



## THE RIGHT TOOLS FOR QUALITY REPORTING

by Paul M. Katz, M.B.A. Chief Executive Officer, Intelligent Healthcare LLC

March, 2004

**In May 2004, Intelligent Healthcare will be reporting the clinical scores for 12 physician organizations on the six California Pay for Performance quality indicators.** Intelligent Healthcare (IHC) will be subject to a single audit to certify the quality scores reported for all of these physician organizations.

During the December, 2003 meeting of IHC's California clients, representatives of these medical groups discussed how they are using IHC's disease and preventive care registry tool to improve their Pay for Performance scores. The medical directors in attendance also described how their organizations are using IHC's registries to improve the quality of care of their patients.

Dr. Susan Fleischman, Medical Director of the Venice Family Clinic (the largest free clinic in the United States) was the guest speaker, describing her organization's participation in a quality collaborative with other community clinics. Funding for the collaborative is from the Bureau of Primary Healthcare (part of the Department of Health and Human Services, Health Resources and Services Administration).

The community clinic collaborative has been successful at helping its members improve the health of their patients – at clinics with few financial resources, minimal data sources, and a difficult patient population. After two years of

working with diabetes disease registries in the collaborative, their quality scores now match, and in some cases exceed, the quality of care in the private sector. The collaborative has three key components.

1. *Patient population disease registries.* In community clinics, these are loaded manually with medical, demographic, and laboratory test results. (IHC's clients have the advantage of registries pre-loaded by IHC from various medical, pharmacy, and laboratory data sources.)
2. *The creation of a learning community.* By bringing clinic representatives together they can share best practices in improving quality, as well as sharing failures.
3. *Rapid cycle quality improvement.* By using the PDSA cycle ("plan, do, study, act"), clinics were able to pilot small changes to improve quality. These can be done without major disruption to a practice. The registry then provides the immediate data feedback (the "study" component of PDSA) to measure the success of the intervention. Multiple small PDSA cycles can lead to significant change over time. An example of one cycle was to have the medical assistants check the registry when preparing charts for a patient visit, and attach to the charts the appropriate laboratory service order form for needed tests, or referral forms for a diabetes due eye exam.



# Intelligent Healthcare LLC

2800 - 28<sup>th</sup> Street, Suite 210

Santa Monica, CA 90405

[www.intelHC.com](http://www.intelHC.com)

## QUALITY REPORTING

by Paul M. Katz, M.B.A.  
March, 2004 (*continued*)

IHC's clients are using similar steps to improve the quality of patient care.

1. *Proactive case management.* Place the patients with the highest acuity in comprehensive case management programs. Acuity is measured using the predictive modeling tool incorporated in the registries. Patients with diabetes with high HbA1c lab test values are also selected.

The registries show the cumulative cost of health care services during the most recent 12 months, allowing the medical directors to monitor through subsequent updates of the registry the financial impact of their case management activities.

2. *Reminders to physicians.* The disease registry database is streamed into a paperless case management system, where it provides point of care reminders to physicians on their registry patients, and input screens to report missing or overdue services.

3. *Reports to primary care physicians.* The quality scores of each physician are compared to their peers in the physician organization on each of the six indicators.

4. *Performance compensation.* Part of the physician salary is based on performance as measured by the quality indicators.

5. *Reminders to patients.* Letters are generated from the registry data to patients that are missing evidence-based services. Patients in the diabetes, asthma, and cardiovascular registries were also sent letters encouraging them to get a flu shot.

In subsequent newsletters, our client medical directors will describe in more detail how they are working to improve the quality of care of their patients.

Consolidating the results from the registries has shown that compared to the dry run conducted by NCQA, our clients are at the top of physician organizations for quality scores. Working with the registries has allowed our clients to identify patients with missing or overdue services, and intervene to have the services provided and appropriately recorded. Soon to be available with the registry tool will be point of care reminders to physicians for services overdue.

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**FOR MORE INFORMATION on  
Pay for Performance quality reporting, and  
Disease Registries  
by Intelligent Healthcare,  
visit our web site – [www.intelHC.com](http://www.intelHC.com),  
or call Paul Katz at (310) 458-6966.**

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## QUALITY OF CARE OR QUALITY OF DATA

*Which will be reported?*

by Paul M. Katz, M.B.A.

