

Aggregating Physician Performance Data Across Health Plans

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Measures Included in The Pilot:

1. Breast cancer screening
2. Colorectal cancer screening
3. Disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis
4. Use of imaging studies for low back pain
5. Diabetes
 - a. Lipid profile for diabetics
 - b. Hemoglobin A1c testing for diabetics
 - c. Urine protein screening for diabetics
 - d. Retinal eye exam for diabetics
 - e. Diabetes composite measure, including all four individual measures.
6. Cholesterol management for patients with cardiovascular conditions (includes high-risk procedures and Ischemic Vascular Disease) – LDL screening
7. Persistence of beta-blocker treatment after a heart attack
8. Annual monitoring for patients on persistent medications
 - a. ACE/ARB
 - b. Digoxin
 - c. Diuretics
 - d. Anticonvulsants
9. New episode of depression
 - a. Optimal practitioner contacts for medication management
 - b. Effective acute phase treatment
 - c. Effective continuation phase treatment
 - d. Depression composite measure, including all three individual measures.

There is widespread consensus among stakeholders in health care that performance measurement and public reporting are fundamental building blocks for a reformed system that provides high-quality, high-value health care. Physician leaders are among the key stakeholders with a keen interest in these efforts, but have identified roadblocks that need to be overcome in order to achieve the promise of performance measurement efforts.

The subject of this issue brief, the Data Aggregation Pilot, represents a major step to addressing issues that have been consistently raised by physicians. It was designed to test solutions to several major challenges, especially the potential problems that occur if physicians receive reports from different health plans, each assessing just a fraction of the physician's entire medical practice. Such reports often show varying results because they may use different measures, methodologies and reporting formats, and physicians can be constrained in their ability to understand and act upon information whose goal is to help them improve overall quality of care.

To meet these and other challenges, the America's Health Insurance Plans Foundation (AHIPF) embarked on the Data Aggregation Pilot, which represents one component of a larger effort known as the High-Value Health Care Project (HVHC). The Quality Alliance Steering Committee (QASC), a multi-stakeholder collaborative comprised of leaders among physicians, hospitals, health insurers, accrediting agencies and the public-sector, developed the HVHC Project in part to support its goals. The Robert Wood Johnson Foundation (RWJF) sponsors the HVHC project with support from the Engelberg Center for Health Care Reform at the Brookings Institution.

Developing better ways to aggregate data from different health plans to ensure valid and reliable measurement of provider performance was a key goal of the Data Aggregation Pilot. AHIPF worked in partnership with physicians and physician organizations to test a standard method for collecting and aggregating data across multiple health plans, and reporting aggregated data to physicians on the quality of care they provide to their respective patients. Having a standard methodology that uses a set of standard agreed upon measures:

- Provides consistency in reporting across health plans;
- Streamlines reporting for physicians and health plans; and

- Offers improved reliability in the feedback of data that are used for quality improvement as the information reflects a greater proportion of the patients within the physician's practice.

Methodology And Data Validation

The Data Oversight Workgroup, whose members have extensive experience in provider quality measurement and reporting initiatives, developed a standard methodology for the pilot project. Workgroup members included leaders from the physician community, as well as health plan representatives, researchers, RWJF and AHIPF project leadership. Ongoing guidance was also provided by the QASC and its Measure Implementation Strategy Workgroup.

The primary functions of the Data Oversight Workgroup were to:

- Determine methodology for data aggregation, including measures and measurement methodology;
- Advise on data to be provided from plans to support measurement, taking into account HIPAA requirements and the reporting needs across plans; and
- Assist with ensuring alignment of these measures and methods between public- and private-sector care improvement initiatives.

The Data Oversight Workgroup engaged in extensive discussions of current issues in measuring and reporting results in provider quality. Members of the Data Oversight Workgroup are active in the efforts of the National Quality Forum and other organizations, thus ensuring alignment with national efforts to measure physician quality. The Data Oversight Workgroup also sought to align the project methodology with the "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs."¹ Finally, lessons learned from leading regional data aggregation efforts in Massachusetts, Minnesota and California informed the methodology.

