

Lessons Learned in Public Reporting: Crossing the Cost and Efficiency Frontier

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This brief provides lessons from communities involved in *Aligning Forces for Quality*, the Robert Wood Johnson Foundation's signature effort to lift the quality of care in America. Public reporting is a cornerstone of the Aligning Forces for Quality program. This brief focuses on the evolving process of public reporting and the challenges associated with adding cost and efficiency measures to reports of quality performance data. A subsequent brief, "Lessons in Performance Measurement: A Community Approach to Reducing Readmissions," will look at readmission rates, one of the most commonly reported cost and efficiency measures.

This brief was prepared by The Center for Health Care Quality within the Department of Health Policy at The George Washington University School of Public Health and Health Services, which serves as the national program office for *Aligning Forces for Quality*.

The core of the Aligning Forces for Quality (AF4Q) initiative is the creation and dissemination of information that can be used to spur improvements for patient care, community action and health system change.¹

In AF4Q communities, "Alliances" of health care providers, payers, plans and patients are answering the call for health care quality information by producing openly accessible public reports of ambulatory and hospital performance. These community reports focus primarily on conditions such as diabetes, heart disease, respiratory diseases and back pain that represent enormous health and cost burdens to communities. As with other sources of publicly reported information, these reports serve as catalysts for improvements and road maps for targeting interventions to raise the quality of health and health care for all residents. (For more information on the AF4Q public reports, see: <http://www.rwjf.org/qualityequality/af4q/focusareas/reporting.jsp>.)

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to improve the quality of health care in 16 communities across the nation, eliminate racial and ethnic disparities in care, and develop models for national reform.

The initiative advances interrelated reforms that experts believe are essential to improving health care quality:

- Performance measurement and public reporting
- Consumer engagement
- Quality improvement
- Payment reform

For more information about AF4Q, please visit <http://www.forces4quality.org>.

Prior briefs described lessons learned from early work developing public reports, including the importance of gaining physician support for these efforts and the need to carefully choose the performance measures to be reported. Those briefs can be accessed at [http://www.rwjf.org/qualityequality/search.jsp?pubtitle=Lessons Learned in Public Reporting](http://www.rwjf.org/qualityequality/search.jsp?pubtitle=Lessons+Learned+in+Public+Reporting).

Recommendations for Successful Community Efforts in Public Reporting:

- Include all stakeholders in the development of the report
- Work closely with physicians or other stakeholders who have “skin in the game”
- Target conditions for public reporting that are relevant to the community’s residents and amenable to quality improvement
- Move cautiously at first – initial reports and data must be accurate, credible and useful

This issue brief describes the activities of the AF4Q Alliances in gathering information about the cost and efficiency of health care and showcases the work of three Alliances working to disseminate this information. The information for this brief was reported by the Center for Health Care Quality within the Department of Health Policy at The George Washington University School of Public Health and Health Services. Staff conducted telephone interviews in February 2011 with select AF4Q project directors to learn about their experiences in this new arena.

Putting Cost and Efficiency Measures on the Table

The Alliances are moving slowly and deliberately toward incorporating measures of cost and efficiency in their publicly accessible reports. Cost and efficiency measures describe the cost to create or deliver specific aspects of care.^{3,4} These indicators address the relationship between health care system inputs and outputs to depict overall efficiency.

A majority of the Alliances are starting with a focus on measurement around readmission rates. That is a pragmatic decision given that the Patient Protection and Affordable Care Act authorized the Centers for Medicare and Medicaid Services to penalize hospitals with higher-than-expected readmission rates beginning in fiscal year 2013. The initial focus is on readmissions among patients with heart failure, acute myocardial infarction and pneumonia, with the penalties for exceeding targets growing from 1 percent of total inpatient charges in FY 2013 to 3 percent in FY 2015. The number of conditions subject to penalties will expand beyond 2015 to include chronic obstructive pulmonary disease, coronary artery bypass grafts, percutaneous coronary interventions and some vascular surgery procedures. The penalties are substantial as they will be based on a hospital’s total Medicare payments for all discharges, not just the named conditions.

Nearly half of the Alliances are also focusing on measurement related to avoidable or non-urgent emergency department visits, while others selected measurement involving unnecessary or preventable admissions. Data for these and other cost and efficiency of care measures come from a variety of sources, including health plans, state hospital discharge data, state Medicaid programs, Medicare reports and state health information exchanges.

