Remarks for National Pay for Performance Summit

Activating Consumers with Effective Messaging and Report Cards

by

Robert Krughoff

February 15, 2007

Center for the Study of Services

Will Discuss Two Ways to Activate Consumers

1. Helping consumers become more discriminating *selectors* of health care *providers*
2. Strengthening the consumer role in *measuring* the performance of *providers*

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Perspective from Consumers' CHECKBOOK/Center for the Study of Services (CSS)—Two Hats

- Provider of consulting/survey administration services to health care organizations
  - For years, have done HEDIS/CAHPS surveys for UnitedHealthcare, Aetna, CIGNA, many smaller plans—also surveys of physicians asking about these plans
  - Implementations of early versions of Group/ Clinician CAHPS surveys, including two largest—
    - For PBGH—480,000 patients in 2006, 180,000 in 2005
    - For MHQP—220,000 in 2005, early testing 2002
  - CMS vendor for Prescription Drug and Medicare Advantage plan surveys

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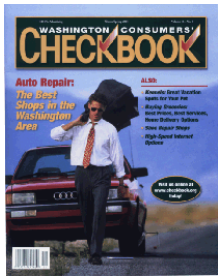
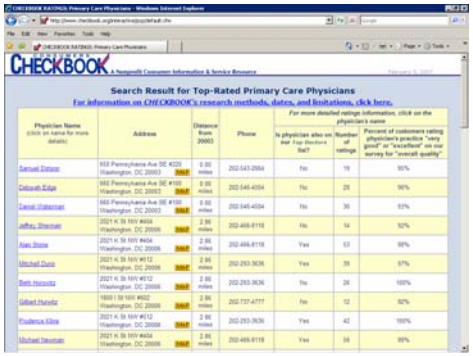
Our Perspective (cont'd)

- Publisher of information directly for consumers in print and on the Web—
  - CHECKBOOK, a Consumer Reports-like magazine on all kinds of local services—from auto repair shops to plumbers to physicians—in seven major metro areas
  - Nationally distributed books rating hospitals, physicians, and health plans
  - Developed first nation-wide survey of members about health plans for public release (in 1994)—265 plans—in cooperation with the U.S Office of Personnel Management
  - Has been a consumer representative on NCQA Committee on Performance Measurement, AHRQ National Advisory Commission, IOM panels, NQF committees, etc.





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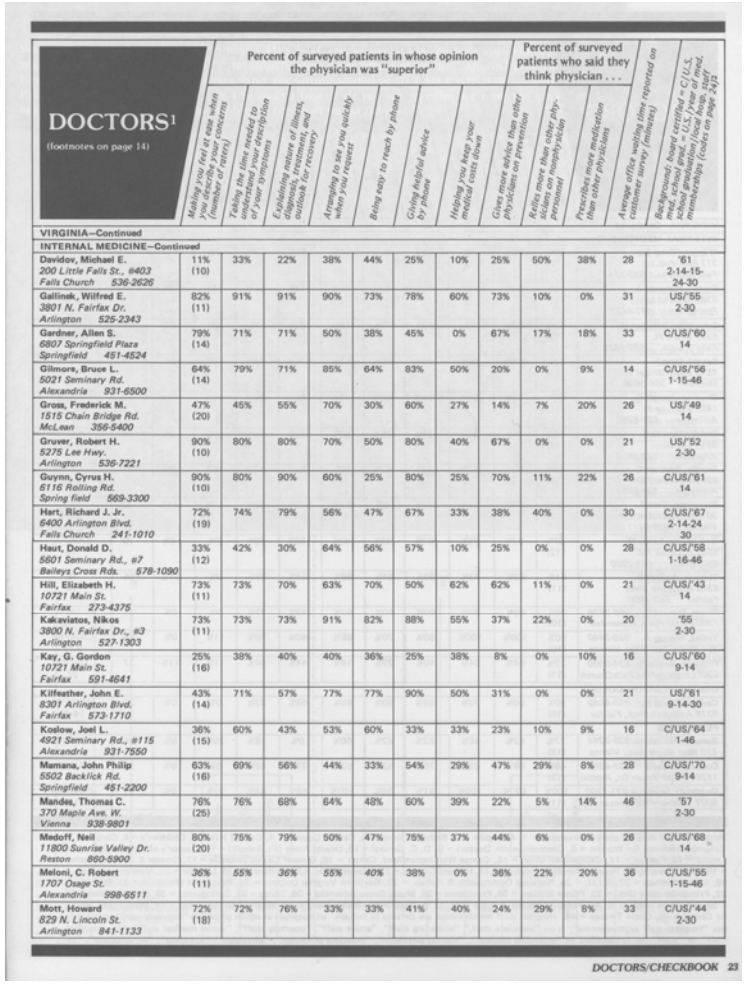
First Published Consumer Survey Ratings of Physicians and HMOs in 1980



