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PHYSICIAN PERFORMANCE

Report Cards Under Development but Challenges Remain

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The Honorable James M. Jeffords
Chairman
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United States Senate

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United States Senate

While information has become available comparing health plan benefits, costs, customer satisfaction, and quality, it is not clear that this information is meeting consumers' needs or expectations. With plans having overlapping panels of physicians and hospitals, it has become increasingly difficult for consumers to differentiate plans. Moreover, few consumers receive information on which to base one of their biggest health care decisions—their choice of doctors. Recognizing this, some organizations are attempting to measure and report on the performance of physicians and physician groups—with the hope that the results can be used to compare the quality of their care and services. How well physician and physician group performance measures assist consumers to make choices and how well they drive improvements in the health care market is unknown. Because of the growing interest in promoting informed health care decisions through public dissemination of performance information, you asked us to examine (1) the issues involved in measuring and reporting on physician and physician group performance, (2) current efforts to develop physician report cards, and (3) initiatives under way that may address impediments to measuring physician and physician group performance.

To meet your request, we interviewed officials of purchasing groups, health plans, accreditation agencies, and federal programs; experts in health care performance measurement; and representatives from organizations that have formed to advance performance measurement. We visited three large health care purchasers—the Pacific Business Group on Health (PBGH), the Buyers Health Care Action Group (BHCAG), and the Health Care Financing Administration (HCFA)—and we interviewed two private health plans that publish physician group report cards—PacifiCare and Health Net—to discuss their efforts to measure and report on physician performance. We also reviewed report cards on cardiac surgeons issued by New York and Pennsylvania state agencies. We based our selection of purchaser groups and state initiatives on their reputations

as innovators in the area of consumer health care information. The health plans we selected have publicly reported the results of their comparisons of physicians in their networks. We performed our work from January 1999 through August 1999 in accordance with generally accepted government auditing standards.

Results in Brief

Measuring performance in health care is challenging in terms of identifying measures that truly reflect the quality of care individuals receive. It is also difficult to make comparisons across plans or providers that account for differences in the patients whom they treat that can affect health care outcomes. Measuring the performance of physician groups and individual physicians is even more difficult. Individual physicians or groups perform a wide variety of services and typically perform any individual service for a small number of patients. Only a fraction of these services can be clearly linked to a measurable outcome. To make meaningful comparisons among physicians, analysts must adjust any measure selected to take into consideration the extent to which a characteristic like the severity of a medical condition affects the outcomes from care. To avoid these difficulties, current approaches to performance measurement generally focus on physician groups instead of individual physicians, and they measure processes such as whether services are provided in accordance with agreed-upon norms rather than outcomes of care. Adding to the challenges, however, are concerns that consumers have regarding the privacy of their personal medical information and that physicians have regarding the accuracy of performance measurement data.

Even though the data and measures that are currently available are limited, several different private and public organizations have developed physician and physician group report cards using these data and measures. For example, two purchasing groups and two California health plans are avoiding some problems associated with measuring the performance of individual physicians (such as small sample sizes) by reporting on the performance of physician groups. In addition, in New York and Pennsylvania, state agencies that have reported on the performance of individual cardiac surgeons since the early 1990s have reported improved performance scores since they began publishing them. While significant, these efforts at physician report cards are in their early stages or are limited in scope, and difficulties remain. For example, medical group report cards provide information that is closer to the level of the individual physician than health plan report cards do but, depending on the size of

the medical group, may not be very helpful for making an informed choice of a physician. In addition, questions about the accuracy and completeness of the data and the adequacy of the risk adjustment methodology limit consumer and physician confidence in the report cards.

Some organizations are collaborating to develop more comprehensive, standardized performance measures and to facilitate the exchange of clinical and administrative data between physicians, plans, and purchasers. For example, several national accreditation organizations have formed a council to develop common performance measures. At the federal level, the Department of Health and Human Services (HHS) is working on a performance measurement system for its Medicare fee-for-service program and has been supporting research and working with other organizations to develop physician performance measures. In addition, HHS is establishing standards for administrative claims and encounter data as well as unique identifiers for individuals, plans, and providers—efforts that should help HHS and others in their performance measurement efforts.

Background

To date, most performance information has provided only data on health plans as a whole. Changes in the health care market—particularly the growth in the size of plans, the shifting of greater financial risk to physicians or physician groups, and the requirement in some cases that beneficiaries receive all their care from selected physicians within a plan—have made plan comparisons less useful for many consumers. Many consumers do not get to choose their health plan and even for consumers who can choose among plans, an individual physician's performance may deviate greatly from the health plan's average. These and other factors have prompted calls for physician report cards that can help consumers select physicians from those available within their health plan.

Report cards are generally publicly released reports on the quality of care that provide comparative information on plan characteristics and performance. One widespread report card for health plans is prepared by the National Committee on Quality Assurance (NCQA). NCQA uses its Health Plan Employer Data and Information Set (HEDIS) to report on plan performance. HEDIS includes more than 60 performance indicators covering quality, access to and satisfaction with care, membership and use of services, finance, and management.

When the development of health plan report cards began, plans were expected to differ significantly in their provider networks, organizational structure, and philosophical orientation, and the differences were expected to be reflected in the overall quality of the plans. But the marketplace has not evolved this way. Instead, to attract members and gain market share, health plans began building larger, often overlapping networks that offer consumers more provider choices than previously available. With the same providers represented in two or more competing plans, it has become increasingly difficult to differentiate between plans. Thus, even for consumers who have a choice of plans, the comparative plan information currently available may not demonstrate differences in plan performance.

Physician practices are also undergoing significant change; more physicians are joining medical groups, and these medical groups are contracting with many health plans. The proportion of physicians in group practices rose from approximately 11 percent in 1965 to 34 percent in 1995.[1] In addition, according to the Medical Group Management Association, its members contract with an average of 21 health maintenance organizations (HMO) and preferred provider organizations (PPO).[2] As physician groups contract with more plans, individual plans may have less influence over physician practice patterns and the quality of services they provide, because any one plan may account for only a small percentage of a medical group's total volume of patients or income.

In addition, a growing number of physicians receive capitated payment—a fixed monthly payment per patient—under which they accept financial risk for providing a portion of or all patient care services. As plans shift more financial risk to physician groups, a group's economic incentive is to minimize expensive services for sick patients. In a 1996-97 survey, more than half of physicians (54 percent) reported that their practices received capitation for some of their patients.[3] In locations such as Seattle, Washington, and Orange County, California, nearly three-fourths of physicians reported receiving capitation for some of their patients. To the

[1]Henry J. Kaiser Family Foundation, Trends and Indicators in the Changing Health Care Market Place (Menlo Park, Calif.: Aug. 1998).

