Another step in improving quality of care in Washington state

# Moving the Ball Down the Field

Quip, the Washington State Quality Improvement Program

A wrap-up report from the Washington State Medical - Education and Research Foundation (WSM-ERF), prepared by Jean Colley

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WSMERF | Quip
Physician led Quality Improvement Program

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## Why Quip?

Since the Institute of Medicine published "To Err is Human" in 1999, the health care industry has focused on efforts to improve health care quality and decrease medical errors. The report created public awareness of quality deficiencies like no report before it, and prompted widespread calls for change.

In 2005, the Washington State Medical - Education and Research Foundation (WSM-ERF) became interested in the concept of offering primary care physicians in Washington state patient-specific data to improve the quality of care in their office-based practices.

The WSM-ERF, founded by the Washington State Medical Association (WSMA), sponsors projects that afford an opportunity for the medical profession to exercise leadership to improve the quality and value of health care for Washington residents.

The WSM-ERF applied for and received a two-year $1 million grant from the Physicians Foundation for Health Systems Excellence to test the concept. Named the Washington State Quality Improvement Program ("Quip"), the project was begun in 2006.

Quip hoped to persuade insurers and other organizations with differing agendas and views to cooperate in expanding the flow of useful information to physicians to enhance the quality of care for patients. Physicians and other practitioners had found many of the insurers' reports on care to be of limited use. Dissimilar standards and guidelines made comparisons across an entire panel of patients difficult. In some instances, the reports involved only a few patients—again, making the information of limited use. Quip was premised on the belief that quality will not significantly improve until all physicians and other providers are given *all* the available information—including patients' names—in a standard format through a single source.

Quip joined a growing list of quality improvement projects in Washington state, most of them in the isolated "silos" of medical practices, hospitals and insurance companies. Quip was the only one that intended to serve the entire state rather than an organization or a region.

Groups of five or fewer physicians provide primary care to hundreds of thousands of Washingtonians. The vast majority of these practices have no comprehensive way to systematically evaluate the care of their own patients against best practices. Quip was meant to supply such an evaluation on a regular basis—in essence, take information out of silos and make it available to the practices that need it.

The Quip program clearly demonstrated that physicians want patient-specific data. Some 600 clinicians signed up to receive quarterly Quip reports. The two-year grant to test the concept was a success, but it did not provide funding to take the program "live." Funds to pay for regular statewide distribution of the reports could not be secured, and in June 2008 the WSM-ERF announced that the program would not be put into full operation.

This report describes the objectives of Quip, the environment in which it was launched, its successes and setbacks and the next steps in Washington state quality improvement.

## Quip's objectives

In the short-term, the primary objective of Quip was to compile and distribute to Washington state primary care physicians reports on their performance compared to best practices on (1) services to chronically ill patients and (2) recommended health screenings.

The reports were to contain information on specific patients so that physicians in pediatrics, family practice, internal medicine and obstetrics/gynecology could improve the care of individual patients. The reports were meant to help all primary care physicians, but especially those without the data aggregation tools to track systematically the care of patients through time. With fewer than 20% of medical practices using electronic medical records, the Quip reports had the potential to fill a major need. To create those reports, Quip intended to ask the major insurers in Washington state to provide claims data.

The long-term objective of Quip was to test the hypothesis that quality improves when primary care physicians receive regular, actionable and comprehensive feedback on their patients who need chronic and preventive services. Quip also offered a valuable chance to find out if health insurers' claims data reflect the care being given to patients in medical practices.

## External environment in which Quip was launched

Although no Washington state organization provided physicians across the state with patient-identified information for quality improvement when Quip was begun, events conspired to blunt its long-term prospects. Quip leaders knew they needed to gain the cooperation of other organizations, but that proved more problematic than anticipated.

In December 2005, the Puget Sound Health Alliance announced it intended to improve health care quality and reduce the rate of cost growth in King, Kitsap, Pierce, Snohomish and Thurston counties. The Alliance, a coalition of business, government, insurers and providers, said it would seek claims data from insurers and produce reports on the quality of care in medical practices in those counties—distributed first to medical practices and then eventually to the public.

The WSMA had envisioned a partnership with the Alliance, but after Quip was funded, the Alliance became less receptive. Whether because the Alliance felt that

Quip competed with its own agenda, or for other reasons, the two organizations failed to create a workable collaboration.

The lack of a partnership with the Alliance spilled over to some of the insurers—making them less interested in sharing their data with Quip.

Then, in June 2006, Regence BlueShield, using claims data, rolled out a new version of Selections, its managed care plan for Boeing employees. It was touted as a "high-performance" network of physicians of especially good quality and efficiency—and excluded about 500 physicians who were in the previous network. Patients and physicians quickly and publicly complained that the data used to create the network were seriously flawed. The Society of Professional Engineering Employees in Aerospace (SPEEA) complained that it understood the data were to be used to help physicians improve quality—not to prevent physicians from caring for Boeing employees.

The WSMA sued Regence, charging that the insurer's methodology to evaluate physicians was flawed. The WSMA and Regence reached a settlement and Regence abandoned the network. (It still offers Selections.) The lawsuit may have been a factor in Regence's decision to provide no data to Quip.

