Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

HOW TO

Insights from the Field: How Reports on Health Care Cost, Resource Use, and Quality Can Better Serve Local Physician Organizations

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Multi-stakeholder health care collaboratives are making progress in collecting and analyzing health care cost, resource use, and quality data from multiple payers across their communities. An important next step in this work is to report the information to local primary care practices, medical groups, and other provider organizations that own and/or manage physician practices (e.g., Independent Practice Associations, Physician Hospital Organizations). All of these physician organizations play a central role in controlling costs while delivering high-quality care, whether through direct patient care or by influencing the delivery of health care for a defined population. In order to play that role effectively, physician organizations both large and small must have information that is understandable, timely, relevant, and usable. Thus, the developers of reports on cost, resource use, and quality face the key question of how to present this complex information in a way that engages and meets the needs of physician audiences.

To help answer that question, this brief shares the findings from interviews with clinical and administrative leaders at physician organizations in Maine and Oregon, where multi-stakeholder collaboratives have been pioneers in privately reporting cost, resource use, and quality data to local physician organizations. Both collaboratives, the Maine Health Management Coalition (MHMC) and the Oregon Health Care Quality Corporation (Q Corp), participated in the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality program as well as the Network for Regional Healthcare Improvement's (NRHI) pilot project to measure the total cost of care at the community level. (Learn more about this ongoing RWJF-funded project at http://www.nrhi.org/work/multi-region-innovation-pilots/tcoc/). While these two reporting initiatives are based on the HealthPartners Total Cost of Care methodology,[1] the findings presented in this issue brief are relevant to any organization that is (or is considering) privately reporting cost, quality, and other performance information to physician organizations to improve the value of health care.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

About the Author

American Institutes for Research (AIR) provides technical assistance for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. From 2010-2015, AIR supported the efforts of *Aligning Forces* communities to promote higher-quality health care at a lower cost.

[1] Total Cost of Care is a National Quality Forum (NQF)-endorsed methodology for measuring all costs associated with treating a physician practice's patients, including professional, facility inpatient and outpatient, pharmacy, lab, radiology, behavioral health and ancillary costs.

Overview of the Research Process

From February to April 2015, a research team from the American Institutes for Research conducted ten 1.5-hour in-person interviews with small groups of clinical and administrative leaders at physician organizations in Oregon and Maine:[2]

- In Oregon, six group interviews were conducted with the staff of adult and pediatric primary care practices and medical groups in Portland, Lake Oswego, Hillsboro, and Bend.
- In Maine, four group interviews were conducted with the staff of medical practice owners in Portland, Augusta, Brunswick, and Bangor.

Across the two states, the 36 interviewees included clinicians, quality improvement managers, administrative staff (including pharmacy and care coordination managers), IT staff, and chief executive officers. The physician organizations were all recruited by their respective collaborative; none was compensated for participating.

The interview protocol used in both states was designed to gather specific feedback on the content and layout of the reports and accompanying materials that Q Corp and MHMC were distributing to physician organizations. Q Corp was in the final stages of developing its first report on total cost of care and quality based on data received from commercial payers. The questions and input from the interviewees—who were seeing the report and their actual cost ratings for the first time—helped Q Corp refine the descriptions, layout, and accompanying information before finalizing the report and sharing it with physician organizations across the state. MHMC, on the other hand, had recently distributed its second annual report on total cost of care and quality based on data from commercial payers participating in an all-payer database. As a result, most interviewees in Maine had some familiarity with the report and few questions about what they were seeing; several were already sharing parts of the most recent report with managers and medical directors in their organizations.

Recommendations for Report Developers

The reports for physician organizations on the total cost of care in Maine and Oregon are in the early stages of implementation, the information in the reports is complex and largely new, and both the collaboratives and the users of the information are aware of various limitations of the data. Yet one of the most striking aspects of the interviews with physician organizations was the extent to which the participants responded positively to the information in the reports, expressed an appreciation for how it adds to the information they have in-house, and perhaps most importantly, acknowledged their stake in making the information better. This reaction reveals the perceived value of these reports to the physician organizations as well as the effectiveness of the two collaboratives' efforts to engage these organizations throughout the process of developing and disseminating the reports.

The seven recommendations below summarize the key findings from the interviews and suggest ways to build on the experiences of these pioneers in reporting total cost of care to health care providers.

Key Findings and Recommendations

1. Convey the message that a report on the total cost of care from a multi-stakeholder collaborative delivers comprehensive and comparative information that most physician organizations do not have and cannot generate on their own.
2. Take the time to build trust and create goodwill with the physician organizations.
3. Be transparent about the data sources, methodology, and any challenges associated with using the data.
4. Tailor the reports to address the information needs of different physician audiences.
5. Make the text and format as logical, user-friendly, and self-explanatory as possible.
6. Provide education and training as part of the roll-out of the report to engage physician organizations in the information.
7. Help physicians understand how they can use the reports to inform their decisions and actions.

