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RE: CHRONIC DISEASE DATA CLEARINGHOUSE
PHYSICIAN/PROVIDER INTERVIEWS – PHASE II

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BACKGROUND

The Clearinghouse Project was the result of a partnership among Oregon health plans/systems and physician groups. The Oregon Health Care Quality Corp (OHCQC), the Oregon Asthma Network (OAN) and the Oregon Diabetes Coalition (ODC) sponsored the work. OMPRO, Riley Research Associates (RRA), and the Department of Human Services (DHS) staffed the project, with the supervision and assistance of the Steering Committee.

Riley Research Associates (RRA) was engaged to conduct on-site qualitative interviews with physician/provider groups in order to solicit their input regarding the Clearinghouse concept, development, and reports. Within the Clearinghouse process, our responsibility was to:

- 1) Assess the viability of the Clearinghouse concept in terms of provider interest in participating versus hesitation to participate. Gather provider input to inform the construction of the Clearinghouse and associated end products.
- 2) Test and fine-tune the Clearinghouse reports, by assessing provider interaction with the data and evaluation of associated end products.
- 3) Conduct final research such as information sharing sessions during which providers may share experiences, opinions, and suggestions regarding the Clearinghouse project.

To complete the end product review and assessment (Phase II), the team was to produce patient lists from participating clinics, get verification of the patient data from the clinics, then collect and merge the patient data from the 12 participating health plans (both commercial and Medicaid), in order to produce sets of uniform reports, populated with patient data. This report summarizes our findings from step 3, the final research component.

Based on the feedback from Phase I, the Steering Committee oversaw the development of four patient/clinic reports. The four reports (as described to clinic participants) were designed to be similar for both asthma and diabetes patients:

- Report A (Table 1) is a report of patients with asthma and diabetes, and are meant to give you an overview of those associated with your practice and what the plans showed us about their care.
- Report B (Table 2 Diabetes; Tables 2-4 Asthma) is what we are calling a “take action” report. Report B lists those patients with asthma and diabetes who may need special attention or follow-up.
- Report C (Table 3 Diabetes; Table 5-6 Asthma) is a detailed report on an individual patient. Such a report could potentially become a part of your patient’s chart and be available at the point of service.
- Report D is an aggregate report which gives you a picture of what your asthma and diabetes practice looks like overall, and compares your practice to that of your peers and system wide benchmarks.

PHASE II - PURPOSE & PROCESS

To complete this Phase, our assignment was to provide the Clearinghouse Steering Committee with feedback from the physician groups, regarding their opinions and perceptions of the Clearinghouse product. To this end, RRA worked with project staff, the sponsoring organizations, and the Steering Committee. The following is a summary of the feedback we obtained through the final round of interviews among participating medical offices. Goals for this phase included determining:

- the accuracy of the process
- the usefulness and of each report
- the overall value of the Clearinghouse program

In addition to assessing content, character, format, and usefulness of the Clearinghouse output, we also asked participants to contrast and compare the Clearinghouse reports with existing sources of patient information, and probed their perceptions regarding future use of – and support for – the Clearinghouse concept.

Had more financial resources and time to produce patient reports been available, we would have preferred to interview a larger group of medical practices. Even so, the four offices that did participate provided a reasonable degree of diversity. There were two urban offices (in Portland), including one independent operation and one hospital-based practice. There was a rural clinic (Forest Grove) and a medical office in Salem. Based on the limited final sample, we would deem these results exploratory, yet insightful.

PHASE II - PARTICIPANTS

Based on a list of ratings and evaluation questions, we scheduled and conducted on-site interviews with representatives from four participating physician offices. The offices included:

- Portland Family Practice / Lisa Kranz & Gayle Dukhart (4-1-05)
- Legacy Clinic - Good Samaritan / Melinda Muller, M.D. (4-4-05)
- Salem Clinic / James Byrkit, M.D. (4/11/05)
- Maple Street Clinic / Scott Kenyon (4/12/05)

A fifth office, Bend Clinic / Dr. Ritzenthaler, maintains an interest in the project, but was unable to complete the analysis of the patient list in time to produce and evaluate the populated data reports.

The four clinics that verified their patient data each received a set of reports in advance of the follow-up interview. Interviews were scheduled and completed with each of the four medical offices. Because of time pressures on the part of clinic staff, not every question was asked in each clinic. Overall ratings and general suggestions were the priority.

For the four clinics, the evaluations usually involved multiple personnel, including physicians (3/4), nurses (2/4), management or quality assurance staff (2/4).

RESULTS

Conclusions

While the overwhelming issue, raised by the medical practitioners, was *missing data*, there was also strong agreement that the Clearinghouse *concept* has great potential.