[2]The Medical Group Management Association is a national professional and trade association. It represents administrators of 7,491 medical group practices that included 181,974 physicians in 1997. PPOs are similar to fee-for-service plans but provide enrollees a financial incentive—lower cost sharing—to receive care from a network of providers that are normally reimbursed at a discounted fee-for-service rate.

[3]Center for Studying Health System Change, Data Bulletin: Results from the Community Tracking Study (Washington, D.C.: Fall 1997).

extent that physician assumption of financial risk affects quality of care, this trend further shifts the focus on quality from plans to physicians.

For most employed Americans, their employer determines the number and type of health insurance plans available to them. For workers whose employers do not offer a choice of plans, report cards that compare plans have no utility. A 1997 survey conducted by the Research Triangle Institute found that less than one in five—17 percent—of private employers that offered insurance to their employees provided a choice among plans.[4] Another study reported that of employers that offer health insurance, 92 percent of small firms and 44 percent of larger firms (those with more than 200 employees) offered only one plan in 1998.[5] Counting employees rather than employers, less than half—only 41 percent—of employees who are offered health insurance can choose from two or more health plans.[6] Health plan report cards may also be of little use to more than 14 million of the country's 40 million Medicare beneficiaries—those who did not have a choice of managed care plans in 1998.[7]

Developing Physician Report Cards Is Challenging

The heterogeneity of health care makes performance measurement challenging in terms of identifying measures that truly reflect the quality of care that individuals receive. Making valid comparisons across plans or providers that ultimately account for patient differences that affect outcomes is also difficult. These challenges are magnified in attempts to measure the performance of physician groups and individual physicians. For example, unlike plans that have a large number of enrollees, individual groups or physicians generally see a small number of patients with specific conditions. These attempts are further complicated by a concern that consumers and physicians have regarding the use of performance measurement data in the first place.

Selecting Appropriate Measures Is Difficult

Medicine involves a wide variety of services, only a portion of which can be clearly linked to health outcomes. Health outcomes are also influenced

[4]The Robert Wood Johnson Foundation, 1997 Employer Health Insurance Survey (Princeton, N.J.: 1997).

[5]Henry J. Kaiser Family Foundation, Health Benefits of Small Employers in 1998 (Menlo Park, Calif.: Feb. 1999), p. 18.

[6]Robert Wood Johnson Foundation.

[7]In 1998, 4 million Medicare beneficiaries had only one managed care plan available in their county and 10.6 million beneficiaries lived in counties with no plan at all. See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).

by factors such as a patient's age, medical history, and heredity. In addition, most individual physicians perform any specific service a relatively few times in a given year, making it more difficult to adjust for differences in patients and creating other statistical problems. Efforts to create report cards on health plans and providers are also complicated by the different needs of consumers. Current attempts to resolve the difficulties of physician performance measurement include aggregating physicians into groups; focusing on certain types of physicians, such as cardiac surgeons, who perform highly specialized services; and substituting measures of process for measures of outcome.

To make meaningful comparisons among physicians, analysts must select measures while taking into account factors that can affect the outcomes of care, such as a patient's medical history. For example, whether the patient is treated for a first or second heart attack affects the likelihood of a successful outcome from cardiac surgery. Measures that did not account for differences in such factors would penalize physicians who treat the sickest patients. Without proper adjustment in the measures, physicians might choose to avoid high-risk patients in order to maintain higher performance scores.[8] Today, such adjustments are limited, and it may never be possible to account for every characteristic of patients that could affect their health outcomes.[9]

Another challenge in performance measurement is that different consumers have different information needs that are not likely to be adequately met all in a single physician report card. Consumers prefer performance information that matches their own medical conditions and situations. For the majority of consumers who are generally in good health, clinical quality indicators may not be as relevant as service quality indicators, such as the waiting times for an appointment. But for individuals with chronic ill health, those who use physician services the most, clinical quality measures may be more critical. It may not be possible to measure and report on physicians at the level of detail that is meaningful and useful to all consumers.

[8]The results of a recent study on physician profiles for patients with diabetes suggests that physicians might refuse to care for sick patients, those who have failed therapy or those who do not adhere to treatment plans, in order to improve their profile scores. See Timothy P. Hofer and others, "The Unreliability of Individual Physician 'Report Cards' for Assessing the Cost and Quality of Care of a Chronic Disease," Journal of the American Medical Association, Vol. 281, No. 22 (1999), pp. 2098, 2104, and 2105.

[9]President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Quality First: Better Health Care for All Americans, Final Report to the President of the United States (Washington, D.C.: 1998).

Current performance measurement practices make an effort to detect physician and physician group practice differences, report on a variety of indicators, and generally avoid the need to identify detailed patient characteristics. One approach to solving the measurement problems associated with individual physicians' seeing only a small number of patients with a given condition is to focus on physicians organized into groups, so that the number of patients with a given medical condition is high enough to provide meaningful data.

Most quality indicators in use today focus on process measures, such as the percentage of women older than 50 in a plan who receive screening mammograms. Many of the measures NCQA uses for health plans in HEDIS are process measures. Measures of medical care process are popular in part because the data required are obtained relatively easily from administrative databases. Furthermore, process measures, particularly for preventive services, avoid the difficulties inherent in trying to adjust the results for differences in patient characteristics. But process measures have many shortcomings: They capture a very limited range of medical services, they tend to measure whether a service was provided when it was called for but not how well it was done, and they focus heavily on preventive care services because the universe of patients who should be receiving them is most easily identified. Outcome measures, those that indicate whether a patient's health improved after care, generally remain elusive.

Assembling Performance Data Requires Cooperation

Creating a physician performance measurement system involves collecting and verifying medical care data. In order to collect the data, the concerns of consumers and physicians regarding how the data will be used must be addressed. To ensure that measures of performance are accurate, the data going into the measures must be verified and free from manipulation.

Physicians are concerned about the potential that inaccurate performance scores will unfairly affect their practice. Physicians we interviewed told us that issues of data quality and the appropriate attribution of performance scores to individual physicians must be addressed before performance measurement data are made public. Although administrative records, such as claims for payment, are readily available for the fee-for-service sector, they often do not include all the information that performance measurement requires, such as a patient's condition or the results of services rendered, and for some indicators they are not collected because they were created for billing purposes and not for performance

measurement. Medical records provide much more complete information, but their analysis is expensive because few records are automated. Gathering information through surveys falls somewhere between administrative data and medical record review in terms of ease and expense. One limitation of ratings of consumer satisfaction is that consumers cannot always tell if the care they received was appropriate or technically good; research has not shown a consistent relationship between consumer satisfaction and the technical quality of care.

