Are Report Cards Measuring Up?

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by Patrice L. Spath, BA, RHIT

Healthcare report cards have been in existence for more than 10 years. Have their efforts to measure and compare performance made a difference? This article looks at the state of the art.

In the late 1960s, researchers in Maine decided to study the use of healthcare services in different geographic areas. What they found was that the use of surgical procedures differs drastically by area-with, for example, rates of hysterectomies performed before age 70 that were 250 percent higher in one area than another.[1]

Almost 30 years have passed since these researchers first put into practice the idea of using healthcare data to compare practices-and performance-among physicians and hospitals. One offshoot of their idea, the healthcare "report card," has now been in existence for more than 10 years.

But how have things really changed? Has the healthcare industry's focused attention on measuring and comparing the performance of health plans, practitioners, and institutions made a difference? In this article, we'll look at the report card state of the art.

Variation Still Exists

Do report cards make a difference? Do more patients receive recommended preventive services? Has there been a noticeable reduction in physician practice variation? Are consumers using comparative data to make informed health plan and provider choices? Are employers considering HEDIS data when contracting with health plans? Is quality of care improving because of the Joint Commission's ORYX project? The answers to these questions are influencing the future of comparative quality reports.

During the last 10 years, the healthcare industry has tested and refined a variety of performance evaluation and measurement reporting techniques. (See Data, Performance, and Accountability) But has the original intent of improving the overall quality of healthcare by comparing performance among health plans, practitioners, and providers been realized? According to many sources, not yet.

For instance, an analysis of recent fee-for-service Medicare data published in the 1999 edition of the Dartmouth Atlas of Health Care shows that healthcare delivery and costs continue to differ widely.[2] Consider these statistics:

- among the 306 hospital regions defined by the Dartmouth researchers, coronary artery bypass graft procedures ranged from 87 percent above the national average to 50 percent below it
- rates of hospitalization continue to correlate with hospital bed capacity, with the medical discharge rate 40 percent higher in areas with a high supply of hospital beds compared to regions with the lowest supply of beds
- two-year mammography rates for Medicare enrollees between age 65 and 69 varied from a low of 12.5 percent to about 50 percent, with an average rate of 28.3 percent
- regions of the country with higher managed care penetration did not show consistently high performance in any area, including preventive care

Given these results, it seems that report card initiatives have not appreciably reduced overall variations in patient care practices.

Some Noteworthy Results

Before we lose hope, however, there is growing evidence that comparative performance reports can have a positive effect in some organizations. For instance, during the first three years of the Northern New England Cardiovascular Disease Study, surgeons simply observed variations in coronary artery bypass graft (CABG) mortality rates but did little to change practices. Once it became apparent that variation in mortality rates among the participating hospitals was not due to patient risk factors (e.g., hospitals with higher mortality rates did not have sicker patients), the surgeons became interested in determining the exact cause of these variations.

Reductions in CABG mortality rates became a priority, and the study group agreed to augment its efforts with a three-component intervention: feedback of outcome data to clinicians, study group training in continuous quality improvement techniques, and site visits. Overall, the area saw a 24 percent reduction in deaths during the 27-month period following the interventions. This reduction in mortality rates has persisted, with a recent study showing that northern New England now has one of the lowest CABG mortality rates in the country.[3]

For this kind of data to be effective, it's clear that numbers alone don't tell the story. If comparative data is to be used to improve performance instead of merely reviewed and forgotten, practitioners must first trust the accuracy and validity of the measurement results. And there must be consensus among practitioners that patient management variations are worth investigating.

Healthcare organizations throughout the country are becoming involved in similar types of collaborative projects using comparative performance data and implementing strategies designed to improve patient care.

For example, at Arlington, TX-based VHA, a large alliance of not-for-profit organizations, seven evidence-based initiatives-for stroke care, acute myocardial infarction, medication error reduction, patient safety, breast cancer, end-of-life care, and congestive heart failure-are in various stages of implementation. At Catholic Healthcare West in San Francisco, 15 of the system's 46 hospitals are currently participating in a clinical collaborative effort to address the care of patients with community acquired pneumonia.

