Voices of Experience: Case Studies in Measurement and Public Reporting of Health Care Quality
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The California HealthCare Foundation is a nonprofit philanthropic organization based in Oakland,
California. The Foundation was established in May 1996, as a result of the conversion of Blue Cross of
California from a nonprofit health plan to WellPoint Health Networks, a for-profit corporation.

The Foundation focuses on critical issues confronting a changing health care marketplace. Grants focus
on areas where the Foundation's resources can initiate meaningful policy recommendations, innovative
research, and the development of model programs.

The Quality Initiative serves as a catalyst in improving health care quality for Californians by fostering
development and dissemination of publicly reported data on quality; promoting efforts to increase use of
this data; and accelerating improvements through collaboration among consumers, advocacy organiza-
tions, the health care industry, purchasers and policy makers. The Initiative, established in 1998, is a pro-
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Introduction

This report profiles eight ambitious health care quality measurement and public reporting initiatives throughout the United States. The leaders of these eight initiatives have been forced to deal with a wide range of issues that arise when designing and implementing a measurement and reporting program on health care quality. The case studies contained in this report cover the following initiatives:

- Physician Value Check Survey, California;
- Massachusetts Health Quality Partnership, Massachusetts;
- Cleveland Health Quality Choice, Ohio;
- Buyers Health Care Action Group, Minnesota;
- California Hospital Outcomes Project and California CABG Mortality Reporting Program, California;
- The Coordinated Autos/UAW Reporting System, Michigan;
- New York State Cardiac Surgery Reporting System, New York; and
- California Cooperative Healthcare Reporting Initiative, California.

To help articulate the issues associated with these kinds of efforts, each case study provides a description of the project, along with insights into the challenges, successes, failures and lessons that can be drawn from the experience. Each profile is broken down into six sections:

- The Sponsors;
- The Initiative;
- Goals and Objectives;
- Key Challenges;
- Results; and
- Lessons Learned.

In sponsoring this report, the California HealthCare Foundation’s Quality Initiative hopes to provide insights and context for organizations considering the launch of similar types of initiatives. To further assist with these efforts, each case study contains contact information of a quality measurement and reporting expert associated with the project, who can answer specific questions about the case study.
Physician Value Check Survey

The Sponsors

Physician Value Check Survey (PVCS) is sponsored by the Pacific Business Group on Health (PBGH), a coalition of large California purchasers. The first survey, conducted in 1996 in collaboration with The Medical Quality Commission, was funded by the Kaiser Family Foundation. The 1998 survey was funded through grants from the California HealthCare Foundation and the PBGH Quality Improvement Fund, with additional funding from participating medical groups and several pharmaceutical companies.

The Initiative

PVCS began as a large-scale longitudinal survey of patients on the performance of provider organizations, primarily medical groups and independent practice associations, in serving patients. PVCS surveys commercial HMO and Medicare HMO patients.

Performance dimensions measured included the following:

- Overall satisfaction with quality of care and services;
- Access to care;
- Two-year changes in physical and mental health functioning of patients;
- Provision of key preventive services, including screening for breast cancer, cervical cancer, and colorectal cancer; and
- Helping patients control two chronic conditions—high blood pressure and high cholesterol.

Both in 1996 and 1998, approximately 1,000 patients from each of the roughly 60 participating groups received the survey, with response rates ranging from roughly 40 to 60 percent. These large sample sizes were intended to ensure that there were enough individuals who responded in multiple years to enable longitudinal analyses of the data, given attrition and non-response.

Results were adjusted to account for differences in the mix of patients across physician groups and weighted to account for non-response. Survey results were provided both to the medical groups and to the public, via newspapers, press releases, and PBGH’s Web site. At present, several parties are working to merge PVCS, Consumer Assessment of Health Plans Survey (CAHPS) and questions from other survey instruments into a new survey of patient experiences with care.

The California HealthCare Foundation is providing funding to RAND and PBGH to work on this effort, while the Agency for Healthcare Research and Quality (AHRQ) provides funding to the CAHPS consortium (The Research Triangle Institute, the Quality Medical Advisory Service, Westat, and Harvard Medical School) for its work on the project, which is known as G-CAHPS (for group-level CAHPS). The new survey instrument, which is referred to by PBGH as the Consumer Assessment Survey, is intended to serve as a national standardized patient survey; it should be released in early 2001. Assuming that it can secure adequate funding, PBGH plans to replace PVCS with this standardized instrument for its next round of surveying, to be conducted in 2001.

Goals and Objectives

Through PVCS and its successor survey, PBGH intends to help consumers to make more informed choices and to provide information to medical groups that can help them improve the care they provide to patients. The hope is that by comparing responses from year to year, PBGH can determine if key indicators of care are improving or declining, and whether these changes are related to the quality of care provided by the medical groups. In asking questions about functional status and control of chronic conditions, PBGH hopes to encourage medical groups to expand their sphere of influence by taking steps (e.g., hiring health education staff) to influence patient behavior and their environmental circumstances.

Key Challenges

Challenge 1: Developing a Survey that All Parties Can Accept

It is very difficult to get all relevant parties to buy into a given survey and measurement methodology. To avoid disputes about specific survey questions, PBGH chose to rely heavily upon existing instruments in crafting the final PVCS survey. The end product was primarily an amalgamation of other surveys that had been rigorously tested.
and accepted by the research community as reliable and valid indicators of health status. Surveys included the Group Health Association of America (a precursor to CAHPS), John Ware (the SF-12 survey), and RAND. Only a handful of the final questions ended up being "original" creations of PBGH.

**Challenge 2: Getting Medical Groups to Participate**

Given financial and other external pressures, it is very difficult to get the majority of medical group leaders to agree to participate in any activity that requires a commitment of time, money or public release of data. To encourage participation, PBGH took the following steps:

*Costs were initially kept low.* Using both internal funding and grants from the Kaiser Family Foundation, California HealthCare Foundation, and pharmaceutical companies, PBGH heavily subsidized the cost of the survey for medical groups. Groups that originally agreed to participate in 1996 paid only $2,000 per survey round while those signing up for the first time in 1998 paid $7,500. Both of these figures are well below the actual cost of $14,000 per survey round per group. Going forward, PBGH hopes that the marketplace—including medical groups and health plans—will begin to recognize the value of the data and information created by this type of patient survey, and will therefore be willing to fund a greater portion of the costs.

*Medical groups were kept involved in the process of survey development, and informed of results before they were made public.* PBGH staff dedicated a significant amount of time to small group and one-on-one meetings designed to make medical group leaders feel comfortable with the project. In addition, group representatives were given ample opportunity to review and comment on the survey before it was finalized. After the survey was completed, the medical groups received the results before they were released to the public.