The missing data were most often manifest in terms of known patient visits, which were determined to have occurred within the timeframe of the report, but did not appear in the report. Two of the practices (PFP and Legacy) were pleased with the accuracy, and were committed to sharing the results with their physicians, while the other two (Salem Clinic and Maple Street), felt the missing data rendered the content of these reports unusable.

There was some speculation as to the reasons for the missing data. Inconsistent coding for patient visits was suspected as a prime reason. Some indicated that when patients visit for multiple reasons, other codes (besides asthma or diabetes) are often used, especially if the other conditions were more complex and/or are reimbursed at higher levels. Similarly, if the patients' visit was scheduled for a different purpose, the asthma or diabetes treatment may not have been recorded. One practice manager said: "There's not a lot of consistency from one practice group to another, about how things are coded."

Without improvements in the comprehensiveness of the records, the effort would likely fail. The two clinics with the most missing data concerns did not, and would not distribute the current reports to the patients' physicians. Their experience suggests that once a physician deems a source unreliable, he/she will never take the time to give it a second chance.

Despite the missing data, there was broad belief in potential value of the Clearinghouse program. Current versions of patient reports from insurance providers are said to "pile up for months," and one clinic reported that physicians routinely "toss them" (unexamined). The Salem and Maple Street Clinic representatives saw less value in the individual patient reports, because they have their own Electronic Medical Records (EMR) systems.

Every clinic expressed great interest in the summary page (Report D), which provided a comparison of results for their clinic (or practice) versus the State of Oregon. Some pointed out, however, that due to the significant missing data, their stats were underreported, thus diminishing the value of the current report.

Missing data aside, the planned content and refined formats portend great usefulness. There were a few exceptions: some felt that office staff require less complex data, particularly if the report was likely to be reviewed by a manager or clerical staff member, rather than by a physician.

One respondent thinks that in order for the information to be viewed as effective by the doctors, the Clearinghouse will need a “champion” at the practice, who will train and promote the information.

Most of the reports were highly valued (assuming the accuracy and completeness can be improved). Two practices gave lower usefulness ratings on some patient reports, but only because their internal electronic medical records system was already accomplishing the same goal.

Overall Program Value Rating

When asked to make an overall assessment of this program, versus the traditional methods of reports, the ratings were clear and highly positive toward the program.

Please contrast and compare the value of the traditional approach of receiving patient information (multiple sources/formats), to this “Clearinghouse” approach (single source/format) (1 – 10 Scale):

Traditional Approach	Rating: 1.4	Clearinghouse Approach	Rating: 8.5
	“Doc’s toss them”		“If accurate”

Key Benefits

Participants think a properly implemented system would increase healthcare efficiency, saving time for the doctors, the practices, and potentially providing patients with more proactive treatment. “The health plans would be the real winners,” said one.

Some believe the Clearinghouse could save patient and staff time, resulting in fewer emergency room and hospital visits. One characterized the Clearinghouse as: “An awesome statewide system (and a) great first step.”

Report D (Aggregate / Comparative Report) was a very compelling report. Medical staff and doctors alike were very much interested in comparing their practices with others. “But if our results are incomplete, it’s not fair.”

Future Considerations

Two of the participants already have an Electronic Medical Registry, and one other anticipates the possibility. The consensus is that reports need to be in an electronic “downloadable” format (such as Excel or Access), if not for importation, at least so that the clinic director can better format and deliver the reports within the practice.

QUESTION BY QUESTION RESPONSES

(Questions appear in bold; responses in regular font)

The Patient List: The first thing we sent you from the Clearinghouse was a list of those we identified as your patients, whether they had asthma, diabetes or both. From this list, it looks like the Clearinghouse defined (X) patients as having diabetes.

Did we find the right patients and did these patients have diabetes or asthma? Did you feel that the number of patients identified was lower than you expected, about right, or higher than you expected?

For the most part, the answer was “yes,” although some problems were encountered. Sometimes patients were listed with the wrong doctor, or a doctor who is no longer in practice. Legacy indicated that patients appeared to be associated with the medical director, as a practical matter, because the interns turned over so rapidly.

To what extent was this information accurate or perhaps surprising? Did you learn anything from this patient list? Was it useful?

Only the missing information (on patient visits) was considered surprising.

Report A (Table 1)

Report A is the list of patients with asthma or diabetes. It’s meant to give you an overview of who has asthma and diabetes and – according to the health plan information -- what their care has looked like.

To what extent was this information accurate or perhaps surprising? Did you learn anything from this report? Did you feel that the number of patients (with asthma/diabetes) was lower than expected, about right, or higher than expected?

