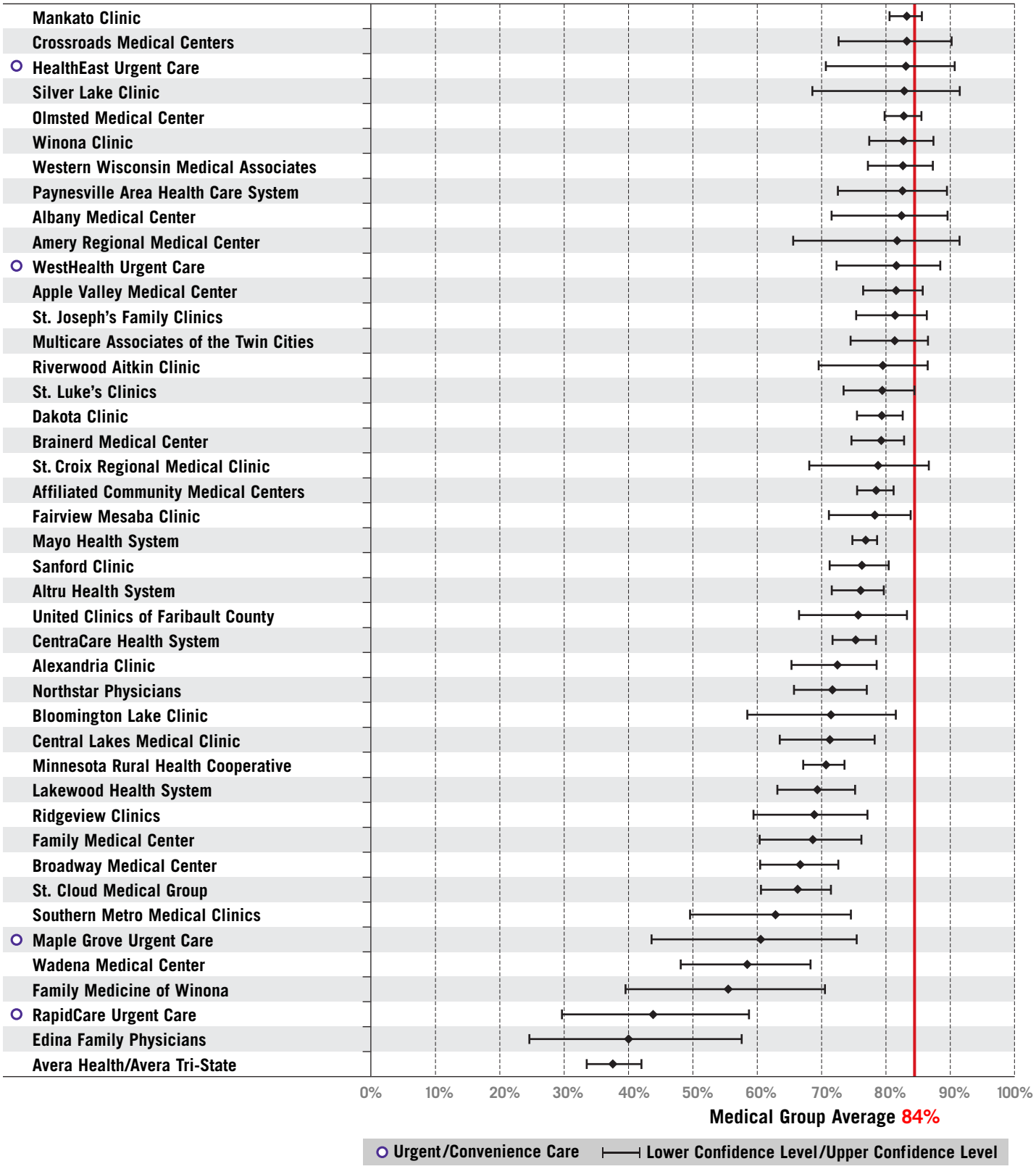
Appropriate Treatment for Children with Upper Respiratory Infection



Appropriate Treatment for Children with Upper Respiratory Infection – *continued*



Getting Better

"Getting Better" measures

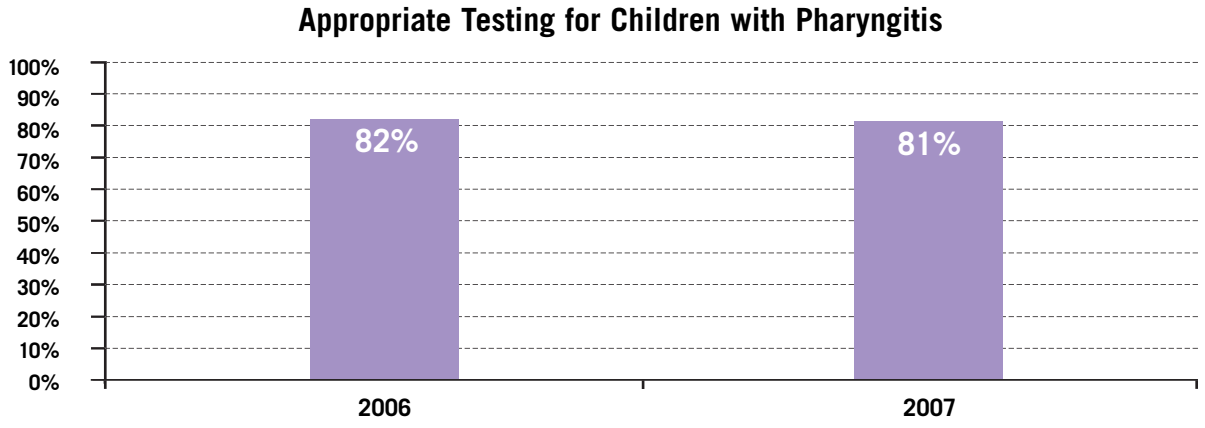
Appropriate Testing for Children with Pharyngitis

Appropriate Testing for Children with Pharyngitis

This measures the percentage of children ages 2–18 who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

The data collected for this measure are from health plan claims. (Note: A higher rate represents better performance (i.e., appropriate testing)

	Statewide Average*	95% CI	Numerator	Denominator
Appropriate Testing for Children with Pharyngitis	80.7%	80.2% - 81.1%	26,865	33,312



