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Healthcare Transparency—Focus on Price and Clinical Performance Information

American College of Physicians

A Policy Paper

2010

ACP American College of Physicians℠
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Healthcare Transparency – Focus on Price and Clinical Performance Information

Summary of Position Paper Approved by ACP Board of Regents, September 2010

What is Healthcare Transparency?

The Institute of Medicine (IOM) defines healthcare transparency as making available to the public, in a reliable, and understandable manner, information on the health care system's quality, efficiency and consumer experience with care, which includes price and quality data, so as to influence the behavior of patients, providers, payers, and others to achieve better outcomes (quality and cost of care).

Price transparency includes:

- physicians, hospitals and other providers publicizing their usual charges for particular health care services, which may vary depending on their contracts and relationships with various payers;
- insurers making available to their subscribers the rates that they have negotiated with physicians and hospitals; and
- government agencies publicly reporting the average prices for common health care services.

Performance transparency broadly refers to making available to the public information related to clinical quality, resource use, and experience of care with individual physicians, hospitals and other providers. Other examples of healthcare performance information include the efficiency of health plans in administrating submitted claims or the percentage of the premium dollars collected that health plans spend for medical services compared to administrative costs and profit (medical loss ratio), or the effect of a particular procedure or product compared to an alternative (comparative effectiveness information), or the methodologies used by payers in making coverage and payment decisions.

Why is Healthcare Transparency Important to Healthcare Professionals and Patients?

Transparent healthcare information is useful for a wide range of stakeholders including patients/consumers, employers/purchasers, health plans, health care professionals, and policy makers. Research has found that transparency can help a patient and their families make informed choices when selecting a health plan, hospital, clinical practice, or choosing among alternative treatments, although there are questions about how well and how often patients make use of such information and how best to present such information to the public. In addition, increased healthcare transparency can allow for increased trust in the patient-physician relationship and health care systems. Transparency can also improve quality, safety and efficiency throughout the healthcare system due to competition and/or the availability of clinical benchmarks.

Recommendations from the Paper

ACP recommends the following:

Price Transparency:

- Any methodology used to publicly report price should be transparent, and contain adequate protections to ensure the reporting of reliable and valid price information.
- Price information provided to patients/consumers should be readily available, presented in a manner that is easily understood and reflective of its limitations.
- Formal governmental or private sector requirements for price transparency should minimize the administrative burden on the participating physicians or other healthcare professionals.
- Price should never be used as the sole criterion for choosing a physician or any other healthcare professional. Price should only be considered along with the explicit consideration of the quality of services delivered and/or the effectiveness of the intervention. The price charged for a specific procedure or service may also not be indicative of the total cost of care, how much the insurance company will pay, or the patient's out-of-pocket costs.

Performance Transparency:

- Evaluation of physician performance should be based on a number of important criteria including information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other healthcare professionals referenced; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations.
- Physicians and other health care professionals need to have timely access to assessed performance information prior to public reporting.
- Standardized performance measures and data collection methodology should be agreed upon by relevant nationally recognized healthcare stakeholders.
- The most effective means of presenting performance information to patient/consumers and educating these information users on the meaning of performance differences among providers should be researched. ACP does not support web-based physician rating sites that rely on subjective and invalidated data.

For More Information

This issue brief is a summary of *Healthcare Transparency – Focus on Price and Clinical Performance Information***.** The full paper is available at http://www.acponline.org/advocacy/where_we_stand/policy/transparency.pdf.

Healthcare Transparency—Focus on Price and Clinical Performance Information

A Policy Paper of the
American College of Physicians

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How to cite this paper:

American College of Physicians. Healthcare Transparency—Focus on Price and Clinical Performance Information. Philadelphia: American College of Physicians; 2010: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

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Executive Summary

This policy paper introduces the general issue of healthcare transparency and proceeds to focus on price and clinical performance transparency—with particular emphasis on issues related to physicians and their relationships with healthcare patients/consumers. It offers an overview of significant issues and activities related to this subset of transparency, reviews current ACP policy and provides new policy recommendations where required. The policy paper reflects the College's general support for the concepts of price and performance transparency contingent on the reported information meeting a number of important criteria including the information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other healthcare professionals referenced; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations. The following specific recommendations are offered in the policy paper:

Price Transparency:

1. **The College supports the goal of price transparency for services and products provided by all healthcare stakeholders to patients/consumers.**

2. **The College recommends that any methodology used to publicly report price is also transparent, and contains adequate protections to ensure the reporting of reliable and valid price information.**

3. **The College recommends that price information provided to patients/consumers should be readily available, presented in a manner that is easily understood and reflective of its limitations.**

4. **The College recommends that any formal governmental or private sector requirement for price transparency minimize the administrative burden on the participating physicians or other healthcare professionals.**

5. **The College recommends that price should never be used as the sole criterion for choosing a physician or any other healthcare professional. Price should only be considered along with the explicit consideration of the quality of services delivered and/or the effectiveness of the intervention.**

Performance Transparency:

6. **The College supports the goal of performance transparency for services and products provided by all healthcare stakeholders to patients/consumers.**

