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HEALTH POLICY STATEMENT

ACCF 2008 Health Policy Statement on Principles for Public Reporting of Physician Performance Data

A Report of the American College of Cardiology Foundation Writing Committee to Develop Principles for Public Reporting of Physician Performance Data

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Preamble

This document is an official American College of Cardiology Foundation (ACCF) health policy statement. This category of documents is intended to promote or advocate a position or is informational in nature and may offer guidance to the stakeholder community regarding the ACCF's stance on health care policies and programs. Health policy statements are not intended to offer clinical guidance and do not contradict existing ACCF clinical policy. These documents fall under the purview of the ACCF Quality Strategic Directions Committee (QSDC). The ACCF QSDC is responsible for developing and implementing all policies and procedures related to topic selection, commissioning writing committees, and defining document methodologies.

The presidential Task Force on Performance Assessment, Recognition, Reinforcement, and Reward (PAR^3) brings together various areas of the College such as the Advocacy Committee, the National Cardiovascular Data Registry, the Performance Measurement Task Force, the Informatics Committee, the Education Committee, the QSDC, and the Coalition of Cardiovascular Organizations to formulate ACCF position and strategy in the value-based purchasing environment. The PAR^3 Task Force recommended the development of this health policy statement to document the official position of the ACCF regarding public reporting of physician performance data. As payer and purchasers move to implement value-based health care purchasing programs (commonly known as pay-for-performance [P4P] programs), medical specialty societies must weigh in on the design and implementation of program elements in an effort to influence stakeholder perspectives and provide meaningful guidance to members.

The Writing Committee made every effort to avoid any actual, potential, or perceived conflict of interest that might arise as a result of industry relationships or personal interest. Specifically, all members of the writing committee, as well as peer reviewers of the document, were asked to provide disclosure statements of all such relationships. Please see Appendix 1 for a listing of the author relationships with industry. Relationships with industry of peer reviewers are listed in Appendix 2.

John E. Brush, Jr, MD, FACC, Chair
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Introduction

The U.S. health care system and its shortcomings are attracting the scrutiny of all those it touches: patients, their caregivers, providers, payers, employers, and policy-makers. Despite the extraordinary resources expended, unacceptable gaps in care and quality persist. In an effort to close those gaps, public reporting of physician, health plan, and institutional performance is increasingly being utilized, as evidenced by the 211 entries in the Report Card Compendium, a database maintained by the Agency for Healthcare Research and Quality (AHRQ) (1). These assessments vary by target, methodology, level of transparency, motive, and potential consequences.

Employers, who are among the major purchasers of health care, are now investing in public reporting as a means to accelerate quality improvement and steer employees to the "best" performers. Hospitals are participating in performance reporting through public-private collaborations, such as the Hospital Quality Alliance (HQA) and the Centers for Medicare and Medicaid Services (CMS) Premier Hospital Quality Incentive Demonstration (HQID), the latter adding bonus payments to the reporting equation. Health plans are publishing performance reports on individual physicians in an effort to influence their members' decision-making. Health care providers and professional organizations are just beginning to provide information regarding quality of care in an understandable and readily accessible way. Finally, "boomer" generation patients, as activated consumers of health care services, are predicted to expect and, in fact, demand ready access to comparative information to guide their health care choices.

The ACCF is supportive of accountability in health care but has concerns regarding public disclosure of performance metrics at the individual physician level. Prior statements by the ACCF have discussed important issues as they relate to performance profiling, such as the principles to guide selection of performance measures (2), risk adjustment methodologies (3), and the policies for pay for performance (4). This health policy statement will center on "physician-level" performance reporting. We review the history of public reporting of physician-specific performance metrics, propose principles to guide public reporting on the quality of health care provided by cardiovascular specialists, and summarize what the ACCF is doing to assist physicians to improve their own quality of care. We point out the ACCF's concerns about public reporting and, through the proposed principles, suggest a way of addressing those concerns and of achieving enhanced transparency that is meaningful to payers, providers, and patients.