*Results were adjusted to account for differences in the health status of the underlying populations.* This step helped to avoid complaints that results were not comparable across groups due to differences in the demographic and case mix characteristics of the populations being served.

*PBGH created incentives for participation.* PBGH recently began giving "Blue Ribbon" awards to outstanding medical groups, with designations based in part on PVCS performance, both overall and within sub-categories. Because award recipients receive recognition in the press, it is conceivable that these strong performers may see increased market share as a result of their good scores.

**Results**

By a variety of measures, PBGH appears to be making progress toward meeting the original goals and objectives of PVCS:

*Medical group support is strong.* Fifty-eight organizations participated in 1996, while 60 took part in the 1998 survey. More impressively, perhaps, 49 of the original 58 medical groups continued their participation in 1998, with the bulk of the "drop-outs" being due to external factors, e.g., mergers and/or bankruptcies, rather than an explicit decision to end participation in the survey. Conversations with group leaders suggest that most see value in the information generated by PVCS; some indicate that they would be willing to pay more to gain access to the survey results.

*Longitudinal study shows anecdotal evidence of improvement.* PBGH is finishing up a separate analysis that shows how well the 49 groups that participated in both the 1996 and 1998 surveys did in caring for the same patients over the two-year period. While the aggregate results do not yet show meaningful improvement, in part due to the long time that it takes to have an impact on measures such as functional status of patients, a number of groups did show significant improvement over the two-year period.

*Anecdotal data suggests that some consumers have seen and are acting on the information.* While the vast majority of California consumers are likely unaware of the PVCS data, anecdotal information suggests that at least some are paying attention to it, as evidenced by activity on the PBGH Web site. More importantly, perhaps, a handful of medical group representatives report that consumers have inquired about PVCS data, either to note the group’s strong or weak performance or to ask why a non-participating group is not included in the data set.

*PVCS is serving as a springboard for a national, standardized survey.* As noted previously, the success of PVCS has been a catalyst for the development of a national, standardized survey instrument.

**Lessons Learned**

The PVCS experience offers the following lessons to other organizations that might be contemplating a similar approach:
Participants must ultimately believe that the survey results are of high value. Although subsidizing the cost of the survey can help to encourage initial participation, medical groups and other relevant stakeholders (e.g., health plans) ultimately will have to extract value from the survey if they are to support the effort over the long term, especially if sponsors find themselves unable to continue the subsidy.

Plan for (and dedicate adequate manpower) to evaluate what happens after survey results are released. Resources are needed both to assist in improvement efforts and to understand the impact of the survey on provider behavior.

If possible, create meaningful incentives for participation and, more importantly, performance. Most medical groups in California and elsewhere around the country are likely to respond favorably to the promise of increased payments, higher enrollment or public recognition as a reward for high or improving scores.

For More Information

Individuals with further questions about PVCS or the Consumer Assessment Survey can contact Cheryl Damberg, Ph.D., Director of Research and Quality at PBGH, via e-mail at cdamberg@ix.netcom.com.
Massachusetts Health Quality Partnership’s Statewide Patient Survey

The Sponsors

Formed in 1995, Massachusetts Health Quality Partners (MHQP) is a collaboration of three large health plans, the Massachusetts Hospital Association (MHA), the Massachusetts Medical Society, the Division of Medical Assistance of the State of Massachusetts, the Massachusetts Business Roundtable, and the Massachusetts Department of Public Health (which joined MHQP in December 2000).

The Initiative

MHQP collects and publishes the results of a standardized survey of adults who have received hospital-based medical, surgical, or maternity care. The first year’s results (from 1997 data) were kept confidential; the first published report, based on results from the second survey, was released in November 1998. While the initial plan was to publish results every two years, problems with the conduct of the survey in 2000 led to the decision not to publicly release the data. MHQP plans to conduct another survey in 2002, the results of which will be released to the public.

Key Elements of the Program are Explained Below:

Voluntary hospital participation. While the survey is voluntary, participation by hospitals has been high. The 51 current participants represent approximately 80 percent of the state’s adult medical and surgical patient discharges and 90 percent of maternity patients.

Use of a valid and meaningful survey instrument. MHQP selected a survey tool developed by the Massachusetts-based Picker Institute, a not-for-profit organization dedicated to improving health care from the patient’s perspective. The Picker Institute conducted the survey on behalf of MHQP. For reporting purposes, MHQP "rolls up" the 50-plus individual survey questions into seven dimensions of care (see box), which are reported separately for adult surgical, adult medical, and maternity patients.

Risk-adjusted scores. All scores are “mix-adjusted” to account for variations in the patient characteristics (such as self-reported health status, age, gender, and education) that have been shown to have statistically significant effects on survey responses.

No explicit rankings. Hospitals are listed in alphabetical order, with their scores shown in comparison to national and state averages. Each hospital’s average score is surrounded by a gray bar that indicates the 95 percent confidence interval for that score. In order to discourage the natural tendency to rank facilities when such rankings are not statistically accurate, MHQP staff made a concerted effort to explain the meaning of these confidence intervals to the public and the media.

Detailed results to spur QI efforts. To help focus improvement efforts, hospitals also receive detailed question-by-question results and benchmarking data from Picker’s national client database.

Goals and Objectives

In sponsoring this project, MHQP hopes to stimulate quality improvement in Massachusetts’ hospitals, both by arming consumers with the comparative measures needed to evaluate hospital performance and advocate for improvement, and by providing hospital leaders with enough detailed data to identify and address areas of underperformance.

The Seven Dimensions of Care

- Respect for patients’ preferences
- Coordination of care
- Information and education
- Physical comfort and pain relief
- Emotional support
- Continuity and transition of care
- Involvement of family and friends

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Key Challenges

Challenge #1: Hospital Recruitment

Convincing hospitals to participate in the survey was not an easy task, as the project was the first in the country in which hospitals were asked to voluntarily participate in a statewide survey project with the results being released to the public. Not surprisingly, there was some reluctance on the part of hospitals to participate, as they feared the potential repercussions of the public release and the high costs of participation, both in terms of time and money. Participating hospitals were asked to pay approximately $5,500 per survey cycle. This cost was in addition to the expense many hospitals incurred for funding internal patient surveys. MHQP leadership made a number of key decisions that led to impressive participation rates:

Using a proven survey instrument. Providers were satisfied with the rigorous research and testing that went into the Picker survey. Quality improvement experts also appreciated the survey’s level of detail.

Keeping the first round of data confidential. To allow providers to become familiar with the survey process and their own institution’s performance, MHQP agreed not to distribute the first round of data that was collected in 1997. This strategy also gave hospitals a chance to make improvements before public dissemination began.

