



Pittsburgh Regional Healthcare Initiative
White Paper Series #4



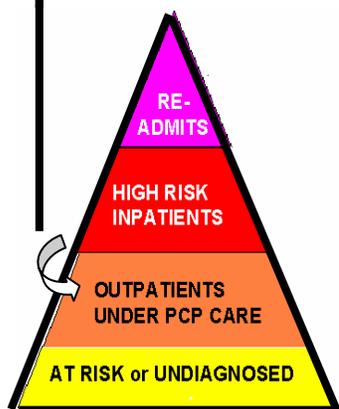
Combating an epidemic with PHIN

PRHI Diabetes and Depression
Working Groups
September 2003

Diabetes and depression

Combating an epidemic with PHIN

P RHI coalition partners are targeting depression and diabetes in our region. What's the connection between these two seemingly unrelated conditions? Both are chronic diseases, usually in outpatients. Both affect a large and increasing percentage of the population in Southwestern Pennsylvania. And both are widely under-treated.



The Diabetes and Depression Working Groups are working to improve care among all populations illustrated in the pyramid, left. The group decided to concentrate on people in the third tier: patients who have been diagnosed with depression or diabetes, and are under a physician's care—before complications arise.

The hypothesis: when practitioners and patients have up-to-the-minute patient information when and where needed, complications and unnecessary hospitalizations related to depression and diabetes could be virtually eliminated.

How it works now

Currently, physician offices have to collect their own data on diabetic and depressed patients, which arrive at different times from many sources (commercial health plans, Medicare, Medicaid and multiple laboratories). The paper reports must then be filed in time for a patient visit, at which time the patient learns the results. The current system's inefficiencies conspire against physicians' ability to provide proper care to every patient, every time.

PRHI partners looked for ways to get timely information into physicians' hands through a secure internet-based connection. The resulting model, called the Pittsburgh Health Information Network (or PHIN—pronounced “fin”), is similar to models in Utah (UHIN), Delaware (DHIN) and Santa Barbara County, California

(SBCCDE).

It takes a village: Collaboration

PRHI partners addressing this challenge included all four of Pittsburgh's commercial health plans, all three of Pittsburgh's Medicaid health plans, and Pittsburgh's two largest commercial labs. Together with numerous healthcare professionals, they proposed to create a database to gather relevant claims data from health plans *and* results from lab tests and combine them into a simple, one-page document for each patient. This information could then be pulled by the physician at the point of care through a secure internet connection.

Information where, when needed

The data could generate a list of chronic disease patients or an individual patient history of basic care received for diabetes or depression. This will:

- ✧ Allow physicians to keep better track of their patients through the list/registry function.
- ✧ Create opportunities to engage in better preventive care.
- ✧ Help reinforce a minimum standard of care that has been established for depression and diabetes through evidence-based, nationally recognized measures.

- ◇ Allow patients to access their data as a step toward becoming more educated and active in their own disease management.

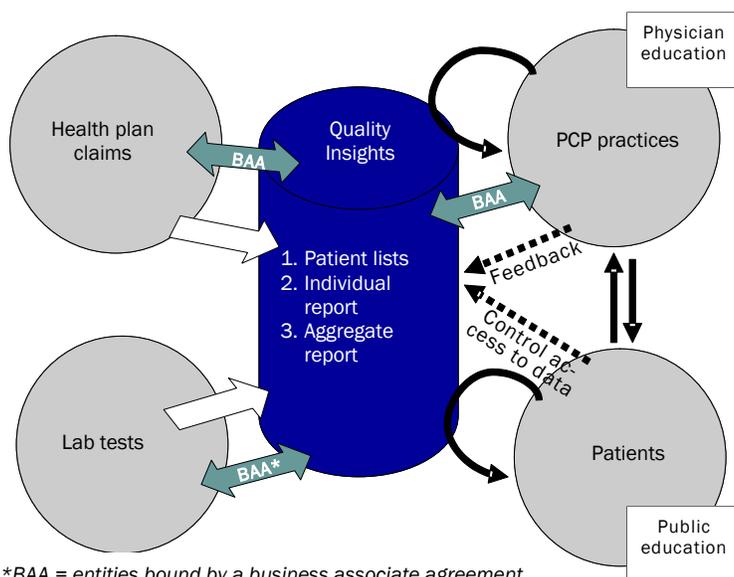
Challenging what's possible

PRHI partners studied ways to make the information readily available securely online. Questions and perceived problems abounded. What entity could act as a neutral, trusted repository for this information? Under strict new HIPAA guidelines, would such a data resource be legal? Could it be confidential enough, yet allow physicians and patients appropriate access? Could it work technically, and still be easy to use?