Alliance Selections of Cost and Efficiency Measurement Focus Areas:

- Readmission rates
- Avoidable/non-urgent emergency department visits
- Unnecessary/preventable admissions
- Total cost of care
- Average length of stay
- Avoidable complication costs
- High-tech imaging
- Care coordination
- Generic drug fills
- Appropriate antibiotic prescribing
- Inappropriate imaging for low back pain

The decision to report information about the cost or efficiency of care is complicated. One reason is that cost and efficiency measurement is not as well developed as other quality measurement practices, and the data is not always intuitive and straightforward. To demonstrate the difference, consider commonplace measures of diabetes. Several Alliances report quality-related information about diabetes care using nationally recognized performance measures. These measures describe processes and outcomes associated with high-quality care and, with some context and explanation, are relatively easy for patients and consumers to understand. Cost and

efficiency measures, on the other hand, may be more difficult to interpret. For example, a hospital's lower readmission rate could indicate higher quality care from the hospital, better care management elsewhere in the community, or some combination of the two. While comparing charges, costs or other measures of resource use across health systems or providers may differentiate providers by their efficiency, the comparison must also control for differences in quality, practice styles, or other variables to present useful and meaningful information.

Even with truly comparative cost information, it is not clear whether consumers will seek out lower cost health care or instead associate lower cost with lower quality care, and vice versa. Information about prices, costs and resource use is inherently controversial. Early pioneers in cost and efficiency performance measurement are working closely with payers and providers to make certain that the information developed can ultimately be used to enhance value for health care consumers.

The overall experience of early adopters reporting cost and efficiency measures demonstrates that this is an extremely important but challenging proposition. Several lessons emerge from their experiences:

- **Engage your community in a conversation about cost and value in health care.** The course may not be easy, but the discussion is critical to overall health care quality.
- **Plan ample time for getting the technical piece right.** The preparation time will allow for open and helpful dialogue that will inform reporting of cost and efficiency measures.
- **Move ahead with currently available metrics while the field refines cost and efficiency measures.** These indicators are bringing communities together in a conversation about cost that will lay the groundwork for evaluating more sophisticated information in the future.

- **Get it right with health professionals before going to consumers.** Don't lose sight that consumer information is the ultimate goal, but it will likely take several iterations to get there.

Early Pioneers – Puget Sound Progresses on Resource Use

The Puget Sound Health Alliance (<http://www.pugetsoundhealthalliance.org/index.html>) issued its first publicly available community report in 2008 with subsequent periodic updates. Each successive report has included either additional insured populations or performance measures. For example, the 2010 report provided information on Medicaid beneficiaries, allowing comparisons across privately and publicly insured populations on performance measures related to asthma, depression, diabetes and heart disease.

Puget Sound does not yet measure or report on the cost of care but has started discussions about measuring the cost of care with the nearly 20 organizations that supply data for its quality reports. Movement in this area is slow and deliberate, with some (primarily purchasers) very interested in engaging the topic and others (primarily providers) generally opposed. Some of the resistance stems from concerns that public information about higher case rates will cause the competitive provider market to drive costs up rather than down. The Puget Sound Health Alliance is committed to working with its data suppliers to encourage them to voluntarily report, but recognizes that ultimately a voluntary approach may not work. Part of the challenge rests with the sheer complexity of the topic.

“We’re working with very sophisticated people and even they are having trouble understanding some of this. Our audience is the providers and purchasers. These are the people who can understand this and who can change the way care is delivered,” said Susie Dade, director of performance improvement for the Puget Sound Health Alliance and director of its Aligning Forces for Quality project.

Given the challenges surrounding cost measurement, Puget Sound has worked hard to separately address resource use – or the “content of care” - before moving further on cost. Puget Sound’s efforts in resource use have started in two areas. First, they are looking at geographic variation in “preference-sensitive care” – how rates of surgical treatment selection vary across the Puget Sound market. Examples include hysterectomies, joint replacement and select non-emergent cardiac interventions like catheterization. Second, Puget Sound is looking specifically at resource use – measured in Relative Value Units (RVUs) - across different delivery systems for the same type of care episode, including hospitalization and professional care during the inpatient stay. An example here is surgery for dorsal lumbar fusion (a common surgery to treat low back pain) or bariatric surgery. This analysis allows them to drill down to better understand the drivers of resource use including length of stay (LOS) in the hospital, physician time and use of ancillaries such as radiology and lab.

Puget Sound is working with its data aggregator to identify high-volume procedures among the commercially insured population that are performed by many providers in the community. They started by looking at 20 types of procedures with at least 100 cases per delivery system. Beyond back surgery and bariatric surgery, these procedures include such things as

hospitalization for C-section and vaginal delivery, prostatectomy, chest pain, cardiac catheterization and laparoscopic cholecystectomy. In many cases, they are seeing statistically significant variation in resource use among different delivery systems.

“At this point, the results raise more questions than they answer, but that’s not a bad thing,” says Dade. Identifying higher and lower resource users creates an opportunity to highlight different practices. The results open the door for a much more focused dialogue between providers of care and purchasers of care about *why* resource use varies, whether or not delivery systems can clearly demonstrate significantly different outcomes associated with higher (or lower) resource use, and the impact on cost of care.