DOCTORS[1]
(footnotes on page 14)

Percent of surveyed patients in whose opinion the physician was "superior"

Percent of surveyed patients who said they think physician . . .

	Making you feel at ease when you describe your concerns (rate this doctor or rates)	Taking the time needed to understand your description of your symptoms	Explaining nature of illness, diagnosis, treatment, and outlook for recovery	Arranging to see you quickly when you request	Being easy to reach by phone	Giving helpful advice by phone	Helping you keep your medical costs down	Give more advice than other physicians on prevention	Refer more than other phy-sicians on nonphysician personnel	Prescribes more medication than other physicians	Average office waiting time reported on customer survey (minutes)	Background, board certified = C/U.S., med. school, grad., U.S./year, med. school graduation, place, hosp., staff, memberships (codes on page 24)
VIRGINIA—Continued												
INTERNAL MEDICINE—Continued												
Davidov, Michael E. 200 Little Falls St., #403 Falls Church 536-2626	11% (10)	33%	22%	38%	44%	25%	10%	25%	50%	38%	28	'61 2-14-15- 24-30
Gallinek, Wilfred E. 3801 N. Fairfax Dr. Arlington 525-2343	82% (11)	91%	91%	90%	73%	78%	60%	73%	10%	0%	31	US/'55 2-30
Gardner, Allen S. 6807 Springfield Plaza Springfield 451-4524	79% (14)	71%	71%	50%	38%	45%	0%	67%	17%	18%	33	C/US/'60 14
Gilmore, Bruce L. 5021 Seminary Rd. Alexandria 931-6500	64% (14)	79%	71%	85%	64%	83%	50%	20%	0%	9%	14	C/US/'56 1-15-46
Gross, Frederick M. 1515 Chain Bridge Rd. McLean 356-5400	47% (20)	45%	55%	70%	30%	60%	27%	14%	7%	20%	26	US/'49 14
Gruver, Robert H. 5275 Lee Hwy. Arlington 536-7221	90% (10)	80%	80%	70%	50%	80%	40%	67%	0%	0%	21	US/'52 2-30
Guynn, Cyrus H. 6116 Rolling Rd. Spring field 569-3300	90% (10)	80%	90%	60%	25%	80%	25%	70%	11%	22%	26	C/US/'61 14
Hart, Richard J. Jr. 6400 Arlington Blvd. Falls Church 241-1010	72% (19)	74%	79%	56%	47%	67%	33%	38%	40%	0%	30	C/US/'67 2-14-24 30
Haut, Donald D. 5601 Seminary Rd., #7 Baileys Cross Rds. 578-1090	33% (12)	42%	30%	64%	56%	57%	10%	25%	0%	0%	28	C/US/'58 1-16-46
Hill, Elizabeth H. 10721 Main St. Fairfax 273-4375	73% (11)	73%	70%	63%	70%	50%	62%	62%	11%	0%	21	C/US/'43 14
Kakaviatos, Nikos 3800 N. Fairfax Dr., #3 Arlington 527-1303	73% (11)	73%	73%	91%	82%	88%	55%	37%	22%	0%	20	'55 2-30
Kay, G. Gordon 10721 Main St. Fairfax 591-4641	25% (16)	38%	40%	40%	36%	25%	38%	8%	0%	10%	16	C/US/'60 9-14
Kitfeather, John E. 8301 Arlington Blvd. Fairfax 573-1710	43% (14)	71%	57%	77%	77%	90%	50%	31%	0%	0%	21	US/'61 9-14-30
Koslow, Joel L. 4921 Seminary Rd., #115 Alexandria 931-7550	36% (15)	60%	43%	53%	60%	33%	33%	23%	10%	9%	16	C/US/'64 1-46
Mamana, John Philip 5502 Backlick Rd. Springfield 451-2200	63% (16)	69%	56%	44%	33%	54%	29%	47%	29%	8%	28	C/US/'70 9-14
Mandes, Thomas C. 370 Maple Ave. W. Vienna 938-9801	76% (25)	76%	68%	64%	48%	60%	39%	22%	5%	14%	46	'57 2-30
Medoff, Neil 11800 Sunrise Valley Dr. Reston 860-5900	80% (20)	75%	79%	50%	47%	75%	37%	44%	6%	0%	26	C/US/'68 14
Meloni, C. Robert 1707 Osage St. Alexandria 998-6511	36% (11)	55%	36%	55%	40%	38%	0%	36%	22%	20%	36	C/US/'55 1-15-46
Mott, Howard 829 N. Lincoln St. Arlington 841-1133	72% (18)	72%	76%	33%	33%	41%	40%	24%	29%	8%	33	C/US/'44 2-30