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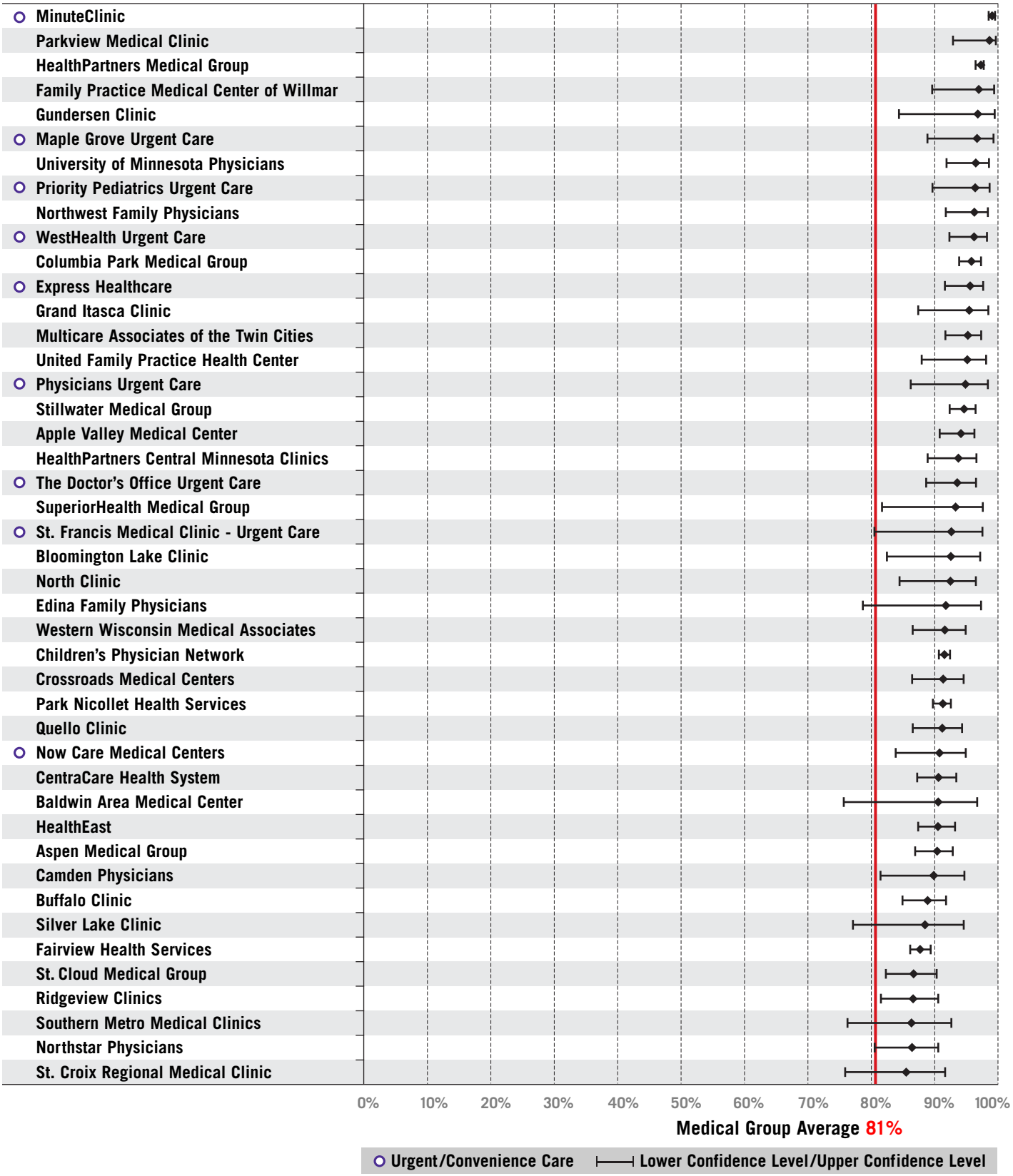
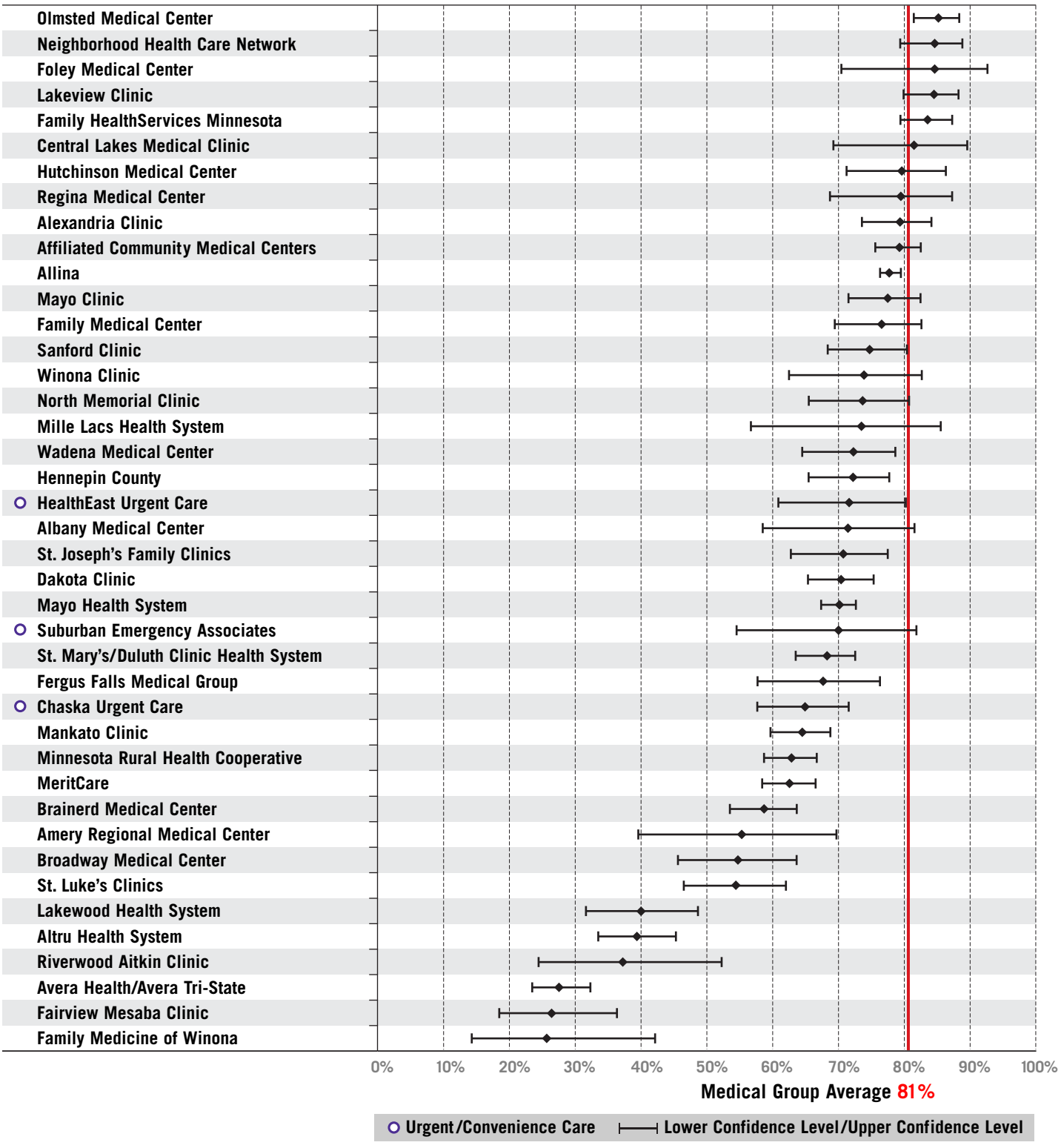
Appropriate Testing for Children with Pharyngitis



Appropriate Testing for Children with Pharyngitis – *continued*



Getting Better

"Staying Healthy" measures

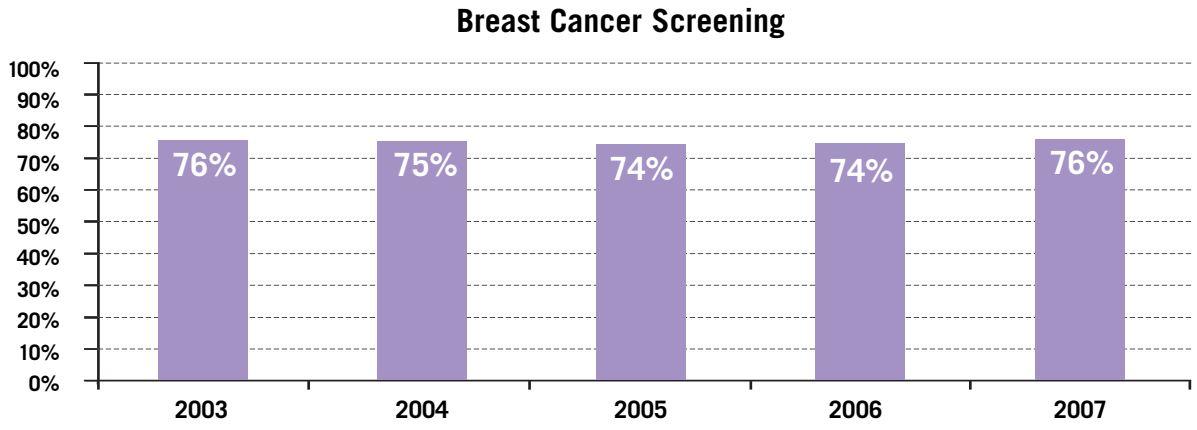
Breast Cancer Screening

Breast Cancer Screening (Mammograms)

This measures the percentage of women ages 50 – 69 who have had a mammogram to screen for breast cancer in the measurement year or the year prior.