Neutral repository: *Quality Insights*

PRHI discovered a powerful partner in “Quality Insights”, our regional Quality Improvement Organization (QIO) reporting to the federal Center for Medicare and Medicaid Services (CMS). They bring their considerable data management experience and infrastructure to bear on this project as part of their own

mandate to improve care for diabetes. The QIO will act as a neutral platform for collecting and collating data from all other sources.



*BAA = entities bound by a business associate agreement

Legal and technical challenges

To systematically address the daunting *legal* and *technical* concerns, PRHI formed two task forces made up of representatives from health plans, labs, the QIO and physician practices. The legal team tackled such questions as:

1. What kind of business agreement can be used?
2. Will physicians' current privacy statements for patients need to be modified?
3. Under what conditions can data be shared across multiple physicians?
4. What are the parameters for sharing mental health data? Are extra safeguards needed?
5. Will physicians be liable for using PHIN data? Conversely, if the PHIN database creates a new standard of care, will physicians be liable for not using it?

Perhaps the legal team's most surprising finding was the extent to which the dreaded HIPAA regulations actually help efforts like PHIN. HIPAA has actually *reduced* liability by establishing clear standards of protection and an industry standard of due care. Physicians are **already** liable for providing a minimum standard of care. PHIN is designed to help them provide that care more effectively.

With PHIN, claims data from health plans and lab values from diagnostic labs flow into the QIO database. These data can help physicians by providing the following information about the patients in their practice:

- ◇ Lists of all diabetic and/or depressed patients
- ◇ Aggregate reports, allowing physicians to benchmark against regional performance
- ◇ For diabetic patients:
 - * Dates of last visit
 - * Dates, values of hgb A1C tests
 - * Dates, values of lipid profiles
 - * Dates of dilated retinal exams
- ◇ For depressed patients:

- * Dates of follow-up visits
- * Dates when prescriptions for antidepressant medications are filled or refilled

The QIO will add Medicare data and build a comprehensive regional database. Rather than pushing yet another report to the physician's desk, physicians could draw data as needed through a website.

ALL information will be available in a common format—no matter which plan or lab it came from.

And it's two-way: physicians can amend and update data so it becomes more accurate with each use.

Patients will also have access to their own data. ☺

The technical team addressed questions like these:

1. How will we handle data transmission?
2. Can data be posted quickly enough to be useful to physicians?
3. Can the QIO handle varying patient identifier systems from different organizations?
4. How can the QIO ensure that only physician practices who have a relationship with a patient can access that patient's data?
5. How will patient history follow a patient across physicians?

Partner institutions conducted research that helped to navigate these challenges as well.

We didn't respond to tuberculosis one case at a time. We didn't leave it up to each individual doctor to handle it. Diabetes and depression are a community crisis, and they require a community response.

*—Bruce Block, MD
Director,
UPMC Shadyside Family Health
Center*

If you would like a copy of the summary document, "Improving Care for People with Diabetes and Depression," contact Tania Lyon, PRHI's Chronic Disease Coordinator, at 412-535-0292, ext 107, (tlyon@prhi.org).

Pilot testing begins

Eleven physicians have agreed to act as a pilot group to test the database in its initial phases. A dozen major Pittsburgh employers, offering health coverage to 90,000 employees and dependents, are encouraging physicians in their health plans to use this resource.

In addition, because both depression and diabetes disproportionately affect lower-income and certain racial groups, we are recruiting the participation of physicians serving those populations (i.e. via Medicaid health plans and physician groups like the Gateway Medical Society).

Some commercial health plans have developed their own programs to improve the care of patients in their systems (i.e., our partner Highmark's Smart Registry). This project helps to ensure that all patients, no matter what their coverage, can have their chronic disease data made easily available to their physicians for improved care.

What if this works?

Physicians well know how to treat diabetes and depression effectively. Yet our region suffers excruciatingly high rates of almost-always preventable complications. If PHIN can be made to work, getting physicians and patients up-to-the-minute healthcare information, proper care can be given to every patient, at every visit. From this

starting point, Pittsburgh can become the Perfect Care Zone, where 100% of diabetic and depressed patients routinely receive the care they need. Southwestern Pennsylvania could become the first place in the country to virtually eliminate the complications of diabetes and depression—a development that would have national implications. ☞

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