Another concern for physicians is the method of determining which physicians should be held accountable for specific actions or outcomes. Some physicians argue that it is difficult to fairly attribute a change in health status to a particular physician because many other factors come into play. For example, some patients may see a variety of physicians over the course of a year, each potentially recommending or performing a needed service. If a patient has not received a particular service, which physician should be held accountable for the omission? Or a physician may have recommended a very effective treatment to a patient, but that patient's condition did not improve because he or she did not comply with the physician's recommendation. The question of attribution becomes even more difficult as systems of health care become more integrated and a "team" of providers rather than one physician is responsible for patients' health care.

Because physicians control the majority of the data necessary to measure their performance, these concerns must be addressed if measurement efforts are to be successful. Physicians are responsible for coding administrative data, whether they are for reimbursement for claims or other data used by managed care plans. Physicians also maintain medical records for individual patients. To automate these records in order to make performance measurement data better would be expensive, and it is unlikely that physicians or physician groups will provide the resources for automation.

Ensuring that the data that are collected are accurate is another challenge. In any measurement system, participants may manipulate the data to improve their performance scores. For example, physicians could exaggerate the severity of patients' conditions to ensure a more favorable rating. Or they could simply avoid taking on difficult cases in order to improve their success rates. Preventing this sort of manipulation requires activities such as auditing the data by comparing them to medical records.

Consumers are concerned about the privacy of their personal medical information, and this concern may lead to rules that restrict efforts to provide objective information on physician performance. One survey found that no more than about one-third of adults in the United States trust health plans and government programs to maintain confidentiality all or most of the time.[10] Meanwhile, consumers want an unbiased, expert source of information about health care quality.[11] State laws vary significantly, but in some states efforts to protect the privacy of medical records could affect efforts to ensure that reported measures are comparable and that the data are not manipulated. For example, in Minnesota, any release of a patient's health records for research purposes requires, among other things, that the provider attempt to acquire the patient's consent and determine that individually identifiable records are necessary, that the researcher's safeguards are adequate, and that the researcher will not use the records for purposes other than those in the original request without the patient's consent. According to a BHCAG official, Minnesota's state privacy laws forced the group to abandon its attempts to collect HEDIS data from care systems and have hampered efforts to obtain survey data regarding quality of care for people with chronic conditions. Finding the appropriate balance between allowing access to medical records to ensure reliable, unbiased information on health care quality and maintaining privacy concerns is subject to considerable debate.

[10]California Healthcare Foundation, Medical Privacy and Confidentiality Survey (Oakland, Calif.: Jan. 28, 1999).

[11]Consumers do not necessarily trust currently available performance information. Three of 10 Americans surveyed said that information on quality of care from groups of doctors or state medical societies had little credibility; 4 of 10 had little faith in information from government agencies, and nearly 5 of 10 said that information from newspapers, television, and other media was not very believable. See Agency for Health Care Policy and Research and Henry J. Kaiser Family Foundation, Americans as Health Care Consumers: The Role of Quality Information, Highlights of a National Survey (Washington, D.C.: 1996).

Report Cards on Physicians and Physician Groups Indicate Progress but Their Usefulness Remains Limited

Several private and public organizations are involved in a variety of activities to measure and report on physician performance. A purchaser and two health plans in California and a purchaser in Minnesota have worked on moving performance measurement down to the level of the medical group or independent practice association (IPA) or, in Minnesota, a care system.[12] In New York and Pennsylvania, state agencies have published risk-adjusted mortality rates for specific procedures performed by cardiac surgeons. While the current report cards demonstrate that some reporting is possible, shortcomings in these physician and group report cards include the doubtful value to consumers of scores for large medical groups, questions about the quality and the expense of collecting the data on which reporting is based, and inconsistencies among the report cards.

Purchaser and Health Plan Report Cards Compare Physician Groups

Several organizations have developed report cards for physician groups. PBGH, two California health plans—PacifiCare and Health Net—and BHCAG in Minnesota have moved a step closer to reporting physician performance by publishing report cards on medical groups and IPAs.

Pacific Business Group on Health

PBGH is a business coalition of 33 public and private purchasers of health care representing more than 3 million employees, retirees, and dependents. As physician networks overlapped more and differentiation in California health plans blurred, PBGH started partnering with medical groups and IPAs on quality improvement initiatives. Together, they developed a publicly reportable measurement tool called the Physician Value Check Survey. In 1996, the survey covered 49 California medical groups (and 9 from the Pacific Northwest) that ranged in size from

[12]A medical group is two or more doctors who work together to provide medical services to patients. Typically, doctors who work in a medical group—both primary care doctors and specialists—share a single office or several offices if the group is very large. An independent practice association is a network of individual physicians who practice medicine by themselves or in small groups (often composed of one type of doctor, such as pediatricians) and who join together as an association to provide a range of primary and specialty care services to patients. Care systems began in 1997, when the employer members of BHCAG began contracting with health care providers directly rather than with health plans. The providers organized themselves into care systems, with some care systems resembling multispecialty medical groups and others looking more like independent practice associations.

approximately 15,000 patients to more than 1 million patients. Responses were obtained from 31,000 patients.[13]

PBGH chose a survey to collect data because it did not have the resources to mount a full-scale medical record review, and the survey was a less costly means of evaluating physician group performance and obtaining information on the consumers' perspectives. So that PBGH could generalize the results to all patients seen by a medical group, PBGH and its partners drew patient samples from each medical group's entire patient population rather than just from PBGH members. PBGH used the survey results to publicly compare medical groups in several areas: a summary report card with measures such as overall satisfaction, a preventive care services report card, and specific report cards on care for high blood pressure and high cholesterol. For each report card, it classified the groups into three categories: above average, average, and below average. (See the appendix for details from the PBGH report card.)

PacifiCare

PacifiCare of California is an HMO that has since 1998 produced a medical group report card called the Quality Index. The publicly reported Quality Index uses measures selected from PacifiCare's internal provider profiles, which contain data on more than 60 clinical and service performance measures for its medical groups and IPAs.[14] PacifiCare selected 14 of these measures for inclusion in the Quality Index.[15] It based its selection on the preferences of focus groups of consumers and the extent to which the physicians could take actions that affected the measured activities.

The information in the Quality Index is compiled from the health plan's administrative databases, customer service department records, and enrollee satisfaction surveys. Thus, the Quality Index reflects the health care experiences and opinions of only PacifiCare enrollees. The Quality Index includes measures of clinical performance, service performance,

[13]According to PBGH's Director of Research, these 31,000 respondents represent more than 8 million enrollees in managed care plans. In 1996, the Physician Value Check Survey was sent to 1,000 patients between the ages of 18 and 70 randomly sampled in each medical group. The overall survey response rate was about 55 percent. PBGH administered the Physician Value Check Survey again in 1998; however, the results from this survey were not available at the time of our review. PBGH officials said they plan to release the 1998 Physician Value Check Survey results on September 23, 1999, with scores on the changes between 1996 and 1998—that is, to see whether for the same group of patients, the physician groups' performance improved, worsened, or stayed the same over time.