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

	Statewide Average*	95% CI	Numerator	Denominator
Breast Cancer Screening	75.5%	75.3% - 75.8%	74,992	99,295



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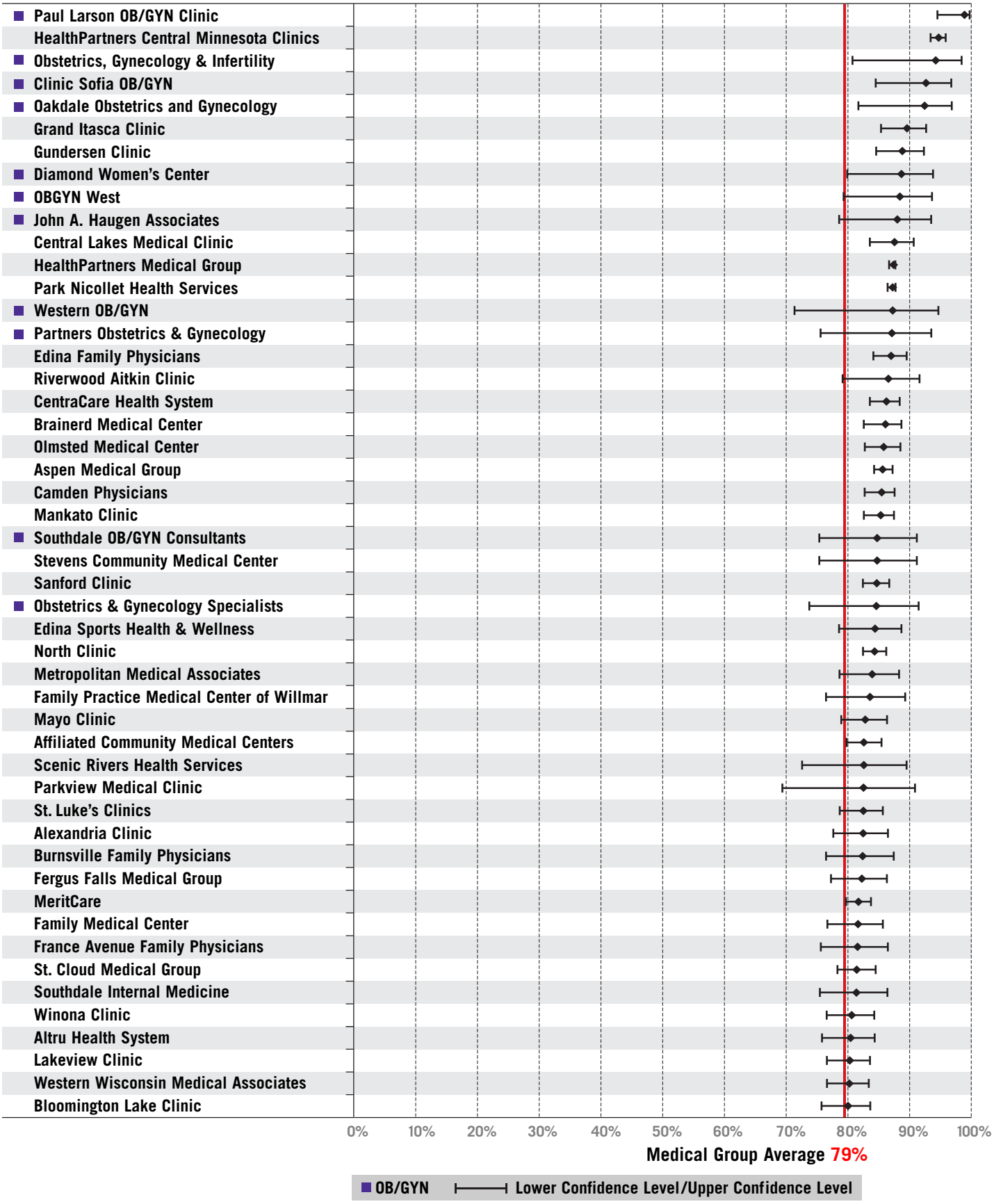
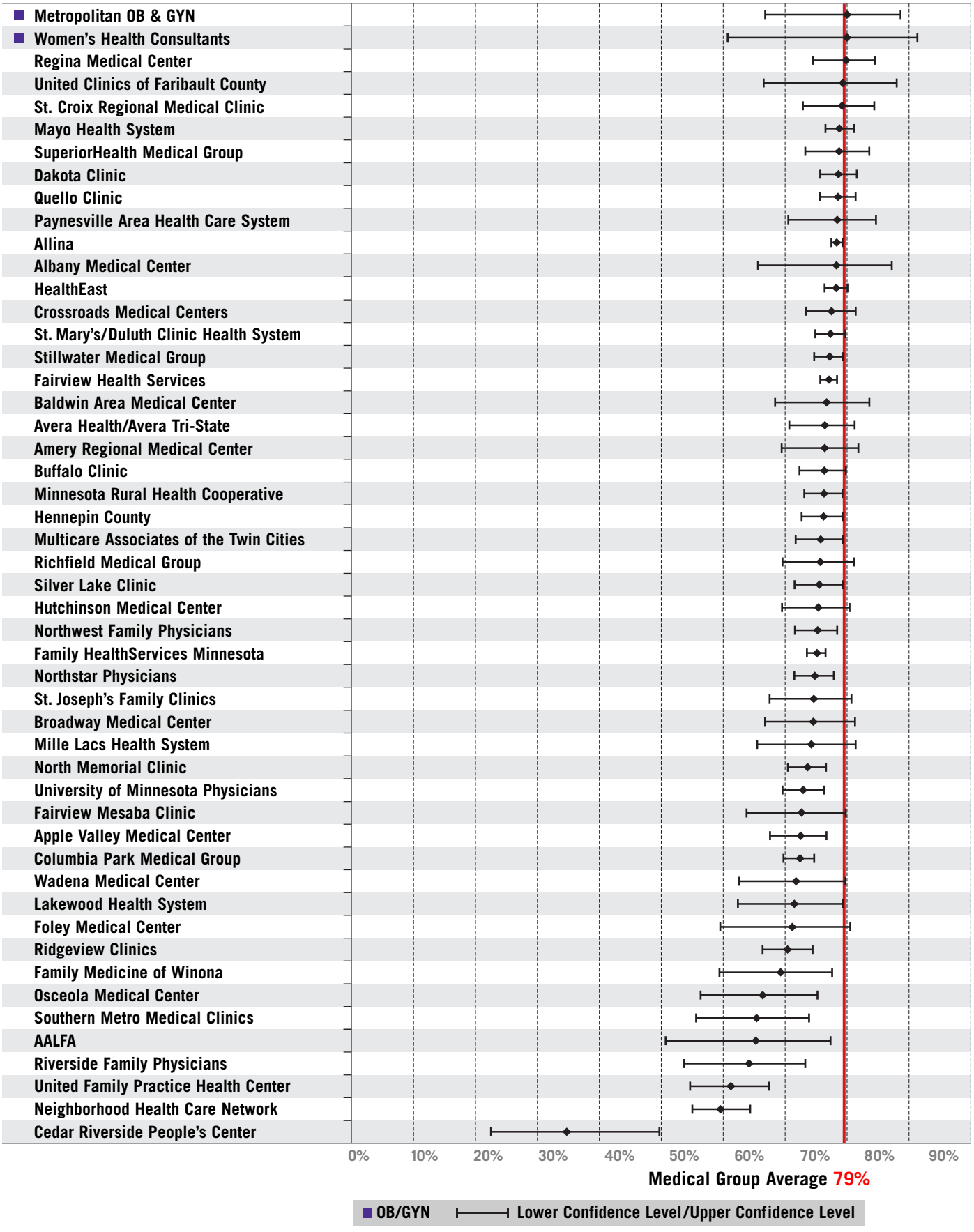
Breast Cancer Screening



Breast Cancer Screening – *continued*



"Staying Healthy" measures

Cervical Cancer Screening

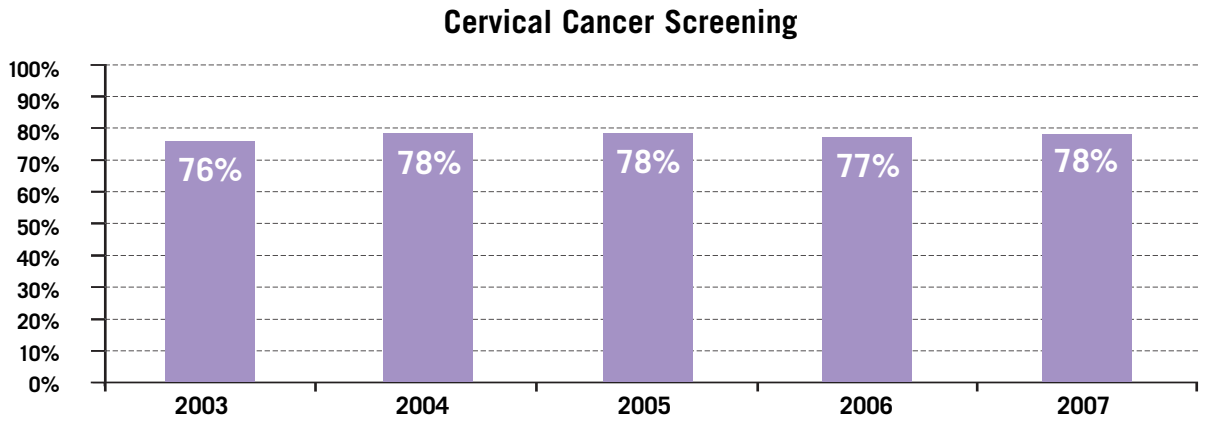
Cervical Cancer Screening (Pap Test)

