

Health Policy Newsletter

Volume 11 Number 2

May, 1998

Article 1

From the Editor Report on Report Cards

David B. Nash, MD, MBA*

* Thomas Jefferson University

Copyright ©1998 by the author. *Health Policy Newsletter* is a tri-annual publication of the Thomas Jefferson University/Jefferson Health System Department of Health Policy, 1015 Walnut Street, Suite 621, Philadelphia, PA 19107.

Suggested Citation:

Nash DB. From the editor: Report on report cards. *Health Policy Newsletter* 1998; 11(2): Article 1. Retrieved [date] from <http://jdc.jefferson.edu/hpn/vol11/iss2/1>.

From the Editor

Report on Report Cards

More than a decade of experience with provider-specific performance reports, sometimes called report cards, has left us with more questions than answers. The virtual torrent of report cards-as evidenced by an entire issue of a scholarly journal devoted to their analysis¹ and the recent publication of a compendium of national report cards,² - leads me to "report on report cards." Concomitantly, I draw your attention to an article reprint by Bentley and Nash³ that accompanies this issue of the Health Policy Newsletter, entitled "How Pennsylvania Hospitals Have Responded to Publicly Released Reports on Coronary Artery Bypass Graft Surgery." Published in the January 1998 Joint Commission Journal on Quality Improvement,² this article reports the results of whether performance data in Pennsylvania, as released in this state's A Consumer Guide to Coronary Artery Bypass Graft Surgery, caused hospitals to change their policies and practices.

Certainly, some key questions emerge. Why publish report cards? What is their impact at the consumer, provider, and system level? What future shape will report cards take and what can we surmise about their long-term value? Despite some well recognized limitations,⁴ such as the lack of consensus as to the appropriate measures to report and the inadequacy and inaccuracy of existing information resources, they attest to the fact that quality cannot be improved without first measuring it and disseminating the results. In my view, differences at the managed care plan level are difficult to discern, especially in our own marketplace, as managed care organizations are contracting with virtually the same provider groups. One is then drawn inexorably to examine individual physician performance. As a clinician, I am very ambivalent about physician-specific measures recognizing the methodologic shortcomings and the blunt tools we have to dissect such a complex body of knowledge. In addition, in more mature managed care markets, as premiums narrow, performance assessment becomes paramount as our way to potentially direct employees to the best providers. In a sense, maybe report cards can reward the best performers with more business. Ultimately, as market forces drive the health care industry, I believe we will begin to purchase care based principally on value-that is, best possible outcome at best possible price, rather than on price alone. Report cards will help us to be more savvy in making those critical purchasing decisions. Certainly, nationally and internationally prominent corporations have already embraced this world view and are heavily vested in improving report card systems in health care.⁵

At the consumer level it's a murky picture. Researchers⁶ have only recently shown us that consumers do not readily understand most published report cards in health care, as demonstrated in a national program entitled "Consumer Assessment of Health Plans" (CAHPS). Consumers yearn for easier-to-understand decision support systems that are disease-specific and answer basic questions about access, trust, follow-up, and other difficult to quantify measures. A rate-based measure such as vaccination rate or mammography rate might be good for an employee benefits manager but falls short for an individual consumer. If you're incredulous about all of this, ask a neighbor how she chose her health system or physician.

At the provider level, there is understandable antagonism-or, at best, a lack of enthusiasm-toward report cards. Researchers⁸ have shown us that even with the best statewide report card available for choosing a cardiac surgeon, cardiologists found it wanting. Others⁷ have decried the entire statewide data collection efforts underway for the last decade in Pennsylvania and New York. Yet, some cardiac surgeons⁸⁻⁹ have actually shown that these same report cards can stimulate them to undergo an agonizing self-evaluation ultimately resulting in an improvement in quality and lowering of costs. Finally, some investigators¹⁰ have rightfully urged that we issue a report card on physician satisfaction with their participation in individual plans and publish these results juxtaposed to more traditional plan-oriented report cards. It's an interesting model.

At the system level, there is compelling evidence that report cards have decreased mortality for procedures such as coronary artery bypass graft surgery in New York and Pennsylvania.¹¹ They have decreased the average length of stay and citywide costs in towns like Cleveland.¹² Report cards have even been credited recently with improving obstetrical services and lowering the rate of Cesarean section in towns like Columbia, Missouri.¹³ Despite some mixed reviews in public hospitals,¹³ I'm convinced that at the system level, report cards stimulate change in the right direction.