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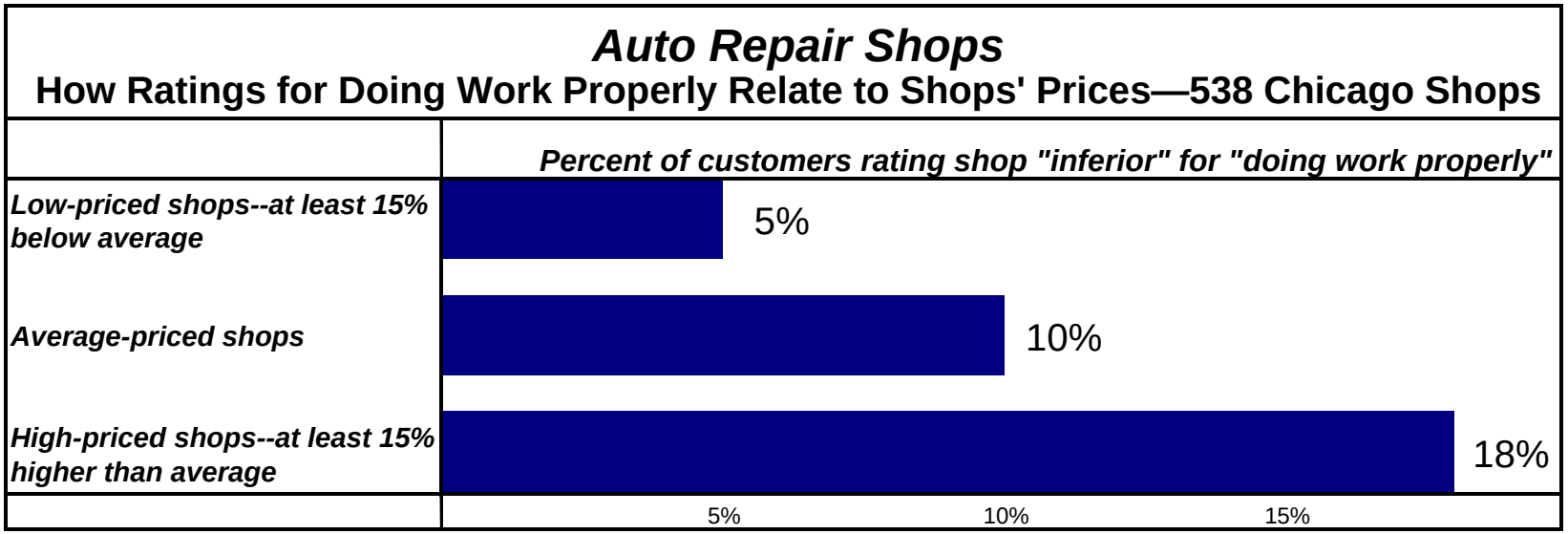
Markets of Local Services Generally Function Badly