[14]PacifiCare profiles medical groups and IPAs that have about 500 or more PacifiCare enrollees. To be included in the Quality Index report, groups must have at least 1,000 PacifiCare commercial enrollees and 500 Secure Horizons enrollees (its Medicare managed care program). Using this methodology, PacifiCare is able to report on physician organizations that provide care to the majority of its enrollees.

[15]The March 1999 Quality Index included 28 measures—14 for PacifiCare commercial enrollees and 14 for Secure Horizons enrollees.

enrollee satisfaction, and administrative data submission. In 1999, the Quality Index included process measures such as "eye examinations for people with diabetes" that were not included in the 1998 report. The reported Quality Index scores are percentile ranks for medical groups or IPAS compared with all other groups. Groups ranking in the top 10 percentile of a measure are considered "best practice" groups for that measure. According to PacifiCare's Medical Director, improvement has occurred in several areas, such as mammography screening rates and retinal examinations for diabetics. (See the appendix for details from the PacifiCare Quality Index.)

Health Net

Health Net is another managed care plan in California with more than 2.2 million enrollees. Its Participating Physician Group Report Card includes information for 131 medical groups in California, all of which are under performance-based contracts. In 1999, a percentage of each medical group's payment is contingent on the quality of care it provides to enrollees, as measured by both their satisfaction ratings and other process measures.[16] Thus, Health Net provides (1) information to the plan's enrollees to encourage them to "vote with their feet" by migrating to the top performing groups and (2) a direct financial incentive for the medical groups that is associated with their performance. Health Net's report card is derived from a satisfaction survey of the plan's enrollees.[17] It includes numerical scores representing the percentage of respondents who reported that they were satisfied regarding each of 17 measures. Health Net divides the medical groups into three categories for comparison: excellent, very good, and good. (See the appendix for details from the Health Net Participating Physician Report Card.)

Health Net is also developing report cards on care for certain chronic conditions. For these, Health Net uses administrative data to identify enrollees with a given condition and sends them a standardized survey that measures such things as the number of work days lost to illness or injury. It also measures compliance with national guidelines on management of the condition or disease. Health Net published a report card on asthma care in December 1998 and is currently working on report

[16]Health Net has three reward components to its performance-based contracts: (1) pay for excellence, given to the top 25 groups; (2) pay for performance, given to groups that exceed fixed performance targets; and (3) pay for improvement, given to groups that improve, even if they are ranked relatively low.

[17]Health Net sent its 1998 enrollee satisfaction survey to more than 500,000 enrollee households in California. According to the President for Health Benchmarks, Inc. (the organization responsible for producing Health Net's physician group report cards), the overall survey response rate was about 30 to 40 percent. Only physician groups with 75 or more plan enrollees responding to Health Net's satisfaction survey were included in the report card.

cards for diabetes and congestive heart failure.[18] (See the appendix for details from the asthma report card.)

Buyers Health Care Action Group

In 1997, the employer members of BHCAG began a program of contracting with health care providers directly rather than with health plans. The providers organized themselves into care systems, with some care systems resembling multispecialty medical groups and others looking more like IPAS.[19] BHCAG set out to adopt HEDIS health plan measures for each care system in the program. However, the purchasing group decided to abandon its effort to use the HEDIS measures because the number of patients within each care system who met the criteria for a particular measure was too small for valid, comparative analysis. BHCAG was unable to identify more than 100 plan enrollees for any of the measures in more than one or two care systems. According to a BHCAG official, BHCAG also decided not to develop the HEDIS data base for the care systems' patient population for two reasons. First, Minnesota's medical record confidentiality law prevented BHCAG from auditing the data to ensure their accuracy. Second, because patients who are not associated with BHCAG member firms are not necessarily obligated to seek primary care from a single care system, it would be difficult to establish the base for many HEDIS measures. Instead, BHCAG developed and distributed a satisfaction survey to members' employees and reported the results to its enrollees and the general public.

In 1996-98, BHCAG reported data on 12 measures from the survey, focusing on such issues as access to services and interactions with physicians. Beginning in 1999, BHCAG adopted a modified version of the Consumer Assessment of Health Plans survey developed by the Agency for Health Care Policy and Research (AHCPR). While BHCAG has approximately 150,000 individuals enrolled in care systems, they are unevenly distributed: About 75 percent are enrolled in three larger care systems. To increase its sample sizes for care outside the Minneapolis St. Paul metropolitan area, BHCAG conducted the survey with Minnesota state employees, which increased the total potential survey population from about 150,000 to about 300,000.

State Report Cards on Cardiac Surgeons

Since the early 1990s, the New York Department of Health and the Pennsylvania Health Care Cost Containment Council have published

[18]Health Net's Asthma Care Report Card ratings were based on a 1996 survey administered to more than 32,000 Health Net enrollees who suffered from asthma. Because only California physician groups with 35 or more plan enrollees responding to the survey were included in the report, the Asthma Care Report Card included information for 47 medical groups.

[19]A characteristic of these care systems that sets them apart from many health plans is that primary care physicians can belong to only one care system.

physician-specific mortality rates for patients undergoing coronary artery bypass graft (CABG) surgery.[20] Because patients' characteristics such as age and other health problems play a large role in the rates of complications and deaths associated with CABG surgery, efforts have been made to adjust the performance measures for differences in patients' conditions. For example, the New York risk-adjustment process incorporates approximately 40 risk factors for each patient. The New York Department of Health also seeks to verify the data through activities such as cross-matching cardiac surgery with other Department databases and reviewing medical records for a sample of cases.

The New York Department of Health reported that the state's CABG surgery mortality rate dropped by more than 30 percent following the publication of the report card, from 3.52 percent in 1989 to 2.44 percent in 1996. Similarly, the Pennsylvania Health Care Cost Containment Council reported that inhospital mortality was 22-percent lower in 1995 than it was in 1991 (3.8 percent compared with 4.9 percent). However, these results and the effect of the report cards have not been without controversy.