History and Current Status of Public Reporting

Cardiovascular specialists, specifically cardiac surgeons, have been the object of public reporting for over two decades in both federal and state initiatives. These efforts initially were directed at hospital performance assessment, with physician data only indirectly included in conjunction with the hospital processes being measured. The Health Care Financing Administration (HCFA)—now CMS—took the lead in this area with the release of hospital-specific coronary artery bypass grafting (CABG) mortality data in 1987 (5). This

effort was later withdrawn because of objections relative to the methodoloy employed (6). It, nevertheless, spawned several physician-led quality improvement initiatives, including the Northern New England Cardiovascular Study Group (NNECSG) and the Society of Thoracic Surgeon's (STS) National Cardiac Surgery Database, which have proven to be highly successful mechanisms for stimulating quality improvement (7,8).

States including New York (9), Pennsylvania (10), and Massachusetts (11) have also implemented cardiovascular public reporting programs. The New York Cardiac Surgery Reporting System (CSRS) resulted in risk-adjusted mortality of cardiac surgery dropping from 4.17% to 2.45% in the first three years of its existence (12) with less dramatic improvements since then (13) but was also associated with some unintended consequences including provider "gaming" and exacerbation of existing disparities in care (14). The Pennsylvania CABG public reporting program has had a similar experience (15). The Massachusetts cardiac surgery reporting program utilized the STS database but also compared performance measures based on these clinical data sources with those from administrative billing sources (16). It was concluded that, "Cardiac surgery report cards using administrative data are problematic compared with those derived from audited and validated clinical data, primarily because of case misclassification and nonstandardized end points."

Public reporting of transplant program data provided to the United Network for Organ Sharing (UNOS) has been successful using risk-adjusted data confirmed by each program audited periodically (17). As a result of this program, the differences in outcomes among programs has become fairly small as each program does its best to improve its results.

CMS re-entered public reporting of hospital quality data in 2005 when it released hospital-level process performance data on acute myocardial infarction (AMI), heart failure (HF), pneumonia, and surgical infection (18). This assessment broadened last year when CMS added hospital-level AMI and HF mortality data to the reported metrics (19).

While physician-specific data have been used in provider incentive programs, public reporting of such data has been limited. The CMS has attempted to collect physician-specific quality data through its Physician Voluntary Reporting Program in 2006 and the Physician Quality Reporting Initiative (PQRI) beginning in 2007 (20). Participation in these programs has been limited, and no performance data are expected to be publicly reported from either program. Other systems have been developed for using actual clinical data in feedback to physicians for the purpose of quality improvement. Approaches such as these have performed well when compared to public reporting and pay-for-performance programs (21,22).

In summary, large-scale public reporting efforts have primarily involved acute events—such as AMI, decompensated HF, or procedures, such as cardiac surgery. They have usually not entailed physician-specific performance measurement but rather have been summated at the hospital level, where statistical stability is greater due to a larger number of cases in the denominators. Finally, the more successful programs have relied on clinical data sources to avoid issues of case misclassification and to allow for risk adjustment of outcomes. Extrapolation of these experiences to the ambulatory setting, where care is provided to patients with multiple comorbidities, occurs over time-spans measured in years, and involves multiple providers, has little or no empiric evidence to support it. With this level of uncertainty, concern has been expressed that programs of physician-level public reporting on ambulatory care processes may lead to unintended consequences that could offset their benefits (23,24).

Existing Reporting Principles

Other entities that have published public reporting guidelines, recommendations, or principles include the American Medical Association (AMA) (25), Massachusetts Medical Society (26), RAND (27), and the AQA Alliance (28). In March 2007, the National Committee for Quality Assurance (NCQA) sought public comment on a Healthcare Effectiveness Data and Information Set (HEDIS) Physician Measurement volume developed in an attempt to create a standardized national approach to physician measurement and reporting. In the fall of 2007, the New York Attorney General entered into agreements with United Healthcare and other national managed care organizations whereby the health plans agreed to abide by certain principles in developing and reporting their physician rating systems (29). Common themes among these various recommendations for public reporting include a primary focus on quality improvement, physician involvement in public reporting programs, risk adjustment of measures, and monitoring for unintended consequences.