[2] Because of scheduling difficulties, one interview with managers at a medical group was conducted via web conference.

1. *Convey the message that a report on the total cost of care from a multi-stakeholder collaborative delivers comprehensive and comparative information that most physician organizations do not have and cannot generate on their own.*

Primary care practices and medical groups have some information about their own costs, resource use, and quality—whether pieced together from their own information systems or from the payers with which they contract. These reports are typically based on multiple data sets that have varying levels of granularity, represent different segments of the patient population, and present a range of different time periods, definitions, measures and standards, explanations, and formats.

What these physician organizations do not typically have is standardized and aggregated information across all or most payers, data on total costs (i.e., costs incurred when their patients receive care beyond their walls), and comparators that enable them to assess their performance relative to others in the community. Representatives of one health system indicated that they receive relatively comprehensive information on costs and quality from a vendor that aggregates their payer data, but noted that the report from the collaborative included metrics and statewide comparators the vendor could not generate. Across the board, the physician organizations in Oregon and Maine perceived the reports from the collaboratives as a useful supplement to the information they usually accessed.[3]

2. *Take the time to build trust and create goodwill with the physician organizations.*

Perhaps the biggest factor contributing to the interviewees' positive response to the reports was the level of trust the collaboratives had built over time with physician organizations in the community. Staff in both Oregon and Maine have invested a great deal of time and effort in educating physician organizations about the multi-stakeholder group and the Total Cost of Care initiative, listening to and addressing concerns from the physicians' perspective to ensure that the report would be relevant, and cultivating a sense of partnership. As a result of these efforts, many of the interviewees perceived the reports as the product of a collaborative effort done for their benefit.

Suggestions for Building Trust

- Reach out to physician organizations, in groups and one-on-one, to inform them about your organization and your initiative to measure and report on costs, resource use, and quality.
- Ask questions about the information physician organizations already have, the information they need, and how they would use that information.
- Make sure physician organizations have a voice in decisions about the measurement and reporting process.
- Be explicit about confidentiality and keep private information private.

The private nature of these reports also contributes to a sense of trust. Physician organizations have legitimate concerns about who will see the results and related information in the reports, when that will happen, and how the reports might be interpreted (or misinterpreted) and used. The collaboratives were explicit about the confidentiality of the initial reports, which the physician organizations understood meant that the reports would not be shared with payers, the media, or the public. The physician organizations appreciated both the confidentiality of the reports as well as the assurance that they would have an opportunity to weigh in on any information that will be shared with others in the future. Both collaboratives are planning to eventually produce a public report with high-level measures on cost for use by consumers and others, but not with the level of detail provided in the private reports for physician organizations.

3. *Be transparent about the data sources, methodology, and any challenges associated with using the data.*

The trust of physician organizations also depends on their confidence in the report content (e.g., rates and measure results) and the underlying data. Based on their experience and knowledge of their clinic characteristics, the managers of practices and groups are likely to have expectations for what the reports should say about their patient mix, high or low-cost areas in the practice, or disease burden. If the content of the report is not consistent with those expectations, the physicians and administrators may question or even dismiss the results altogether. To avoid that scenario, multi-

[3] One caveat is that the organizations participating in these interviews were all selected and initially contact by the coalitions, thus creating the potential for selection bias.

stakeholder collaboratives must provide the physician organizations with sufficient information about the report's data sources, definitions, and technical methodology so that the physicians and administrators can knowledgeably weigh the aggregated data against their assumptions.

Physician organizations understand that no dataset is perfect and that these types of reports are one step in the ongoing evolution of timely, complete, and reliable information on cost, resource use, and quality. Even with this common understanding, report developers must be clear about the challenges – and limitations – of the data so that physician organizations are comfortable with using the information to inform decisions about how they deliver care.

For example, the reliance on claims data for the Total Cost of Care measures—plus the time required to aggregate, analyze, and prepare the data for reporting—meant that the results received in spring 2015 reflected medical services provided more than a year before. Several interviewees expressed particular concern about the "age" of the quality scores since the physician organizations are accustomed to more timely scores based on data drawn from their electronic medical records. Yearly distribution of the reports is also an issue for physician organizations. While they can use the annual reports to identify "red flags" and major shifts in cost or quality, they would prefer more timely or frequent reports to assess the impact of recent changes they have made in their own policies or practices and to monitor trends in performance.

Both the Oregon and Maine collaboratives acknowledged the limitations of the underlying datasets and the report content and helped the physician organizations understand how they could explain and interpret the results (for example, clarifying that the quality scores provide important information about the care delivered at the time that the costs were measured). The collaboratives are also exploring ways to address the concerns about timing. For example, both are looking into the possibility of developing and releasing the private reports with updated content more frequently, possibly every six months.