Some researchers assert that performance reporting has played a significant role in the decline in the CABG surgery death rate. They point to evaluations and improvements in CABG surgery processes, changes in referral patterns–such as concentrating the most difficult cases with top-performing physicians–and a reduction in the number of surgeons who perform these procedures only a few times each year.[21] Critics of the New York program contend that performance reporting is not responsible for a decline in the mortality rate. They claim other factors such as surgeons' electing not to operate on critically ill patients and possibly referring high-risk cases to out-of-state practitioners. They also question how much the mortality rate has declined, suggesting that an apparently spurious increase in the risk factors may have accounted for most of the total reduction in the statewide risk-adjusted mortality rate.[22]

[20]New York is expanding its project to include balloon angioplasty.

[21]Edward Hannan and others, "Improving the Outcomes of Coronary Artery Bypass Surgery in New York State," Journal of the American Medical Association, Vol. 271, No. 10 (1994), pp. 761 and 766.

[22]Jesse Green and Neil Wintfeld, "Report Cards on Cardiac Surgeons: Assessing New York State's Approach," New England Journal of Medicine, Vol. 332, No. 18 (1995), pp. 1229 and 1232.

The Usefulness of Physician and Physician Group Report Cards Remains Limited

The early experience with physician report cards indicates that organizations are able to address some of the methodological challenges in performance measurement and provide some comparative information. However, their ability to accurately report on broad measures of physician performance in a useful manner remains limited.

First, while the current report cards measure the performance of physician groups that are smaller than health plans, the medical groups may still be too large to make the cards useful to consumers. One medical group that appears in all three California report cards includes nearly 700 physicians. A consumer faced with the task of selecting a physician could question whether having a set of summary statistics covering so many physicians is really any more helpful than having planwide performance measures for thousands of physicians.

Next, the quality of the data and the expense of collecting them are also issues. PBGH, BHCAG, and Health Net used surveys to gather data. As with all survey data, they reflect only the views of patients who chose to respond and then record their recollection or perception of the care they received, which may or may not be accurate. To address these issues, steps must be taken to see if there is bias among respondents compared with nonrespondents and to limit questions to those that patients are likely to answer accurately. And while surveys generally cost less than medical record reviews, they are still expensive to conduct. According to one PBGH official, the Physician Value Check Survey costs approximately $15,000 per medical group.

PacifiCare's Quality Index relies more heavily on gathering and analyzing administrative encounter data for its performance scores—a process that is generally less costly than using surveys but that has other limitations. Administrative data reflect how physicians report the services and procedures they provided rather than the patients' recollection. However, in some cases, the administrative data are not complete. According to PacifiCare's Medical Director, the plan receives data from physicians on only about 70 percent of their encounters with patients. He added that publishing the Quality Index has dramatically increased the volume of encounter data submissions. Before the Quality Index was published, PacifiCare received information on about 2 million encounters each month; 2 months after its publication, the plan was receiving data on about 5 million encounters per month. Despite the increase in the volume of encounter data that medical groups provide, some groups question the completeness and the quality of the raw data.

Third, current report cards do not provide consistent results. For example, the PacifiCare and Health Net report cards demonstrate some of the difficulties when different organizations measure groups in different ways. The two plans use different methods and different data sources: PacifiCare uses administrative and other internal data sources, and Health Net uses enrollee satisfaction survey responses. The two plans also base their performance measures on a subset of a patient population—plan enrollees rather than all patients in a medical group. Enrollee satisfaction scores from the two plans were significantly different in some cases. From the enrollees' responses, Health Net classified one medical group as "excellent"—a classification it gave to only about one-fourth of the medical groups—while PacifiCare classified the same group in the bottom third. A consumer looking at Health Net's report card might be more inclined to select that medical group than a consumer looking at PacifiCare's report card, while a consumer who read both report cards would be confused as to how a single group could get such disparate ratings from two plans' enrollees. According to experts we interviewed, such divergent scores on similar measures lead to skepticism among physicians and the general public about the usefulness of report cards.

Finally, the differences in the specifications of the measures and presentation issues may cause additional confusion. While the report cards measure some of the same aspects of care, their measures of clinical quality can be defined and reported differently. For example, one plan may report the percentage of enrollees who were satisfied with a service, while another might report only the percentage who indicated that they were very or extremely satisfied. In addition, reporting issues such as the relative scale a plan uses can accentuate narrow differences among medical groups. For example, under PacifiCare's scale, if all plans in the comparison fall between 85 and 95 percent on a particular measure, the group performing the service 85 percent of the time could show up in the bottom 10th percentile, while the group performing the service 95 percent of the time could be listed as a "best practices" group. Conversely, if all the groups perform a recommended service less than half the time, some of them will still be ranked as best practices groups. Such complexity in interpreting the results can make consumers wary of report cards.

New Collaborative Efforts and Data Standardization May Help Meet Some Challenges

While the work of purchasers, plans, and state agencies represents progress toward resolving the difficulties with measuring health care quality, further development is needed. Several national groups have been organized to cooperatively develop standardized approaches to measurement-related issues. In addition, HHS is taking some steps to facilitate better performance measurement. These efforts are in their infancy, and it will take time to see what, if any, effect they have on measuring physician performance.

Professional Organizations Are Beginning to Collaborate on Improvements to Physician Report Cards

Developing a commonly accepted, standardized set of performance measures is a critical step in creating a system of performance measurement that will allow "apples to apples" comparisons in health care. Some of the organizations we talked to have recently joined together to address participant concerns about performance information and the factors in the marketplace that impede the flow of data. It remains to be seen whether these coalitions can forge agreement on critical issues that must be addressed in the long term. For these organizations to be successful, disparate groups will have to reach consensus on a number of issues and that will take time.

The California Information Exchange is a partnership of purchasers, providers, and other organizations established to promote and protect the exchange of data among health care partners such as health plans, purchasers, and providers.[23] According to one Exchange official, the group was formed, in part, to overcome political impediments to the exchange of health care information. The Exchange has formed working groups to develop agreements to be used to define the content, proper use, and format for enrollment data; provider and provider group identifiers; laboratory and encounter records; individual patient identifiers; member identification cards; eligibility data; and pharmacy records. To date, the Exchange's work groups have adopted agreements or rules of exchange for enrollment data, encounter data, eligibility data, member identification cards, and pharmacy records. The Exchange plans to test these agreements in a series of pilot projects.

The Performance Measurement Coordinating Council is sponsored by three health accreditation agencies: the American Medical Association's American Medical Accreditation Program, the Joint Commission on Accreditation of Health Care Organizations, and NCQA. Comprising 15

[23]Exchange partners include the American Medical Group Association, the California Association of Health Plans, the California Healthcare Association, the California Medical Association, the National IPA Coalition, and the Pacific Business Group on Health.

members chosen by the founding organizations, it was created in May 1998 to develop efficient and consistent performance measures for different levels in the health care system. The Council brings together organizations working on quality measurement in different areas of the health care industry with different points of view on attribution, the public reporting of performance data, and the like. For example, the American Medical Accreditation Program comes from an organization dedicated to representing the interests of physicians and is most cautious about attributing performance data to individual physicians and reporting on performance to the public. At the same time, NCQA, which is a health plan accreditation organization, is a strong advocate for the public reporting of data. The progress of the Council illustrates the time it can take to work on performance measures. For example, it took the Council 8 months to progress from its formation to the announcement that it intended to develop a common measurement agenda and to address a range of performance measurement issues. As of May 1999, one year after its formation, the council had identified and started work on diabetes care measures—the first of its measurement sets.