While there were some surprises, the patient information was considered generally consistent with clinic records.

Is having this patient list, with a summary of their services useful to you? What would make it more useful?

Respondents considered Report A as very useful. Several suggested that it would be clearer and easier to evaluate the report if a field were left blank, rather than filled it with the word “unknown.”

On a scale from one to ten, where ten means “highly useful,” how useful is this report?

Ratings of 6 to 9 were given for “asthma” while ratings of 3 to 10 were given for “diabetes.” The one giving a 3 would have given a higher rating if the data were up-to-date.

What could make it better?

Highlighting entries that are more than six months past due, would make the report better. Enabling the merging of spreadsheets, text, and other files (with their registry) would also improve it.

Report B (Table 2 Diabetes; Tables 2-4 Asthma)

Report B is the “take action” report. The idea is that a provider or case manager can look at the report and know what actions to take to improve the care of the patient. We could also provide other tools – like address labels and postcards.

Missing data is a problem. A doctor suggested leaving a space blank instead of “unknown.”

Report B flagged some patients that might have needed follow-up. Did you (do you) see a value in this report? Why or why not?

“The report is valuable if it is accurate, comprehensive, and current.”

Regarding the information on the exception report, how might this fit in with your practice? What other information or in what other format would you prefer it?

Some respondents wanted telephone numbers and address labels (for the scheduler); others wanted information on prescription substitutions, and surcharges without doctor's instruction. The preference for a blank space rather than "unknown" was repeated. One practice manager thought Report B – Asthma "Take Action Report" was too complex for office staff: "This report could simply show the number of prescription refills in past 12 months, versus the average."

For asthma patients, this report covers patients who maybe overusing beta2-agonists or under-using controller medication and those who have received treatment at an emergency department or hospital. Are there other factors that would be useful?

Information on the potential issues that may arise, a more simplistic value (for front office personnel), and the number of prescription refills in the last twelve months (compared to the average), would be useful.

Can we designate on the reports that a patient is 'out of compliance' with recommended guidelines. Does this create a liability?

No particular concern was noted. Automated phone reminders were suggested. One respondent stated that Blue Cross had tried this, but the information they provided was incorrect.

The report also provided follow-up tools (like address labels, a sample letter, a reminder postcard and some chart stickers). Do you see a value in any of the tools? What would make them (more) useful?

Some said their systems already provide the follow-up tools (EMRs), but others think the address labels and the sample letter would be very valuable. While those with EMRs didn't see a value in chart stickers, one said they would "cut & paste" the sample language for their own system.

On a scale from one to ten, where ten means “highly useful,” how useful is this report?

Again, the completeness of the data limited participants’ ability to rate the usefulness of the report: one respondent gave a rating of three, while the other ratings ranged from five to nine and one-half (more complete data would have produced higher ratings).

What could make it better?

Data that is no more than three to six months old, using a “blank” for missing data, and telephone numbers would improve this report.

Report C (Table 3 Diabetes; Tables 5-6 Asthma)

Report C is a detailed report on an individual patient. The idea with such a report is to have information from the Clearinghouse available in the patient’s chart so it is available at the point of service.

On a scale from one to ten, where ten means “highly useful,” how useful is Report C?

Likewise, ratings ranged widely from one respondent to the next, depending on the completeness of the information. One respondent felt the introduction is good but too long. Another said the report is, “nicely formatted.”

What could make it better?

Current and accurate information, and a way to highlight those who are out of compliance, would improve this report.

Report D

Report D is an aggregate report that shows you information about your practice as a whole, and compares your performance to other practices in the state.

What did you think of the practice summary information?

Most of the respondents liked the summary information. “Doctors are very competitive,” (and will work harder if they appear to be rated lower than their peers), said one. Another respondent found it interesting to compare the emergency room visits to hospitalizations. One questioned how this chart could consider the doctor’s guidelines: “Who sets these guidelines?”

Were there any surprises?

A respondent was surprised by the peer information; they thought it was, “a good reality check.” Another was pleasantly surprised by both the asthma and diabetes ratings, because they had not seen it before, “it’s nice to know all our efforts have made a difference.”

How important is the comparison data? If not, what – if anything -- would make that data (more) useful?

Multiple respondents brought up the issue of accuracy. One respondent thinks a practice would need a “champion” for the report, otherwise the doctors would devalue it. Providing “target numbers” for diabetes would make the report more useful.

If you were able to use the aggregate report, how did you use it? (If not) Why not? Were there enough cases? (If not) How many cases would be needed?

