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Reporting of Health Care Provider Performance
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Public Reporting of Physician and Hospital delivery-of-care performance has been under discussion for over a decade and attempts to design and deploy such have been underway for the past 4-5 years. Two programs which have met with some success are in California which is reporting on hospital performance and in Massachusetts which is reporting on Primary Care Group performance.

The medical literature contains extensive discussions on the reliability and validity of current reporting. Physicians and hospitals are obviously concerned with the metrics which are being reported. Other studies are concerned that reported data be in a format which is comprehensible to patients. Still others have studied the determinants for who uses the published performance results and what the best way of promoting its use is. One study showed that two elements added to the successful use of the data. One was the promoting of its use by e-mail. This seems intuitive as it means that the recipients are computer literate and computer users. The other element showed that retired people used the publicly reported data more often, which simply relates to available time and probably to the need for more medical services.

Voluntary Reporting by Healthcare Providers

What appears to be missing in the medical literature concerning quality reporting is public reporting voluntarily initiated by provider groups. It is in this regard that SETMA has begun reporting quality results on our provider performance. In doing this, SETMA has engaged in conversations with several national organizations which both represent physicians and/or which endorse quality measures. And, it has been in regard to the requirements of the National Committee for Quality Assurance (NCQA) for recognition as a Patient-Centered Medical Home that SETMA expanded its quality measures tracking and then determined to publicly report those results.

Over the past year, SETMA has expanded our quality measurement to include:

1. Physician Consortium for Performance Improvement (PCPI) quality measures for hypertension, diabetes, congestive heart failure, chronic renal disease, chronic stable angina, acute coronary syndrome, and others.
2. National Quality Forum (NQF) quality measures for diabetes, preventive healthcare, older adult care and many others.
3. Healthcare Effectiveness Data and Information Set (HEDIS)
4. Ambulatory Care Quality Alliance (AQA)
5. Physician Quality Reporting Initiatives (PQRI)
6. SETMA Quality Audits for Lipid Management and Chronic Renal Disease Stage I-III

These quality measures are designed and displayed in the EMR so that SETMA providers can measure their own performance at the time of their seeing patients. This makes it possible for SETMA providers to improve their own performance which is the principle reason for creating these functionalities to begin with. In our December 3, 2009 Your Life Your Health article entitled, “Transforming Healthcare: Public Reporting of Provider Performance on Quality Measures,” we identified six reasons for public reporting; they are:

- First, we want to know what we are doing. Without auditing our performance, we will never know how we are performing. The COGNOS Project will allow us to objectify our performance. We will no longer "think" we are doing well; we will know if we are doing well and so will our patients and our community.
- Second, we want to improve what we are doing. Evidenced-based medicine, with the treatment targets established by science, can tell us where we want to be. If we know where we are and if we know where we want to go, we can design a way to get there.
- Third, when we know that a patient is not treated to target or to goal, we want to know why. COGNOS will allow us to know if evidenced-based standards of care are being employed. If they are, and if the patient is still not to goal, it will allow us to address hindrances and/or obstacles to the patient getting to goal.
- Fourth, we want to change provider behavior. The medical literature is replete with evidence of "treatment inertia," the nature inclination of people, even well-intentioned people, not to change things. Change requires that there be more pain or discomfort in staying the same as is required to make a change. SETMA believes that comparing provider performance and publishing that performance internally by patient name and externally as an aggregate practice performance will motivate providers to change.
- Fifth, we want to change patient behavior. Like the frog dropped into a kettle of cool water which is then placed on the fire, changes in a patient's health are often so subtle and so slow that devastation overtakes them before they realize they are sick. SETMA has used and intends to expand the use of patient data, through the COGNOS Project; to create discomfort in patients to make them "jump out of the heating kettle" of deteriorating health before it is too late.
- Sixth, we want to examine through statistical methodology and epidemiologic-principles patterns of care and outcomes. We want to be able to ask questions and analyze our data to get answers both retrospectively and then prospectively to those questions.

Public Reporting of SETMA’s Performance: Where Can you find it?

SETMA is ready to do it’s first Public Reporting of treatment results. The following reports were deployed January 22, 2010 on www.jameslhollymd.com:

- PCPI Diabetes
- PCPI Hypertension

- NQF
- HEDIS

These reports can be found by going to Public Reporting and then clicking on the drop down navigation button of the same name. The group of quality measures are first described then illustrated and at the bottom of the screen there is a section entitled "Public Reporting – Current Reports." By clicking on these links, the treatment results will be displayed. Some of the measures are not yet reported because the tools for capturing the data have only recently been developed. Others will be added to the website soon.

