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The Leading Edge

Improving the value of healthcare delivery using publicly available performance data in Wisconsin and California

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ABSTRACT

The healthcare industry must change in order to provide higher quality care and lower costs for patients; one method to improve both cost and quality used in Wisconsin and California is leveraging publicly reported claims and costs data. Wisconsin has been building comprehensive, publicly available clinical and administrative data sets: the Wisconsin Collaborative for Healthcare Quality (WCHQ) established in 2003 and the Wisconsin Health Information Organization (WHIO) established in 2009. The WCHQ and the WHIO allow physician groups to compare themselves with one another on cost and quality across 920 distinct episode treatment groups (ETGs). The ETGs include all components of care for a specific disease during a defined period. Since 2002 California has developed public reporting of quality data for physician groups and health plans through its Integrated Healthcare Association (IHA) and since 2008 its Right Care Initiative (RCI). In both states these data are used to identify best practices and opportunities for improvement, enhance care outcomes, and increase value for patients.

1. Introduction

Healthcare in America must change to deliver higher quality care at lower costs. Building comprehensive publicly reported claims and costs databases are a proven way to drive improved physician performance and costs. A cohort study of WCHQ members found that providers in WCHQ, who publicly report outcomes, significantly improved measures relating to diabetes, coronary artery disease, uncomplicated hypertension, and screening and preventative measures.[1] Based on a comparison of the Dartmouth Institute's analysis of Medicare billing data, the WCHQ members also outperformed their counterparts regionally and nationally in breast cancer screening and testing glycohemoglobin and low-density lipoprotein cholesterol in patients with diabetes.[1] The development and methodology of the databases is critical because high quality data are essential for providers to make decisions for improvement.

Wisconsin and California have moved toward developing all-payer claims databases to publicly report on cost, quality, and value. Although the databases were started for different purposes, the access to actionable data has created opportunities for improvement at the physician, clinic, and population level in both states. These databases have filled an information gap that limited providers' ability to know how they are performing on cost and quality. Providers and consumers are now able to access data and view reports such as the Consumer Reports analysis that used WCHQ data to detail the quality performance of Wisconsin physician clinics in terms that consumers could understand and use to make decisions about where they receive care.[2] In California, the data are provided through the Office of the Patient Advocate.[3] Wisconsin and California have been successfully utilizing the claims data to improve patient care for about a decade, but further progress can be achieved by cross-matching claims and outcomes data to better inform patients of the value of their healthcare dollar.

2. Public databases in Wisconsin

Wisconsin ranks second in the nation, narrowly surpassed by Minnesota, on a recent cost and quality index from the Agency for Healthcare Quality and Research.[4,5] When physicians see that their results compare poorly with those of their peers, they use the data to improve how they deliver care to patients. Public reporting of physician cost and quality began in Wisconsin in 2003, and the quality of physician performance have improved statewide.[4] In April 2013, participants in AHRQ's Charter Value Exchange[1] were asked, "What is your opinion about the impact of public reporting

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on quality improvement in your region?" More than 80% of respondents reported moderate or substantial impact.

2.1. Wisconsin Collaborative for Healthcare Quality (WCHQ)

The WCHQ began in early 2003 when groups of providers in the state wanted to be able to compare performance between providers to provide improved quality care. WCHQ collects data from all available sources: billing systems, lab information, clinical data, problem lists, and medication lists. Member organizations create global data files that include patients' demographics, documented healthcare visits, and clinical data (labs, blood pressure, preventive care, medications) for each measure's specified period of time. Reports on groups and clinic sites are published annually on the WCHQ website. Custom reporting can be delivered at any frequency for specific groups, sites, and providers.

The data-validation process, performed before publication, is highly rigorous. It validates the thoroughness and accuracy of member organizations' data, primary care provider identification, and patient-level data. There is a Performance Measures Audit Committee that oversees the audit process and offers guidance on data policy and development of procedures.