Enlisting the support of MHA. MHA’s Board of Trustees played a critical role in garnering support among a critical mass of hospital CEOs who committed to the project early, which encouraged others to join.

Focusing on promoting improvement, not ranking results. Along with choosing a report format that consciously discouraged rankings, MHQP’s leaders hosted numerous networking and education sessions where providers and payers worked together to identify and address the root causes of underlying performance problems. MHQP also worked with the media to highlight improvement initiatives.

Encouraging CEOs to comment in the report. Hospital CEOs were encouraged to include a letter detailing how their hospitals were responding to the information provided by the survey.

Using risk adjustment (and taking time to explain the methodology). While it had a relatively minor impact on the data, use of risk adjustment helped to satisfy providers’ concerns about the validity of the information. It was also helpful to have a well-spoken, respected health statistician available to explain the risk-adjustment process.

Challenge #2: Negotiating Advertising Principles for Hospitals

MHQP and MHA wanted hospitals that performed well and that engaged in quality improvement activities to be able to promote these facts. But they also wanted to discourage inappropriate rankings among hospitals. Thus, in an effort to support the spirit of collaboration and continuous improvement that motivated the project, all hospitals were asked to voluntarily agree to a set of principles for advertising and promotion that were adopted by MHA’s board of trustees. (See box below for a summary of these principles.)

Results

This survey project has generated more visibility and more activities related to patient-centered improvements in the delivery of health care than has any other project of its kind.
in Massachusetts. While there is no evidence that consumer decisions are being influenced by the reports, the MHQP initiative is clearly driving quality improvement in participating hospitals. (Examples of process improvements appear in the box below.) In addition, a handful of hospitals linked MHQP survey results to the bonuses of key clinical and administrative leaders.

MHQP’s leaders expect that these process changes will lead to an improvement in outcomes that will be documented by future survey results.

**Lessons Learned**

MHQP’s experience offers the following lessons to other organizations contemplating a similar type of initiative.

**Emphasize quality improvement.** While any effort of this type must be careful to strike the appropriate balance between public accountability and improvement, emphasis should be placed on stimulating quality improvement rather than on performance comparisons. This emphasis proved to be a powerful catalyst for change for MHQP, even though this effort was voluntary and not accompanied by any changes in purchasing strategy. To assure providers that the true focus of the effort is on improve-

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**Examples of Process Improvements**

- **For medical patients:** improved disease information packets, follow-up calls to heart failure patients post-discharge, day-of-admission discharge planning programs, redesigned admitting processes, revamped hiring procedures to emphasize a more people-oriented patient care staff, and increased use of registered nurses on patient floors.
- **For surgical patients:** an information sheet providing answers to the top 10 most frequently asked questions, an interdisciplinary task force to address pain management, and improved communication during physician rounds.
- **For maternity patients:** improved educational materials (with a focus on discharge planning), systems to allow patients to actively participate in developing birthing plans, post-discharge breast feeding interventions, education programs to improve coordination of care, and special programs to increase partner involvement and understanding.

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**Evaluate success by measuring behavior change among providers rather than consumers.** As a corollary to the first lesson, it is important to gauge the success of the program by assessing the extent to which providers engage in quality improvement activities as a result of it. Consumers may or may not use the publicly-released information. But even if they do not use it, consumers benefit by the improvements taking place within provider organizations.

**Do not underestimate the costs—especially the time commitment—required to conduct a public release of data.** There are significant costs associated with preparing for the public release of survey data, such as developing (and preparing a plan for how to communicate) the desired message, and working with the press and editorial boards to help them understand this message. All of the key players within MHQP—especially MHA—spent a significant amount of time on these tasks in order to ensure that the public interpreted the information correctly.

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**For More Information**

Individuals with further questions about the MHQP patient survey project should contact Barbra Rabson, Executive Director of MHQP, at 781-466-9071 or via e-mail at rabson@mhqp.org.
Cleveland Health Quality Choice

The Sponsors

The Cleveland Health Quality Choice (CHQC) Program, which formally terminated its operations in 1999, began a decade earlier as a partnership of the Greater Cleveland Hospital Association, the Academy of Medicine of Cleveland (representing more than 2,900 area physicians), Cleveland Tomorrow (a group of 50 CEOs of large corporations), the Health Action Council of Northeast Ohio (HAC, a business purchasing coalition of 140 small, medium and large employers), and the Council of Smaller Enterprises (representing nearly 16,000 small businesses). The founding members elected a board that oversaw all CHQC activities.

The Initiative

From 1993 to 1999, CHQC released semi-annual reports summarizing risk-adjusted quality outcomes, efficiency of care, and patient satisfaction for all Cleveland hospitals, in the areas of intensive care, general surgery, general medicine and obstetrics.

Two separate reports came out every six months. The first one—a highly technical report intended for trained users (such as the quality improvement staff within the hospitals)—assigned numerical values to each of the data sets. A second report summarized the data for consumers by reporting one of the following "scores" ("better than expected," "as expected," or "worse than expected") to represent performance in each of four areas: surgery, general medicine, intensive care, and obstetrics and gynecology. The Cleveland Plain Dealer, the area’s largest newspaper, typically gave prominent coverage to the summary version; in recent years, this version also was posted on the Internet.

The total direct and indirect costs of the program were quite large, especially for the hospitals that bore the brunt of the burden. Each participating hospital had to spend roughly $65,000 to cover both vendor fees and data gathering costs.

Goals and Objectives

CHQC was founded on the clear premise that employers would eventually use the data to restructure their health care purchasing programs to reward high-quality, cost-effective providers with additional patient volume. The idea was for employers to commit themselves to incorporating objective performance information into their purchasing decisions, thus giving providers an incentive to improve their quality and efficiency. The underlying assumption was that many employers would abandon the use of health plans in favor of "direct contracting" with hospitals.

Key Challenges

CHQC faced a number of challenges since its inception. Ultimately, these challenges led to the termination of the program in 1999.

Challenge 1: Employers’ Failure to Purchase as Promised

While the information was packaged for consumers, the primary audience for CHQC data was really the employer community. But not long after the launch of CHQC in 1989, the employer push toward value-based purchasing seemed to lose steam. Part of the problem was the long lead time in getting data released: the development of the customized measurement system itself took roughly two years, and it was 1993 before the first report was released. During this time period, several factors softened many employers’ resolve, including the turnover of key high-level employees who had championed CHQC and the beginning of a marked decline in health care inflation. Even
after data reports came out showing meaningful variation across hospitals, many employers were reluctant to act on data from a single point in time. Ultimately, the vast majority felt uncomfortable moving away from their health plan-based purchasing models.