The National Forum for Health Care Quality Measurement and Reporting is a private, nonprofit entity whose purpose is to develop a comprehensive quality measurement and public reporting strategy. The Forum followed from the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.[24] Goals for the Forum include allowing meaningful quality comparisons of health care providers and plans and promoting competition in the quality of health care services. In March 1999, the Forum planning committee approved the initial members of its board of directors. Representation on the Forum's board is broad, including academic researchers and representatives from AHCPR; HCFA; representatives from consumer, public, and private purchasers; providers and plans; and research and quality improvement councils. As with the Performance Measurement Coordinating Council, the Forum's efforts are taking time. The Forum took approximately 9 months to select its board of directors and does not expect individual work groups to begin work until early 2000.

[24]Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Quality First: Better Health Care for All Americans, Report to the President of the United States (Washington D.C.: 1998).

HHS Is Taking Steps to Report on Medicare Physicians' Performance and to Standardize Health Data

HHS has been involved in performance measurement through its administration of the Medicare program, efforts to standardize health data, and support of research. In addition to meeting the information needs of Medicare beneficiaries, these efforts can have a substantial effect on report cards generated by private purchasers and plans. Because most of HHS' initiatives are still in progress, this effect has yet to be determined.

The Balanced Budget Act of 1997 (BBA) requires that HHS provide comparative data to Medicare beneficiaries including information about the benefits, quality, and performance (to the extent available) of health care options in their area to assist them in making informed choices under the Medicare+Choice Program.[25] To provide better quality and performance comparisons, HCFA contracted with Health Economics Research Inc. in September 1997 for assistance in developing a performance measurement system. The contractor is studying the feasibility of using HEDIS measures for fee-for-service Medicare at the group practice, local, and national levels. As part of this 3-1/2-year contract, five clinical measures relevant to the Medicare population—retinal eye examinations for diabetics, follow-up care after mental health hospitalization, breast cancer screening with mammography, beta blocker treatment after a heart attack, and the Health of Seniors survey results—are being examined at four large group practices.

Although the study on HEDIS measures for group practices is not expected to be completed until 2001, some difficulties, such as those associated with small sample sizes, have already been identified.[26] For example, while the four group practices each had between 4,000 and 40,000 Medicare fee-for-service beneficiaries, sample sizes for each measure fell considerably once population subsets of gender, age, or condition were identified. HEDIS specifies 411 patients as a sufficient sample size, but this was obtained only for two of the three claims-based measures—breast cancer screening and retinal eye examinations. For these two measures,

[25]Created by the BBA, the Medicare+Choice program is designed to allow beneficiaries to choose health care from Medicare's traditional fee-for-service program and a range of health plans, such as health maintenance organizations and provider-sponsored organizations, participating in Medicare.

[26]In addition to the challenge of developing comparable performance information for group practices under fee-for-service Medicare, HCFA will have to ensure that the information provided to beneficiaries is clear, sufficient, and helpful to their decisionmaking or it will not be used. For example, we previously reported on problems with HCFA's efforts to provide comparative information on health plans—HCFA had not provided information that was easy for beneficiaries to understand. See Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996) and Medicare: Progress to Date in Implementing Certain Major Balanced Budget Act Reforms (GAO/T-HEHS-99-87, Mar. 17, 1999). Physician-level information runs the risk of having similar problems.

the sample size was large enough only for the three group practices with more than 20,000 Medicare fee-for-service beneficiaries.

HHS' efforts to establish standards for information transactions and data elements, including unique identifiers for individuals, plans, and providers, may also have an effect on performance measurement systems. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), HHS is required to adopt standards to support the exchange of information on administrative and financial health care transactions.[27] The standards are to include data elements and code sets for the electronic exchange of information; unique health identifiers for health care providers, health plans, employers, and individuals for use in the health care system; and security protections against the unauthorized disclosure and use of health information. The standards are to apply to all health plans, health care clearinghouses, and health care providers that transmit health information electronically.[28]

Some standards under development, such as the unique identifier for individuals, have been contentious. In response to concerns about privacy, three bills were introduced in the 105th and 106th Congresses to repeal the requirement for HHS to adopt a standard unique health identifier. While the two bills from the 105th Congress expired and one is pending before the current Congress, the Omnibus Consolidated and Emergency Supplemental Appropriations Act for 1999 (P.L. 105-277) provided that no funds available under the act be used to adopt a final standard for individual unique health identifiers until legislation is enacted specifically approving the standard. While the implementation of the HIPAA standards has the potential to significantly improve the usability of the health data available for performance measurement, it will not address all the data challenges, such as those related to data accuracy.

An additional HHS effort under way to further physician performance measurement is the development of a consumer satisfaction survey for fee-for-service Medicare beneficiaries. AHCPR officials said that they are interested in adapting the CAHPS survey—an instrument for measuring consumer satisfaction and experience with health plans—to the provider

[27]Transactions include health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health care payment and remittance advice, health plan premium payments, first report of injury, health claims status, and referral certification and authorization.

[28]Under HIPAA, standards were required to be enacted by August 21, 1999, regarding the privacy of individually identifiable health information that is electronically exchanged. Because this deadline was not met, HIPAA now requires the Secretary of HHS to establish standards by regulation no later than February 21, 2000.

level. AHCPR is studying the use of the CAHPS survey with smaller units, such as group practices or individual physicians. In addition, AHCPR is sponsoring research on performance measurement and is working with others to develop a framework for measuring health care performance.

Conclusions

Consumers could use more information on the quality of health care providers to help them make informed choices about where to seek care. Comparative information on physicians is important to all consumers, whether they enroll in traditional Medicare or in a private health plan or face a choice of primary care physicians when they join a managed care plan. Yet the field of physician performance measurement is still in its infancy. Challenges to developing physician report cards include selecting performance measures that satisfy the information needs of various audiences and gaining the cooperation of physicians and consumers required to assemble consistent and credible performance data. The experience of several organizations in producing medical group or specialty care report cards indicates that steps can be taken to better inform consumers, but the challenges that remain limit the report cards' usefulness. Given sufficient time, public and private efforts to develop a consensus on standardized data collection and comparable quality measurement may lead to more useful measures for consumers through a more efficient system for providers and plans nationwide.

