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Common Barriers with Quality Measure Reporting

Presented by [Dr. Paul Kleeberg & Phillip Deering] (55-minute Webinar) [08-22-2012]

Angie: I’d like to introduce Jerri Hiniker. She’s a Program Manager for preventive services for the QIO program at Stratis Health. Jerri does quite a bit of work within the HIT and EHR arena’s as well. Welcome Jerri.

Jerri Hiniker: Thank you Angie and welcome to today’s webinar on overcoming barriers. This is the third webinar in the series of activities in learning sessions that is part of a learning collaboration of REACH, the Regional Extension Center for Minnesota and North Dakota. Stratis Health, Minnesota’s Medicare Quality Improvement Organization or QIO. North Dakota Healthcare Review is the QIO for North Dakota.

Our presenters today are Dr. Paul Kleeberg, the MIO for Stratis Health and REACH Clinical Director and Phil Deering, Stratis Health Manager of Program Development and Implementation. We’re also joined today by Connie Geyer, a Quality Improvement Specialist for North Dakota Healthcare Review and my counterpart in North Dakota.

I want to start today by providing you with a little background on this collaborative effort between REACH and the QIO from North Dakota and Minnesota. For those of you who may not have had a chance to participate on our previous webinars, I know we reviewed this in our first webinar that we presented but I notice we have a few new faces and I want to make sure everybody knows why they were invited to this webinar today.

As I said earlier, this is the third webinar in the series of activities that are part of the learning and action network or what we refer to as LAN. Because we’re partnering with REACH you are also enabled to participate in these LAN events, which are focused mostly on the use of health information technology to improve quality and physician practices.

Participation in the learning and action network will further enhance your efforts to successfully earn EHR incentives and achieve public recognition for your HIT efforts and provision of high quality care. This is a collaborative, part of the national initiative that’s been coordinated by the Centers for Medicare and Medicaid Services (CMS) and the Quality Improvement Organizations (QIO) in each state and territory.

With the invitation to this webinar you should have also received the documents with the dates of the upcoming webinars, which are usually schedule every other month and that goes through December of 2013. The previous webinars have been recorded and are located on the Stratis Health website. Feel free to contact Connie or myself for anymore information about LAN or if you have any other questions about how to access webinars. We’ll have a slide at the end of this webinar with our contact information.

I also wanted to review a little, so what we’re going to do today, the process for this webinar what we’re looking for is sharing from everyone on the phone. We want this to be a learning activity where we can all learn from each other, so we’re going to start
with the clinic sharing and discussion on the information. As mentioned, we’re focusing on the barriers that you may have encountered when trying to do reporting from your EHRs, both can be related to any quality initiatives you’re working on for meaningful use or PQS or even some of the other initiatives that you need to report measures from.

With that too we’ll have input from Dr. Kleeberg and Phil Deering and hopefully, that even amongst the clinics themselves that someone encountered a barrier that another clinic was able to overcome. As you’re sharing your information we’ll be capturing it so you can see it on the slides in front of you as you’re telling us about the barriers you’ve encountered.

We’ll put the barrier up and what resolution you tried and we’re hoping you had a successful resolution but anything you try that maybe even if it wasn’t successful if you can share it with us that would be great.

When you’re sharing your barriers if you could identify yourself and the clinic you’re from that would be helpful. And with that I’m going to turn the webinar over to you, the participants. I’ve spoken to a couple clinics prior to this call that I know have some successful processes in place for overcoming barriers, so if someone would like to start by sharing that would be great.

Dr. Kleeberg: I think I can break the ice to ask if any of you has started and attempted to use your quality measuring with some of your providers and ask that you share some of your experience with that.

Barb Anderson: Hi from Mankato, Minnesota. We actually do some reporting, we have a monthly scorecard that we keep for the entire clinic that is high level reporting, as far as our diabetes, IVD and BMI, interventions and our depression measure. We also do what we call IT meetings where we go out to the individual clinics on a rotating basis, so we have one month where it will be the measures that we’re submitting and any other measures that we’re following through the clinic and we take those scores and data to the facilities themselves.

