Sponsors of the Oregon Chronic Disease Data Clearinghouse And Tracking System Pilots

Using Data to Improve Chronic Care: Building Capacity and Connectivity in Oregon

Highlights from the Pilots Projects: Chronic Disease Data Clearinghouse and Asthma and Diabetes Tracking Systems

September 2005

For more information see www.Q-corp.org

Acknowledgements:

Funding for this project was provided by

Oregon Department of Human Services, Chronic Disease Program, and

Northwest Health Foundation

with additional contributions from AstraZeneca, GlaxoSmithKline and Regence BlueCross/BlueShield

More than 200 people at 40 organizations also provided substantial in-kind resources. Without their support this project would not be possible.

For more information:

OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

Nancy Clarke, Executive Director
Oregon Health Care Quality Corporation
111 SW Fifth Avenue, Suite 2800
Portland, OR 97204-3693
Phone 503-273-5935
nancy.clarke@q-corp.org

OregonAsthmaNetwork

Kirsten Aird, MPH
Department of Human Services
Oregon Asthma Program
800 NE Oregon Street. Suite 730
Portland, OR 97232
Phone 971-673-1053
kirsten.g.jensen@state.or.us

Oregon Diabetes Coalition

Jean Anderson
Department of Human Services
Oregon Health Promotion and Chronic Disease
800 NE Oregon Street, Suite 730
Portland, OR 97232
Phone 731-673-0984
jean.r.anderson@state.or.us

Reports are available at www.Q-corp.org

Chronic Disease Data Clearinghouse
Steering Committee Members

Jody Pettit, MD, Steering Committee Chair	Oregon Health Care Quality Corp, and Providence Health Systems
Grieg Anderson	Oregon Diabetes Coalition
Beverly Bauman, MD	Oregon Health Sciences University- Pediatric Services
Lynn Bentson, MD	First Care Physicians
William Hersch, MD, FACP	Oregon Health Sciences University
Sean Karbowicz, Pharm. D.	Regence Blue Cross Blue Shield of OR
Lisa Kranz	Portland Family Practice
Karen Main, MPA	Oregon Asthma Network
Csaba Mera, MD	ODS Companies
Melinda Muller, MD	Legacy Health Clinics
Douglas Perednia, MD	Kietra
Mike Rohwer, MD	Phtech
Karen Stral	Mercer HR Consulting
Dave Witter	Witter & Associates

Chronic Disease Data Clearinghouse Participating Health Plans:

CareOregon
Clear Choice
Family Care
Lifewise
Mid-Valley IPA
The ODS Companies
Oregon Medical Assistance Program
PacifiCare
PacificSource
Providence Health Plans
Regence BlueCross BlueShield of Oregon
Tuality Health Alliance

Chronic Disease Data Clearinghouse Test Practices:

Legacy Clinics Good Samaritan (Portland)
Maple Street Clinic (Forest Grove)
Portland Family Practice (Portland)
Salem Clinic (Salem)

Chronic Disease Data Clearinghouse Contributing Clinics:

Albany Internal Medicine Group (Albany)
Bend Memorial Clinic (Bend)
Calcagno Pediatrics (Gresham)
Corvallis Clinic (Corvallis)
Doctors Clinic (Salem)
Good Shepherd-Hermiston Medical Center (Hermiston)
Grants Pass Clinic (Grants Pass)
Legacy Clinic Emanuel, Children & Adolescents (Portland)
Legacy Clinic St. Helens Pediatrics (St. Helens)
Mid-Valley IPA (Salem)
OHSU Internal Medicine (Portland)
Peace Health Medical Group (Eugene)
Samaritan FirstCare Physicians (now Albany Internal Medicine Group-Albany)
Samaritan Internal Medicine (Corvallis)
Southern Oregon Pediatrics (Medford)
Tuality Health Alliance (Hillsboro)

Asthma Tracking Clinics:

Legacy Clinic Emanuel Children and Adolescents (Portland)
Tuality Health Alliance (Hillsboro)
Marion Polk Community Health Plan, organized under Mid-Valley Independent Physician Association (Salem)

Diabetes Tracking Clinics:

Interhopsital Physicians Association (Portland)
Samaritan Health Services (Corvallis)
Legacy Clinic Good Samaritan (Portland)

Using Data to Improve Chronic Care: Building Capacity and Connectivity in Oregon

Project Highlights
September 2005

Oregon's health plans and clinic pioneers have completed ground-breaking, collaborative pilot efforts to improve the quality of care provided to people with chronic conditions. Changing the way care is delivered – from a system developed for acute diseases to one more suited for chronic conditions – is extraordinarily difficult. Under the leadership of the Oregon Health Care Quality Corporation, Oregon Asthma Network and Oregon Diabetes Coalition, partners have worked together on pilot efforts to build the capacity and connectivity in Oregon that is needed to support high-quality, cost-effective care for people with chronic conditions.