Another challenge can arise if the underlying dataset is incomplete or the data sources vary. Because Q Corp could not use Oregon's all-payer claims database for this report, each of the segments of Q Corp's report includes data from only a subset of payers in the state. Also, the collaborative used slightly different datasets, with variations in the data sources, for the cost and quality portions of the report because of legal restrictions from certain payers regarding the use of the aggregated data. Specifically, variations in data use agreements with data suppliers limited the collaborative's ability to use certain data segments or types of data for different types of measurement. Acknowledging these types of constraints on the use of data sources can help with appropriate interpretation of the reports and address questions about the data that would otherwise undermine its credibility. Some physicians in Oregon, for example, noticed inconsistencies in the report content that were due to the difference in the underlying data sources used for each section. Once they understood that the differences were due to the variations in data sources, they were able to move beyond the concern that the results seemed inconsistent and instead focus on what the data revealed.

Suggestions for Being Transparent

- Explain the methodology and calculations behind the data and assure physician organizations of its reliability.
- Be forthright about the limitations of the data but also clear on the ways in which the data surpass what is currently available.
- Work with the physician organizations to identify ways to work around, and ideally overcome, those limitations.

4. Tailor the reports to address the information need of different physician audiences.

There are several ways to think about the different audiences for the information shared in these types of private reports. One important distinction is between the primary care practice, which is focused on the costs and quality of care for its patients, and the medical group, which is likely looking at performance results across multiple practices and in some cases, across a larger system.

Some medical groups questioned how individual practices would use the detailed reports and what additional information they might need. In Oregon, for example, some medical group leaders suggested sending the reports to them before the clinics so they could provide the clinics with additional context and interpretation and make a connection to relevant quality improvement efforts happening across the medical group. Representatives of the medical groups in Maine expressed interest in nearly all of the information in the report and talked about how they use it to

inform upper management as well as to identify opportunities for specific physician practices to improve their performance. However, some of the medical group leaders thought the reports include too much information for the primary care practices to use effectively on their own. While the reports are relatively short, with only six to eight pages of results, each page includes numerous data tables and graphics. The administrators perceive the time and focus required to review and analyze the potentially complex information in these reports in order to determine where to focus improvement efforts as onerous for clinicians who have limited time available. Several interviewees noted that they would provide their practices with specific graphics and tables rather than the entire report.

Another consideration is the difference between adult and pediatric practices as audiences for the reports. If the reports are to be distributed beyond adult practices, some of the charts and measures that are appropriate for a panel of adult patients may need to be adapted to the needs of pediatric practices. For example, a report for pediatric practices could eliminate the adult measures and related definitions that do not apply to pediatric practices, add measures for conditions that are prevalent among pediatric patients (e.g., measures related to treatment for attention deficit disorder), and respond to concerns about holding these practices accountable for costs and utilization perceived to be beyond their control, such as patients' use of urgent care centers.

Suggestions for Tailoring Report to Specific Audiences

- Work with physician organizations to get a solid understanding of likely users of the reports and their information needs.
- Tailor a report for pediatric practices with measures relevant to those practices.
- Over time, move toward dynamic online reports so specific audiences can customize the pages (e.g., one page with the data needed for care management) and drill down into the details to better understand what underlies performance in a given area (e.g., the drivers of high costs for patients with a chronic condition).

Finally, each physician organization encompasses different audience subgroups with their own roles, focus areas, and perspectives. Audiences for the reports include administrators and board members, practicing physicians and other clinicians, quality improvement staff, care coordination managers, pharmacy managers, and data analysts or IT staff. Each audience has its own knowledge base, ways of interpreting the data, and goals with regard to meeting professional needs; they may want to use the information for quality improvement initiatives, to support a request for funds, for overall planning, to track trends, or to work with individual clinics or physicians.

5. Make the text and format as logical, user-friendly, and self-explanatory as possible.

In general, the interviewees commended the readability and clarity of the collaboratives' reports and appreciated the effort that went into presenting so much information in a concise and logical manner. But several of them also pointed out that they are accustomed to reviewing and interpreting the kinds of data presented in the report and questioned whether others—particularly practicing physicians in individual clinics—would find the reports as easy to understand

Suggestions for Improving the Usability of the Report Content

- Get input from likely users about the organization and order of information within and across pages.
- Develop and include a glossary that defines key terms, describes the population segments included (and excluded) in each section of the report, and explains aspects of the methodology.
- Do not assume all readers are familiar with medical or financial terms; define them where they are used, if possible, or in a glossary.
- Confirm with different types of report users that the data formats in the report (e.g., data tables, scatter plots, bar graphs) meet their needs and adjust the formats as needed.
- Give each page a title that specifies the main topic addressed by that page. Don't make readers figure out the topic on their own.
- Use headings and white space to label and separate subtopics on the same page.
- Use fonts to draw attention to key pieces of information; also, pay attention to how font choices (e.g., font size, bolding, color, spacing) affect what readers notice and what they ignore.
- Avoid jargon; spell out abbreviations and acronyms (even common ones like PMPM).

and use. Some interviewees whose jobs did not regularly involve the use of performance information on costs and quality confirmed that revisions to make the report more self-explanatory would be welcome.