It’s totally transparent, they know where everyone else is standing and they know what everyone else is doing. We take those out every three months as a collective group. Somebody from quality research goes out and meets with them if they have questions. We try to help them with that as best we can. We do a different thing every month for quality on a three month rotating basis.

Dr. Kleeberg: What was your biggest challenge in getting this started?

Barb Anderson: I really thought the transparency would be an issue but it hasn’t been, but in quality ourselves it’s trying to get discreet data so we don’t have to do it by hand to get it out. We’re getting more and more discreet data, but it’s not all that way so that’s a contention point for us. We’re working on it, so it has to do with our EHR and how they’re inputting it. Of course, there are always those who don’t want to follow the rules.

Dr. Kleeberg: One of the challenges has been collecting discreet data and is it a possibility that the MDs, Pas or NTs could put that data in or other staff.

Barb Anderson: It all depends on what it is. It’s a team effort. Some things the person that’s rooming the patient can do it, other times it’s pulled electronically into a database but sometimes it’s the provider and it all depends on what it is and where it is in the system. We’re trying to streamline it as much as we can as we go along.

Dr. Kleeberg: How much of it would you say is a technical barrier? Sometimes it can be challenging given the new EHR that you’re using to be able to find some of these things as a professional and provider.
Barb Anderson: Technical meaning having the ability to do it discreetly or the provider knowing how to do it discreetly?

Dr. Kleeberg: It's 9:30 so it's not in the workflow which makes doesn’t make sense to anybody except a coder, etc. that kind of technical.

Barb Anderson: We try to do a lot of training. The EHR staff works closely with us also and once we get a new procedure or workflow that's gone through clinical ops then the EHR staff will train everyone on that and we're also troubleshooting so if they have questions they can always call us.

Percentage-wise I don't know if I could make an educated guess on that, but in that respect maybe 20%. They know how to do it but it's always one more click type thing, but I think they're seeing the benefits of some of the workflows on stuff on the back-end now. It's always where some people will be tough nuts to crack but I think it's getting better in that respect.

Dr. Kleeberg: Barb, I know you're not the only person with that challenge. I know a number of people that are on this call who have experienced that challenge of either it's a technical issue, workflow issue or could be a hard issue of actually spending the time and energy to find that.

Would anyone else like to share their challenges with that or potential solutions you've tried to find for this?

Barb, thank you for being courageous and breaking the ice.

Barb Anderson: You're welcome.

Nancy Malt: Hi, from St. Rivers.

Dr. Kleeberg: Hi.

Nancy Malt: We certainly have experienced similar challenges and one of my biggest challenges is communication, being able to communicate with everybody that needs to be trained. It's a rare thing that everyone is present at the meetings, because of vacations, schedules and then catching up with them and that one that missed a training to be able to know where to go.

Dr. Kleeberg: You may have hearts in hands but the challenge right now is the know-how of how to be able to do it and how to disseminate that information so they're able to define those codes and elements that need to be collected, do I understand that correctly?

Nancy Malt: Yes. The more you require of your staff and providers to meet all reporting requirements, the more there is the need for sustainability to give back and review what we looked at six months ago and if we're still capturing that because now we want to add this. Just to keep everyone on task is challenging.

Phillip Deering: Hi Nancy, that challenge, I think we all face it of this increasing burden of documentation that we need to keep up. Do you use any kind of online system or repository, where the documentation is easily available so if someone missed something there's a way for them to retrieve it or have you thought about any of those solutions?

Nancy Malt: I don't know that we'd have the resources for that. What we have implemented is from training of our nursing staff, because again you always miss somebody as to, at least have the minutes of the meeting available outlining what was implemented and each staff member is required to review and sign off on that to be sure everyone's at least seeing it.
Phillip Deering: That's a good idea. Just to follow up, Dr. Kleeberg was referring to these notions of head, heart and hands and we may cover this more, but in our change management model we think of that as a great checklist for people, so if you're trying to change behavior you may well need to get everybody intellectually aligned so they understand what's going on, what the plan is and that has a huge amount to do with communication.