**Challenge 2: Growing Hospital Clout**

While employer interest waned, the power of hospitals increased due to mergers and affiliations. A market that in 1989 was largely a collection of individual hospitals had turned by the mid-to-late 1990s into one dominated by several large, multi-hospital systems. The leaders of one of these systems, The Cleveland Clinic System, had expressed reservations about CHQC since its inception, feeling that the risk-adjustment system unfairly penalized its performance scores. In January 1999, CHQC halted operations when The Cleveland Clinic System, who controlled roughly one in three hospitals in the market, withdrew from the program.

**A New Reporting System in Cleveland**

The Big Three automobile manufacturers (which were not a part of CHQC) have joined forces with HAC and the United Auto Workers to implement a new patient-care reporting system in Cleveland. This new system measures both patient satisfaction and a set of clinical outcomes. The initial report was released in December 1999 with data from 10 hospitals. Most Cleveland area hospitals have refused to participate. The ultimate fate of this effort remains to be seen.

**Results**

During its years of reporting, CHQC undoubtedly had an impact on the marketplace:

*A handful of employers acted on the information.* Only a few purchasers restructured their health care purchasing so as to develop direct contracts with some of the better-performing hospitals. A few others used CHQC and other data to influence the composition of the hospital networks of their health plans. Most used the information as a check that costs were under control and quality was adequate, if not exemplary.

*Hospitals used the data for QI purposes.* CHQC data and reports gave quality improvement personnel within the hospital community valuable comparative information that they could use to guide their improvement efforts. Even in the absence of market share shifts, the public nature of the CHQC data has helped to motivate hospitals to improve. Improvements in outcomes of care in Cleveland hospitals exceeded the level of improvements nationally.

*Net result was reduced LOS and mortality rates.* In fact, trend data from the CHQC program indicate that hospital LOS and risk-adjusted mortality have declined significantly since the program’s inception. For example, mean LOS for patients with one of six general medical diagnoses fell from 7.6 days in 1993 to 5.9 days in 1996, while risk-adjusted mortality rates fell from 7.0 percent to 5.4 percent during this same time period. (Of course, there is no way to quantify the role that CHQC played in this decline.)

**Lessons Learned**

CHQC offers a number of lessons for other organizations embarking on quality reporting initiatives:

- Ensure that the data is used for its intended purpose. CHQC began with the very clear intention of encouraging employers to restructure their health care purchasing; when this failed to materialize, the project slowly began to lose steam.

- Include health plans whenever possible. Health plans were never a part of the CHQC program. By the time CHQC leadership contemplated switching to plan-based measurement, it had little or no support in the plan or employer community.

- Get an initial report out relatively quickly. Spending several years building a customized measurement system used up valuable time, resulting in lost momentum.
For More Information

Individuals with further questions about Cleveland Health Quality Choice may contact Dwain Harper, Principal, Contemporary HealthCare Associates, at (561) 225-6222 (or via e-mail at dwainharper@email.msn.com) or Dale Shaller, Program Director, Quality Measurement Advisory Service, at (651) 430-0759 or via e-mail at dshall@dshall@prodigy.net.
The Sponsors
The Buyers Health Care Action Group (BHCAG) formed in 1988 as a collaboration of 14 large employers in the Minneapolis area. Today, BHCAG has 52 members and associate members in Minnesota and South Dakota, the vast majority of which are large, private employers. The State of Minnesota Department of Employee Relations (DoER), representing 150,000 state employees and their dependents, is an associate member.

The Initiative
In 1997, BHCAG launched a purchasing initiative that uses a combination of financial incentives and cost/quality performance information to help the employees of participating members choose among competing provider “care systems”—groups of primary care physicians (PCPs), specialists, hospitals, and other care providers that have come together to offer a comprehensive set of services.

The Key Elements of This System

Standardized benefits and care system cost groupings. Each year, care systems are invited to bid on a standardized benefits package that BHCAG’s members have agreed to offer if they participate. Based on these bids, care systems are then classified into one of three cost groups. Presently, 28 care systems participate in the program: 16 in the Twin Cities area and 12 in other communities.

Employers free to set own purchasing policy. BHCAG members are free to decide not to offer the care system model, or to offer other options, such as health plans, alongside it. And while the cost groupings serve as a guide, employers may set their own contribution policies. At present, more than 30 employers offer the care system model, with 140,000 of 250,000 BHCAG employees and dependents enrolled in one of the care systems.

Performance information to help consumers. Each year, employees and their dependents receive descriptive information and patient-reported satisfaction scores at the care system level. These include scores on overall satisfaction with the clinic and the individual doctor or nurse, access to care, how well doctors communicate, getting referrals and care, waiting times for appointments and in waiting rooms, and courtesy, respect, and helpfulness of staff. Scores are reported separately for adults and children, with one of three scores given in each category: better than average, about the same as average, and worse than average. This information is available in written form, on touchscreen kiosks at employer sites, and via the Internet.

Risk-adjusted payments to care systems. Employer payments to care systems are adjusted to reflect the health status of the enrollee population.

Goals and Objectives
BHCAG’s goal is to empower consumers to transform the market by giving them the tools and incentives needed to migrate to high-quality, cost-effective providers. By setting up a system that rewards the best performers, BHCAG hopes to stimulate quality and efficiency improvements among providers.

Key Challenges
This section reviews the key challenges that BHCAG faces with respect to providing comparative performance information at the care system level.

Challenge 1: Financing Performance Measurement
Data collection and reporting is much more expensive at the care system level than it is at the health plan level. In BHCAG’s case, 150,000 employees and dependents who previously signed up with three or four health plans are now enrolled in 28 different care systems. As a result, survey costs are much higher. To help share the burden, BHCAG, DoER and the Minnesota Department of Human Services split the expense of the surveys, which are conducted once every two years.

Challenge 2: Going Beyond Satisfaction Scores to Clinical Quality Measures
With 140,000 members spread out among 28 care systems (and with 55 percent of these members enrolled in three systems), BHCAG simply cannot generate adequate sample sizes to measure clinical indicators. And even if the number of enrollees were sufficient, financial considerations and Minnesota’s patient confidentiality laws would prohibit the use of such measures on a broad scale.

To overcome these problems, BHCAG has piloted a few programs to look at clinical quality in some of the larger...
care systems. One current initiative is evaluating the care of patients with diabetes in three care systems. In a separate effort, BHCAG also launched its annual "Excellence in Quality" awards, which are designed to recognize care system achievements in providing high-quality clinical care to enrollees.

Challenge 3: Ensuring that Consumers See the Information

BHCAG’s experience suggests that most consumers pay attention to performance information if they see it. Yet some focus groups suggested that employees have not in fact seen the information. In one case, an employer failed to distribute performance reports to employees. To get around this problem, BHCAG is currently intensifying its efforts to ensure that consumers are aware of and have access to the information.