This measures the percentage of women ages 21–64 who received one or more Pap tests to screen for cervical cancer in the measurement year or the two years prior.[1]

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	77.6%	77.4% - 77.8%	188,566	243,056



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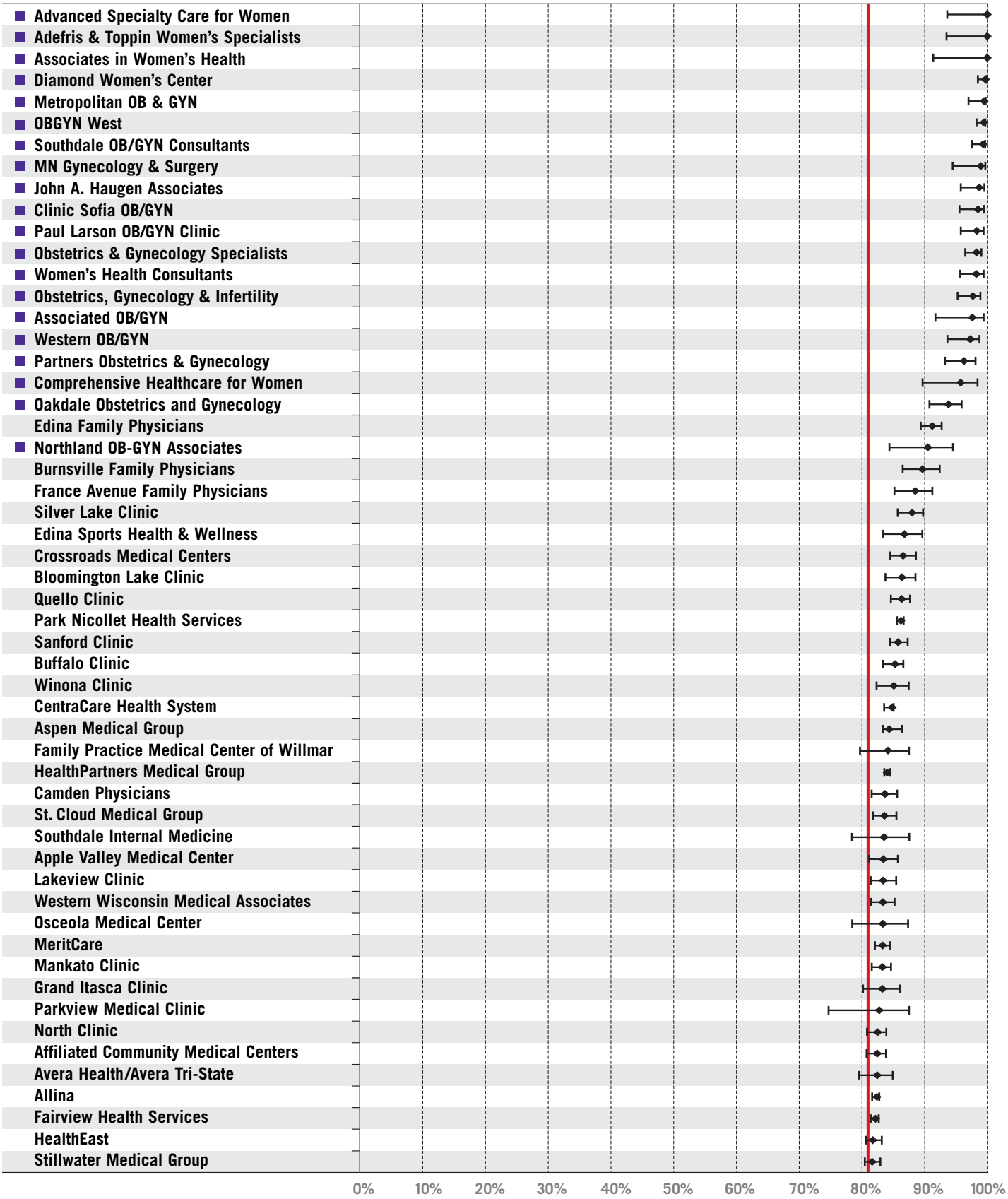
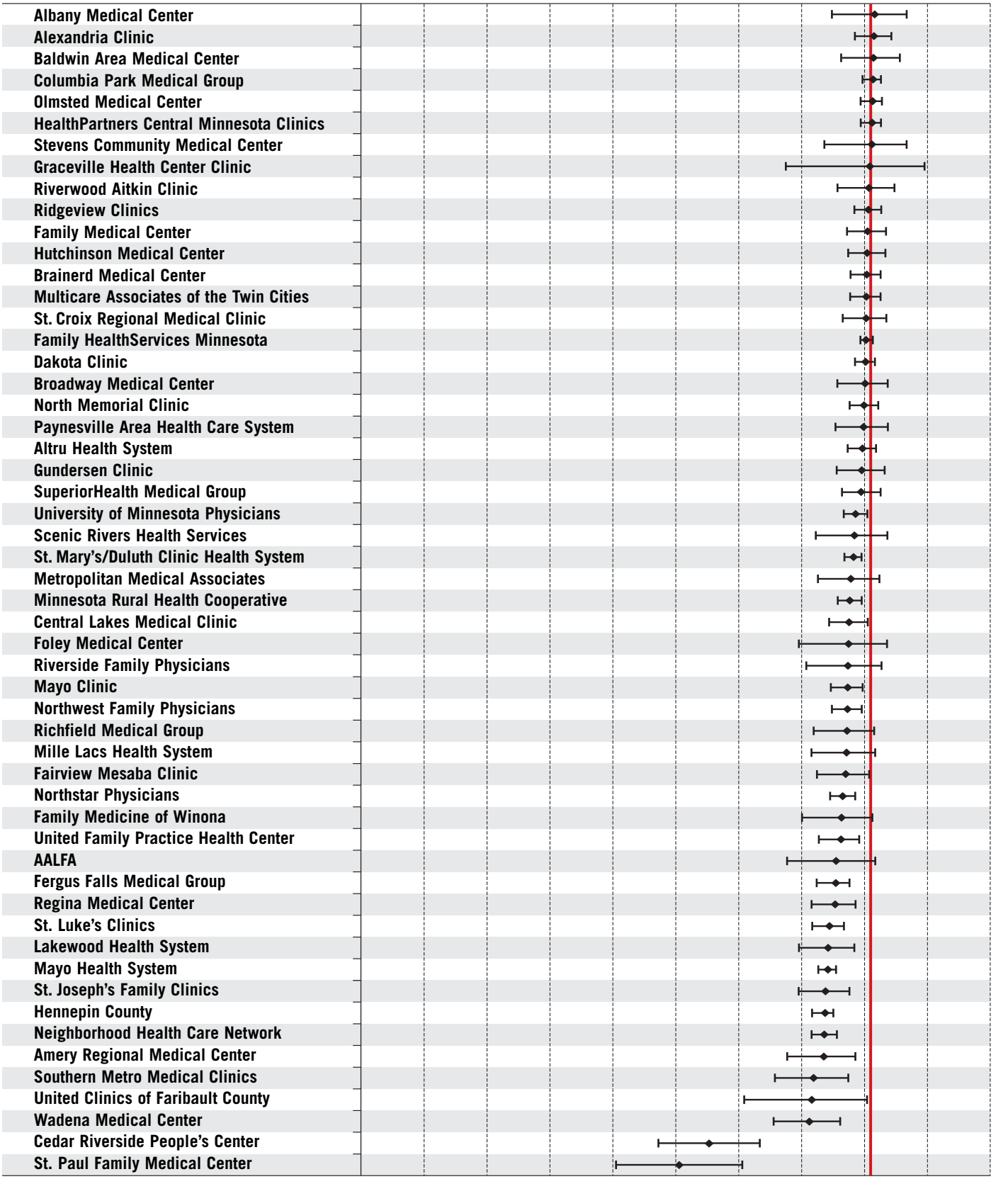
Cervical Cancer Screening