We talked about the heart piece motivation and that's where things like the transparency would come up and sharing the data and we all know that a lot of our professionals are relatively competitive and want to see what others are doing to compare themselves to others, so we want people to change therefore we need some kind of motivation.

Barb talked earlier, whether people saw it as a pain or something extra they had to do, but now they're starting to see some benefits and I bet you're also seeing that same thing. Finally, that notion of hands, in the end too often we put actual barriers to people who are willing to do this stuff, but we don't take time to train them or as Dr. Kleeberg referred to, the interfaces and the hoops we have to go through actually present challenges.

Over time then we want to make sure that we’re actually empowering the people with the training and with the little improvements or flow sheets, those are the things we can build into our EHRs. That's that nomenclature that we were referring to earlier.

Barb Anderson: This is Barb from Mankato again. I agree. The competitiveness has paid off. We see a couple providers that are really competitive and say now you’re at 80% and I’m only at 50%, what are you doing that I’m not doing? I just had an email flash across my screen, we also have a three person EHR support and they’re each assigned a few departments so they get consistency.

They hold what they call open gym sessions as well as our IT department is going to do where they have a set time, maybe an hour or two at sites and then they will have a topic for that open gym but the providers, nurses or anybody can come ask questions, learn or whatever.

They also have been working with the providers one-on-one. They will actually go out and work whatever their schedule is for the providers and provide them one-on-one time so if they're having problems with something or don’t know how to do something or any kind of questions they can do that.

When we at Quality Resources go through things like I had PHQ9 (a dirty word in my book), we have some providers that just can’t quite get the discreet data. They're not filling it in where they need to and what I’ve been doing and noticed is that somebody is really lagging as far as they're rates are down and I’ll go in to see what the problem is. I’ll personally send them an email and say this is what’s going on and you need to do it this way. If you need help let me know and I’ve had success with that.

I had one provider say I guess I need to be a little more attentive to the scores where I put them because I thought the nurse was doing it the way it needed to be done. That cleared it up.

Phil Deering: A fascinating lesson that is behind the scenes is the whole notion of the feedback loop. The best way to think about it is that sometimes you’re in a hotel shower trying to get the temperature right, so you turn it one way and you’re freezing and you turn it back the other way and you’re burning, so the trouble is the thing you can adjust is too far away from the water heater so you can never get it right.

Similarly, if you can give people who are doing the job feedback quickly, they can understand what they’re doing, put it in the context of their activity and move to correct it.
If you wait for three months and then tell the person oh, your PHQ9s are way off, it's like you could have told me earlier. I think that’s a tremendously wise thing to do any time you can shorten the feedback loop and give people information they're much more able to act on it.

**Barb Anderson:** One other thing to go with that is if you have somebody that’s doing a fantastic job we try to let them know that too. You’re 99% awesome! That helps.

**Dr. Kleeberg:** I know that North Dakota Blue Cross Blue Shield has a methodology for collecting and sharing quality measures with some of the providers. I was wondering if there was someone on the call that could talk about that, and also in a sense, relate it back to what Phil just said. Is the feedback loop rapid enough and is it accurate enough that they can adjust their temperature freely or does it take them more time and do they move it too far getting scalded.

Tina, I know you're out there but I don’t know if you use that Medi Q Home process in your clinic.

Is there anybody from North Dakota on the call that can begin to address that for us?

**Connie Geyer:** I know a little bit about Medi Q Home from working in the clinic. Those offices that are signed up to work with Medi Q Home... Medi Q Home or MD Insight is the vendor which interfaces with their EHR and uploads that information midnight each night, so the data is current. Whether they access that and whether they share it with their providers I don’t know, because each provider can have a scorecard or what they can do is many of the physicians have the nurse go in to MD Insight and print out a data sheet prior to the physician going into the office to visit with the patient.