Results

BHCAG has achieved significant progress towards its goal of transforming the marketplace. Care systems have responded to the data by implementing a variety of quality improvement programs:

- A few of the largest care systems that initially received poor scores on access have embarked on an ambitious plan to re-engineer their scheduling systems. As a result, wait times for routine appointments have fallen among some systems from 45-60 days to as low as two days.
- Many care systems have begun to offer evening hours. Both employees and employers like this because appointments no longer interfere with the work day.
- One care system that scored poorly in the area of physician communication has launched a comprehensive training program for its doctors. Over a two-year period, the system’s scores improved markedly – from the lowest among all care systems to the median.
- One system participating in a pilot study on diabetes initiated a number of programs to improve care. This system scored markedly higher than the other two pilot study participants on a variety of measures related to diabetes care.

Consumers respond to data and incentives. Using 1998 data on the enrollment decisions of employees who faced the maximum financial incentives, BHCAG found that the four lower-cost systems experienced enrollment increases ranging from 15 percent to 57 percent. At the same time, three out of four high-cost systems experienced declines. One high-cost plan that also scored poorly on patient satisfaction lost nearly 20 percent of its enrollees. Among systems with similar costs, those with better-than-average patient satisfaction ratings tended to see enrollment gains, while those with below-average scores suffered declines. Analysis of data from 1999 confirms the trends seen from the 1998 data. While scores were more bunched together than in the past, consumers did appear to punish high-cost care systems with low satisfaction scores. One such system lost 30 percent of its BHCAG members.

Lessons Learned

The BHCAG experience offers the following lessons to other organizations contemplating a similar type of purchasing model and quality reporting initiative:

- The potential to gain market share and the public display of information serve as strong incentives for those being measured to participate and improve performance.
- Consumers will act on both incentives and performance information.
- Consumers must see the information to act on it. It is critical to commit resources to make sure that consumers receive performance information. Interventions that might help include constant follow-up with employers, direct mail, newsletters, on-site meeting with employees, and placing posters in lunch rooms.
- Provider-level measurement is expensive; collaboration can reduce costs.

For More Information

Individuals with further questions about BHCAG can contact Steve Wetzell, Executive Director, at (612) 896-5190 or via e-mail at stevew@isd.net.
The Sponsors

The California Hospital Outcomes Project (CHOP) is sponsored by the California Office of Statewide Health Planning and Development (OSHPD). The California CABG Mortality Reporting Program (CCMRP) is sponsored by OSHPD in partnership with the Pacific Business Group on Health (PBGH), a coalition of large purchasers concentrated primarily in California.

The Initiative

The Original Program: CHOP

CHOP began in the early 1990s after the state legislature mandated the development of annual reports documenting risk-adjusted, hospital-specific outcomes in three clinical areas: heart attacks, back surgery and maternity care. The reports are based on discharge data that hospitals were previously required to report to the state; there is typically a three-year data lag, meaning that reports released in 2000 will contain 1997 data.

In the past few years, state officials and other health care leaders in California became concerned that very few people were paying any attention to CHOP data. A number of factors contributed to this problem:

- The time lag meant that the data had little relevance to hospitals, consumers, or employers;
- Hospitals, especially those that performed poorly, believed that the risk-adjustment methodology was flawed, making the data unreliable;
- The reports themselves were technical, lengthy, and therefore not user-friendly, in part due to the hospitals’ insistence that they be allowed to place a comment letter in the report.

The Next Generation: CCMRP

To get around these problems, OSHPD joined forces with PBGH to launch a new, voluntary hospital outcomes project. Project leaders decided to start with heart bypass surgery (coronary artery bypass graft), a common procedure for which there are existing models for outcomes measurement.

They also made several key decisions designed to encourage consumers, purchasers, and hospitals to make use of the information:

- Information would be collected from medical records, making it more timely. The first report, still in draft form in the fall of 2000, contains 1998 data. OSHPD plans to release future reports with a nine- to twelve-month month lag;
- The type of clinical information collected allows for more robust risk adjustment, thus minimizing the possibility that hospitals will deem the data unreliable;
- PBGH is lending financial resources as well as its expertise in presenting and marketing information to consumers to ensure that the reports are shorter, user-friendly, and widely disseminated.

Goals and Objectives

The objective of both projects is to encourage hospitals to focus on quality improvement. The underlying theory is that hospitals have limited ability to objectively compare their performance with their peers and that the existence of CQI programs within hospitals is not enough; external “grading” is needed to help motivate providers. Even if consumers and/or purchasers are not yet using the information, the chance that they might use it and that the data are in the public domain should serve as an impetus for improvement.

Key Challenges

The key challenge was how to recruit hospitals to participate in the voluntary CCMRP program. Already unhappy with the mandatory CHOP program, many hospitals were not inclined to participate. Several steps were taken to encourage recruitment:

Step 1: A "Carrot-and-Stick" Approach

OSHPD and PBGH used a clear "carrot-and-stick" approach with hospitals. The "carrot" was that they agreed to spend the time and resources necessary to "do things right" with respect to risk adjustment. They agreed to collect the type of data (e.g., ejection fracture rates, angina
and heart failure classifications) necessary to develop a methodology with which everyone would feel comfortable. To ensure the comparability of data, they also agreed to audit medical records and to conduct training classes with hospital representatives. The "stick" aspect was equally important. OSHPD representatives made it clear that if enough hospitals did not sign up, they would resort to the mandatory CHOP model and use the discharge database to produce the CABG report.

Step 2: Keeping Hospital Costs and Time Commitment to a Minimum

OSHPD and PBGH made an effort to help keep hospital costs and time commitment to a minimum. First, they "piggybacked" on a database developed by the Society for Thoracic Surgeons (STS) that already collected the necessary data from STS member hospitals, roughly 40 to 45 of which were located in California. Thus, these hospitals spent only a few minutes extracting the information from an already up-and-running database. For non-STS hospitals with other types of databases, OSHPD committed to finding ways to download the needed data from their existing information systems. And if this approach did not work, OSHPD provided a ready-made software program to assist with data collection. PBGH and the state government also paid for the more expensive aspects of the program, such as medical record audits and training.

Step 3: Rewarding Participation Rather Than Performance in Short Term

PBGH committed that it would not use the information to inform purchasing decisions until at least three reports has been released, thus giving hospitals time to understand their current performance and to implement improvement efforts where necessary. PBGH also gave hospitals special recognition for agreeing to participate in the program.

Results

While the CHOP program appears to have had little impact in the market, the CCMRP program seems to be off to a promising start, with support from both the hospital community and the state legislature.