## Successes and setbacks

After numerous fruitless meetings with Alliance representatives during the first months of 2006, Quip decided to proceed alone. The first step was securing the services of a data vendor, which was completed in July 2006.

A full-time project manager was recruited to oversee the day-to-day operations of Quip and serve as the principal contact person.

The work of selecting standards for best clinical practice was started. Quip convened panels of physician-experts who volunteered their expertise to provide guidance and feedback on the Health Employer Data and Information Set (HEDIS) measures deemed relevant and useful, especially for office-based medical practices. As a result of the work of the panels, Quip adopted 22 quality and preventive care measures as guidelines for use statewide. They covered diabetes, asthma, heart failure, coronary artery disease and depression, and screenings for breast, cervical and colorectal cancer and certain immunizations.

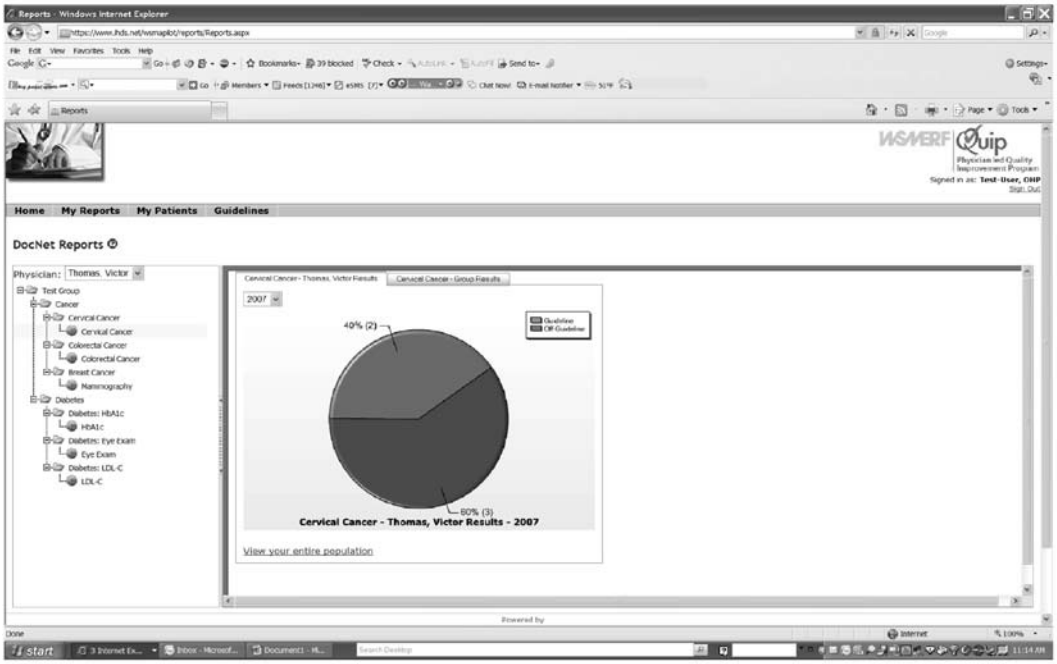
Quip worked with an information management company to create a conceptual model to (1) "assign" specific patients to specific physicians who are primarily responsible for their care, (2) identify those patients to the physician, and (3) compare their care to the guidelines. This methodology, based on the concept of a "medical home," takes into account the fact that many patients receive care from more than one physician. It assigns patients to the primary care physician who had the largest number of claims for those patients in the preceding two years. Patients, whether in health maintenance organizations, preferred provider organizations or other arrangements, were to be included.

At the same time, Quip was introducing itself to the health insurers and asking for their cooperation in sharing their claims data. Because the concept of sharing data with outsiders for a project like Quip was new, the insurers were cautious in stepping forward. Originally, Quip envisioned entering into "business associate agreements" with the insurers. Premera, however, raised concerns about HIPAA. As a result, Quip decided to enter into business associate agreements with individual physicians in order to produce their reports. Physicians (or their delegated employee) needed to register through OneHealthPort, a secure HIPAA-compliant web portal that most practices and insurers were already using for administrative purposes. Quip would collect and aggregate the data from the insurers and make the reports available through OneHealthPort to primary care physicians who had registered. Practices needed only to have Internet access to view and print their reports.

Teams of attorneys, compliance officers, operations and information technology staff from the insurers met with Quip staff from spring to fall of 2007 to negotiate the data sharing agreement and to work out the details of the data transfer and data validation. The job proceeded slowly because insurers' IT staff had to fit the Quip data transfer and validation into their existing work flows.

Between March and May 2008, IMI, Quip's data vendor, worked with the insurers on the complex task of receiving their claims data and ensuring that what was transferred mirrored what had been sent.

Quip ultimately combined patients' claims and pharmacy data from the participating insurers to generate a customized quarterly report complete with a registry of patients. Each primary care physician in the state who had signed up through OneHealthPort was to receive a report.