The standard methodology developed for the project required the following steps: selection and implementation of quality measures, establishment of rules for assigning patient responsibility to physicians, and approaches to addressing issues related to small numbers and peer comparisons/benchmarks. The quality measures selected for the project included commonly accepted performance measures that span both prevention and management of common chronic conditions, e.g., measures relating to cancer screenings, diabetes, cardiovascular disease, rheumatoid arthritis and depression. The Data Oversight Workgroup chose the measures because they are in broad use, and because they are generally well-accepted by the two audiences whose buy-in was critical to the pilot project's success: physicians and health plans. In addition, measures needed to be well-specified and able to be captured electronically through claims-based analyses. Composite measures of quality were also implemented, including those for diabetes and mental health.

The project methodology was tested in the two pilot states of Florida and Colorado. The AHIPF project team engaged the largest insurance plans operating in Colorado and Florida, facilitated their participation in the project, and then obtained the measure numerators and denominators from each participating health plan that were subsequently aggregated across health plans to generate physician-level performance data. To ensure consistency in implementation of measures and measurement methodologies, software tools were developed for the project and implemented at the health plans. Ingenix, the vendor selected through a competitive bidding process, developed the software tools and provided technical assistance to the health plans.

The project staff extensively validated the project data and software tools. The National Committee for Quality Assurance (NCQA) also validated the data and tools independently. NCQA was selected in a competitive bidding process to ensure that the project methodology was implemented accurately.

Testing The Results With Physicians.

After collecting, aggregating and validating the data, the next goal was to communicate the aggregated quality measure results to physicians and solicit their feedback. To do this, AHIPF created an online portal, the AHIPF Physician Portal. Approximately twenty thousand physicians across Colorado and Florida, representing specialties relevant to the project, received letters that:

- Informed them about the pilot project and its purpose;
- Highlighted the availability of performance data pertaining to their patients; and
- Encouraged them to log on to the secure portal to access their performance results and provide feedback to the pilot.

Specifically, the Portal allowed Colorado and Florida physicians to:

- Establish a secure, online account accessible only to them;
- Confirm that they were indeed the individual physicians whose patient data were provided;
- View their quality measure results aggregated across all plans for 19 clinical process-of-care measures for their patients;
- Compare their performance to that of their peers using multiple benchmarks; and
- Review detailed information about the pilot – including measure specifications and attribution rules.

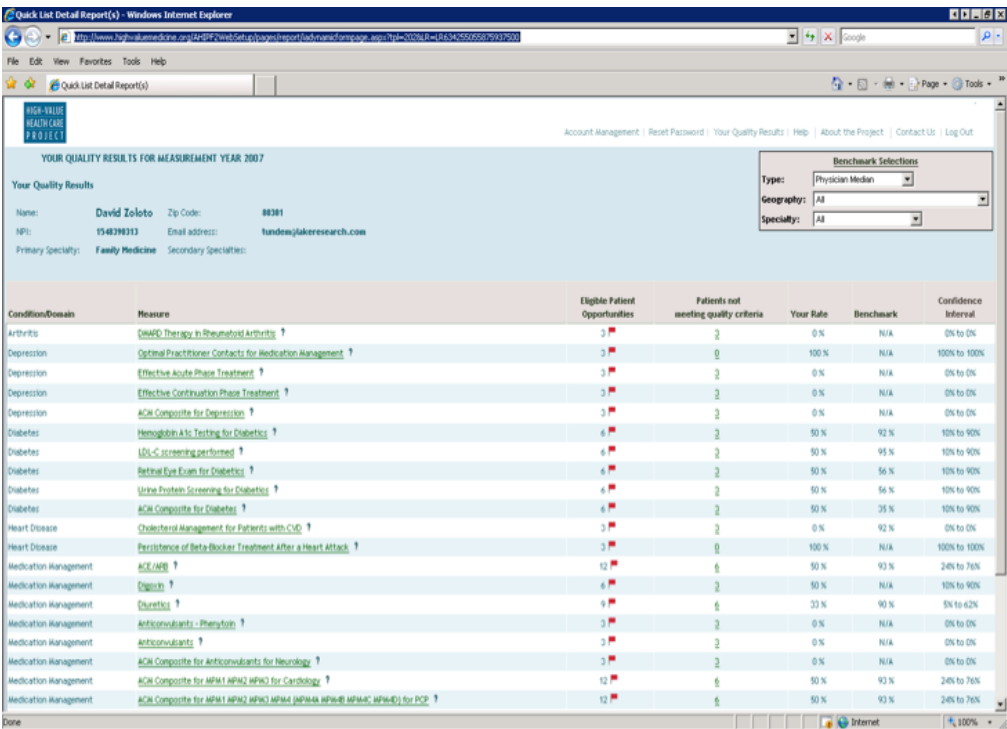
Physicians who accessed the website could view their individual performance measure reports and compare their performance to their peers by specialty and region through the website's benchmarking tools.