Agency Comments

We obtained informal comments on a draft of this report from the Senior Clinical Adviser in HCFA's Office of Clinical Standards and Quality. She agreed with the report's general findings. She suggested that under the fee-for-service payment system, we highlight the problem of determining which physician is accountable for managing a patient's care. The logistics of establishing the linkages by means of existing medical records is another area of concern that she recommended we stress in the report.

We also obtained comments on the draft from an expert in quality measurement who suggested that we include more information on the methodological challenges of assessing physician performance. He felt that a stronger critique of the validity of currently available measures would be helpful in the analysis of physician report cards. He noted that it is impossible to differentiate among providers with current physician report cards and warned against the dangers of misinformation. He encouraged us to place more emphasis on the need for research efforts to develop better measures that provide valid information and to improve our

understanding of preferred clinical strategies. He also emphasized the need for developing electronic medical records for access to clinically relevant data.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. We will then send copies of this report to the Secretary of HHS and others who are interested. We will also make copies available to others on request.

The information contained in this report was developed by Rosamond Katz, Assistant Director, Mark Ulanowicz, and Patricia K. Yamane. Please contact me at (202) 512-7114 or Rosamond Katz at (202) 512-7148 if you or your staff have any questions.

Sincerely yours,

Janet Heinrich
Associate Director, Health Financing
and Public Health Issues

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Abbreviations

AHCPR	Agency for Health Care Policy and Research
BBA	Balanced Budget Act of 1997
BHCAG	Buyers Health Care Action Group
CABG	coronary artery bypass graft
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
IPA	independent practice association
NCQA	National Committee on Quality Assurance
PBGH	Pacific Business Group on Health
PPO	preferred provider organization

Report Cards Comparing Medical Groups

In California, a purchasing group, the Pacific Business Group on Health (PBGH), and two health plans, PacifiCare and Health Net, have moved a step closer to reporting on physician performance by publishing report cards on medical groups and independent practice associations (IPA). In addition, another purchasing group, the Buyers Health Care Action Group (BHCAG) in Minnesota, has published report cards on care systems, which can be similar to large medical groups. Below, we illustrate the information generated on 3 of the 11 medical groups common to all three California report cards and one Minnesota care system. In California, medical group A includes more than 100 physicians, medical group B has 675 physicians, and medical group C has more than 300 physicians. In Minnesota, the care system includes 550 physicians.

Pacific Business Group on Health

PBGH publishes a report card on medical groups that is based on its Physician Value Check Survey. Figure I.1 shows the scores for three southern California medical groups as reported on the PBGH Internet site. The numerical scores are divided into three categories that indicate relative measures of performance: above average, below average, and average.

Figure I.1: 1996 PBGH Physician Value Check Survey Scores for Three Southern California Medical Groups

↑ Numerical Scores Above Average ↓ Numerical Scores Below Average	Medical Group		
	A	B	C
Summary Report Card			
Overall Satisfaction	80	82 ↑	73 ↓
Overall Rating of Care	65	70 ↑	61
Ease of Getting Care	59	65 ↑	60
Promptness of Care	45	55 ↑	49
Quality of Care	64	69 ↑	58
Doctors' Communication Skills	64	68 ↑	58
Courtesy of Office Staff	66	71	63
Blood Cholesterol			
Had Cholesterol Checked	79	87 ↑	86 ↑
Medicine Prescribed for Cholesterol	32	35	36
Taking Medicine for Cholesterol	76	76	62
Doctor Advised Patient to Eat Less Fat	75	79	79
Doctor Advised Patient to Lose Weight	35 ↑	38 ↑	17
Doctor Advised Patient to Exercise	61	65	57
Cholesterol Normal Now	47	47	57 ↑
High Blood Pressure			
Had Blood Pressure Checked	96	98	98
Medicine Prescribed for Blood Pressure	72	61 ↓	59 ↓
Taking Medicine If Prescribed	87	86	78
Doctor Advised Patient to Eat Less Salt	55	59	61
Patient Advised to Lose Weight for Blood Pressure	38 ↑	27	16
Blood Pressure Normal Now	86	78	90 ↑
Preventive Care Services			
Flu Shot	54	83 ↑	70
Cervical Cancer Screening	87	89	88
Breast Cancer Screening	90	90	86
Prenatal Care	66	61	80

Note: The numerical scores represent scores based on survey responses for the medical groups. Scores above and below average indicate a relative measure of the groups.

Source: Pacific Business Group on Health, California Consumer Healthscope, at http://www.healthscope.org.

A consumer reading this report card would learn that medical group B received high overall scores for satisfaction and cholesterol screening. However, a person with high blood pressure would notice that while groups B and C scored below average in prescribing medicine for high blood pressure, group C had better success reducing its patients' blood pressure. People with diabetes would not find any information specific to the treatment of their condition.

PacifiCare

PacifiCare's Quality Index report card reflects the health care experiences and opinions of members of the PacifiCare health plan only. Figure I.2 shows the 1998 Quality Index scores for the same medical groups highlighted in figure I.1. The numerical scores represent a percentile rank for a medical group compared with that of all other groups. PacifiCare identifies groups as best practice groups for a particular measure if they are in the top 10 percent relative to other groups. These are denoted by a diamond next to the number in the table.

Figure I.2: 1998 PacifiCare Quality Index Scores for Its Commercial Members at Three Medical Groups

	Medical Group		
♦ "Best Practice" Groups (Top 10 Percent)	A	B	C
Clinical Quality			
Cervical Cancer Screen	0.89	0.44	0.31
Mammography	0.96 ♦	0.61	0.90 ♦
Congestive Heart Failure	[a]	[a]	0.93 ♦
Service Quality			
Access-Related Complaints	0.81	0.15	0.42
Transfers to Different Medical Groups	0.95 ♦	0.70	0.44
Benefits Appeals	0.66	0.34	0.95 ♦
Satisfaction			
With Medical Group	0.66	0.89	0.27
With Primary Care Physicians	0.72	0.92 ♦	0.18

[a]Data below threshold: the medical group did not have enough PacifiCare enrollees with congestive heart failure to allow for statistically valid measurement.

[b]Includes responses from both commercial and Secure Horizons members.

Source: PacifiCare.

The comparative performance information in figure I.2 is limited and selective and may not be adequate for choosing a medical group. A consumer reading this report card would learn that PacifiCare members using medical group B were not happy with their access to care relative to the other groups' patients—it scored in the bottom 15 percent for access-related complaints—but were very satisfied with the group's primary care physicians—rating them in the top 10 percent in satisfaction. The report card also indicates that medical group C was in the bottom third of medical groups for cervical cancer screening but in the top 10 percent for benefits appeals to PacifiCare.