Cervical Cancer Screening – *continued*



"Staying Healthy" measures

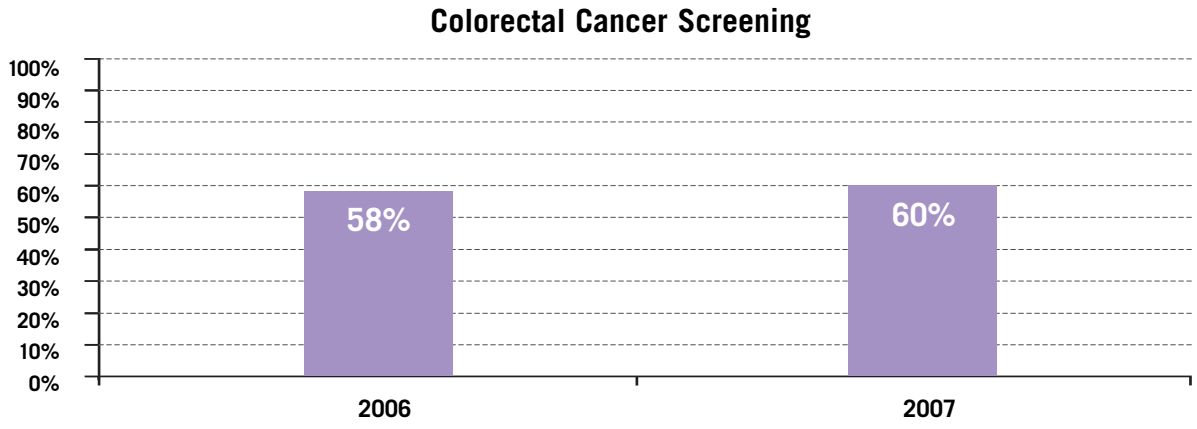
Colorectal Cancer Screening

Colorectal Cancer Screening

This measures the percentage of adults ages 50–80 who had appropriate screening for colorectal cancer.

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	59.7%	58.6% - 60.8%	3,772	7,386	234,131



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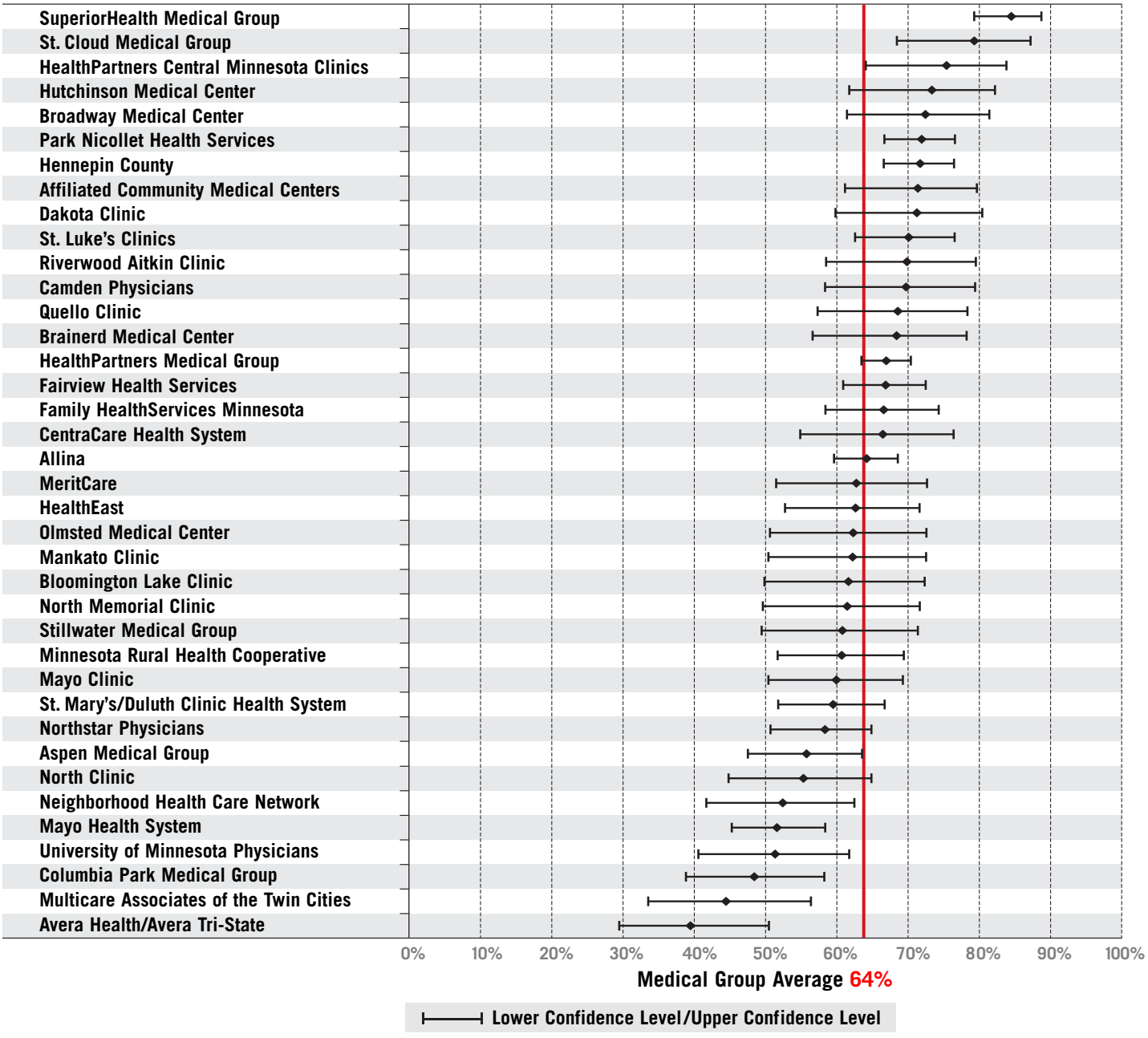
Colorectal Cancer Screening



"Staying Healthy" measures

Cancer Screening Combined

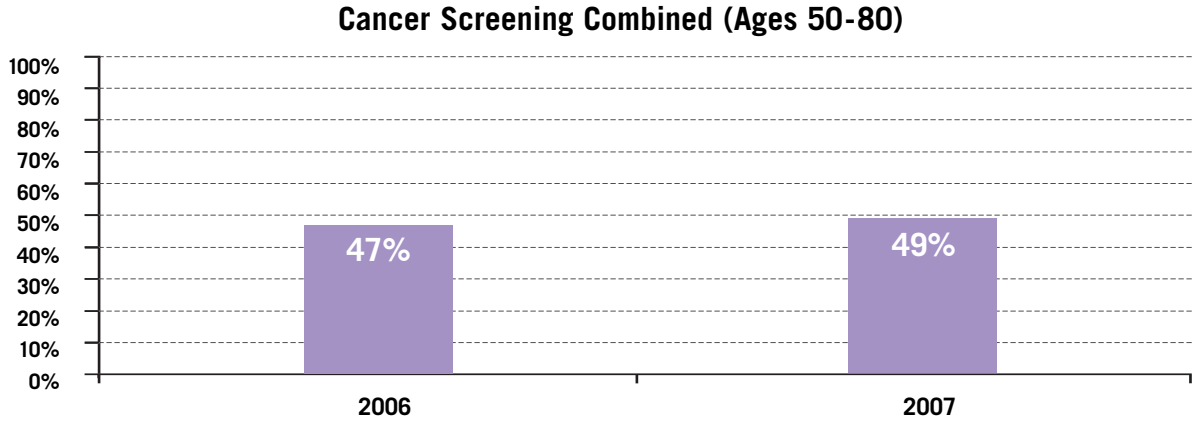
Cancer Screening Combined (Ages 50-80)

This measures the percentage of adults ages 50–80 who received appropriate cancer screening services (breast, cervical, colorectal). A patient must be up-to-date for ***all three components*** to be considered up-to-date for this measure.

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

(Note: This measure uses the same denominator as the Colorectal Cancer Screening measure. For this combined measure, males received an automatic "pass" for the breast and cervical cancer screening components.)