One respondent thinks that most doctors will attempt to self-correct, using the report.

Do you have any staff specifically assigned to work with patients on disease management (for example, checking up on patients not seen in a long time)?

Two of the four respondents have no one specifically assigned to disease management, one respondent does, and one has a part-time staff member for disease control (as time allows).

If you do have staff assigned for this purpose, why? If not, why not?

One respondent has staff assigned, because the medical and lab staffs are glad to be a part of the team. “It makes them proud to see the achievements.” One said the staff is provided through a grant.

For those who don't have staff assigned, it's usually because there is no compensation provided for such a position, and they feel are able to manage without the expense, although they admit the analysis often ends up, “on the back burner.”

How would you rate this clearinghouse plan, in terms of its potential to have a positive impact on the cost-effectiveness of healthcare delivery to your patients? (One means no potential, ten means enormous potential)

All participants gave high marks for the “potential” of the system. Average Rating: 8.5

Delivery Issues

Who will be the primary user of each report?

Some clinics send each doctor their patient data. One respondent would “slice and dice” the information. One manager would send, “out of compliance data” to applicable doctors. Another said, they would send the (B) “take action” reports to schedulers, the (C) chart data to the nurses, and the (D) practice summary data to the doctors.

What (else) could you or would you do with the reports, if we made the changes you suggested?

Combining old reports with new ones, and sharing results with a process improvement department, were possibilities.

How often should the reports be delivered? (For example, monthly, quarterly, semi-annually, annually?)

Most of the respondents would like to see the reports quarterly. The comparative ratings (Report D) could be semi-annual.

Should the frequency be different for different conditions or reports? For example: some reports (Reports B & C) deal with “patient issues” while others (Reports A & D) deal with “system issues” (the latter of which may be desired on a less frequent basis).

One said yearly for the diabetes report; one said twice a year for the asthma report.

What form of report delivery would work best for you or your practice? (For example, fax, CD-ROM, email, mail, secure website, etc.?)

Most were adamant about receiving electronic versions (that can be imported into data base programs, such as Excel or Access). One said email, one preferred a secure website, and one favored a CD-ROM. A less automated clinic prefers hard copies in the mail.

What source for the information makes the most sense to you, or do you care who integrates the data?

The consensus was that it should be an independent source, not affiliated with any practice or insurance provider. Clinic-level data is more acceptable than practice-level data. A third-party source, such as OMPRO would work.

How would this system fit into any plans your organization may have for a system of Electronic Health Records, or Electronic Disease Registry? How proactive would your clinic be, in terms helping, such as logging in Doctor’s names to order reports?

One respondent would be very proactive; they would like EDR downloadable files. A respondent suggested that the reports would be easier to print out than

to scan and that a database might allow them to sort and create reports of their own. Another said they wished they had EDRs, but can't afford it, and are looking for an "alert system" to pull together information and update charts.

A Few Final Questions

What would you like to see as Clearinghouse next steps? What would be useful? What level useful? Clinic level? How would/could the IPA assist you in doing the work? Care optimization? Making life better for doctors?

The key is to work toward greater quality and accuracy. "Trust in (these types of reports) needs to be established, or the doctors will ignore them." One respondent would like to see more cities added, more information on patients, and progress towards real-time data.

How will these work as an on-going process? Will it be sustainable?

One respondent thinks the reports are definitely sustainable, "like with Providence." Another suggested, "Sustainability requires not making (clinics) input their patient lists each time." Sustainability is attainable if the missing data are found and the reports are accurate.

For asthma, we struggled with whether Report A should be a list of all your patients with asthma (intermittent through moderate persistent) or just those with severe persistent asthma. We also wondered if we should broaden the report all together, and include those with conditions like COPD, chronic bronchitis, chronic wheezing, reactive airway disease or others. Who do you think should be included in this report?

Virtually everyone agreed that the system would be most effective and efficient if cases were limited to patients with chronic conditions.

One manager suggested the Clearinghouse model could also work well in the treatment of hypertension.

What final thoughts or suggestions would you offer?

One suggested that color might not be good for some (who lack color printers), but they like the how yellow gets their attention. Another thinks the doctor and patient listings need to be unified, rather than listed in varying ways.

In Conclusion

Everyone agrees that the Clearinghouse concept is vastly superior to the burdensome and erratic array of reports they now receive. Most recognize the potential value of better source data (i.e.: subscriptions *filled*, versus *written*). There is much speculation as to the reasons why patient records are incomplete (whether systematic or programmatic).

In the end, it was broadly recognized that with timely and complete data, the Clearinghouse reports portend great potential for closing a critical communication loop in the treatment of chronic conditions.

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