Health Net

Health Net's Participating Physician Group Report Card is derived from a satisfaction survey of the plan's members. Figure I.3 shows selected Health Net report card scores for the same three southern California medical groups as shown in figures I.1 and I.2. The numerical scores represent the percentage of respondents who reported that they were satisfied regarding each measure, and the groups are classified as excellent, very good, or good.

Figure I.3: 1998 Health Net Participating Physician Group Report Care

★★★★★ Excellent ★★★★ Very Good ★★★ Good	Medical Group		
	A	B	C
Overall Regional Rating	★★★★	★★★★	★★★★★
Quality of Care Overall	★★★★★	★★★★	★★★★
Thoroughness of Exam	88.0%	88.3%	86.0%
Skill and Experience of Doctor	93.5	93.8	90.3
Interest in Your Medical Problems	86.2	87.5	83.8
Friendliness and Courtesy of Staff	89.6	91.3	89.4
Amount of Time With Staff or Doctor	83.5	85.6	78.0
Advise and Encourage Preventive Health	82.0	82.7	76.4
Outcome of Care	88.6	87.2	85.3
Access to Care Overall	★★★★	★★★★	★★★★★
Access to Care When Needed	87.8%	92.1%	90.4%
Arrangements for Appointments	84.8	89.6	89.1
Length of Time Waiting at Office	73.5	76.8	72.9
Length of Time Between Appointments or Visits	71.3	80.8	81.5
Contacting Doctor Late or on Weekends	68.9	77.8	69.0
Access to Specialty Care	79.7	82.7	77.4
Access to Care in an Emergency	83.8	88.1	87.9
Ease of Seeing Doctor of Choice	87.2	86.9	87.5
Medical Group Satisfaction Overall	★★★★★	★★★★	★★★★★
Recommend Group to Family or Friends	87.4%	88.3%	83.1%
Overall Satisfaction	88.2	90.3	85.7

Source: Health Net Participating Physician Group Report Card, Sept. 1998.

A consumer reading this report card would find that the three medical groups were largely undifferentiated. They all were rated either very good or excellent, both overall and within the three broad categories of quality of care, access to care, and medical group satisfaction. Unlike the PacifiCare Quality Index report, the Health Net participating physician group report card provides information only on members' satisfaction with each issue—it does not provide information on the extent to which

particular services, such as mammograms or cervical cancer screenings, were provided.

Health Net is also developing report cards on care provided by medical groups for certain chronic conditions. Figure I.4 shows the asthma report card scores for medical groups A and B. Medical group C did not have enough asthma patients responding to the survey to be included in the comparison. The four stars denote “very good.”

Figure I.4: 1998 Health Net Asthma Report Card

★★★★★ Excellent ★★★★ Very Good ★★★ Good	Medical Group	
	A	B
Overall Regional Rating for Asthma Care	★★★★	★★★★
Quality of Care		
Treated by an Asthma Specialist	8.0%	16.3 %
Did Not Overuse Bronchodilator	89.6	84.8
Used Steroid Inhaler Regularly (Among Moderate and Severe Asthmatics)	25.0	23.9
Used Peak-Flow Meter Daily	0	8.7
Given Instructions on How to Use the Peak-Flow Meter	26.0	28.6
Given Instruction on What to Do if Peak-Flow Falls Below a Certain Level	26.0	24.5
Discussed With Physician How to Trigger Asthma Attack	77.5	78.6
Quality of Services		
Satisfied With Waiting Time to Get an Appointment	86.0	75.0
Satisfied With Ease in Reaching a Doctor or Nurse by Phone	78.0	77.1
Satisfied With Getting Urgent or Emergency Care for Asthma	87.5	92.9
Satisfied With the Quality of Communication With Doctors and Nurses About Asthma	74.0	75.0
Satisfied With the Skills of Doctors	85.7	87.5
Satisfied With the Overall Quality of Care Received for Asthma	82.0	87.8
Outcomes of Care		
Physical Functioning (Percentile)	46.6	53.8
Social or Mental Functioning (Percentile)	52.4	50.0
Was Not Absent From Work or School for Asthma in the Last Month	58.0	38.8
Did Not Go to Emergency Room for Asthma in the Past Year	77.1	78.7
Was Not Hospitalized for Asthma in the Past Year	96.0	95.9

Source: Health Net Participating Physician Group Asthma Care Report Card, Dec. 1998.

For patients with asthma trying to choose a medical group, the Health Net asthma report card provides a considerable amount of information on clinical quality, including information on outcomes of care. It indicates that even though both groups were rated very good for asthma care, no patients with asthma in group A and fewer than 1 in 10 in group B reported

using a peak-flow meter daily, even though daily use is recommended in national clinical guidelines. In addition, the report tells consumers that a higher share of the survey respondents from medical group A reported no asthma-related absences from work or school in the past month than respondents from medical group B.

Minnesota's Buyers Health Care Action Group

BHCAG is currently reporting on 12 measures focusing on such issues as access to services and interactions with physicians. Figure I.5 shows the results of the BHCAG survey for one care system, a 550-physician multispecialty medical group. The comparison rating shows whether the survey ratings for the care system are better than, similar to, or below the average rating. The numerical scores are the statistics for each measure.

Figure I.5: 1998 BHCAG Report Card on One Care System

★★★ Better Than Average ★★ Similar to Average ★ Below Average	Very Satisfied or Excellent	Satisfied or Very Good	Neutral or Good	Dissatisfied or Fair/Poor	Comparison to Average Rating
Overall Satisfaction With Care at Clinic	61	32		7	★★
Overall Quality of Care and Service	62	32		6	★★
Overall Access to Care That You Need When You Need It	28	40	22	10	★★
Ease of Seeing the Doctor of Your Choice	53	34	1	12	★★
Availability of Medical Advice by Phone for Nonemergencies When Clinic Is Closed	26	39	20	15	★★★
Availability to Schedule Appointments at Convenient Times	50	38		12	★★
Satisfaction With Appointment Wait Time for Minor Illness	56	33		11	★★
Satisfaction With Reception Area Wait Time Before Visit	52	35		13	★★
Amount of Time Doctor Spends With You	54	35	1	10	★
Attention Paid to What You Say	64	28	1	7	★
Explanation of Medical Procedures and Tests	65	30		5	★
Outcomes of Care, How Much You Were Helped	60	30	1	9	★

Source: Choice Plus 1999 Consumer Satisfaction Survey Results.

A consumer reading this report card would learn that this care system was scored average by its patients in terms of overall satisfaction and quality of care but was scored below average in the areas related to interaction with physicians, such as a physician's explaining medical procedures and tests.

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