In these pages, previously, I've reported on the cutting edge work of the Foundation for Accountability in Portland, Oregon, ("Just the FACCTs," September 1997, Vol. 10, No. 3) and the evolution of the American Medical Accreditation Program (AMAP) for measuring individual physician performance in the outpatient setting ("Slicing Up the Quality Pie," May 1996, Vol. 9, No. 2). These national programs have a great deal of merit and will continue to push the national report card agenda. In my view, FACCT in particular will clear some of the murky waters surrounding consumers and report cards by providing us with more readily interpretable and meaningful measures. AMAP will involve thousands of physicians nationwide in the report card process. Serious limitations remain, however, and future report cards must use timely data, provide us with information about the process of care, and give us actionable information at reasonable cost.¹⁴ I come back to the concept that we must measure in order to improve, and we must disseminate those measures in report cards. Do report cards improve quality? I think the answer is a guarded yes. I'm looking forward to the day when report cards engender anticipation and unequivocal opportunity for positive reinforcement.

Finally, I'd like to bring your attention to a second item enclosed in this issue of the Health Policy Newsletter: subscription information about an exciting new journal I urge you to familiarize yourself with, called *New Medicine*. In its second year, *New Medicine* is forging a unique niche in the literature on innovations in medical/health care management and continuous quality improvement. Some might call it "the business of medicine." The time to take advantage of this journal's wealth of cutting-edge, expert-driven content is now: The publisher of *New Medicine* is offering a time-limited subscription rate of 40% off the regular price for all Jefferson Health System members. As health care professionals navigating an often choppy sea, we cannot afford not to prepare for the sweeping changes in the new health care marketplace. I believe you will find *New Medicine* to be a concise, invaluable review of the latest developments in our field.

As always, I am interested in your views.

- David B. Nash, MD, MBA, Editor

References

1. Evaluation and using report cards. J Comm J Qual Improv January 1998;24:entire issue.
2. Atlantic Information Services, Inc. Health care report cards. Third edition. Pub. Atlantic Information Services, Inc. Washington, DC, 1997.
3. Bentley JM, Nash DB. How Pennsylvania hospitals have responded to publicly released reports on coronary artery bypass graft surgery. Jt Comm J Qual Improv 1998;24(1):40-49.
4. Slovensky DJ, Fottler MD, Houser HW. Developing an outcomes report card for hospitals: A case study and implementation guidelines. J Hlthcare Mgmt 1998;43:15-34.
5. Mullen P. A conversation with Xerox's Helen Darling. Managed Care Oct 1997;51-62.
6. Hibbard JH, Jewett JJ. Will quality report cards help consumers. Health Affairs 1997;16:218-228.
7. Green J, Wintfeld N. Report cards on cardiac surgeons: Assessing New York state's approach. N Eng J Med 1995;332:1229-1232.
8. Schneider EC, Epstein AM. Influences of cardiac surgery performance reports on referral practices and access to care. N Eng J Med 1996;335:251-256.
9. Dziuban SW, McIluff JB, Miller SJ, et al. How a New York cardiac surgery program uses outcomes data. Ann of Thoracic Surg 1994;58:1871-1876.
10. Borowsky SJ, Goertz C, and Lurie N. Can physicians diagnose strengths and weaknesses in health plans (editorial). Ann Int Med 1996;125:239-241.
11. Chassin MR, et al. Benefits and hazards of reporting medical outcomes publicly. N Eng J Med 1996;334:394-398.
12. Rosenthal GE, Quinn LQ, Harper DL. Declines in hospital mortality associated with a regional initiative to measure hospital performance. Am J Med Qual 1997;12:103-112.
13. Longo DR, Land G, Schramm W, Fraas J, et al. Consumer reports in health care: Do they make a difference in patient care? JAMA 1997;278:1579-1584.
14. Luce JM, Thiel GD, Holland MR, et al. Use of risk adjusted outcome data for quality improvement by public hospitals. Western J Med 1996;164:410-414.
15. Thomas JW. Report cards: Useful to whom and for what? Jt Comm J Qual Improv 1998;24:50-51.