	Statewide Average* (Weighted)	95% CI	Numerator	Denominator (Patients sampled)	Total Eligible
Cancer Screening Combined (Ages 50-80)	49.3%	48.1%-50.4 %	2,855	7,386	234,131



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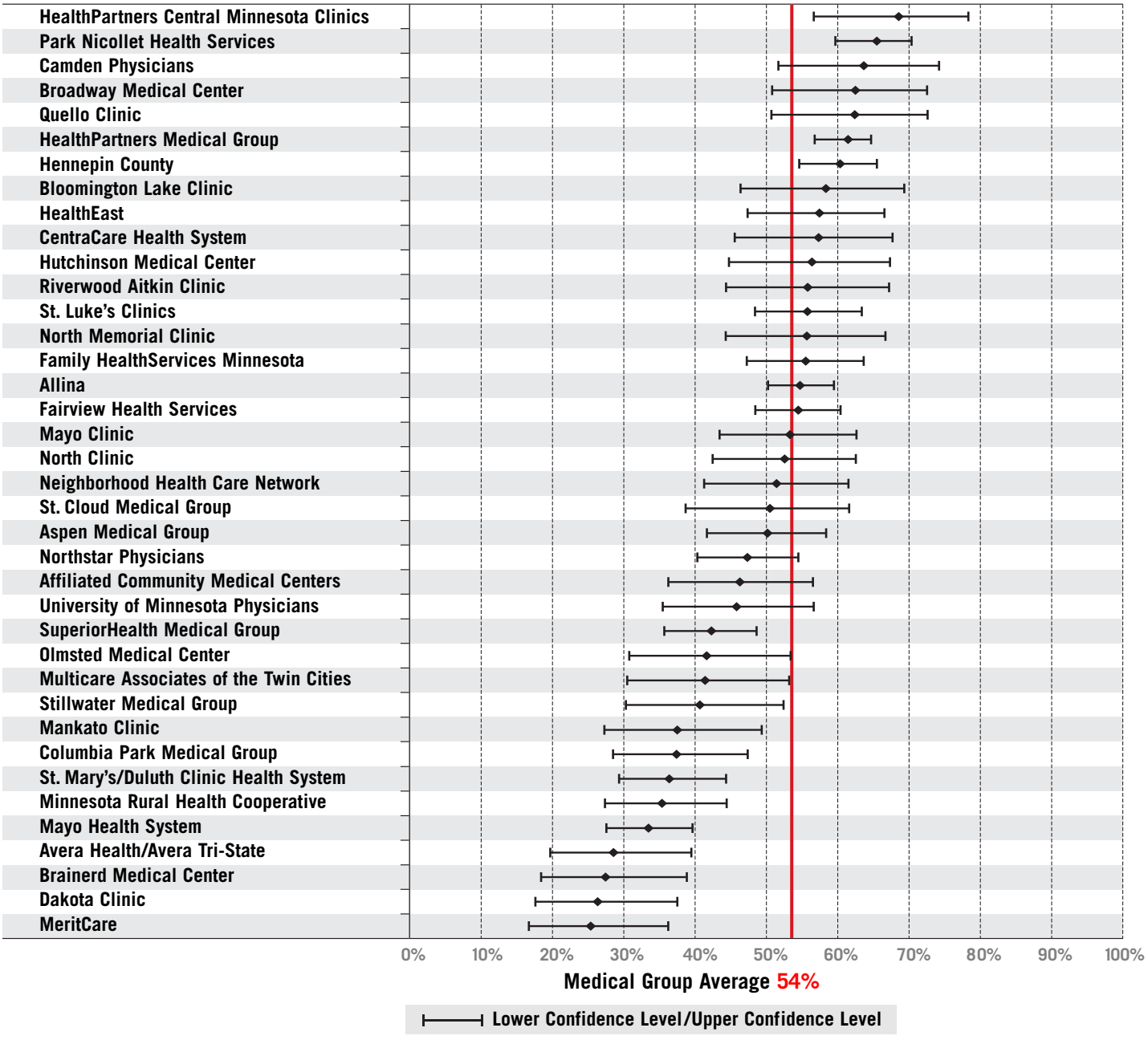
Cancer Screening Combined (Ages 50-80)



"Staying Healthy" measures

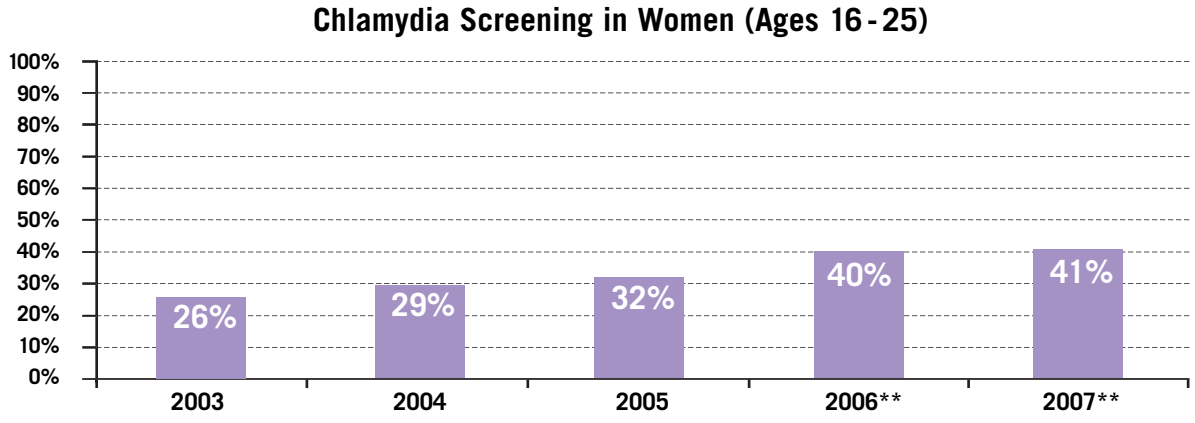
Chlamydia Screening in Women

Chlamydia Screening in Women

This measures the percentage of women ages 16 – 25 who 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)	40.8%	40.3% - 41.2%	18,426	45,212



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**Note: Technical coding issues were identified for seven provider groups so their chlamydia screening rates were suppressed in 2006 and 2007.