- For example, among 538 Chicago auto repair shops, big price differences, big quality differences, no correlation between price and quality—
- For example, to fix 1997 Camry XLE's water pump and timing belt—
  - $795 at Gossinger Toyota, which was rated "inferior" for "doing work properly" by 15 % of surveyed customers and had a 35% failure rate on emissions repairs
  - $375 at North End Garage, which had ***no*** "inferior" ratings from surveyed customers and had only a 20 % failure rate on emissions repairs



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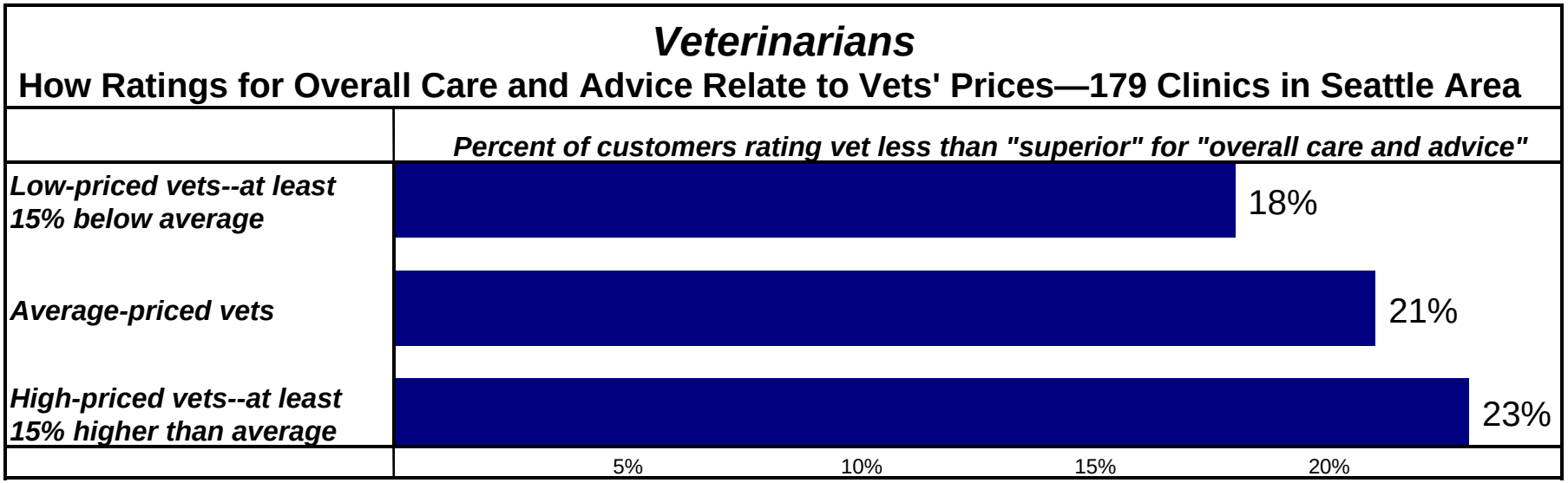
Markets of Local Services Generally Function Badly

- There is market dis-function in wide range of services—tree care, roofing, air conditioning repair, appliance repair, pest control, and many more.
- Consider results for veterinary clinics, analogous to human health care services but without much insurance coverage to diminish the consumer's interest in cost containment. Shown below are findings for 179 veterinary clinics in the Seattle area--