Cost-Driven Decisions Persist

Cost continues to be a major influencing factor when employers choose health plans for their workers. Of the 1,377 companies that responded to a 1999 survey sponsored by the Kaiser Family Foundation and the Health Research and Educational Trust, only 10 percent reported considering HEDIS measurement results when selecting health plans.[4]

Instead, they were interested in the number of physicians in the plan (68 percent), physicians' reputation and credentials (67 percent), and cost (67 percent). Sixty-five percent of the survey respondents were fearful of rising healthcare costs, indicating they might have to switch health plans because of cost concerns. Only 26 percent said they might have to switch health plans because of quality concerns.

Although quality information is now publicly available, evidence suggests that consumers, not unlike employers, also respond more to price. A 1998 study conducted by the RAND research institution found that 51 percent of consumers whose employers paid a fixed amount of their premium opted for the least expensive health plan, whereas the lowest priced health plan was only chosen by 31 percent of consumers whose employers paid 100 percent of the premium.[5]

Some regional business coalitions are trying to change the attitudes of purchasers and consumers by disseminating quality information on hospitals, health plans, and physicians in their area.[6] These groups are beginning to provide convincing evidence that quality is just as important as cost when making healthcare purchasing decisions. Nonetheless, with insurance industry warnings of continued premium increases, it remains doubtful that quality-based purchasing decisions will soon become the norm.

Getting Across the Barriers: What's Next?

In the early 1990s, the greatest barriers to creating comparative performance data were a lack of standardized, well-defined measurements and questions about the feasibility of gathering information. Today, these hurdles still exist, but they seem less formidable. Other challenges, such as how comparative data are reported and used to improve the quality of care, continue to frustrate quality report card proponents.

Selecting Measures

The proliferation of evidence-based clinical practice guidelines has allowed the development of clinical performance measures that reflect "best practices" based on literature recommendations. For example, the measure "percent of patients with the diagnosis of acute group A streptococcal pharyngitis that have either a positive throat culture or rapid antigen detection test" is derived from the evidence-based guideline "Diagnosis and Management of Group A Streptococcal Pharyngitis" developed by the Infectious Diseases Society of America.[7]

Because developers of comparative performance measurement sets rely on the same evidence-based guidelines to define ideal clinical practices, many groups are using the same (or very similar) condition-specific measures.

In an effort to expand the scope and availability of validated, ready-to-use measures, the Agency for Healthcare Research and Quality (AHRQ), the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and other philanthropic organizations are funding various projects to develop and test additional clinical performance measures for specific conditions, patient populations, and healthcare settings.[8] In most instances, it is no longer necessary (or practical) for individual health plans, practitioners, or institutions to expend resources on developing and testing clinical performance measures. Much of this work is already being done on a national level.

The importance of the healthcare process also must be taken into consideration when selecting clinical performance measures. It may be less important, for example, to measure how often there is no diagnostic confirmation of the organism causing a patient's sore throat and more important to determine how often patients are prescribed beta blockers after experiencing an acute myocardial infarction.

The significance of measuring a particular clinical process or patient outcome continues to be a point of controversy among organizations. While the clinical measures found in the HEDIS measurement set have become the "gold standard" for comparing health plan performance, the system nevertheless is criticized for addressing too few important aspects of healthcare delivery, such as use of antibiotics for HIV-related pneumonia and follow-up after an abnormal Pap smear.

The same controversy surrounds the Joint Commission's initial choice of core performance measures for hospitals.[9] Hundreds of validated performance measures are available for numerous clinical conditions, and yet the Joint Commission focuses on only 25 measures covering five conditions (acute myocardial infarction, heart failure, community-acquired pneumonia, surgical procedures and complications, and pregnancy and related conditions).

Whether participation in a comparative performance measurement project is voluntary (such as the HEDIS project) or mandatory (such as the ORYX project), the sponsoring organization must be sensitive to the burdens placed on participants. The importance of measuring a particular clinical process or patient outcome must be carefully weighed against the costs of data collection.

What Consumers Want to Know

The need for consumer-relevant information also influences today's comparative performance measurement reports. Theoretically, consumers should be able to use publicly available performance data when selecting health plans or caregivers. But the average healthcare consumer is ill-prepared to interpret evidence-based clinical performance measurement data.