That then gives him or her a little update on the patient like blood pressure, cholesterol, mammograms, etc. it just gives them a snapshot of that patient and possible opportunities for care they might be missing. I don’t think from the facilities that I know, I don’t know how much they're sharing a scorecard with their providers. I know they're picking and choosing, maybe sharing with pediatricians and OBGYNs, but I’m not sure why that is.

I’m sure there’s some resistance there as well, but that’s what I know of the facilities that are using MD Insight.

**Phil Deering:** Again, folks at scenic and I don’t know if there are others here from that northern network on the call, but back to the feedback loop. We’ve seen some sample reports that were identified where not only were physicians numbers being shown for quality measures, but there were comparisons to other physicians in the same network, others to the Minnesota Community Measurements and if I remember correctly, maybe even patients in the age group or certain types of patients, for example, for your diabetic patients than you had further information about smoking rates for diabetics as opposed to the general population.

Do I have that right?

**Nancy Malt:** Yes, that’s part of our internal QI and then we try to bring in the outside reporting processes to show our providers and staff how we’re doing in comparison. So the smoking rates compared to what’s required for measurements and then how we add up internally.

Then we started last year and we’re bringing it back to show nursing provider teams how they’re addressing smoking cessation and smoking status, that’s a piece we were struggling with. So that transparency helps.
Phil Deering: I’m not sure but I think in some cases providers tend to bring up this notion that their patient panel is unique in some way from the broader numbers. Indeed in northern Minnesota, smoking rates in the general population might just be much higher than in Minnesota as a whole.

What I felt was so interesting is that not only were you seeing Minnesota as a whole, but it was within the network of clinics that are spread across that most northern quadrant of our state. Then again it seems to make it more personal, thus I the provider could internalize that more and maybe it was more of an impudence to work hard on those measures.

Dr. Kleeberg: So far we’ve identified a couple of areas that seem to be a particular challenge.

1. First, getting the diagnostic codes into the charts or all the discreet data that’s necessary for accurate data reporting.

2. Second, communication and training in getting folks (break in audio)

Have any of you folks out there tackled either of those two and found creative solutions to either?

Nancy Malt: I would say that we’re required to be able to capture things for our outside reporting requirements, so you definitely tend to build your EMR to be able to accomplish that, depending on what system you’re on. It’s a work in progress but once you start it and continue to add to your forms it becomes doable and the providers are on board, if you keep them in the loop during the whole process. It can happen.

Dr. Kleeberg: Good. (26:45…audio interrupt)

Phil Deering: Culture changes I know are always particularly difficult and we all know they take a while. How did the overall leadership of Lakewood oh, by the way weren’t you all on Public Radio today?

Stephanie: I don’t know we could have been.

Phil Deering: There was a story about Lakewood Health System and using a telemedicine option for your ER.

Stephanie: No, there is another Lakewood out there, so it may be them.

Phil Deering: Maybe, anyway it was a very interesting story this morning. Back to our topic, how did the clinic overall leadership start to address those issues of the culture change? How do you even begin to bring up those discussions and how are they going so far?

Stephanie: When I was working as a clinical informaticist we identified the need for this culture change to happen so we developed a group here called ‘chub user group’. That consisted of stakeholders as a medical director, we had two providers, a physicians assisted center if you will, director of nurses and an actual nurse from the clinic and IT department, HIM and I think that was it.

We had all these stakeholders at the table and we discussed current state, this is where we are, this is where we want to be so what do we need to do to accomplish this goal?

That took months to have those discussions because we had family practice in the room, OB/GYN in the room and everybody wants their own thing and they want it all customized to their needs.