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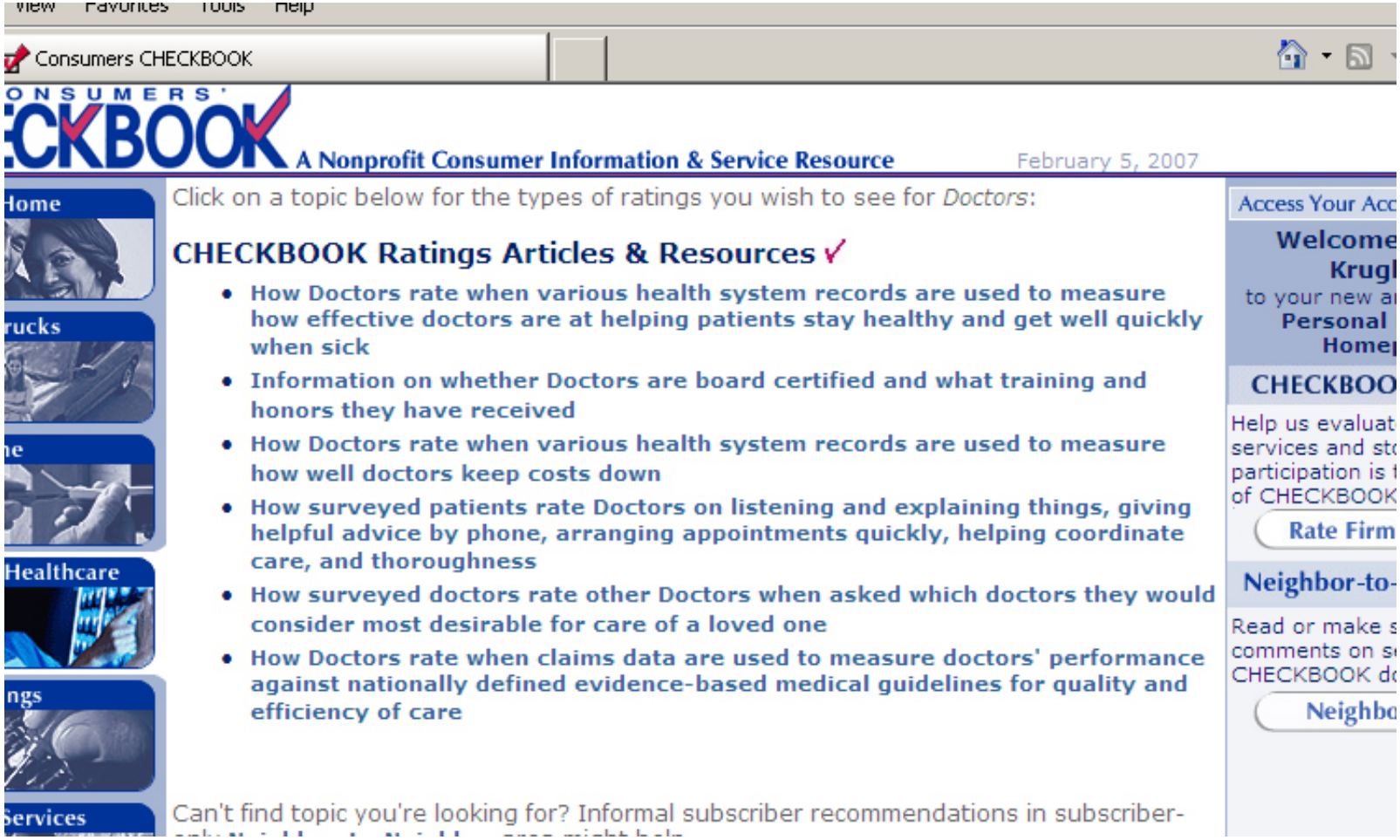
Making Health Care Markets Work Is Even Harder