When asked to comment on specific written and graphic elements in the report, interviewees offered a variety of suggestions. Some focused on minor changes to improve clarity and readability, such as using large fonts for page titles and section headings and spelling out acronyms. The interviews in both Maine and Oregon revealed that report users did not necessarily pay attention to text in small type, even when it appeared on multiple pages.

Other suggestions called for more significant changes in the organization and layout of tables and graphics, primarily to group related information together. A pharmacy manager, for example, wanted to see all of the information related to pharmacy costs, resource use, and quality on one page. Other interviewees suggested rearranging the pages so metrics that are more directly influenced by and engaging to physician practices (such as quality measures) would be more prominent and those less easily influenced (such as inpatient care) would be less prominent.

The inclusion of a glossary in both reports and a set of frequently asked questions (FAQ's) in the Oregon report played an important role in making users comfortable with the content of the report. Several interviewees commented on the ease of finding the explanations they needed, in contrast to other reports they receive that do not spell out acronyms, define each clinical reference or other terminology that is unique to the report, or explain how each cost, resource use or quality result was calculated.

6. *Provide education and training as part of the roll-out of the report to engage physician organization in the information.*

How the reports are distributed has implications for who sees the results, what information they need to understand the results, and how the results might be used. As noted, both collaboratives distributed these private reports to participating primary care practices and medical groups. In Maine, some practice owners then decided what specifically to emphasize with their practices. Neither collaborative sent the private reports directly to individual physicians.

Suggestions for Preparing Physician Organizations for the Report

- Create a video to introduce the report to new users and convey the value of the reports.
- Provide supporting materials (e.g., FAQs, cover letter) that provide context for the reports and help readers understand their relevance.
- Offer in-person support and training to help organizations understand and interpret the information.

It is important to provide a variety of education and training opportunities as part of the roll-out of the reports to help ensure all audiences understand and are engaged in the information. Both collaboratives approached the rollout of these private reports for clinics and medical groups very carefully. Before distributing the reports, the collaboratives laid the groundwork for acceptance by educating physician leaders and others about the project's purpose and the methodology, comparing and contrasting the information to what the physician organizations already had, and creating a shared vocabulary about measurement and improvement. In Maine, for example, this effort involved stakeholder meetings as well as regional in-person trainings where MHMC staff walked practice owners through the reports in detail and taught them how to interpret and use the information. MHMC also offered in-person consultation and created an online tutorial video. In addition to providing in-person support, Q Corp hosted an event, conducted two webinars, and provided background information through a set of FAQ's and a cover letter that accompanied the report. Several interviewees attributed their comfort with the report to these various tactics.

7. *Help physicians understand how they can use the reports to inform their decisions and actions.*

The ultimate goal of private reports on cost, resource use, and quality provided to physician organizations is to inform decisions and actions that improve the value of health care. The reports, therefore, must be relevant and usable to the physician organizations. At this early stage, collaboratives are largely focused on reporting reliable and understandable information. But they are starting to explore ways to make the information more "actionable"' for physician audiences.

Q Corp, for example, presented each practice with a cover letter that highlighted the practice's strengths and weaknesses as well as a FAQ section that included ideas for using each section of the report.

Several interviewees in Maine and Oregon commented that the practices need a better understanding of which factors that affect cost, resource use, and quality are in their control and how to apply the report's information to make positive changes in their practices. Some of the medical groups did not expect the collaborative to identify areas where a physician practice could make the biggest impact, seeing that as the medical groups' responsibility. However, several interviewees suggested that the collaboratives could look across the community to identify where improvements are occurring at the clinic-level and provide case studies or examples of how clinics have used the reports to achieve improvement.

Conclusion

The initial efforts of statewide multi-stakeholder collaboratives in Maine and Oregon to produce and distribute private reports on cost, resource use, and quality offer useful insights into the challenges associated with this kind of reporting and what it will take to provide physician organizations with information they can use to deliver high-value health care. As in the early days of quality measurement and reporting, the measures, the data sources, and the methods are evolving and will continue to improve—even as the collaboratives and others following their lead learn from their experiences and improve on the understandability, relevance, and usefulness of the reports.

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