Researchers have found that condition-specific measures are of limited value to consumers choosing health plans or providers. The public appears to want more information about the actual experiences of patients "like them" and how well they fared with a particular hospital, physician, or health plan. Shoshanna Sofaer, director for the Center of Outcomes Improvement Research at George Washington University, suggests that in addition to satisfaction data, healthy consumers want to know how people

are treated when they do get sick (e.g., was access to care timely? Was specialty care available if needed? Did patients feel they were denied necessary services?).[10]

Most report card efforts include some consumer satisfaction measures. In 1999, health plans involved in the HEDIS measurement project began using a modified version of the Consumer Assessment of Health Plans survey (CAHPS), a tool sponsored by the AHRQ. The CAHPS survey includes core questions that measure people's satisfaction with the experience of care, as well as supplemental questions for Medicare and Medicaid patients, the chronically ill, and other groups.[11]

Satisfaction survey results are common to most quality report cards disseminated by health plans, regional business coalitions, and institutions. And a second type of consumer-based healthcare quality measurement is emerging-one focused on consumers' needs and expectations. In 1995, the Foundation for Accountability (FACCT) began developing and testing survey instruments that can be used to gather information from consumers about whether the healthcare system is helping them stay healthy, recover from acute problems, and manage chronic illnesses.[12]

For a patient with asthma, the FACCT survey includes questions such as:[13]

- were you observed using the inhaler by the doctor or nurse to make sure you were doing it right?
- do you know how to adjust your medications when your asthma gets worse?
- do you know what to do if you have a severe asthma attack?

FACCT is spearheading a national effort to integrate patient-based information with more traditional clinical performance measures. During the past two years, FACCT has worked with the Joint Commission and NCQA to incorporate FACCT measures into the clinical outcomes reporting systems of those two organizations.

Patient surveys are currently being used to gather HEDIS measurement information from older adults about flu shots, from women about management of menopause, and for several HEDIS pediatric measures. The Joint Commission did not include FACCT measures into its first complement of core performance measures for hospitals.

While some physicians and outcomes experts advocate the use of clinical performance measures derived from patient-reported data, other groups question whether patients can accurately report on their healthcare experiences. Studies are already under way to answer the accuracy question. If it is found that patient-reported data is reliable, surveys may become the tool of choice for gathering information about patient experiences and collecting data that is difficult to find in administrative data or even patient records.

Standardizing Measures

Relief may be in sight when it comes to standardizing healthcare performance measures and the data elements necessary to create measures. The newly formed National Forum for Healthcare Quality Measurement and Reporting (National Quality Forum or NQF), is charged with developing consensus among the many healthcare performance measurement stakeholders.

Originally conceived at the recommendation of the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry, the NQF is a public/private partnership of representatives from all aspects of the healthcare industry.[14] Launched in July 2000, the NQF will not create measures but help to standardize them, improve the information technology infrastructure, and attempt to get consumers to focus on performance. Time will tell whether this collaborative attempt at standardization will be successful.

Another group, the Performance Measurement Coordinating Council (PMCC), was formed in early 1999 by an alliance of the NCQA, the Joint Commission, and the American Medical Association. The PMCC plans to decrease inconsistent data demands by creating evidence-based clinical measures from data elements that all three groups can share.

How Much Does It Matter?

How valuable is the information? This is the question that continues to plague comparative performance measurement reports. Measurement results may not be adequately adjusted for patient variables, such as severity of illness or patient preference. The information may be outdated, especially when claims data is used to create the measures. A representative of Press, Ganey Associates, a South Bend, IN-based company that measures patient satisfaction, suggests that "improvement processes cannot be effective if based on information as much as a year old."[15]

Measurement results may be misleading. The list of 100 Top Hospitals published for the last eight years by the Baltimore-based information services company HCIA-Sachs, was recently criticized by researchers at Yale University for potentially giving the wrong impression to consumers.[16] HCIA-Sachs' methodology relies heavily on resource consumption data (length of stay and charges) and does not take into account clinical performance (e.g., mortality, postoperative complications, readmissions).[17] While the publishers of the 100 Top Hospitals list have never claimed the data reflects a hospital's clinical performance, consumers could easily get the wrong impression.

Physician groups are also voicing concerns about how the results of comparative performance reports are interpreted. Many managed care organizations "grade" physicians with performance data gathered from administrative data sets and patient records. Recent studies of physician-specific report cards have revealed several concerns:[18] , [19]

- a considerable number of false-positive diagnoses were found in the administrative data (e.g., patients labeled as hypertensive did not actually have this condition)
- laboratory performance measures were not adequately captured by administrative data (e.g., cholesterol measurement tests were performed but not reflected in the claims data)
- study populations were too small in many instances to allow for detection of reliably true practice variations

Healthcare institutions participating in comparative performance measurement projects
are also finding discrepancies between administrative data and information contained in patient records, as well as difficulties interpreting measurement results when the sample size is small. These methodological problems decrease the value of performance measurement data.