- Consumers think of themselves as spending insurer's money.
- Social policy says we want to design the insurance system to protect against catastrophic expenses and don't want a system where the rich get better care because they can pay for more expensive providers.
- Inelasticity of supply, especially at the individual physician level, prevents market response to demand shifts.
- There are special health care measurement challenges. One challenge is that when trying to protect or repair a *living organism*, good outcomes don't always follow even the best procedures—so assessment has to be probabilistic. (In contrast, if a mechanic or roofer does the job right, we can expect a good result each time).
- Consumers find evidence-based provider quality comparisons confusing and unconvincing (while they will act on even a single recommendation from a friend, relative, or physician).

To Move Consumers, Info Must Resonate

In a 2-week www.checkbook.org experiment, 804 subscribers chose which of several types of ratings info they wanted on physicians



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Type of Physician Ratings Info Consumers Want First Is Not What Most Policy-Makers Are Focused on

Type of rating information consumer could choose to view on the website	***Percent of consumers for whom this type of rating information was the <u>first</u> choice***
How ***Doctors rate when various health system records are used*** to measure how well doctors ***keep costs down***	3%
How Doctors rate when ***claims data are used to measure doctors' performance*** against nationally defined evidence-based medical guidelines ***for quality and efficiency*** of care	6%
How ***Doctors rate when various health system records are used*** to measure how effective doctors are at helping patients ***stay healthy and get well quickly when sick***	7%
Information on ***whether Doctors are board certified and what training and honors*** they have received	9%
How surveyed ***patients rate Doctors*** on listening and explaining things, giving helpful advice by phone, arranging appointments quickly, helping coordinate care, and thoroughness	23%
How surveyed ***doctors rate other Doctors*** when asked which doctors they would consider most desirable ***for care of a loved one***	51%
Percentages do not add to 100% because of rounding.	

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Lessons from the checkbook.org Experiment

- If we expect consumers to act on claims-based or record-based data, we have to make it more compelling to them. Maybe it will help if we—
  - Make it more understandable
  - Make it more independent and credible
  - Let them see how it tells them about things that matter to them—staying alive and healthy and recovering quickly
  - Make sharp distinctions among providers
- Many consumers are receptive to information from surveys of other consumers—although not overwhelmingly
- Consumers trust doctors to evaluate other doctors

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Consumer Trust in Physicians' Recommendations Is an Opportunity

- Patient's will choose providers their physician recommends.
- This is the way most specialists and many PCPs are chosen now—through physician referrals
- If we want to influence consumer choice through this path, we need to—
  - Learn how physicians now judge their peers and decide on referral choices
  - Get physicians to buy into appropriate quality and efficiency criteria for measuring their peers.
  - Give physicians meaningful information on their peers—better opportunities to observe their peers—for example, through shared medical records.
- We should also take a look at the validity of surveys of physicians about their peers and how to design them to minimize bias—
  - CHECKBOOK has evidence that docs recommended by surveyed docs also rate high with patients, have superior credentials, do better on high-risk procedures (cardiac by-pass), have low rates of disciplinary actions
  - Patients might have more faith in plan and purchaser efforts to cut costs if there was also publication/recognition of doc recommendations of docs

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Surveying Consumers About Their Experience of Care with Their Physicians

- Remainder of my remarks are about our ***Project to Design a Collaborative Model to Survey Patients About Their Experience of Care With Their Physicians***
- Such surveying can help activate consumers because—
  - The consumers are the evaluators and therefore have leverage on providers
  - The consumers can provide information that can identify needed changes in the system and in individual physicians
  - What consumers say about physicians is one of the things most likely actually to influence consumer's choices of physicians in the marketplace
- CHECKBOOK/CSS launched this collaborative design project last August
- Objective is eventually to produce survey-based assessments of most physicians in U.S.