We developed the understanding that you need to have a standard foundation workflow. You need to start there and once you have that built where it fits, then you can go up and have your custom for specialties not for a particular provider, but for that specialty of OB/GYN, cardio gastro or whatever it may be.
Then, once they realize the benefit of this collaborative effort and developing core forms, it really started making sense to them. It's been quite a work in progress. Our Chub user group has been going for eight months and in that time we've looked at the standard foundation, got them on the same page with that, got the buy-in that this isn't just about me but we're looking at this as a system so how can the form we're creating now help not just me but someone else down the road.

It's been a lot of work, 7:00 a.m. meetings every other Friday for two hours, but really we just had to dig in, get dirty and have those conversations.

**Phil Deering:** That's a good story and again, I think there are some elements that we see repeatedly in successful change efforts.

First, you didn't try to do everything at once before you started doing something. I think so often that an important piece, willingness to say okay well we're not going to get everybody's stuff perfect before we start challenging people to take part in this.

Second, when you bring people in together maybe initially everyone is a little anxious and they're only looking out for themselves, but humans have this amazing ability to work together.

So as you start to work together and start to see some successes those then can build on each other and it seems like you're beginning to enter that period where the hard work is beginning to pay off and now actually in some of those meetings people may look forward to them, even though they have to come in so early because there's a sense of success.

That's important for us to be able to enjoy our work and be creative and cooperative.

**Stephanie:** It's been very beneficial and I'm a little nervous. I'm not in CI anymore but we decided after six months which actually drug out to eight months that we're going to change the group and bring in different providers, because we finished our core forms. The goal was to finish our core forms and bring in this new group, so that's getting people engaged.

**Dr. Kleeberg:** You describe a process that I've seen take place in large health systems and other places like Phil says that are successful. You give the key stakeholders around the table to devote the time and energy into building the groundwork so it can go outward as opposed to it and really creating a vision for where you want to go as a group, as opposed to responding to each individual requirement or squeaky wheel that comes to your desk.

One of the challenges that folks have, especially in information technology who want to try to please people, they tend to jump to fixing it right away for someone, when really sometimes you need to look at it from a bigger picture. I want to take a moment here to talk a little about the role of leadership.

When I put this slide together I was thinking of it in terms of the creation of the report, but I think I can actually modify this a bit to be more appropriate to what we're talking about today. We aren't just talking about the data being in there and that the report is therefore created, vetted and sent out.

We're really talking right now about the more fundamental stuff like what Phil said the eyes, ears, heart and hands, to get the data in there so we have something we can measure and that we have people believing there is value to doing this even though I did it anyway so why do I need to document it.
Really, in any particular project the role of leadership is steep. The leader must set the direction, the stage and must recognize that this is an investment that the organization is going to be involved in and the leader must also recognize that it can’t be done by just the IT person, just one or two people, but has to be a system and cultural change. That’s not something you can just parachute in and expect to happen, it’s something that takes spurred evolution.

So when I talk here in a sense and said they must report creation for the technical resources, but at the same time what we’re talking about now is looking at a team that’s going to set this up and look at how do we build this? How do we measure it? How are we going to lay it out so we have the foundation and collect the data in a meaningful way?

You also need to evaluate the report prior to dissemination you want to test your decisions about your workflow that you’re designing, your interfaces and the way you’re setting up your record and testing with your providers to say does this really make sense and fit into how you’re doing things. Then, once you have it in place you need to send it out, so if it’s a report we’ve talked about disseminating the report and allowing people to see it.

Getting that out requires time but just as does communication, training and helping people to understand how to use the EHR. That time away from clinic that’s potential lost income. That’s potential time away from your family, so again the leaders must really demonstrate not only that they’re willing to do that but they’re willing to put in the extra time to make it happen.

If people see the leader going home at the usual time when they’re working long hours, that doesn’t make for a good example. They want to see the leader getting in and helping out just as much as anything else.