Hospital participation is high. Eighty out of the roughly 110-115 hospitals that perform CABG agreed to participate. OSHPD was originally hoping for at least 25 hospitals.

State government commits funding. While PBGH financed several aspects of the program in the first year, the State Legislature has authorized OSHPD funds to cover these expenses going forward.

Program is being expanded. PBGH and OSHPD representatives are currently planning to expand this voluntary program to measure outcomes of adult patients in intensive care units.

It is too early to gauge any impact in the marketplace. Given the hospitals’ favorable response to date, it seems likely that they will pay much more attention to this data than they did to the CHOP reports.

Lessons Learned

The CHOP and CCMRP projects offer the following lessons:

- Providers must understand and believe in the risk-adjustment methodology being used.
- Data must be reasonably timely; three-year lags will not work.
- Overly technical and lengthy reports are unlikely to garner attention.
- Recruitment efforts will be more successful if the costs of participation are low and if providers feel that their concerns are being taken into account. That said, a strong "stick" – such as the possibility of a state government mandate or the threat of selective contracting – will also help generate interest.

For More Information

Individuals with further questions about CHOP or CCMRP should contact Cheryl Damberg, Ph.D., Director of Research and Quality at PBGH, at cdamberg@ix.netcom.com.
The Coordinated Autos/UAW Reporting System (CARS)

The Sponsors
The CARS Project was sponsored by General Motors (GM), Ford, Daimler-Chrysler, International Union of United Auto Workers (UAW) and the Greater Detroit Area Health Council (GDAHC), a broad-based coalition of business, labor, hospitals, health plans and others in Southeast Michigan.

The Initiative
Several years ago, the sponsors came together to develop a common measurement methodology and presentation format for information on the performance of health plans. While each sponsor still produces its own report card and open enrollment materials, the categories for measures included in the report and the presentation of information (e.g., language, graphics, rating system) are now standardized. The sponsors agreed to use HEDIS measures and RAND’s methodology for analyzing data. They also used the Foundation for Accountability (FACCT) categories for presenting information, with the presentation format (e.g., use of “stars”) derived from previous reports put out by some of the individual sponsors. In addition, the sponsors developed a common request for information (RFI) from health plans.

Each report card indicates whether a plan is accredited by the National Committee for Quality Assurance and how well it rates with respect to consumer satisfaction, access and service, staying healthy, and getting better and living with illness. These last three categories, drawn from FACCT, are composite measures that “roll up” more specific measures into one overall rating.

Goals and Objectives
First and foremost, the sponsors wanted to improve consumer decision-making by providing accurate and useful information on quality. By collaborating, the sponsors hoped to minimize the confusion that resulted from inconsistencies across report cards. Because family members and friends very often worked for different automobile manufacturers in Detroit, a given individual could be exposed to two or more report cards that varied in the following ways:

- Sponsors used slightly different measures to represent similar aspects of a given health plan’s performance;
- The same measures could have different results because sponsors relied on different methodologies;
- Each sponsor used its own format for presenting results, which resulted in inconsistent interpretations of the data by consumers.

In addition, the sponsors hoped to take inefficiencies out of the system by reducing the administrative burden on health plans. Plans often had to respond to multiple RFIs, each of which requested similar information, but in a slightly different way.

Finally, it was hoped that a coordinated effort would produce consistent, comparable data that would provide clearer direction for health plans on where to focus quality improvement initiatives. In the past, plan representatives had complained that each purchaser gave them different “grades” on the same or similar measures, making it difficult to determine where in fact improvement was needed.

Key Challenges
Participants in the CARS project faced two key challenges:

Challenge 1: Forging Consensus
Without question, the critical challenge involved forging consensus on common measures, measurement methodologies, and reporting formats. A number of key steps helped the partners come to agreement on these critical issues:

Using existing, familiar models rather than trying to invent a customized approach. The sponsors very quickly became comfortable with RAND’s approach to measurement. One respected representative who was familiar with FACCT’s work took responsibility for introducing that reporting methodology to the group.

Keeping the planning committee small, so as to minimize the potential for gridlock. Each sponsor designated only one or two representatives. Equal representation was also seen as important, so as to avoid the perception that one organization had more power than another.
Using an outside consultant, RAND, to lay out the advantages and disadvantages of various options. RAND gave a presentation laying out the pros and cons of a 5-star versus a 3-star rating system.

Setting, and adhering to, tight deadlines for making decisions. The impending deadline forced the group to come to closure on contentious issues.

Challenge 2: Balancing Continuity with Improvement

As the science of measurement and reporting progresses, program sponsors are constantly balancing the desire to produce a consistent report with the goal of improving the overall quality of the report.

To keep this balance, the planning committee has adopted a number of "rules of the road," including: The look of the report should remain fairly consistent from year to year; any changes should be incremental in nature; any newly developed HEDIS measures will not be incorporated for at least a year.

Results

Anecdotal evidence would suggest that the CARS project is beginning to achieve its goals:

- Consumers seem less confused than in the past. Employers report fewer phone calls from confused employees and/or dependents, while health plans report that their members seem less confused with the standardized, consolidated report. More importantly, surveys suggest that the vast majority of consumers read the report cards, and that many would like to receive even the more detailed information. Most consumers apparently use the information to validate their current choice of health plan, since very few report that they have used the information to switch;

- Health plans report that the standard RFI saves a significant amount of time and effort. The plans also appear to be paying more attention to the data for quality improvement purposes, as evidenced by new programs that are being implemented in response to the standardized report card. For example, several plans that scored very poorly in the first year’s report card have subsequently improved. And two plans have recently put programs into place to improve their adolescent immunization rates.

Lessons Learned

The CARS project offers the following lessons to other organizations that might be contemplating a similar collaborative approach among purchasers:

- Choose familiar partners. The automobile manufacturers, GDAHC, and UAW had all worked together on health-related activities in the past, so the players and personalities were used to working together and thus capable of reaching agreement on potentially contentious issues.

- Ensure that all parties are committed to the benefits of collaboration. Each participant must demonstrate this commitment by being willing to compromise in order to forge consensus on critical issues.

- Whenever possible, make use of existing, respected measurement and reporting systems. These systems can save time and help to avoid the inevitable controversy that arises when different parties try to agree on measurement and reporting issues.

- Invite health plans to comment on how project is implemented, not whether it happens in the first place. After the first year of the program, health plan representatives were invited to comment on specific aspects of the program’s implementation. As a result, program sponsors received valuable input on difficult operational issues (e.g., how to adjust scoring weights within measurement categories) while avoiding up-front resistance.