Controversies still exist regarding consumers' use of publicly available healthcare performance information. Whether consumers will use comparative quality data to choose among health plans, practitioners, and institutions remains an unanswered question.

Consumers may not wish to assume the purchaser role. Though more rigorous evaluation tools are being used to measure quality in healthcare, there is little evidence that consumers currently rely on measurement results to make choices. Quality ratings may become more important to consumers as out-of-pocket costs increase. But more than likely, consumers will continue to depend on federal and state governments, accreditation groups, and employers to "police" the clinical performance of healthcare organizations.

Report Cards Won't Go Away

The factors that led to the proliferation of comparative performance measurement projects and public disclosure of results are still in place. Healthcare costs continue to rise. Purchasers are still seeking value for their healthcare dollars. There is still a need to eliminate unnecessary, and many times costly, variation in patient management practices. Add to that a growing consumer concern that managed care has adversely affected quality and that medical errors are on the rise, and it seems likely that quality report cards will remain an important aspect of healthcare delivery.

The measures included in comparative healthcare quality reports will continue to evolve. This may cause a short-term increase in the number of data elements that must be reported to external groups. In time, information technology improvements will make it easier to capture timely and accurate clinical data, and manual data collection burdens should eventually decline. Surveys may replace some of the traditional data sources as tools for gathering patient-reported information become more reliable.

In the final analysis of the future of healthcare quality report cards, there is only one certainty: HIM professionals with clinical data management skills will continue to be in great demand by healthcare organizations, purchasers, and regulatory and accreditation groups.

Data, Performance, and Accountability

The genesis of report cards dates from the 1980s, when several groups began to promote the use of comparative data to improve healthcare performance. An early example is the Health Care Financing Administration's (HCFA) calculation of raw death rates for all hospitals in the US, using the data available in the Medicare claims file (MEDPAR) and made public for the first time in 1986.[20]

In 1989, a coalition of health maintenance organization (HMO) representatives and large employers met to answer the question, "How can purchasers understand what 'value' their healthcare dollar is purchasing, and how can they hold a health plan accountable for its performance?" From this effort came the Health Plan Employer Data and Information Set (HEDIS), a core set of performance measures for managed care organizations now maintained by the National Committee for Quality Assurance.[21]

Around this time, healthcare groups initiated projects that would allow practitioners and providers to compare performance. For instance, in 1986 the Maryland Hospital Association started to develop and refine performance measures that could be used to compare performance among hospitals.[22] In 1988, the Joint Commission on Accreditation of Healthcare Organizations began to field test several hospital performance measures.[23] These efforts gradually evolved into the Joint Commission's current ORYX initiative.

In the late 1980s local practitioner alliances, such as the Northern New England Cardiovascular Disease Study Group, started collecting and comparing patient morbidity and mortality results in an effort to reduce the impact of practice variation on patient outcomes.[24]

By 1992, several national and regional comparative performance measurement projects were well under way. Data from these projects were intended to be used by payers, regulators, practitioners, and institutions to identify unnecessary practice variation and improve quality of healthcare services. But for the most part, the general public was still unaware of the existence and potential uses of healthcare performance data.

This changed in October 1993 with the introduction of President Clinton's healthcare reform plan. Under the proposed National Quality Management Program, a public system of accountability for healthcare quality would be created to provide consumers with meaningful performance information. The proposal included recommendations to develop a core set of quality and performance measures that apply to all health plans, institutions, and practitioners.

Although the president's regulatory solutions to rising healthcare costs failed, in the mid-1990s free-market forces took over and continued to influence performance measurement initiatives. Many of the principles of healthcare reform, such as health plan consumer satisfaction surveys and development of core quality measures, were incorporated into federal Medicare and Medicaid managed care regulations. Private health plans, providers, and practitioners expanded their performance measurement activities, and public disclosures of performance results became commonplace.

At this time medical, nursing, and allied health professional organizations began to develop specialized comparative performance measurement projects, such as the National Cardiac Surgery Database sponsored by the American Society of Thoracic Surgeons.[25]

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