Better public data needed to help patients compare and choose physicians

In the fading hours of 2010, Medicare launched Physician Compare, a website required by the health reform law. The initial site (medicare.gov/find-a-doctor) offers limited information for now and isn’t user-friendly. Even so, the move helps kick-start two core elements of health reform: giving consumers more information and re-inventing the doctor-patient relationship.

If all goes well, consumers will soon be able to routinely consult detailed information on the Internet about doctors before choosing one. They’ll glance at the basics—where the doctor went to school, office location, board certification, her research and who funded it. They’ll then check the ratings by hundreds (and eventually thousands) of a doctor’s patients. Finally, consumers will compare physicians’ scores on a "dashboard" of 20 or so clinical and outcomes measures.

That’s the vision that emerges from the three pages of the Patient Protection and Affordable Care Act that authorize Physician Compare. But it’s also the vision embodied in other sections of the law, many initiatives now under way, and it’s certainly the vision harbored in the hearts of healthcare leaders, payers and consumer activists. Namely, collect accurate data; give doctors reliable feedback about their performance; reward those who perform well; sensitize consumers to variations in the quality of care; and let consumers choose on the basis of accurate, easy-to-understand comparative information.

This is a vision, however, that gives physicians heartburn, almost as much as the managed-care wars of the 1990s. They bristle at the increased scrutiny and contentious debate and even litigation that has escalated. After complaints from doctors’ groups, in 2008, New York’s then-attorney general, Andrew Cuomo, now the state’s governor, pressed Cigna HealthCare to stop “tiering” doctors based on financial metrics alone. Cigna agreed and other insurers in New York, and then nationwide, agreed to stop using financial measures alone to rate or tier doctors.

Since then, however, state medical societies have sued, or threatened to, in Massachusetts, California, Connecticut and Texas—alleging physician quality measurement initiatives were based on inaccurate or misleading data. The American Medical Association, joined by 47 state medical societies, sent an open letter in July to the health insurance industry alleging widespread “unscientific methodologies and calculations” in physician ratings. In January, the Minnesota Medical Association asked the state’s second largest health plan, Medica, to delay the rollout of a rating of 9,400 doctors, saying the initiative was unfair to doctors and prone to errors.

Physicians’ groups last year also pressed the federal government hard to scale back the initial phase of the Medicare electronic health record adoption program. The tension created by these push-backs stalled progress but didn’t stop it. The EHR adoption program launched Jan. 1, and several thousand doctors have already signed up. Many insurers and employer groups are profiling doctors. Consumers Union, the publisher of Consumer Reports, joined forces with the Society of Thoracic Surgeons last year to post ratings of 221 cardiac surgery programs nationwide. And even the AMA-led Physician Consortium for Performance Improvement has generated dozens of quality measures that are in wide use.

With the federal government now poised to gather and publish physician-level data, here are some steps needed to move ahead:

- Implement measures that matter to consumers. Patients need information and data on doctors that is understandable and actionable. The National Quality Forum, the multi-stakeholder entity that endorses measures, must move faster to approve new ones that matter to people, not just healthcare experts.
- Standardize measures and collection methods. Today, it’s possible for a physician to be rated poorly by one insurer and highly by another. That’s frustrating for everyone. There’s an urgent need to standardize and harmonize measures and collection so physicians are not flummoxed by a dozen or more measurement platforms. The trick is to harmonize while preserving flexibility so measures and collection can evolve and improve. Innovation must be promoted.
- Aggregate data across multiple payers. Data is statistically iffy, and even meaningless, unless there is enough of it. Aggregation of health outcomes data across multiple payers and insurers, private and public, simply must occur to achieve the numbers required to permit robust assessments of quality and performance at the individual physician level.
- Pull data from EHRs as soon as possible. One in four doctors is now using a basic EHR system, and 1 in 10 has a “fully functional” system. Many of the latter group are affiliated with HMOs and integrated systems. In 2011, all such health plans and systems should test the extraction of data for full public reporting.

As for Physician Compare, the initial site needs an overhaul. It should in 2011 become a vehicle for public education about physician quality, just as its sister site, healthcare.gov, helps people navigate the world of private and public health insurance.

There’s no stopping the debate over the health reform law. But there should be broad agreement that consumers deserve more and better information on the providers in whose hands they put their lives. «

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