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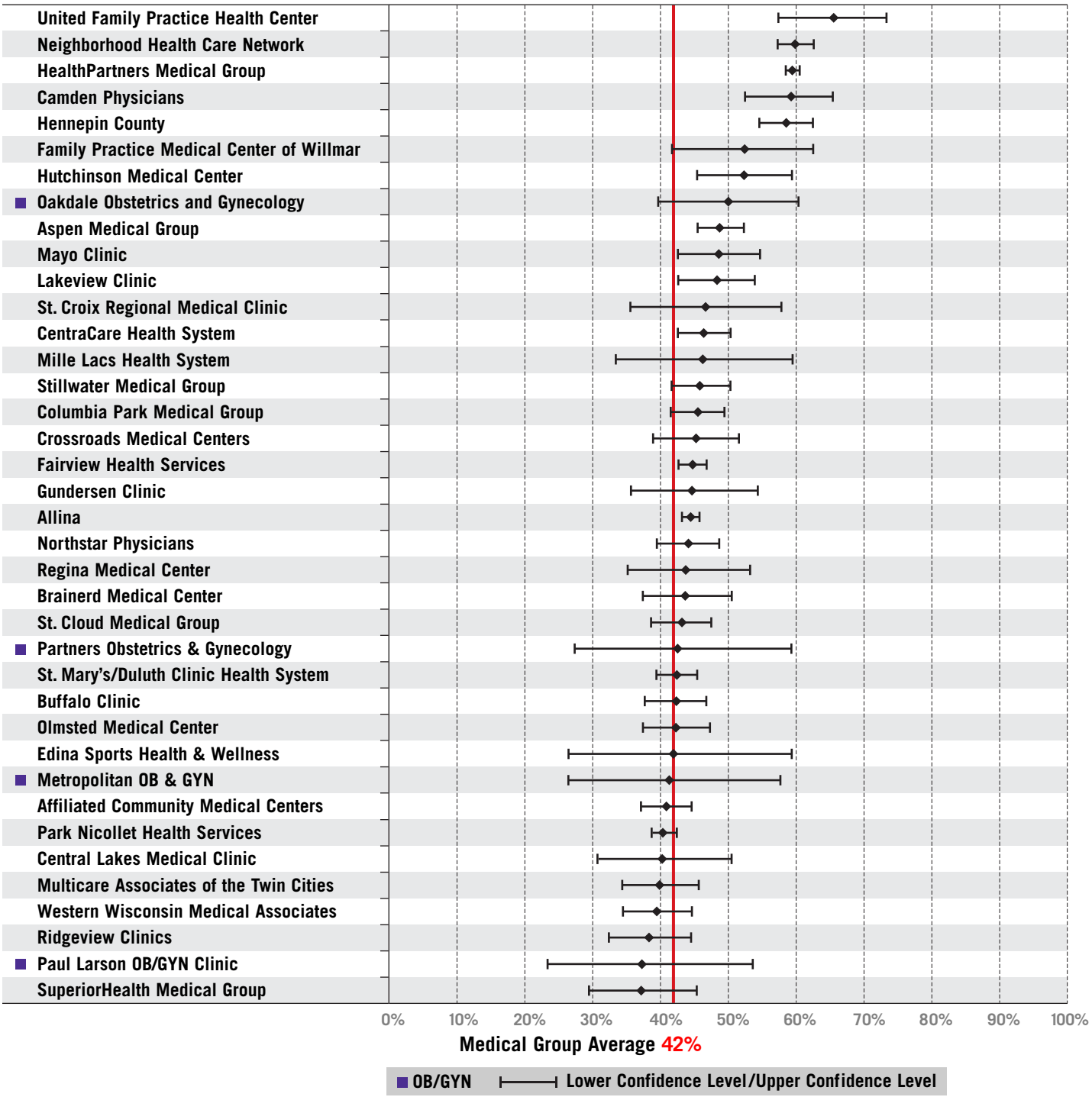
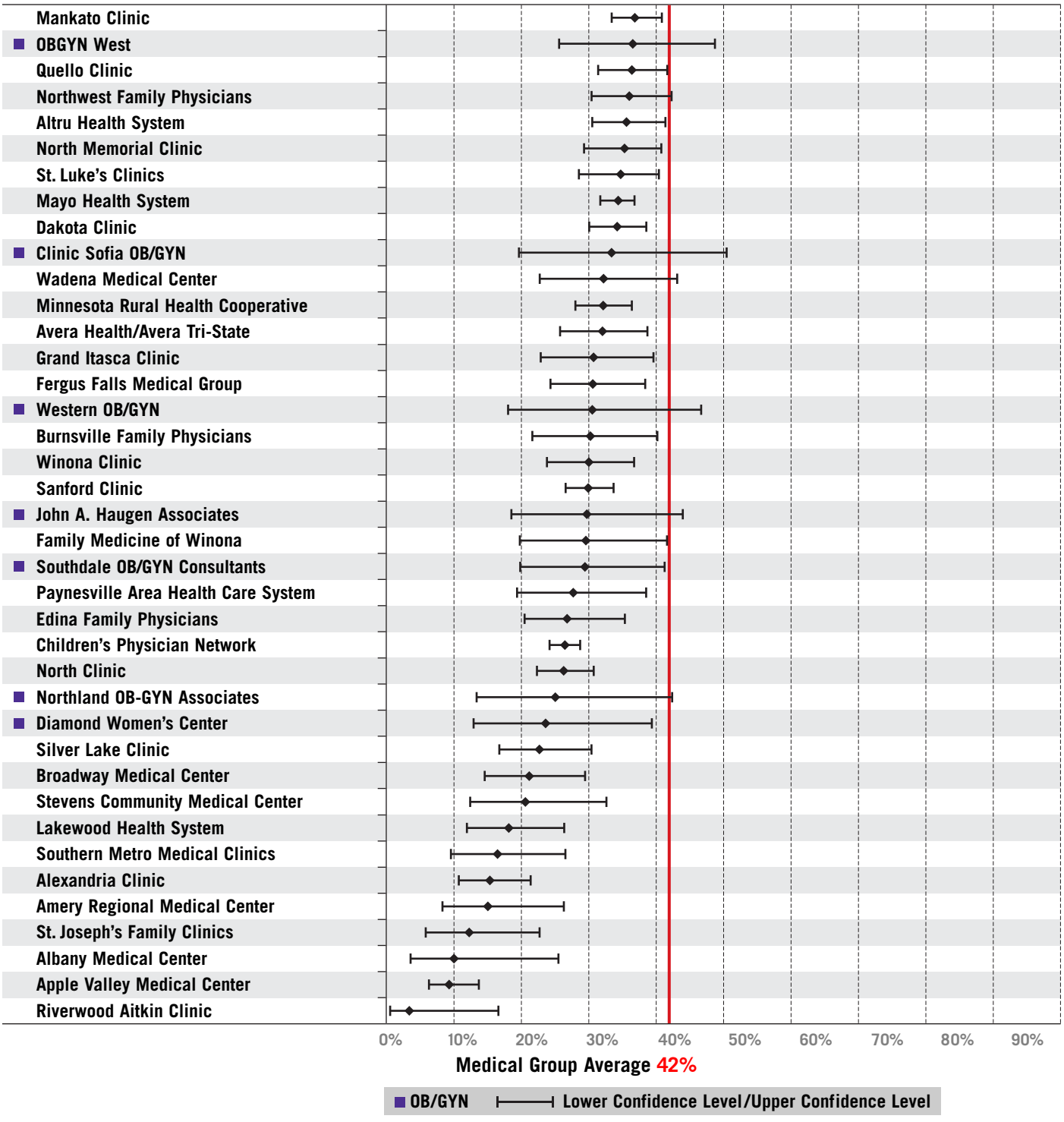
Chlamydia Screening in Women (Ages 16-25)



Chlamydia Screening in Women (Ages 16-25) – *continued*



"Staying Healthy" measures

Childhood Immunization

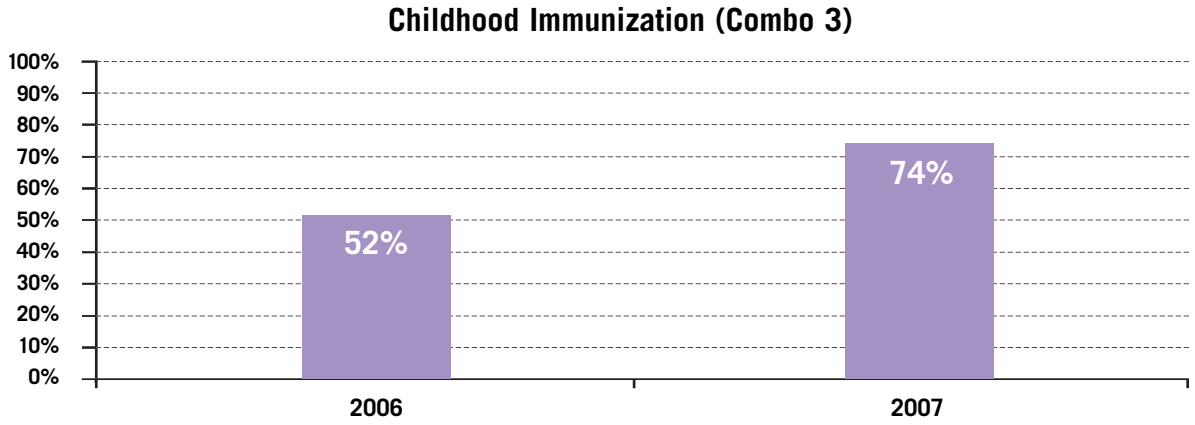
Childhood Immunization (Combo 3)

This measures the percentage of children two years of age who had the following vaccines by their second birthday:

- Four DTaP/ DT
- Three IPV
- One MMR
- Three H influenza type B
- Three Hepatitis B
- One VZV
- Four pneumococcal conjugate

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 & pneumococcal conjugate	74.4%	73.2%-75.5%	3,982	5,610	20,434