For More Information

Individuals with further questions about the CARS program should contact Renee Turner-Bailey, executive director, Healthcare Quality Consortium at (313) 323-0711 or via e-mail at rtbailey@ford.com.
The New York State Cardiac Surgery Reporting System

The Sponsors

The New York State Department of Health (NYDOH) sponsors this project, with oversight by the Cardiac Advisory Committee (CAC) of New York State. CAC is composed primarily of cardiac surgeons, cardiologists, generalist physicians and consumers; its role is to advise NYDOH on the quality and appropriateness of cardiac care in the state of New York.

The Initiative

Since 1989, NYDOH has collected and analyzed data on all patients undergoing open-heart surgery in New York. Using data that all hospitals submit to the state’s Cardiac Surgery Reporting System (CSRS), the state publicly releases annual reports with hospital-specific information on case volume, crude mortality rates, and risk-adjusted mortality rates. NYDOH also identifies those hospitals with higher- and lower-than-expected mortality rates.

In addition, the state releases risk-adjusted mortality rates for three-year periods for each surgeon who performs an operation in each of the three years, or who has performed at least 200 operations within the three-year period.

To assist hospitals and their affiliated surgeons, CSRS provides each facility with detailed data on case volumes and actual and risk-adjusted mortality rates for the hospital and each of its surgeons. Hospitals can also use CSRS resources to determine the risk of in-hospital mortality for a given heart bypass surgery patient on the basis of New York State experience.

Goals and Objectives

The goal of the CSRS is two-fold:

- To stimulate quality improvement by providing information that will help both hospitals and NYDOH in their respective quality improvement activities; and
- To provide consumers with information that will help them to make more informed decisions when selecting cardiac service providers.

Key Challenges

NYDOH faced a number of challenges as it launched CSRS:

Challenge 1: Ensuring that the Data Are Reliable and Can Be Trusted

The biggest challenge facing NYDOH was to provide data that are reliable and trustworthy. In particular, there was a concern that the public release of information would lead some providers to attempt to lower their mortality statistics by avoiding or not reporting results for high-risk patients, or by overreporting certain risk factors.

The key to removing the incentive for this kind of behavior was to ensure that the data were clean and comparable across institutions, and that the risk-adjustment system adequately accounted for patients with the highest risk. State representatives felt that using administrative data, such as that in available discharge databases, would not suffice.

To ensure the validity of the data, NYDOH took a number of steps:

- To confirm that hospitals report data for all patients, NYDOH compares the data to the list of patients from the statewide database on hospital discharges;
- To ensure the accuracy of data, NYDOH maintains rigorous auditing activities, including reviews of hospital’s coding of risk factors. Where discrepancies occur, the hospital is asked to recode. NYDOH also conducts an independent audit of a sample of hospital data, comparing submitted data with information in the medical records.

The net cost of this program is several hundred thousand dollars a year, funded out of NYDOH’s budget. In addition, each hospital commits roughly one-half to one full-time equivalent (FTE) to CSRS.

Challenge 2: Ensuring Appropriateness of Surgeon-Specific Data

Originally, CSRS did not intend to release surgeon-specific information, believing that the relatively low annual volumes would result in highly variable mortality rates that would likely be misinterpreted. However, the newspaper Newsday prevailed in a lawsuit forcing the state to release the surgeon-specific data. Not surprisingly, the physician community reacted negatively to this event; the CAC
voted overwhelmingly to recommend that hospitals submit data in a way that would make it impossible to identify individual physicians.

Believing that surgeon-specific information was important to understanding the role of surgeon skill in CABG outcomes, NYDOH negotiated a compromise with CAC whereby surgeon mortality rates were calculated for three-year periods and only attributed by name to surgeons who performed at least 200 operations in a single hospital during that time period. This compromise ensured that the data would yield statistically reliable mortality rates. In recent years, this policy was expanded so that surgeon-specific rates also were published for surgeons who performed at least one operation in each of the three years.

Challenge 3: Ensuring that Media and Public Interpret Data Correctly

Initial press coverage of the data tended to overemphasize numerical rankings, even when the differences between hospitals were quite small and not meaningful either statistically or clinically. The media also tended to ignore the role of the CSRS program in stimulating quality improvement. Not surprisingly, the provider community was unhappy with this type of coverage.

In response, NYDOH began an intensive effort in 1992 to educate the media. In all press releases, press conferences, and interviews, NYDOH representatives would emphasize that rankings are inappropriate and that only the risk-adjusted rates are meaningful. They also highlighted the value of the data in quality improvement efforts. Over time, journalists became more responsible in interpreting the data and spent more time emphasizing the efforts of hospitals to use the information to improve quality.

Results

The evidence suggests that CSRS has had a positive impact on the quality of CABG care in New York. During the first four years of the program (1989 to 1992), risk-adjusted mortality rates fell by 41 percent, from 4.17 percent to 2.45 percent. Unadjusted mortality rates fell from 3.52 percent to 2.78 percent during that same time period, and have subsequently continued to fall. Improvements occurred across-the-board, with the highest percentage declines in mortality occurring in the poorest-performing hospitals.

Medicare data suggests that the improvement in New York during the 1989-1992 time frame was greater than elsewhere in the country. In fact, during this period the percentage decline in New York’s CABG mortality rate was the third highest of any state in the nation, even while the state’s Medicare CABG mortality rate was the lowest in the nation. In other words, New York enjoyed a low mortality rate that continued to decline at a relatively rapid pace.

While other factors outside CSRS certainly played a role in this decline, strong anecdotal evidence highlights the power of the CSRS program in stimulating quality improvement. Over the years, there have been a number of reports on how hospitals have used CSRS data. For example:

- A number of major hospitals used the data to identify processes that need to be improved. For example, one poor-performing hospital restructured its treatment of emergency patients, reducing its mortality rate for these patients from 26 percent in 1992 to 0 percent in 1993. Another hospital put in place a program to more closely monitor pre-operative bleeding.
- Between 1989 and 1992, 27 low-volume surgeons with much higher-than-average mortality rates stopped performing CABG in the state.
- CAC efforts to give advice to poor-performing programs has had a significant impact; one program suspended operations until it found a new chief and restructured operations.
- Some hospitals shifted high-risk patients to surgeons with superior performance, while others moved cases away from surgeons whose principal training was not in adult cardiac surgery.

Interestingly, there is mixed evidence as to whether consumers have responded to the data; one study found no evidence of any change in consumer behavior, while a second found that some consumers have in fact switched hospitals as a result of the data.

Lessons Learned

The CSRS experience offers the following lessons to other organizations that may be contemplating a similar approach:

- Significant resources are necessary to ensure that the data are clean and comparable across institutions;
information gleaned entirely from administrative databases, which are currently available to many state governments, is likely not enough.

- Sponsors must devote time and resources to educating the media and public about the meaning and appropriate use of the data.