Chief Executive Officer, Intelligent Healthcare LLC

January, 2002

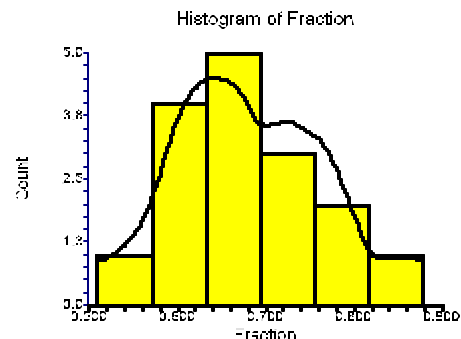
Taking a few moments away from the constant drumbeat about rising health care costs, we have been working to address another unresolved issue - physician account-ability for *the quality of care provided to their patients*. Many initiatives measure the quality of care of HMOs and hospitals. These are often accomplished using statistical sampling techniques, from patient (consumer) attitude surveys, and a review of a small number of medical records. Because there are only a few hundred HMOs and a few thousand hospitals, sampling medical records is a practical method for measuring clinical quality. It is not possible to use the same techniques to measure quality for tens of thousands of physicians. The methodology to measure quality of care of physicians will use administrative data. The majority of this is electronic records generated when physicians bill for their services.

*Accurately measuring quality of care requires good sources of information on patient care.* The goals for the just completed Benchmark Study of Health Care Provided by Physician Organizations were to test administrative data for a large sample of physicians in medical groups, its application to measuring quality and cost, and to develop meaningful and actionable benchmarks for physicians to use for self assessment. We processed administrative data for the services provided to 1.7 Million

HMO enrollees, receiving care from physicians associated with 17 medical groups/IPAs in California. This is a statistically large sample when compared to the statewide HMO enrollment of approximately 10 Million enrollees outside of Kaiser.

The results measuring quality of care for clinical services were not what was expected. Rather than a normal or bell shaped distribution of values in the histogram (such as percent of patients with diabetes that had a Hemoglobin A1c test), the findings were in a bimodal shape, indicating two types of results. The left most mode on the bimodal distribution shows the results for medical groups missing data, while the right mode shows results for medical groups with complete data.

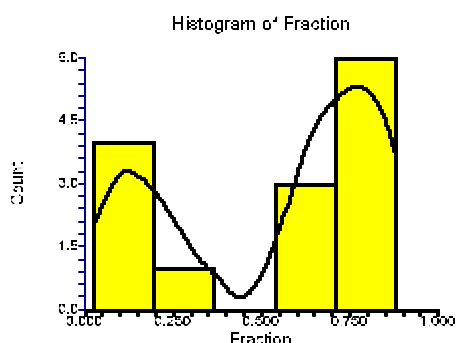
*Sample histograms: "Bell-shaped" [chart below = complete data] and "bimodal" [chart on next page = incomplete data].*



## QUALITY OF CARE OR QUALITY OF DATA

by Paul M. Katz, M.B.A.

January, 2003 (*continued*)



*The lack of complete data necessary for widely used quality measures is a problem that needs to be addressed, before physicians will accept the results of these types of measures, and change the way they practice medicine. For the cost, utilization and access indicators, complete data was generally available, and the histograms more closely resemble a bell-shaped “normal” curve. With the large sample of patients and physicians included in the Study, these findings provide documented evidence of the limitations of administrative data to accurately measure quality of clinical care.*

In the Study and for many common quality measures, we looked for the information needed to identify special patient populations and their health care services - patients with diabetes, asthma, and cardiovascular disease. These patients predictably require more health care services, benefit when quality is good, and are more susceptible when quality (including access) is poor. Finding the right administrative data for this small population among the hundreds of millions of data elements used in the Benchmark Study amounts to finding the proverbial “needle in the haystack”. The process is complicated because it requires linking disparate claims, encounter, and pharmacy data bases kept by

physicians, medical groups, and health plans. The next and most important step, making this special patient information readily accessible to physicians to help them improve their care to these patients, is arduous.

Our recommendation (see POLICY CONSIDERATIONS in the Findings Report) is to set up a process to select and segregate the data needed to identify and track the services provided for special patient populations by developing disease registries. *These registries are small databases that store the administrative data for these special patient populations, with the logic to compare services being provided against evidence-based guidelines for expected services, and reporting functions that make this information available to the physicians. As an outcome of the Benchmark Study findings, we are working with ten medical groups to develop these registries, and are forming a new quality collaborative among medical groups to share best practice information to improve the care for these special patient populations.*

To learn more about the Study and review the findings, go to [www.intelHC.com](http://www.intelHC.com) and click on the BENCHMARK STUDY button. The page has a listing of the EXECUTIVE SUMMARY, REPORT FINDINGS (narrative & policy considerations), APPENDIX (acknowledgments, references, indicator list/specifications, study results/statistics), or the complete Bench-mark Study report (102 pages), which can be viewed or downloaded.