Oregon's health plans and clinic pioneers have completed ground-breaking collaborative pilots to build the capacity and connectivity in Oregon that is needed to support high-quality, cost-effective care for people with chronic conditions.

The Need:

Unlike most acute conditions, chronic care must be managed as an on-going partnership between the patients and their providers. Building and using tracking systems to manage care at the point of service is a fundamental part of practice redesign that is required to manage this partnership. High quality chronic care requires that appropriate delivery systems use registries to:

- manage a list of people who have diseases such as asthma and diabetes,
- track the care they receive from a multitude of providers through data sharing,
- prompt action based on evidence-based decision support
- monitor individual management and outcomes
- report population results

Oregon's visionary partnership has tackled the task of creating and sustaining such tracking systems in the existing fragmented delivery system where data reside in silos.

The Pilot Results:

Partners have taken a two-pronged approach to build the capacity and connectivity for tracking systems through a series of pilot projects.

"We discovered one asthma patient was being repeatedly admitted to a hospital across town. By assigning a social worker to help with medication management we probably recouped the entire cost of the registry development."

Provider Registry Capacity:

Six organizations developed registries for either asthma or diabetes and integrated them into delivery systems. All six of the projects successfully completed their planned pilot project, demonstrated improved care of their patients, and leveraged the pilot project beyond its original scope within their organizations. The projects each demonstrated that implementing system improvements is complex, takes time, and requires dedicated leadership working effectively with clinicians and provider staff to implement better systems to serve their patients.

Connectivity Between Systems:

A Chronic Disease Data Clearinghouse merged claims data from eleven health plans to provide better tools to help clinicians manage diabetes and asthma care. The political and legal hurdles to sharing data were successfully addressed. The technical challenges were met for four test clinics, resulting in a series of paper and electronic reports that physicians identified as significantly more useful than separate health plan reports. The substantial remaining technical challenges to scaling the project to more clinics were identified. **The pilot demonstrated, above all else, that no single entity has all the data that is needed to manage patients' care.** The need for cross-plan coordination of data was thoroughly substantiated.

The pilots have clearly demonstrated that building capacity for electronic management of patient information across delivery system silos is essential to quality care. People with chronic diseases are cared for by multiple clinicians, all of whom need a full picture of the care that is provided. Pilots have shown that assistance, convening, facilitation, and small grants can leverage significant change at the practice level. Pilots have shown that data fragmentation is a serious barrier to quality care that must be addressed through coordination of health plans, health systems, clinicians, purchasers and patients.

"For the first time we know which prescriptions our patients are and are not filling. It's pretty alarming."

The Challenge

Since these pilot projects began, national attention has galvanized demands for improving the availability and connectivity of electronic health records that share data through health information exchange. Oregon's cooperative approach, as shown in these pilots, is our greatest asset for addressing the challenge. As we merge the chronic disease pilot project results with the evolving vision for a national health information infrastructure, Oregon's leaders have an opportunity to work "the Oregon way" through collaborative partnership.

Many organizations have provided substantial direct and in-kind contributions to complete these pilots. The bulk of the resources for coordination were provided by the Oregon Department of Human Services Chronic Disease Program and the Northwest Health Foundation. These organizations are important resources for start-up and evaluation, but do not expect to be the on-going source for funding. Healthcare organizations need a centralized data coordination resource in order to function as a system. Funding that central resource is an essential responsibility of all stakeholders.

Call to Action:

Supporting a patient is rarely the sole responsibility of a single provider. Data must be shared across the community of care givers in order to appropriately serve people with chronic diseases. Oregon's health care stakeholders should expand and finance the partnership to jointly address the challenges of developing community-wide, data-sharing systems.

To Learn More:

The partners are releasing a series of reports that summarize progress. These are available at **www.Q-corp.org**.

- Chronic Disease Data Clearinghouse Pilot Project: Project Summary and Recommendations, Steering Committee, September 2005
- Chronic Disease Data Clearinghouse Evaluators' Assessment, September 2005
- Chronic Disease Data Clearinghouse Vendor Final Report, OMPRO, August 19, 2005
- Chronic Disease Data Clearinghouse Physician/Provider Interviews Component I, Riley Research, December 30, 2003
- Chronic Disease Data Clearinghouse Physician/Provider Interviews Component II, Riley Research, 2003
- Evaluation Report for Asthma Tracking Grants, Oregon Department of Human Services Asthma Program, September 2005
- Evaluation Report for Diabetes Tracking Grants, Witter & Associates