Physician Feedback.

After viewing their performance reports via the AHIPF Physician Portal, physicians had the opportunity to provide feedback on their performance measure reports, the measures and the overall usefulness of such performance measures via an instant, website online survey. In an effort to gather more robust, qualitative feedback, a number of physicians in each state were invited to participate in an online focus group with their peers. The findings from both the survey and focus groups provide insights into what types of information are useful to physicians. We believe the findings from physicians who provided feedback on the pilot can help inform future performance measurement and reporting efforts.

Despite early skepticism, once physicians explored the portal, they were encouraged by its possibilities and generally shared three universal recommendations for improving future portals

1. **Physicians' time is limited, so less is more.** Physicians wanted to see a less text-heavy site that is more immediately and intuitively navigable by a first-time visitor. They stress that it needs to be easily accessible and understood – not just for physicians, but also for members of their staff who would likely use the site.
2. **While less is more, physicians may want to be able to access more information easily, and so formatting is important.** In some areas of the site, the level of background information provided overwhelmed the physicians. Yet in other instances, they wanted more information immediately available about the methodology, or the rationale for including certain performance measures and not others. The use of roll-over text and pop-up boxes may be an effective way to provide background and supporting information in small, digestible doses rather than automatically included with other text, or grouped together under headings such as “About the Pilot Project.”
3. **Usefulness is contingent upon timeliness.** For demonstration purposes, this pilot used data that are several years old. Though physicians expressed interest in looking at a similar site in the future, they said that in order to be useful, the data had to be very current, and wherever possible, longitudinal.



Conclusion And Next Steps.

Finding a way to give individual physicians consistent and comprehensive information on an entire panel of patients is a fundamental first step to improving the quality of care in the United States. The Data Aggregation Pilot project demonstrates the feasibility of implementing such an approach using data from multiple health plans. Lessons learned from the pilot build upon knowledge recently gained from similar performance measurement initiatives in a number of communities across the United States. As part of RWJF's signature initiative to improve the quality of health care in the United States, *Aligning Forces for Quality* (AF4Q) communities created public reports of physician measurement that patients can access to find out which doctors, in their community, deliver the best care. Through RWJF-funded research², researchers found that – like physicians – consumers want timely data that is longitudinal and clearly presented. While the audiences of the reports created by the HVHC project and AF4Q are quite different, lessons learned from both initiatives could allow expansion of performance measurement efforts to other areas of the country, and have brought the possibility of developing a reliable, nationally-consistent data aggregation and reporting methodology created by private plans or an alliance of health care stakeholders one step closer to fruition. Finally, the scarce local resources of private- and public-sector organizations can then be used for quality improvement, or for enhancement of the performance information where desired, rather than developing and maintaining disparate performance measurement efforts.

The pilot project represents a major step towards addressing the issues that physicians have identified and is a building block to successful performance measurement; ensuring physicians have consistent performance information across multiple payers based on an entire patient population. This project demonstrated that such a large scale effort is feasible; keys to its success were the multi-stakeholder input and involvement. Results from the pilot could help form the basis for a quality measurement roadmap. Such a roadmap will need to initially rely on administrative data for performance measurement, but as clinical data become more readily available, it will evolve to integrate clinical data in performance measurement.

More information about the Data Aggregation Pilot is available online at <http://www.healthqualityalliance.org/hvhc-project/data-aggregation-and-integration>

¹ Consumer Purchaser Disclosure Project. <http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf>, 2008.

² Successfully Reporting & Communicating Performance Measures: Lessons from Consumers. Princeton, NJ: Robert Wood Johnson Foundation, 2009.