Puget Sound’s hard work in resource use is paying off. The Alliance has been working for more than a year with a resource use workgroup that includes purchasers, plans and providers. In April, they began the process of delivering blinded data on resource use to hospitals in their market (each hospital was told who they were in the analysis); the Alliance’s purchasers also saw all of the blinded data. At the end of May, the hospitals and purchasers will come together in a joint meeting to discuss appropriate uses of the data and to get their feedback about how they would like the data to be disseminated within the market. Ultimately, it is the Alliance’s Board of Directors who will make the final decisions. This is very complex information that is not easily digested by a lay audience, so it’s unclear at this point how much of or how fast this information will be publicly reported.

“Our resource use analysis is a bit like peeling an onion. There are many layers and it’s very important for our stakeholders to take it a step at a time to understand and make sure that the conclusions that are being drawn are directionally correct. We want to keep our community stakeholders engaged throughout the process. It’s not a gotcha opportunity. It’s about a partnership and facilitating a conversation. It’s about working to improve value together, as a community,” Dade said.

Early Pioneers – South Central Pennsylvania Reports Inpatient Cost and Efficiency Indicators

The South Central Pennsylvania AF4Q Alliance (<http://www.aligning4healthpa.org/>), known as Aligning Forces for Quality – South Central PA (AF4Q-SCPA), issued its first public report in 2009. AF4Q-SCPA public reports include quality measures related to both hospital and ambulatory care with a particular focus on diabetes and coronary heart disease. In line with AF4Q’s requirement to identify cost and efficiency measures for public reporting, the Alliance added new metrics in three areas: average LOS, overall readmission rates and average total charges for patients with diabetes related conditions, heart attack, heart failure, pneumonia, and stroke. The information for the report comes from Pennsylvania Health Care Quality Alliance, which aggregates inpatient quality data from a variety of state and national sources. The cost and efficiency measures are generated from state hospital discharge data collected by the Pennsylvania Health Cost Containment Council. The data is risk-adjusted and includes only statistically significant indicators.

AF4Q-SCPA's first report featuring cost and efficiency measures was released in November 2010. The illustration below features a screenshot from the Alliance's most recent online report from early 2011. The screenshot shows average LOS for patients with diabetes-related conditions at the four hospitals in Adams and York counties. The report includes a clear explanation of the importance of the indicator and links to additional clinical information for consumers. It also provides guidance about preferred rates for average LOS (with outliers removed), and presents the state average as a benchmark for comparison.



Although other Alliances have experienced pushback from their communities around publicly reporting LOS data due to varying interpretations of this information, most stakeholders in this community embraced the idea of reporting LOS from the beginning.

“Here, the employers and payers see longer LOS as overall more expensive, not attractive to patients and putting the patients at risk of hospital-acquired infections or complications,” said Chris Amy, project director of AF4Q-SCPA. “The bottom line is longer stays equate to higher costs. We don’t want to push people out of the hospital, but we don’t want people to be in the hospital too long.”

Providers, payers and patients can each understand why LOS is a valuable measure to them. Reporting average LOS allows community members to have a conversation about where things stand, why there might be variation and how providers can improve care.

To complement the LOS indicators, the South Central Pennsylvania Alliance also chose to report readmission rates as part of its focus on efficiency. AF4Q-SCPA's efforts to report readmission rates coincided with an overall effort in the community to reduce readmissions ahead of the impending federal readmissions penalties. The public reporting focus on readmissions served as a catalyst for collaboration between hospital and ambulatory care providers to better manage discharges and follow-up care to prevent readmissions. "Our inpatient quality improvement folks have been willing to work with our ambulatory care providers and extended care facilities to keep people out of the hospital, or treat conditions before they get to the hospital in the first place," Amy said.

Since these data have been made public, local providers have requested even more current data for their own use in quality improvement efforts. Recognizing that the data reported can be as much as 12-18 months old, the Alliance worked with local hospitals to create a system to provide ambulatory care and extended care providers with much more timely data on preventable admissions to make it more feasible for providers to prevent further readmissions. The Alliance works closely with ambulatory and extended care providers to ensure they receive information from the hospital within 24 hours of discharge and schedule follow-up appointments with patients within five days of discharge.

Readmission data are publicly reported in the same fashion as LOS for the four hospitals in the area. A total of 17 separate readmission measures are presented related to five conditions: diabetes, heart attack, heart failure, pneumonia and stroke. Depending on the condition, rates are presented for 30-day readmission rates (as is the case in a measure for 30-day all cause readmission rate for heart attack patients), overall readmission rates (for example, the measure for overall readmission rate for patients with diabetes-related conditions), or rates for complicating factors (such as the measure for readmission rate for aspiration pneumonia patients with complications or infections). Website users can view each indicator individually by hospital or compare the four hospitals in the area with a state benchmark. Guidance for interpreting the information is presented in an easy-to-read format and links to additional information are provided.