ACC Principles

Physician performance data, particularly in the area of ambulatory care, are new and lack a solid evidence base supporting their utility. Thus, it would seem prudent to conduct pilot studies before widespread adoption on this approach. RAND, AQA Alliance, NCQA, and the Massachusetts Medical Society have proposed such programs. Those who proceed with physician-level public reporting on performance at this point should base their programs on the following principles:

1. **The driving force behind physician performance measurement and reporting systems should be to promote quality improvement.** Ideally, any assessment program should promote improvement in the quality and outcomes of care and have limited unintended consequences. Some believe that the ultimate goal of public reporting of physician performance is,

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instead, to place information into the hands of the consumer. This belief comes from a philosophy which says, "Let patients know what physician performance is and they will vote with their feet." This approach is based on two assumptions, both of which have a weak evidence base. The first is that the currently available performance measurement methodology gives an accurate picture of the quality of care rendered by the individual cardiovascular specialist. The science of physician performance measurement, in fact, is only beginning to issue guidance about case mix adjustment and adequate sample size (3). The second assumption—that there is a surplus of cardiovascular specialists from which the consumer can choose—is also a problem since data show that we are actually facing a shortage of such specialists as our population ages (30,31). A well-designed public reporting program should, therefore, be aimed at raising the performance of all providers, thereby increasing access to high-quality cardiovascular care for everyone.

2. **Public reporting programs should be based on performance measures with scientific validity.** The evidence supporting the clinical processes that are the focus of the measures being used should be explicitly stated. In addition, the program should be transparent with respect to data sources, the validation of the data collection, and the statistical and reporting methodologies used including the limitations of those methodologies. Public reporting programs should make this information available to physicians and the public along with the results of any testing of the measurement system. Other key elements of public reporting for which the evidence base should be clear include the methodologies used for risk/case-mix adjustment and for attribution of specific measures to specific providers. Recent publications describe important methodologies to be used in these areas as well as in the design of composite measures (3,32). These are critical elements to ensure the credibility of public reporting. In general, clinical as opposed to administrative data sources are favored for provider performance reporting to maximize accuracy and completeness (16).

   Physicians, through their specialty societies, are well-qualified to understand the clinically relevant issues facing the field as well as how these can be translated into credible performance measures. Public reporting entities should, therefore, select cardiovascular disease performance measures from the robust sets already developed by the ACCF and the American Heart Association (AHA) with the AMA's Physician Consortium for Performance Improvement (PCPI). It is similarly strongly recommended that whenever possible measures used in public reporting be endorsed by entities such as the National Quality Forum (NQF) since metrics endorsed by this sort of multi-stakeholder organization have generally gone through a rigorous development and approval process.

3. **Public reporting programs should be developed in partnership with physicians.** Clinicians are responsible for the burden of data collection and should be ultimately the drivers of provider quality improvement. Therefore, physicians should participate in testing the measurement system prior to any public reporting and should be offered feedback in a manner that would help inform and stimulate practice change. Additionally, for private health plans, provider contracts should contain the physician's consent to public reporting of physician quality data before any such program is undertaken. Health plans should afford physicians the opportunity to review their data before public release and the ability to formally appeal information they believe to be incorrect.

4. **Every effort should be made to use standardized data elements to assess and report performance and to make the submission process uniform across all public reporting programs.** A universal reporting format will lower the administrative burden of data entry; facilitate comparative analysis; maximize provider participation; and, therefore, create the most meaningful platform for performance assessment and improvement. This will require public and private reporting entities to work together to develop the necessary standards. Such standards for some clinical data already exist in the STS database and in the ACCF's National Cardiovascular Data Registry (NCDR™). The ACCF in partnership with the AHA is also developing key data elements and definitions that should be utilized to harmonize data collection for cardiovascular conditions (33–35). In addition, the ACCF and AHA are working with the NQF, CMS, The Joint Commission, NCQA, and the PCPI to harmonize performance measures.