- While consumers may not directly act on data, its mere presence in the public domain may be enough to stimulate quality improvement among providers.

- Carefully crafted risk-adjustment systems can accurately account for high-risk patients and thus remove the incentive for providers to avoid caring for these patients.

For More Information

Individuals with further questions about the New York CSRS should contact Ed Hannan, Ph.D., at the School of Public Health at the State University of New York at Albany. Dr. Hannan can be reached at (518) 402-0297 or via e-mail at elh03@health.state.ny.us.
The California Cooperative Healthcare Reporting Initiative (CCHRI) was founded in 1994 as a collaboration of purchasers, health plans, and providers dedicated to giving California's consumers important information about health plans. CCHRI is governed by an executive committee consisting of 15 elected representatives (five each from participating health plans, purchasers, and providers) that meets monthly. The Pacific Business Group on Health (PBGH), a coalition of large purchasers, is responsible for administering the program.

The Initiative

Since 1995, CCHRI has released an annual report that compares the performance of most health plans in California on a common set of clinical quality measures, drawn from the Health Plan Employer Data and Information Set (HEDIS) and from the NCQA member satisfaction survey (CAHPS 2.0H).

Key components of this effort include:

**Measures.** The specific measures reported upon have changed slightly from year to year. For the year 2000, CCHRI is reporting on several HEDIS measures drawn from the effectiveness-of-care domain (one of seven domains covered by HEDIS), as shown in the box below. The survey also reports on several measures that fall within the following categories of the NCQA member satisfaction survey: overall assessment, interaction with physicians, the referral process, and member services.

**Ensuring comparability.** CCHRI takes steps to ensure that results are accurate and comparable across plans. Provider groups are given a common patient pool list generated by the plans with which to work. Providers and plans then collect data, relying primarily on medical chart review and, to a lesser extent, administrative data.

**Issuing of reports.** CCHRI issues two separate reports. The report to the public, which is short and user-friendly, provides numerical scores and also rates plans as "above average," "average," or "below average" for each of the measures. Until recently, actual scores were not provided to consumers. It also provides comparisons to statewide averages. A second report offers much more detail to participating plans and to employers.

**Rating the performance of medical groups.** Because the provider panels of many major health plans in California are quite similar, a number of purchasers are interested in performance measurement at the medical group level. For their part, many large medical groups believe that provider organizations are the appropriate unit of accountability. A number of health plans already publish data on the performance of medical groups, but because each of these reports covers enrollees from only one plan, the data are sometimes inconsistent and/or statistically insignificant, due to small sample sizes.

To address these issues, CCHRI has a three-pronged approach to provider-level measurement:

**HEDIS measures.** Through pilot studies, CCHRI found that the financial and personnel costs of data collection, primarily chart review, were too high for all but the largest and most sophisticated medical groups. As a result, CCHRI has temporarily suspended plans to report HEDIS results at the provider level, but is now putting together a program that will give providers incentives to beef up their administrative data systems, with the eventual goal of reducing the costs of data collection.

**Telephone access survey.** A variety of health plans had developed telephone surveys of providers to measure average waiting times for various types of appointments, including routine consultations with primary care physicians (PCPs), urgent care appointments with PCPs, and routine and urgent care appointments with specialists. CCHRI worked with these plans to standardize the survey and conduct it...
on their behalf. In 1999, CCHRI released its first report from this standardized survey, which published only statewide averages. The 2000 report will include results at the health plan level, and may also detail medical group performance if sample sizes are large enough. The ultimate goal will be to report results at the level of the medical group.

Patient survey. The Physician Value Check Survey (PVCS) is currently being standardized into a national consumer assessment survey that will become a formal part of CCHRI's provider measurement efforts. For more information, please see the separate profile of PVCS.

Goals and Objectives

In reporting on the performance of both health plans and providers, CCHRI’s goal is to help consumers and purchasers to make better decisions about their health care, and to aid health plans and providers in their quality improvement efforts by identifying potential areas of under-performance.

Key Challenges

CCHRI faced two key challenges in developing and operating its program.

Challenge 1: Getting Health Plans and Providers to Participate

Plans and providers would not readily participate in CCHRI without a compelling business case for doing so. To enlist participation, CCHRI made a conscious choice to design the program to create economies of scale in data collection, thus reducing the burden on plans and providers. In essence, CCHRI saved plans and providers both time and money by centralizing and coordinating a data collection effort that each health plan was already obligated to undertake, due to NCQA requirements. In addition, major purchasers that are a part of CCHRI, including PBGH and CalPERS, created financial incentives that are tied to HEDIS scores and satisfaction measures.

Challenge 2: Forging Consensus Among Plans and Providers

Plans and providers in California do not see eye-to-eye on many issues. Not surprisingly, getting them to agree on key components of program design was not an easy task. Two elements helped to ensure success. The first was the aforementioned incentive for plans and providers to participate. Most plan and provider representatives truly bought into the CCHRI concept and therefore were dedicated to making it work. Second, equal participation at the executive committee level ensured that no one group could dominate. The concept of equal participation extended to separate committees that were formed to oversee each major project (e.g., HEDIS reporting, member satisfaction surveys, access surveys); these committees made decisions with respect to often-difficult operational issues.

Results

CCHRI appears to have been successful in meeting at least some of its objectives:

Health plan participation is high. The vast majority of California's health plans have participated in CCHRI since its inception. At present, 16 out of 17 major plans participate; these plans represent approximately 95 percent of commercial HMO enrollees in California.

Scores are improving. The 1999 report showed improvement in the average utilization of a number of preventive clinical services, including adolescent MMR (measles-mumps-rubella), which jumped by 26 percent, childhood immunizations (13 percent), retinal exams for diabetics (16 percent), and post-delivery check-ups for women (12 percent). CCHRI administrators are confident that the public nature of CCHRI's reporting is at least partially responsible for stimulating these improvements.

Lessons Learned

The CCHRI experience offers the following "lessons learned" to other organizations that might be contemplating a similar approach:

- Whenever possible, "piggyback" on existing data collection and reporting efforts. With so many demands on them already, plans and providers will not respond kindly to new projects that require scarce time and financial resources.

- If possible, look for ways to actually reduce the costs and time required for plans and providers. The best opportunity for savings is to forge economies of scale in data collection.
Provider organizations are not yet ready to report HEDIS measures. Most lack the manpower and financial resources to collect the data from medical charts, while administrative data systems are not yet sophisticated enough to allow easy access to the required information. Near-term efforts need to focus on assisting providers in bringing these administrative systems up to speed.

For More Information
Individuals with further questions about CCHRI can contact David Hopkins, Ph.D., Director of Health Information Improvement at PBGH and Administrator of CCHRI, via e-mail at dhopkins@pbgh.org.