Public Reporting and Practice Management

No one undertakes a project like this without some angst. There is no pattern to follow as we don't know anyone who has done or who is doing what we have undertaken. Second, what is being reported is a process and not a finished product. To this end, the following is a note which was sent to SETMA providers last week:

> "Attached are results for the Physician Consortium for Performance Improvement (PCPI) for Diabetes Management for SETMA providers from October 1 to December 31, 2009. These and other measures will go up on our website today at www.jameslhollymd.com under Public Reporting. We believe that over the next year, we will see dramatic improvement as providers learn:
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> 1. How to make sure that they are documenting their work in order to get credit for their performance.
> 2. Attend to Chronic illnesses at the same time a patient is seen for an unrelated acute or chronic issue.
> 3. Redesign their personal workflow in order to make sure that quality measures are addressed.
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> "Our intent is that these reports will be for educational and motivation purposes and not for punitive purposes. Being among the first to voluntarily publicly report results and doing it over as extensive an area of patient concern, as we intend, is daunting and some would say 'risky,' but we believe the positive benefits to our patients, our practice and our profession will far outweigh any such imagined or potential risk.
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> "It is our expectation that we will report results quarterly. As we expand our COGNOS Project (for more information on that, see www.jameslhollymd.com under Public Reporting, COGNOS Project), it will be possible for our providers to utilize a 'digital dashboard' to 'drill down' into this data, to further evaluate how they can improve their results.
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> "For instance, when it is seen that 5%+ of patients with diabetes have not had a Hgb A1C in the past six months, it will be possible for the provider to query the system and ask:

1. Were these patients not seen, or were they seen and a HgbA1C was not done?
2. Is the patient's diabetes so well controlled over such a long period of time that it is excessive to measure the HgbA1C more often than ever 9-12 months?
3. Are there patients whose charts indicate they have diabetes but who in fact do not?

"It will be possible then for the provider to initiate correspondence either by e-mail or letter to the patients whose care is deficient to have them seen. These are unchartered waters but we believe the water is deep, the obstacles are few and the sailing will be smooth."

The key to finishing is starting

One of my favorite, personal axiom is: "I have started many things that I did not finish but I have never finished anything that I did not start." Simplistic? Yes, but absolutely true. We have started. I expect that a year or ten years from now, we will look back on this effort and think how simply we began, but the key is we have begun.

Part of SETMA's lore is an experience we had in May, 1999, four months after starting the use of the EMR. A description of that experience concludes the introduction to our website's new EPM-Tools Section's Introduction. It expresses our philosophy and motivation for this new and at present incomplete function to our website:

"Celebration "It was in May, 1999, that we had a sentinel event which has continued to define our efforts in development of EPM. In that month, my co-founding partner, Dr. Mark Wilson, speaking of where we were in the use of the EMR, lamented, 'We haven't even begun to crawl.' He was discouraged and worried that we had bought a very expensive and useless toy.

"I responded, 'Mark, when you oldest son turned over in bed, did you call you wife and say, "this retarded child can't even crawl all he can do is turn over in bed?" Or, did you cry out, "Come see, he turned over in bed?" The reality is that you celebrated his turning over in bed. You expected him to crawl and to walk, in due time, but right now you enjoyed his progress. So shall I; you're right; we aren't even crawling but we have started. If in a year, all we're doing is what we are presently doing, I will join your lamentation, but until then I am going to celebrate that we have begun.'"

Transforming Healthcare with the power of information and with the power of auditing

Perhaps the greatest problem in healthcare is that change which helps or harms a patient takes place over a long period of time. Learning to see slow, gradual processes requires slowing down our frenetic pace and paying attention to the subtle as well as the dramatic.

The slowly boiled frog does not react to the slowing heating water because the frog does not become uncomfortable until the damage has already been done.

The slow "boiling" which comes from the deterioration of health requires a new methodology for effecting change in patient and provider behavior. Part of that will be achieved by enhancing the capability of a healthcare provider to create discomfort in the patient in order to effect change which will benefit the patient in the long run. Part of that will be achieved by the creation of discomfort in the provider via self-auditing at the point of care which allows the provider to measure his/her performance against an accepted standard.

Because the processes which ultimately destroy health are mostly painless and are invisible, effective intervention requires making the effect of those processes apparent. Data display, which is longitudinal (over time for the same patient) and comparative (show in contrast to the results of other patients), can create discomfort in the patient and provider, which discomfort can contribute to change.

Public Reporting – Provider Improvement – Patient Health

We believe that public reporting will result in provider improvement and ultimately in benefit to our patients. As you review our published results today, join us in celebrating that we have begun. And, expect with us that one year form now we will see a remarkable improvement in both our performance and in the health of our patients.