5. **Performance reporting should occur at the appropriate level of accountability.** Recognizing the complexity in the delivery of health care, the Institute of Medicine called for "shared accountability" as one of its principles for a national system of performance measurement and reporting, stating that improvement "can be achieved only through the collaborative efforts of multiple providers and multiple care settings" (36). Indeed, the modern practice of cardiovascular medicine is accomplished by teams of providers that include nurses, nurse practitioners, physician assistants, primary care physicians, and physicians in the various subspecialties of cardiology. While individual provider data have value to the team in its effort to improve quality, these data are unlikely to be useful to payers and patients. In addition, it is highly unlikely that an individual provider sees a sufficient number of patients to establish statistical validity. Thus, mea-

surement and reporting should take into consideration that the unit of accountability is the provider team that has assumed the care of the condition or patient population in question. These accountable units can range from a solo practitioner, through a small group practice, to a large multi-specialty practice. Reporting at the accountable entity level recognizes the realities of modern-day practice, directly addresses the problematic issue of attribution, and promotes health care teamwork. Attributing an outcome or measure to a single physician oversimplifies performance measurement at best. At its worst, such an approach undermines the preferred model of team-based care and the ideal collaborative design necessary to deliver patient-centered, effective, and safe health care.

6. **All public reporting programs should include a formal process for evaluating the impact of the program on the quality and cost of health care including an assessment of unintended consequences** (37). Physician performance measurement, particularly in the ambulatory setting, is still in its early stage and there is limited experience with public reporting of these measures. The potential impact of unintended consequences on the quality and cost of care is great, especially with respect to patient access to care and physicians' practice patterns. Those who choose to publicly report data should be accountable for analyzing their program's consequences—both good and bad; reporting the results of those analyses to all of the involved constituencies; and modifying the program in order to achieve maximum benefit for patients. These rigorous analyses will not only serve to make reporting programs more effective but should also provide a stimulus for focused health-services research and offer the potential for providing an invaluable laboratory for quality improvement.

ACCF Activity and Future Directions

The ACCF as a professional society, together with its state chapters and individual members, has a tradition of quality measurement and improvement. The College's approach—a combination of information and quality improvement tools—has proven effective in improving cardiovascular care without employing public reporting.

In 2003, the ACCF revised its guiding mission to state that it would advocate for optimal patient care through the development and application of clinical practice guidelines. Stated another way, the College is dedicated to assisting clinicians in delivering high-quality, safe, effective, and efficient care. Achieving these goals has required nothing short of a transformation and marked expansion of the College's programs and processes. These include working in partnership with the AHA to produce cardiac data standards for use in electronic medical records and performance measures, evidence-based clinical practice guidelines (38, 39), and performance measures developed using a rigorous methodology (2). In addition, the ACCF has developed appropriateness criteria (40) to promote the optimal use of technology and, through its NCDR™, is building the infrastructure needed to systematically measure and feed back cardiovascular care patterns to participating hospitals and physicians. The ACCF also has carried out highly successful quality improvement projects that have broken new ground on how to achieve collaborative quality improvement through programs, such as its Guidelines Applied in Practice (GAP), Door to Balloon (D2B: An Alliance for Quality), and its newest Take ACTION campaign.

In working to achieve the goal of improved delivery of quality cardiovascular care, the ACCF is concerned about the opportunity costs presented by public reporting programs. The ACCF believes that our nation's energies and limited resources would be best spent developing the systems of care that are designed to achieve the high-quality and efficient care desired by all. These systems include organized approaches to care, such as the chronic care model and provider-based, patient-focused disease management programs. Efforts are also underway to develop information on the effectiveness of various clinical interventions and communicating that information to providers and patients in a meaningful way. Many stakeholders, including the ACCF, are addressing the challenge of developing and gaining the widespread adoption of robust, interoperable health information technology to support these more sophisticated and effective approaches to patient care. We face the daunting challenge of finding the capital to invest in these new systems while designing new compensation models to support them. The critical question that remains is whether, given finite resources, physician-level reporting will help improve the quality of care or whether such reporting may actually serve as an impediment to other efforts aimed at achieving provider- and practice-level quality improvement.