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Organizations Involved in Collaborative

- Health plans have had, and are expected to have, a lead role as contributors of samples of patients to survey, and as contributors of financing for surveys.
  - Those that contribute will have the right to use the data—in provider directories, P4P, network design, etc.
- Others who might contribute include medical groups, specialty boards, government agencies, malpractice insurers, and foundations.
- Others who will have a continuing role in planning will include employers, consumer groups, physician organizations, and researcher organizations.
- Plans that contracted for our project to design a collaborative model are Aetna, CIGNA, Humana, and United. AARP contracted for a policy paper to come out of the design process.
- Being part of the current design project does not commit to participation in pilot or rollout surveys.

Why Survey Patients About Physicians?

- Patients are *the* source of information on physician-patient communication, trust, advice on prevention/self-help, and consumer satisfaction, and are a potential source of information on care coordination.
- There is significant research showing that physician-patient communication—the physician's listening and explaining—is important to clinical outcomes.
  - Listening is essential to diagnosis.
  - Explaining is essential for compliance/adherence—for the patient to know what to do and be motivated to do it.
- Trust in the physician is important to compliance and also, if efficiency-minded physicians advise against unnecessary tests and treatments, their patients will need to believe the advice is given with the patient's best interests in mind.
- Prevention/self-help advice can matter. There is good evidence that physicians' advice against smoking affects patient behavior. What the physician says about diet, exercise, and other disease-specific prevention/self-help behaviors may also to matter.

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Why Survey Patients About Physicians? (cont'd)

- Whatever the relationship of patient survey results to outcomes, patient satisfaction is important in its own right.
  - Important that for roughly $2 trillion in health care expenditures, consumers feel some level of satisfaction.
  - Americans won't put up with a system if they find it unsatisfactory.
- In an environment where consumers are skeptical about the motivations of purchasers and plans, consumers may be more trusting of, and less resistant to, policy and practice changes that move toward better use of tests and treatments *if* the consumers know that purchasers and plans are regularly seeking patient feedback.
- There is evidence that better communication and satisfaction makes consumers less likely to sue over malpractice.
- Plans and other health care organizations can use patient survey results to—
  - Add information to provider directories and steer consumer choice of providers
  - Pay for performance
  - Design networks
  - Give recognition to top performers
  - Motivate and guide quality improvement

Why Plans and Others Should Collaborate

- A physician's rating by a patient is not much affected by which health plan the patient is a member of, so one set of survey results can serve all.
- Collaboration results in sharing of costs across plans and others and avoiding duplicative overhead.
- Collaboration makes it possible to adequate sample size per physician (by itself, a plan may not have enough of a physician's patients to do a meaningful survey).
- By collaborating, we can minimize survey frequency and the burden on respondents.
- A collaboration may insulate against possible physician resistance.
- A collaborative or many parties will be in a better position than an individual plan to get government and other support.
- If many parties collaborate, the public will get results in a consistent, fair fashion.
- Individual organizations can still distinguish themselves by how they use the survey results.

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A Dose of Reality

- Cost of survey is about $220 per physician.
- That's about $110 million to get results on 500,000 physicians.
- Main factors that affect costs—
  - How often survey is done—every three years vs every year cuts the annual cost from $110 million to $37 million
  - How many plans share in cost for a physician
  - What other organizations contribute to cost. For example—
    - Specialty boards have expressed interest in contributing because they can use survey results in Maintenance of Certification programs
    - Malpractice insurers might pay for the data for use in underwriting
    - Medicare and Medicaid might eventually contribute
  - Number of completed surveys required per physician—for example, cutting from average of 45 completes per physician to 37 completes per physician cuts cost by 20% and still will allow statistically significant distinctions among physicians
  - Whether just a subset of specialty types is included—for example, PCPs, cardiologists, gastroenterologists.