AF4Q-SCPA has also moved forward with reporting average total charge data for particular conditions. Similar to LOS and readmissions, average charge data may be viewed individually to see trends over previous years or compared with other area hospitals and the state benchmark. Amy cautions that charge data may not be as meaningful for patients since it represents the "sticker price," which is not the actual amount billed to or paid by insurance plans.



The reports have clearly had a significant impact in the community, although the data are being watched much more closely by hospitals than consumers at this point. Using focus groups and surveys, the Alliance is actively seeking consumer reactions to the report to understand how it can make the reports more consumer-friendly. Creating a more streamlined report that scales back the number of indicators and includes only those that are most meaningful for consumers is under consideration.

Early Pioneers – Memphis Begins Community Conversation about Cost

The Memphis Alliance (<http://www.healthymemphis.org/>), known as Healthy Memphis Common Table, has taken yet another approach to reporting cost and efficiency data based on its own community context. Healthy Memphis Common Table began its work in cost and efficiency with a series of community conversations bringing cost to the forefront for consumers, providers and payers alike. The Alliance hosted community meetings presenting health care cost trends for the county and facilitating discussions with national experts in cost and efficiency. According to Reneé Frazier, CEO of Healthy Memphis Common Table and director of the Aligning Forces for Quality project, seeing the numbers presented at the county level compared to national averages provided an ‘Aha!’ moment for many as they began to grasp the critical need for work in this area. This community buy-in helped to set the stage for the Alliance’s work in this area, including introducing cost and efficiency measures in its public reports.

Healthy Memphis Common Table released its first community report in early 2010, focusing on hospital quality indicators. The Alliance decided to begin its reporting efforts using data from Hospital Compare to ensure credibility with providers before broadening its reports to include additional data. The Alliance introduced several cost and efficiency measures in its most recent report, including 30-day readmission rates for heart attack and heart failure, and median Medicare payments for specific medical procedures.

The Memphis Alliance is highlighting this publicly available data on a new website (<http://www.healthcarequalitymatters.org>) to begin an ongoing community conversation about health care quality and costs.

“The Hospital Compare data has enabled us to have conversations with the hospitals about where their costs are coming from,” said Frazier. “It’s helped tremendously to open conversations. If these cost and efficiency activities are not about providing better care, and if the plans aren’t going to be realigning incentives, it’s going to be a bit of a challenge.”

Memphis, like AF4Q-SCPA, reports 30-day readmission rates related to heart attack, heart failure and pneumonia. Rates are presented by hospital for the six hospitals in the area. The report highlights how the information should be interpreted and indicates whether local hospitals’ rates compare favorably with the national rate.

Memphis is actively engaged in discussions about how to present cost data in a way that is meaningful for consumers and providers. The Alliance’s first report of cost data provides Medicare payment rates by hospital for nearly 70 medical procedures and allows comparisons.

As the Memphis Alliance looks ahead in anticipation of reporting additional data, it is setting its sights on new indicators, such as potentially avoidable emergency department visits by cost, payer, and disease or condition. The Alliance hopes to inspire a strategic community approach to preventing ambulatory care sensitive and preventable admissions and emergency department visits, where health plans, primary care providers and hospitals are all working together to improve care management.

Crossing the Frontier

Taking a collaborative approach, the Aligning Forces for Quality communities are working closely with payers, purchasers, providers and patients to report on cost and efficiency data from local hospitals and physicians. To be successful, Alliances should start work early, engage their communities, begin with easily accessible metrics, and release the data to health care professionals first. Successfully reporting this information can begin an important conversation about how we pay for the care we receive, spurring improvement in our care delivery system.

¹ For more information about Aligning Forces for Quality, see www.rwjf.org/qualityequality/af4q/.

² A separate issue brief, “Lessons in Public Reporting: Physician Buy-In is Key to Success,” describes the importance of involving physicians in each of these important decisions from the earliest stages of development. This report can be accessed at www.forcesforquality.org.

³ For more information about cost and efficiency measures, see: Romano PS, Hussey P, Ritley D. “Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives.” Rockville, MD: Agency for Healthcare Research and Quality, May 2010. AHRQ Publication No. 09(10)-0073. <http://www.ahrq.gov/qual/perfmeasguide/>.

⁴ McGlynn, EA. “Identifying, Categorizing, and Evaluating Health Care Efficiency Measures.” Final Report (prepared by the Southern California Evidence-based Practice Center—RAND Corporation, under Contract No. 282-00-0005-21). Rockville, MD: Agency for Healthcare Research and Quality, April 2008. AHRQ Publication No. 08-0030. <http://www.ahrq.gov/qual/efficiency/efficiency.pdf>.

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