Conclusions

At its best, public reporting on the performance of cardiovascular specialists is intended to stimulate focused efforts to eliminate the gaps in care—from omission, commission, and inappropriateness—that jeopardize the health of patients and contribute to excessive expenditures. Poorly designed programs risk misleading patients about the quality of their care, damaging the therapeutic relationships with their providers, and creating greater disparities in care delivery. To avoid these unintended consequences and to achieve transparency that contributes to sound decision-making, the ACCF recommends public reporting programs that are based on scientifically valid performance measures using clinical rather than administrative data whenever possible. The programs should be designed in partnership

with those being measured and should report performance at the level of the accountable entity in order to reflect the realities of current cardiovascular practice and to stimulate excellence in team-based care. Finally, the ACCF supports programs that fully disclose their methodology and that systematically evaluate for adverse as well as beneficial results. The principles outlined in this document point the way forward for physician performance reporting programs in a way that will fulfill the legitimate need for transparency while promoting both the wise use of resources and the delivery of high-quality health care.

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APPENDIX 1. WRITING COMMITTEE RELATIONSHIPS WITH INDUSTRY—ACCF 2008 ACCF 2008 HEALTH POLICY STATEMENT ON PRINCIPLES FOR PUBLIC REPORTING OF PHYSICIAN PERFORMANCE DATA

Writing Committee Member	Research Grant	Speakers' Bureau/ Honoraria/ Expert Witness	Stock Ownership	Consultant/ Advisory Board/ Steering Committee
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Ms. Eileen P. Hagan	None	None	None	None
Dr. Michael J. Mirro	None	• Cambridge Heart • Medtronic • St. Jude Medicine	• Medical Informatics	None
Dr. Eric D. Peterson	• American Heart Association • Bristol-Myers Squibb • Merck • National Cardiovascular Data Registry • Sanofi • Schering-Plough • Society of Thoracic Surgeons	None	None	None
Dr. Janet S. Wright	None	None	None	None

This table represents the relationships of committee members with industry that were reported by the authors as relevant to this topic. It does not necessarily reflect relationships with industry at the time of publication. A person is deemed to have a significant interest in a business if the interest represents ownership of 5% or more of the voting stock or share of the business entity, or ownership of $10,000 or more of the fair market value of the business entity; or if funds received by the person from the business entity exceed 5% of the person's gross income for the previous year. A relationship is considered to be modest if it is less than significant under the preceding definition. Relationships in this table are modest unless otherwise noted.

APPENDIX 2. REVIEWER RELATIONSHIPS WITH INDUSTRY—ACCF 2008 HEALTH POLICY STATEMENT ON PRINCIPLES FOR PUBLIC REPORTING OF PHYSICIAN PERFORMANCE DATA

Peer Reviewer*	Representation	Research Grant	Speakers' Bureau/ Honoraria/ Expert Witness	Stock Ownership	Consultant/Advisory Board/Steering Committee
Dr. Linda D. Gillam	• Official—ACCF Board of Trustees	None	None	None	None
Dr. Mark J. Zucker	• Official—ACCF Board of Trustees	None	None	None	None
Dr. Alfred A. Bove	• Organizational—ACCF Quality Strategic Directions Committee	None	None	None	• General Electric Healthcare • Insight Telehealth • Pfizer Pharmaceuticals
Dr. Kenneth Brin	• Organizational—ACCF Advocacy Committee	None	None	None	• CPT Editorial Panel
Dr. John E. Brush	• Organizational— ACCF PAR[3] Committee, ACCF Quality Strategic Directions Committee	None	None	None	None
Dr. Matthew Budoff	• Organizational—ACCF Advocacy Committee	None	• 2006 Defense of CT Scanning	None	• General Electric

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Peer Reviewer*	Representation	Research Grant	Speakers' Bureau/ Honoraria/ Expert Witness	Stock Ownership	Consultant/Advisory Board/Steering Committee
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ACCF indicates American College of Cardiology Foundation; PAR^3, Performance Assessment, Recognition, Reinforcement, and Reward Committee.