A Dose of Reality—cont'd

- More factors that affect costs--
  - What response rate is targeted (for same number of respondents—starting with a larger sample and pushing less hard will save money)—27% vs 40 % response rate will cut costs by 10% to 15%
  - Protocol options—
    - Nonprofit mail rates possibly cuts 20%
    - First wave by e-mail might save in future if—
      - Plans collect e-mail addresses
      - Spam standards and blocks can be accommodated
      - Privacy issues with shared or corporate e-mail addresses can be addressed

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What CHECKBOOK/CSS Has Done in the Planning Project

- Interviewed representatives of plans, specialty boards, physician organizations, purchasers, consumers, researchers, government, foundations, others
- Created a distinguished advisory committee from all these groups
- Drafted a description of a collaborative model for comment
- Met in person with the advisory committee to discuss the draft model and answer key questions
- Worked to shape the final protocol for the Group/Clinician CAHPS survey that soon will be approved by the NQF

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What CHECKBOOK/CSS Will Be Doing in Coming Months

- Write up description of the collaborative model based on feedback from advisory committee and others
- Seek several communities that are interested in being sites for pilot surveys for the collaborative
- Recruit health plans, specialty boards, medical groups, foundations, and others to participate in, and contribute to, the pilot projects
- Hope to launch pilot projects this spring

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Some Key Features of the Draft Model

- Use the Group/Clinician CAHPS survey questionnaires developed by AHRQ as approved by NQF.
- Use a Group/Clinician CAHPS mail survey protocol endorsed by NQF—but continue to work during NQF's approval process to ensure that the protocol is not unnecessarily costly.
- Conduct the surveys using samples of patients for each physician drawn at random by the collaborative from plans' pooled patient/member lists.
- Conduct the surveys using major health plan financing once every three years for any given physician.
- Set up a mechanism for physicians and medical groups voluntarily to arrange to pay to have comparable surveys conducted more frequently than the surveys that plans are willing to finance or in geographic areas where plans are not financing surveys. The collaborative would still independently draw patient sample from plan lists if possible.
- Set up a mechanism for physicians and medical groups voluntarily to pay to have standardized surveys done if physicians will not be included in surveys for which plans are providing financing or providing survey-able sample.

Key Features of the Draft Model—cont'd

- For surveys done with major health plan financing, divide the plan financing responsibility among plans based on factors that include number of physicians for which the plan wants data and number of plan members.
- Explore partnerships for public reporting of physician performance scores—other than in plans' provider directories (WebMD, CR, others?).
- Have the survey responses analyzed by the collaborative with appropriate case-mix adjustment and have the collaborative supply survey results to licensed recipients—scores on each question and composite, results of tests of statistical significance, and respondent-level data files (after removal of any data that might be used to identify patients).
- Give plans and other users flexibility in how they can use or report the survey results, but not to change any given physician's underlying score (for instance, by using a case-mix adjustment procedure different from that used by the collaborative). Require all to adhere to well-accepted reporting principles (for example, AQA's principles for public and provider reporting).
- Allow individual physicians an opportunity to see their results before public release.

To Move Toward Collaborative's Goal of Widespread Surveys of Patients About Physicians

- CSS/CHECKBOOK and purchaser and consumer leaders need to—
  - Try to arrange for plans that collaborate on patient surveys to be scored higher by plan evaluation tools like NBCH's eValuate, NCQA's Quality Plus, and Leapfrog's scorecards.
  - Work with Bridges to Excellence, NCQA's Medical Home effort, Medicare measurement programs, and other programs to ensure that P4P programs and network designs reward physicians who participate and score well in patient surveys.
  - Work with specialty board leadership on integrating patient survey results into Maintenance of Certification and quality improvement programs.
  - Work with malpractice insurers and their associations to assess the usefulness of a physician's patient survey results as an underwriting element.
  - Work with AQA leadership and CMS/AHRQ to move the collaborative patient survey approach forward on the agenda of BQIPs and Value Exchange pilots—and possibly to make collaborative patient surveys the initial organizing catalyst for coalitions in some communities.
  - Recruit community coalitions, including some involved in RWJ projects, to move forward the collaborative patient survey approach in their communities.

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