A panel of physician experts selected guidelines for best clinical practice for Quip, using the Health Employer Data and Information Set (HEDIS) measures deemed relevant and useful for office-based medical practices. The Quip reports to primary care physicians contained graphs showing the percentages of patients receiving care—or not—according to the guideline for best practice for each of 22 measures. This graph covers cervical cancer screening. The graph contains links to lists of patients by name and whether they are "on guideline" or "off-guideline."

Bringing the insurers on board was much slower than originally envisioned. Nonetheless, Quip obtained full data sets from Premera for its insured business, Group Health Cooperative, the Medicaid program and Molina. Unfortunately, Regence BlueShield declined to participate.

Quip extensively publicized the coming availability of the reports. Arthur Sprenkle, MD, medical director of Quip, conducted continuing medical education classes for physicians statewide, outlining the details of Quip and describing the value of patient-identified, actionable reports.

Some 600 physicians signed up, testimony to the power of the concept and the need for patient-specific data. However, more physicians from Western than Eastern Washington signed up for the Quip reports. Without Regence, which has greater market share in Western Washington, the data for west-side physicians were significantly less than needed to create comprehensive and actionable reports.

Although the Western Washington data were not plentiful, Quip determined that it would still be useful to test the data it had obtained. In June 2008, Edmonds Family Medicine, Sound Women's Care, and Birth and Family Clinic, all in Edmonds, agreed to beta test the reports. They would compare their own records with Quip's reports to determine where they agreed and where they differed.

In addition, beta testing would evaluate the larger question of whether claims data are a reasonable surrogate for chart review.

The beta testing showed the validity of the conceptual model of a medical home that "assigns" specific patients to specific physicians who are primarily responsible for their care. At the beginning of Quip, many observers were skeptical that such a methodology could actually work, given the fact that many patients see more than one physician. In fact about 88% of the time, the physician in the beta-testing clinic agreed with the assignment.

The Quip reports and the beta-testing clinics' records were generally in accord on the use of best practices, but that accord did not reveal whether the patient had received quality care from practitioners outside the beta-testing clinics. The Birth and Family Clinic reported that most of their diabetic and cardiac patients visit specialists for those disorders. The clinic may not know what the specialists are doing either in the way of preventive or chronic care. That fragmentation challenges the validity of the notion of a medical home, but it could be addressed by adding specialists to those physicians who receive Quip reports on patients with chronic conditions.

The beta-testing also revealed where refinements in the Quip methodology were needed. For instance, the definition of primary care practitioners should be expanded to include advanced registered nurse practitioners.

Overall, the patient-specific information proved to be very useful to the clinics. They could see where they were doing well on chronic care and preventive screenings, and

where they needed to improve. Claims data with patient names attached turned out to be a reasonable substitute for chart review. (The reports would have provided a much fuller picture to the practices had Regence agreed to supply its data.)

## Value of the concept

In *Crossing the Quality Chasm*, the Institute of Medicine's follow-up report to *Err is Human*, the authors recommend that patients receive care based on the best available scientific knowledge and that care not vary illogically from clinician to clinician. Quip attempted to respond to that recommendation. No organization before Quip had offered primary care physicians across the state of Washington data on all the patients in their care—not just their Premera patients or their Molina patients or their Regence patients—compared to best practices.

The 600 physicians who stepped forward and signed up for Quip proved that the concept is viable. Physicians need and want useful and comprehensive clinical data and feedback to improve their practices. Guidelines, disease management programs and bonuses for "effective" care are all being used to improve quality, but those tools do not facilitate efficient evaluations across entire panels of patients.

## What's next?

It has been nine years since the Institute of Medicine published *To Err is Human*. Quality improvement is no one-year or even one-decade project. In that context, Quip "moved the ball down the field" by demonstrating that when offered, physicians will elect to receive data to improve their care to patients. Quip asked whether physicians want patient-identified data. The answer was "yes," and Quip proved it could provide that data.

But, no single quality improvement project is likely to transform the delivery of health care. Instead, transformation will occur piece by piece—and that is happening already.

Patients' confidence in the quality of the medical care they receive is crucially important. The WSMA recognizes that changing the delivery of health care to meet the rising expectations of patients is a complicated endeavor and that collaborating with organizations with sometimes competing agendas is a difficult task.

The WSMA is committed to the long term. It will leverage the successful test of concept embodied in Quip to deliver the message to policymakers that patient-identified information is what individual physicians sorely need to improve the quality of care of every single patient. Without data showing the care provided to individual patients by individual physicians, efforts at quality improvement will fall short.

However, data from insurers is only a first step. The WSMA will also stress to policymakers that to improve clinical practice, investments must be made in technology, including electronic medical records.

The association will leverage the valuable technical expertise gained through Quip as it continues to exercise leadership in quality improvement efforts. It will promote and support innovative ideas and programs that help physicians offer better care to patients.

The WSMA's primary priority is to make Washington a better place to practice medicine and to receive care. Quip has been a successful expression of that priority.

## Thank you

Thank you to Premera, Group Health Cooperative, the Medicaid program and Molina for making the commitment to Quip in both data and resources. Finally, thank you to the beta-testing clinics and to all the other clinics and individual physicians who took the time to register for Quip reports and in so doing, affirmed the value of the concept.

## WSM-ERF