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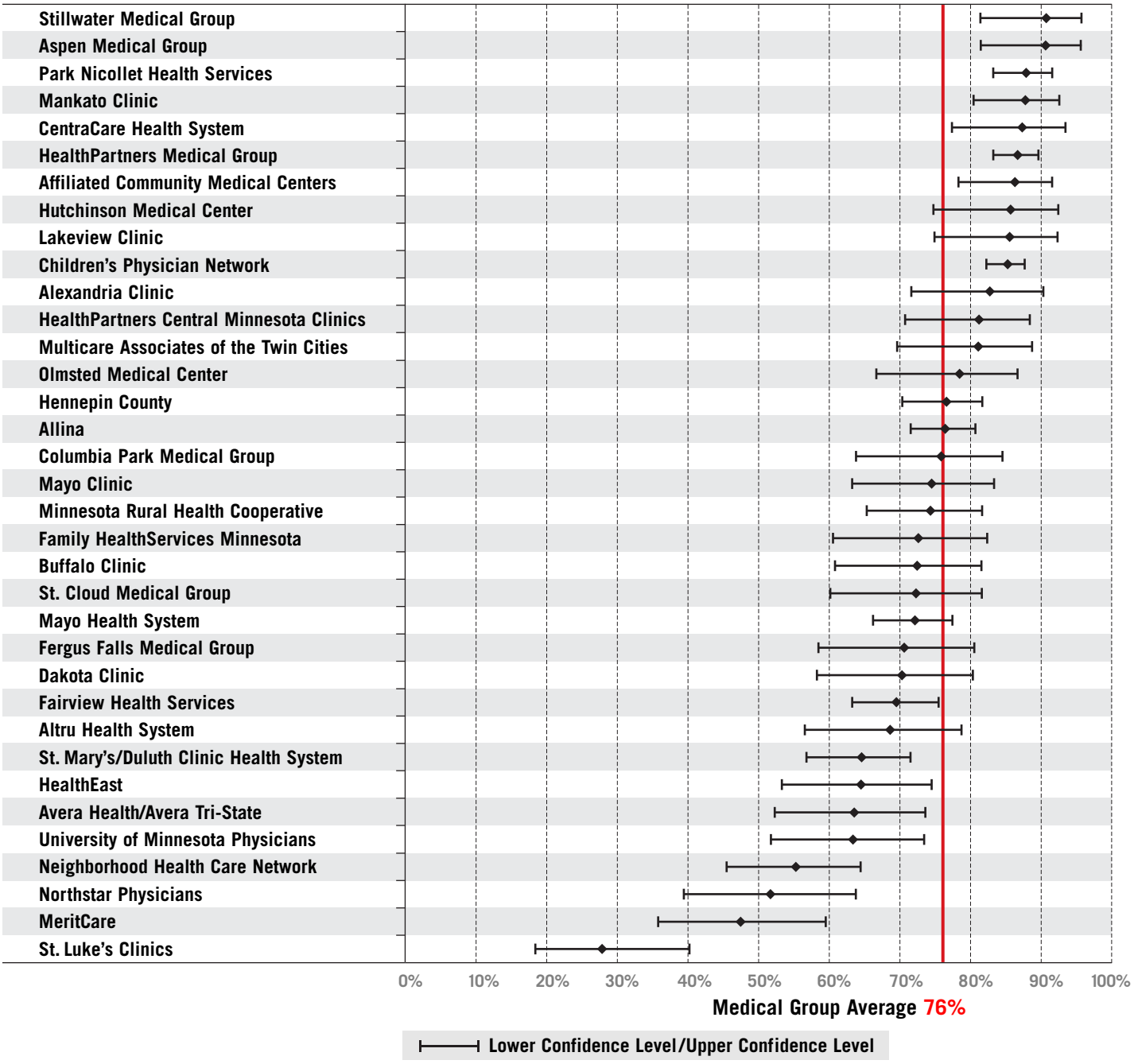
Childhood Immunization (Combo 3)



Future Plans

At MN Community Measurement, we continue to refine and expand our measurement and reporting of clinical quality measures. In 2008, we will expand the process of gathering data directly from medical groups to include depression care, and we will explore the addition of a new asthma all-or-none measure. The Optimal CAD Care measure will broaden to become Optimal Vascular Care. We are evaluating the possible addition of a specialty procedure measure such as the outcome of joint replacement and a standardized cost measure that can be used across the community.

MNCM can play an important role by making our data available to researchers to further the science of measurement and quality improvement. MNCM provided data for two research studies in 2007 and is working to identify other researchers who can use MNCM data to evaluate the impact of health care quality improvement strategies. MNCM also contracted with the Minnesota Department of Human Services this year to evaluate the results of our measures for Minnesota Health Care Program enrollees. We hope participation in these efforts will further our understanding and knowledge of the best methods to impact health care quality in our community.

For the first time, our results were used by the accredited health plans to achieve higher accreditation standards. Eventually, we hope to be a single source for all clinical data used in our market. For example, results collected through direct data submission could be used in our market for multiple purposes – health plan quality accreditation, regulatory requirements, recognition programs by purchasers and health plans – to reduce the number of chart review requests experienced by medical groups each year.

While we see increasing engagement in our transparency efforts among the healthcare and purchaser communities, we have yet to command consumer attention as fully as is necessary to help drive change. To that end, MN Community Measurement will also focus on the consumer's need to access and use health care information. In 2008, 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 of a patient-provider encounter that could have bearing on the patient's ultimate health outcomes. MNCM will also pilot new Web site innovations, testing models on how best to communicate results with consumers so that the information is relevant to their needs.

We will continue to provide our measures for the Minnesota Bridges to Excellence (BTE) program sponsored by the Buyers Health Care Action Group (BHCAG). Eleven employers with nearly 700,000 covered lives were included in the analysis this year. Thirty-six clinics and three medical groups met the BTE threshold of 20 percent for the Optimal Diabetes Care measure for care delivered in 2006 and were recognized by BTE in June 2007. BHCAG is already working to expand the program with additional measures and employers in 2008.

Our vision is to be the trusted source for performance measurement and public reporting of quality data across the spectrum of health care and an effort that drives change by serving as a resource for providers to improve care and for patients in making decisions about their care. We are working to catalyze our community to work together on health care measurement to reduce costs and maximize value.

Acknowledgements

The *2007 Health Care Quality Report* is a collaborative 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 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:

The health plans and county-based purchasing organizations that contributed data for this report: Blue Cross and Blue Shield of Minnesota, First Plan of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, PrimeWest, Sanford Health Plan, South Country Health Alliance and UCare.

The medical groups and clinics that submitted data for this report: AALFA Family Clinic, Alexandria Clinic, Allina Medical Clinic, Altru Health System, Apple Valley Medical Clinic, Aspen Medical Group, Columbia Park Medical Group, Crossroads Medical Centers, Dakota Clinic, Fairview Physician Associates, Family HealthServices Minnesota, Family Medical Center, Family Practice Medical Center of Willmar, HealthEast, HealthPartners Medical Group, Hutchinson Medical Center, Mayo Clinic, MeritCare, Multicare Associates, North Clinic, Park Nicollet Health Services, Paynesville Area Health Care System, Prairie Family Practice, Ridgeview Medical Center, Southdale Internal Medicine, St. Cloud Medical Group, St. Mary's/Duluth Clinic, St. Paul Heart, University of Minnesota Physicians, Western Wisconsin Medical Associates and Winona Clinic.

The Data Planning Group, delivering technical guidance on data specifications and collection: Sarah Cook-Burton, Jane Gendron, Ann Herzog Morrison, Kathleen Hulting, Tracy Kueter, Karen Oudekerk, Monica Simmer, Alex Tava, Jim Theurer, Diane Wehrle and Rachel Woods.

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We also wish to thank all medical groups and clinics in Minnesota and in communities that border Minnesota for their continued commitment to quality improvement as a means to provide the best care possible.

90 Medical Groups (Primary Care) Reported in 2007

AALFA
Affiliated Community Medical Centers
Albany Medical Center
Alexandria Clinic
Allina
Altru Health System
Amery Regional Medical Center
Apple Valley Medical Center
Aspen Medical Group
Avera Health/Tri-State
Baldwin Area Medical Center
Bloomington Lake Clinic
Brainerd Medical Center
Broadway Medical Center
Buffalo Clinic
Burnsville Family Physicians
Camden Physicians
Cedar Riverside People's Center
CentraCare Health System
Central Lakes Medical Center
Children's Physician Network
Columbia Park Medical Group
Crossroads Medical Centers
Dakota Clinic
Edina Family Physicians
Edina Sports Health & Wellness
Fairview Health Services
Fairview Mesaba Clinic
Family HealthServices Minnesota
Family Medical Center
Family Medicine of Winona
Family Practice Medical Center of Willmar
Fergus Falls Medical Group
Foley Medical Center
France Avenue Family Physicians
Graceville Health Center Clinic
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
Riverside Family Physicians
Riverwood Aitkin Clinic
Scenic Rivers Health Services
Silver Lake Clinic
Sioux Valley Clinic
Southdale Internal Medicine
Southern Metro Medical Clinics
St. Cloud Medical Group
St. Croix Regional Medical Clinic
St. Joseph's Family Clinics
St. Luke's Clinics
St. Mary's/Duluth Clinic Health System
St. Paul Family Medical Center
Stevens Community Medical Center
Stillwater Medical Group
SuperiorHealth Medical Group
United Clinics of Faribault County
United Family Practice Health Center
University of Minnesota Physicians
Wadena Medical Center
Western Wisconsin Medical Associates
Winona Clinic

Additional Provider Types Reported in 2007

2 Endocrinology Clinics

Endocrine and Diabetes Associates
Mark P. Stesin, MD

3 Cardiology Clinics

Metropolitan Cardiology Consultants
Minnesota Heart Clinic
St. Paul Heart Clinic

20 Obstetrics/Gynecology Clinics

Adefris & Toppin Women's Specialists
Advanced Specialty Care for Women
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
Women's Health Consultants

13 Urgent/Convenience Care Clinics

Chaska Urgent Care
Express Healthcare
HealthEast Urgent Care
Maple Grove Urgent Care
MinuteClinic
Now Care Medical Centers
Priority Pediatrics
Physicians Urgent Care
RapidCare Urgent Care
St. Francis Medical Clinic Urgent Care
Suburban Emergency Associates
The Doctors Office Urgent Care
WestHealth Urgent Care

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