**FOR MORE INFORMATION ON THE DEVELOPMENT OF DISEASE REGISTRIES**, please contact Paul Katz at [pkatz@intelHC.com](mailto:pkatz@intelHC.com) or (310) 458-6966. ###



## WINNING THE HEALTH CARE WARS

*begins with the right information*

**by Paul M. Katz, M.B.A.**

Chief Executive Officer, Intelligent Healthcare LLC

July, 2002

With the focus of the Country on the war on terrorism, President Bush signed the Bio-Terrorism Preparedness Act while ignoring the system-wide health care problems that affect millions of people every day. High inflation, inappropriate application of new technologies, medical errors, the uninsured, inefficiencies and waste continue to plague patients, providers, and purchasers of health care coverage.

In a small way, my recent \$25 copayment for a prescription for children's amoxicillin, an older antibiotic which 6 years ago carried a retail price of less than \$10, and a \$40 copayment for a 10 ml. bottle of children's ear drops, demonstrates the impact of health care inflation. The trend to require higher patient copayments to control costs is ineffective when the patient has too little information and little control over the prices they are charged. The system-wide problems are not due to the failure of capitalism, or the competitive health care business model. Rather they are a result of changes in the power to influence health care, recognizing that no individuals or institutions can alone solve our National-wide health care problems.

Borrowing from Joseph Nye's provocative article on America's inability to use military power alone to fight terrorism on an Inter-

national scale ("The New Rome Meets the New Barbarians", The Economist, March 23, 2002), we can also look at the changing powers influencing health care as a three dimensional chess game. The *first dimension* of the chess board includes federal and state governments with multiple roles in health care: as large purchasers for Medicare and Medicaid, as large payors to hospitals, physicians, and other providers, and as regulators.

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### *Intelligent Healthcare LLC*

*continues to expand its services to help our purchaser, payor and provider clients improve operating efficiencies, counter rising cost trends, and improve quality.*

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In the 1980's, the federal government made significant changes in the formula to pay hospitals (DRG system), and began implementing the physician RBRVS payment system. Both of these changes dramatically affected how providers were compensated by Medicare and most other health care payors. However, the recently implemented federal cutbacks in Medicare payment rates to hospitals and physicians are less likely to stick, because of the other power bases influencing health care.



# Intelligent Healthcare LLC

2800 - 28<sup>th</sup> Street, Suite 210 Santa Monica, CA 90405 [www.intelHC.com](http://www.intelHC.com)

## **HEALTH CARE WARS** *(continued)*

by Paul M. Katz, M.B.A.  
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On the *second dimension* of this chess board are various large private health care purchasers, payers, and providers. As a result of consolidations, a few large employers, employer coalitions, insurance carriers/ HMOs, hospital systems, and pharmaceutical manufacturers are dominate. The latter have been successful at increasing prices for their old products (like amoxi-cillan and ear drops) in the United States far above prices paid for old drugs in neighbor-ing Canada and most other developed nations. Hospitals have successfully pushed through large price increases, in part as a result of the consolidation of hospitals into large hospital systems.

The *third dimension* of this chess board has various advocacy organizations, including medical associations, and health care consumer and patient advocacy groups. The advocacy groups have gained power by using the Internet to attract and build coalitions of patients, physicians and consumers across the country. Consumer and patient advocacy groups now can claim to rightfully champion the traditional patient-provider relationship, formerly the claim made by the medical associations.

Tackling the growing Nation-wide long term health care problems will require building consensus, and finding allies among all of the players on this chess board. For now, most

consumers and patients will likely find themselves paying more for less health care access and services.

Intelligent Healthcare LLC continues to expand its services to help our purchaser, payor and provider clients improve operating efficiencies, counter rising cost trends, and improve quality. Over the last year, we incorporated patient and patient population risk measurements into our standard cost and utilization reports, and several of the advanced Web-based drill down reports.

This analysis allows us to differentiate between higher costs due to controllable physician decisions and uncontrollable patient illness burden. Our reports helped one payor client turn an operating loss in 2001 into a profit in 2002 by steering patients to the most cost-efficient providers for their conditions.

Another payor client is using our calculated physician productivity score to reward physicians with better cost and care outcomes. One capitated medical group client used the case mix and cost calculations by employer group to justify to an HMO higher payment for several large employer patient populations.