With reports again, we’ve already heard today that in comparing to others using your clinic, pod or providers is the valuable thing to do. Again, that can be done over a lunch or any time. At first, in my experience, when the reports were shared with me and my clinic on our diabetes care there was a lot of that’s not my patient, that’s not true, blah-blah-blah, a lot of complaints.

Eventually we began to drill into it and realized that is true and I think it was Barb that mentioned that after a while providers began to ask each other why are your numbers so good what have you done? We are a pretty competitive bunch, so taking the time and courage to at first send it out blindly but eventually send it out so everyone can see it is an important step to this process.

When we talk about reports again, we’re taking time for the process improvement just as it takes time for the process improvement after an EHR is in. You never get it in perfectly the first time. You always have to reevaluate every template to make sure your decisions are correct.

Finally, with the EHR and looking at your report, you could begin to think of ways that you can do what we call clinical decision support intervention and by that I’m not talking about the urge to hit somebody over the head with a hammer and say you didn’t do something. I’m talking about creating a flow chart so people can see what’s going on or talking about that thing that Medi Q Home will allow and have a sheet of paper in the door where the doctor goes into the room understanding what can be done with this particular patient so they can do it in advance.

We’re talking about ready access to the guidelines and things they need to know in order to manage those patients. All those things take time and energy, so for success at all these levels it really takes dedication on the part of leadership to be able to devote the time and energy of their staff and themselves to making something like this a reality.
Phil Deering: That was a terrific summary. One of the things that I was thinking about here and I think Stephanie brought it up a little bit, I know I’ve heard it from many of our REACH clients and especially for small clinics, you’re being confronted by increasing numbers of organizations around this or that thing and diabetic reports you do for Blue Cross Blue Shield may be slightly different than the ones you need to do for Meaningful Use and for Minnesota Community Measurement, etc.

I’m very interested to know two things.

- First, on a change management and communication level, how do you deal with that? To some extent it seems to me legitimate provider push back around the fact of wait, why are we reporting to so many people?

- Second, has anyone come up with any way to take that off the providers shoulders and back-end and make sure you’re able to format and ship the data out to those entities that are requiring it or is it requiring different workflows to enable some of these different measurement points?

Lynn, maybe you can talk about some of those frustrations. I know it must make a number of your members tense.

Lynn Gudenuf: It does make them very crazy. I think the goal though is to understand what the measures are and the detail around the measures and how it’s being documented. I think it goes back to having the measure components documented in discreet data fields so that you can pull out the data and then apply whatever threshold or criteria is required of the specific measure to be able to report it to the various parties.

Dr. Kleeberg: Just out of curiosity, I’ve seen some clinics that have challenged this because they do not require data to be entered as discreet data elements in things like problem fields, etc. They will allow free text to be put in there and that can sometimes cause issues. Is that a problem with you or is anyone else encountering that problem?

Lynn Gudenuf: The free text fields are rampant with the various systems we work with. It is a real challenge to move from free text to the discreet data fields. It takes a lot of time and energy between the clinics and their vendors and sometimes the priority just doesn’t get moved up. Then you’re faced with having to add abstract through narrative text.

Phil Deering: Have you tried to do any sort of cost benefit studies to see, here’s how much we’re spending every spring and summer doing these abstracting exercising vs. the time we might need to spend to get everybody, all the providers doing this as discreet data?

Dr. Kleeberg: That would be a tough study.

Phil Deering: Yes, it might well be.

Bill Nercessen: I’m the medical officer at FBA and we know the costs for our nurse abstractors and programmers, etc. to pull the information. We can probably even break it down by pair or reporting agency for Minnesota Community Measurement Blue Cross, Health Partners and others.

We could probably take my time, Lynn’s time and other people’s time and approximate how much of our time is spent on reporting and cost that out as well, but how do you measure the benefit? It’s kind of a nebulous concept where we think there’s a benefit in comparing providers as far as how they’re doing with diabetes or ischemic vascular disease and putting things high up on the chart and so forth.