2.2. Wisconsin Health Information Organization (WHIO)

The WHIO is a public–private data mart that spans providers and systems and aims to improve quality, cost, safety, and transparency in Wisconsin. WHIO was created in 2009 as an offshoot of WCHQ because the need to combine cost and clinical outcomes became apparent and WCHQ could only provide clinical outcomes not cost measures. It aggregates private-insurer and Medicaid data from various settings, including physician offices, outpatient services, pharmacies, labs, and hospitals. Process quality measures from claims data are available to individual providers, who can track their performance over time, compare themselves with peers at any juncture, and identify best practices. The process quality measures report created by WHIO indicates process quality performance by showing the number of compliant process quality measures with the total number of possible process quality measures for each opportunity.

The Health Analytics Exchange, a WHIO subdivision, is an all-inclusive healthcare-claims data set that supports tracking, analysis, and value-based measurement of episodes of care (quality divided by cost). Providers can access data from more than 920 episode treatment groups (ETGs) to measure and compare performance. Fig. 1 shows the top 10 ETGs for the Marshfield Clinic Internal Medicine Group, compared with its peers. High-cost categories are identified by comparing performance of each category such as radiology, lab, pharmacy, or emergency room to the ETG average provided by WHIO. Marshfield Clinic currently has 34 National Committee of Quality Assurance (NCQA) recognized Patient Centered Medical Homes (PCMHs). Marshfield Clinic has used clinical process and outcome data to drive performance improvements at a system, division, department, and individual level for a decade.

3. Public databases in California

The IHA is a multi-stakeholder group of health insurers, medical groups, hospitals, health systems, suppliers and academic representatives committed to improving the performance of California's healthcare delivery system. Its signature program, the California Pay for Performance Initiative, is the largest such private sector program in the United States.[6] IHA was first created because employers were seeking comparative information on cost and quality.

3.1. Integrated Healthcare Association (IHA)

Since 2002, the IHA has collected data on clinical quality in six priority areas: prevention, cardiovascular, diabetes, maternity, musculoskeletal, and respiratory conditions. The initial IHA quality indicators focused on HEDIS process quality of care measures, some patient experience measures in the areas of communication and coordination of care, and measures of the meaningful use of health information technology. In 2009, the IHA added appropriate resource use as an indicator (inpatient readmissions, inpatient utilization, outpatient procedures utilization, emergency department visits, and generic prescribing). In 2011, total cost of care was added. All measures are risk-adjusted, and each physician group's results are compared against statewide and regional benchmarks as well as against its own performance over time. Nearly 200 physician groups representing 35,000 physicians who care for nearly 10 million commercial HMO/POS members participate. Seven California health plans representing the majority of the state's insured population provide the data and incentive payments based on the aggregated results.[3]

3.2. Right Care Initiative (RCI)

The RCI, launched in 2008, aims to reduce mortality and morbidity among California's 15 million managed health plan enrollees.[7] By focusing on cardiovascular disease (emphasizing hypertension), diabetes (emphasizing prevention of heart attacks and stroke), and hospital-acquired infections, the RCI is pushing California health plans and their associated physician networks to achieve the 90th percentile on HEDIS hypertension and cardiovascular disease performance targets in the areas of blood pressure, lipids, and glucose control. Information on interventions for intensive ambulatory care management, medication protocols, and patient activation and engagement are shared monthly at "University of Best Practices" meetings. These efforts are currently designed to improve community-wide population health in the areas of health disease and stroke in San Diego, Sacramento, and Los Angeles. The publicly reported data are presented at an annual summit, and awards are given to the top and most-improved performers.

4. Putting the data into practice

4.1. Improving physician group performance

In Wisconsin, Ministry Medical Group, a division of Ministry Healthcare, has used WHIO data to study cost and utilization for its PCHMs and to determine performance based incentive pay. Ministry Medical Group has seven sites with National Committee for Quality Assurance (NCQA) recognition; the remaining thirteen sites are expected to receive recognition in September 2013. The WHIO data were used to highlight potential areas of improvement, based on the risk-adjusted cost index and utilization — specifically, hospitalization rates, 30-day readmission rates, and emergency room visits. Problems identified by the WHIO data (and sometimes internal data) were used to prompt change. Departments now display their data and metrics in their offices, and the monetary incentive structure for primary care physicians (PCPs) is now tied, in part, to performance metrics: about 15% of their non-relative value units bonus is based on the department's performance on cost, quality, patient satisfaction, culture, access, and the risk adjusted cost index provided by WHIO.

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