We can give you the information you need to win your health care wars. More information on risk analysis and our other services can be found at [www.intelHC.com](http://www.intelHC.com). Click on "Risk Adjusting" under SERVICES, or call Paul Katz at (310) 458-6966.



## DEVELOPING QUALITY BENCHMARKS *for Physicians*

by **Paul M. Katz, M.B.A.**

Chief Executive Officer, Intelligent Healthcare LLC

April, 2002

**The Benchmark Study of Physician Organizations** has been funded by the California Healthcare Foundation, which is based in Oakland, California. The Foundation is a non-profit philanthropic organization with a mission to expand access to affordable, quality health care for under-served individuals and communities, and to promote fundamental improvements in the health status of the people of California.

Our Study will develop quality benchmarks for administrative and clinical performance for medical groups, independent practice associations, medical foundations and other forms of organized physician practice. The Study will use administrative data (electronic data sources), as opposed to traditional sources – usually medical record abstracts or a hybrid of administrative data and medical records. This research will provide new methods to measure the success of physician organizations in various payment models to provide cost-effective and quality health care for consumers. More specifically, the Study will:

1. *Develop indicators that measure the quality of care provided by medical groups.* For example, the guiding principle of delegating medical care management to physicians has that by granting them clinical autonomy, they would be encouraged to provide collaborative and co-

ordinated care, emphasize prevention, improve patient access to necessary services, and realize cost savings. Our research will develop Benchmarks specific to physician practices, that will allow the physicians (and other interested parties) to see how well they are meeting quality standards. The Study will develop and test Benchmarks applicable to organized physician practices in any payment model.

2. *Establish the methodology to apply quality indicators exclusively to administrative data for medical groups.* Indicators from HEDIS (modified for purely administrative data), medical review criteria for patient norms (such as access to primary care physicians and various medical specialties), utilization rates of select procedures, and costs for significant conditions such as asthma and diabetes are covered in the Study. The list of Study indicators is available on our Web-site at [www.intelHC.com](http://www.intelHC.com) under the Benchmark Study button.

3. *Test the indicators to determine if they provide meaningful and actionable results for medical groups.* The Study will provide physicians with quality indicators, the methodology to use them, and Benchmarks specifically designed for physician practices. The indicators can then be used by the medical groups to measure and improve their own performance, and objectively measure their individual physicians. Other interested parties would be able to use these indicators to monitor the ability of physicians to provide high quality care.



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## QUALITY BENCHMARKS *(continued)*

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April, 2002

4. *Apply risk adjusters to the data to measure the impact of underlying patient condition on the indicators.* As shown in a recently published paper by Greenfield, et. al. in the *Annals of Internal Medicine* (Vol 136, No 2) accounting for differences in patient acuity is necessary when comparing physicians on quality indicators.

The Study will develop new quality measurement methods by calculating the overall “illness burden” of the patient population cared for by each physician group. This process will account for differences in patient condition that can affect the results for each quality indicator. For example, when comparing medical groups’ care of diabetic patients, we will account for measured differences in care needed between moderate and severe cases, where extra services provided for more complicated cases may not always produce better measured outcomes.

The quality indicators used in the Study are based on existing indicators from HEDIS and other sources, which have been modified to apply to the way physicians practice medicine. This is the first Study to look at *all* of the care provided by a statistically significant sample of medical groups, rather than the HMO/insurers reporting on only the services for their patients, often representing a small part of a medical group’s services. The Study will comprehensively look at the quality of care

provided by over 20 medical groups practicing in similar markets.

For their participation in the Study, in addition to reporting on the illness burden of their practice, the medical groups will receive:

1. A report of their performance against the benchmarks developed for each indicator,
2. The group’s performance compared to the other participants on each indicator,
3. The group’s performance on the new “Pay-for-Performance” quality indicators, which the six largest HMOs in California will use in 2003 to pay quality bonuses, and
4. The methodologies and technical specifications needed to test their data against the indicators.

Our Web-site [www.intelHC.com](http://www.intelHC.com) includes more information on the Study. Click on “Benchmark Study” to view/download documents, including:

- S Study Paper: Review of Research & Use of Quality, Cost and Utilization Indicators
- S Listing of Advisory Group Members
- S Physician Organization Invitation to Participate
- S Data Privacy & Security Statement
- S Study Quality Indicators
- S Information Technology Survey
- S Completed Sample of Information Technology Survey
- S Data Dictionary/Options for Data Submission

Please visit our “Benchmark Study” Web-site page for regular updates as the Study progresses.