How would you measure the benefits of those activities?
Dr. Kleeberg: From the experience I’ve had in working with an HER, speaking just for me, the benefits I had later on was the fact that those discreet elements could help drive certain tools that assisted me in what I was providing and it made it easier for me to tie it to things like radiology orders or other things when I needed to order something and include a diagnosis on it.

If I had a free text it wouldn’t work whereas a real diagnosis it would work. One of the things I’ve seen where the providers embrace it is when they recognize that there’s a reason for quality to do something like that. Our experience in task actually allowed for the provider to enter free text element only after they jumped through a lot of hoops. So we wanted to make entering free text more challenging than entering discreet elements within the field.

If they wanted to enter free text they had to enter a discreet thing called ‘other’ and then they could use the comment field or some other thing in order to put the other name in there, so if legitimately the person could not find the right diagnostic code, it could go in there and then someone later could search for ‘other’ and correct it.

That is one element and the other element I’ve heard is where someone was talking about putting out a little cheat sheet of the most frequently ordered diagnostic codes so the providers could get those. Potentially, an in basket or some other messaging method you could use for your coder if you’re having trouble with something so they can repair it for you.

Potentially, there are products out there or websites that will help the provider find an ICE9 code or CPT code or something like that, easily, again if they’re trained to or already have access to those particular tools. I think there are ways you can make entering a free text element more challenging than it is right now and potentially begin to move traffic in that direction.

Again, that’s a leadership decision because there’ll be plight for that if it is made more challenging to enter free text.

Barb Anderson: Hi again from Mankato, this is Barb. I totally agree with that. We have also gone that route trying to make it and get harder to do the free text route. The other thing is we’ve gone through the HER steering committee that we formed for which things like this go through and we included in that group administration, all the way down to the nursing staff, IT and our health information HER director. That’s been vitally important getting feedback from each of them to make sure you’re going in the right direction.

The other thing too and I don’t know everyone would agree, but we’re so regulated by what we submit as far as outside vendors that we have to submit to or whatever, but sometimes we’ve thought till you lose the, what’s best for the patient thought, and that’s what we’re working towards is what’s best for our patients and they have that globally so that it encompasses all the requirements of each of the vendors that we have to publicly report.

If we can’t pull discreet data and the question was what are the costs or the worth, well I think you have to look at the worth too if you don’t dig for it and you’re public reported scores are low because you aren’t doing that and getting everything. It’s difficult to measure in that respect, but we’re trying to go at it now with the theme of what’s best for our patients.

Dr. Kleeberg: That is so true and very key. Frequently, in some of the groups I’ve worked with when we were caught in trying to make a decision, we had to bring ourselves back to the fact that we’re doing this for patients and they’re the center of it all, so we need to look at it from their perspective. Thank you for making that comment.
Jerri Hiniker: We’re just about to the end of our hour. I do want to make sure if there is anything else anyone wanted to share before the end that they have that opportunity.

With that we’ll wrap up. Phil led in really great to our October webinar, which will be on Harmonizing Measures. What we would like to hear from those of you who were on the call today is to get some of your examples and the different measures you have to work on and do clinic reports for such as Meaningful Use, PQRS, Minnesota Community Measurement, North Dakota what types of measures you have to report on at a state level.

If you could share those with us you can send them to myself or Connie. In October we’ll talk about what some ways are that you can work on those measures so it’s not like you’re running how many different reports, what are some ways to harmonize the measures. Something that’s been happening to as the Federal and State level to help harmonize measures.

You will also get a copy of this slide deck. We’ll clean up the notes and we’ll send it to everyone, so you’ll have the contact information and schedule for the upcoming webinars.

Angie will give you the link in order to click and do the evaluation. We appreciate your feedback it’s very helpful to us in planning future webinars. Thank you all for being on the webinar and for those who participated, we appreciate your time.

If you have questions, contact us at info@stratishealth.org.

This material was prepared by Stratis Health, the Quality Improvement Organization for Minnesota, under a contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-MN-C9-12-18 091712