7. **The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, "Linking Physician Payment to Quality Care."[1] Quality measures used to evaluate physician performance should be:**

   - **reliable, valid and based on sound scientific evidence**
   - **clearly defined**
   - **based on up-to date, accurate data**
   - **adjusted for variations in case mix, severity and risk**
   - **based on adequate sample size to be representative**
   - **selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance**
   - **reflective of processes of care that physicians and other clinicians can influence or impact**
   - **constructed so as to result in minimal or no unintended harmful consequences (e.g., adversely impact access to care)**
   - **as least burdensome as possible**
   - **related to clinical conditions prioritized to have the greatest impact**
   - **should be developed, selected and implemented through a transparent process**
   - **easily understood by patients/consumers and other users**

8. **The College highlights the importance of "process transparency" in the public reporting of healthcare performance information—the explicit delineation of the methodology and evidence base used to develop the measures being reported.**

9. **The College reaffirms the importance of physicians and other healthcare professionals having timely access to assessed performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper "Developing a Fair Process through which Physicians Participating in Performance Measurement Programs can Request a Reconsideration of Their Rating."[2]**

10. **The College reaffirms the "ACP Policy Statement Pertaining to Health Plan Programs to Rate Physicians."[3] and recommends that the expansion of public reporting of physician performance differences takes into account the technical capability to report reliable, valid and useful differences.**

11. **The College supports the use of standardized performance measures and data collection methodology, consensually agreed upon by relevant nationally recognized healthcare stakeholders, in efforts to publicly report the performance of physician and other healthcare professionals. In addition, the College supports the collection of both public and private data by trusted third party entities so that physician and other clinician's performance can be assessed as comprehensively as possible.**

12. **The College, while recognizing and supporting the increased patient/consumer interest in obtaining and providing physician performance information, does not support the use of web-based physician rating sites that rely on subjective and invalidated data, and do not meet the College's standards for physician performance measurement.**

13. **The College supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers, and to educate these information users on the meaning of performance differences among providers and on how to effectively use this information to make informed healthcare choices.**

Transparency is defined as "characterized by visibility or accessibility of information especially concerning business practices" and "readily understood."[4] When applied to the healthcare arena, the concept of transparency typically focuses on the public reporting of information and processes. For example, healthcare transparency has been defined by the Institute of Medicine (IOM) as making available to the public, in a reliable and understandable manner, information on the health care system's quality, efficiency and consumer experience with care, which includes price and quality data, so as to influence the behavior of patients, providers, payers and others to achieve better outcomes (quality and cost of care).[5]

The issue of transparency has been raised regarding multiple healthcare aspects. An overview of the major domains of healthcare transparency is provided in Table 1.

Table 1 MAJOR DOMAINS OF HEALTHCARE TRANSPARENCY

TRANSPARENCY DOMAIN	MEASURES	PHYSICIAN EXAMPLE	FACILITY OR SYSTEM (PLAN) EXAMPLE
Clinical Quality and Safety	Structural Process Outcome	Medicare Physician Quality Reporting Initiative (PQRI)	Healthcare Effectiveness Data and Information Set (HEDIS)—NCQA
Resource Use	Episode of Care Cost Yearly Per Capita Cost Number of hospital bed days	Medicare Physician Resource Use Measurement and Reporting Program	Leapfrog Hospital Resource Use Measures
Efficiency	Clinical quality outcome relative to resource use (cost)	NQF project to develop valid physician efficiency measures	Leapfrog Hospital Efficiency of Care Measures
Patient Experience of Care	Survey Subjective Global Ratings and Testimonials	Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Clinician and Group Survey "Rate MDs", "Dr. Score"	Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Hospital and Health Plan Surveys, Hospital Compare (HHS)
Professionalism	Qualifications Professional Standing Training Adverse Actions	Board Certification, Maintenance of Certification, Licensure, Maintenance of Licensure, Professional Society Membership, CME, Sanctions, Tort claims	Not applicable
Healthcare System/Facility Recognition Accreditations for Meeting National Standards	Accreditation	Not applicable	Joint Commission, URAC, and NCQA
Financial relationship Physicians and other Healthcare Professionals	Public reporting of relationship	Federal and State Medical Payment Sunshine Laws Medicare Self Referral and Anti-Kickback Laws Medical Journal Conflict of Interest Policies and Statements	
Financial relationship between Physicians and other Healthcare Professionals, and Industry	Public reporting of relationship		
Health Insurance Company Processes	Medical loss ratio, Efficiency of claims processing, Criteria for preferred provider status	Not applicable	AMA Report Card for Insurance Companies

Audiences for transparent healthcare information range across the entire spectrum of stakeholders including patients/consumers, employers/purchasers, health plans, providers and policy makers.[6] A recent Commonwealth Fund survey of healthcare opinion leaders concluded that "transparency in healthcare is essential for moving towards a higher performing health care system in the United States.[7]

The literature reflects a number of potential benefits from increased healthcare transparency including:[8,9,10]

- Improved availability of information needed by consumers to make informed healthcare choices
- Increased trust in the patient-physician relationship and health care systems
- Improved quality, safety and efficiency throughout the healthcare system due to competition and/or the availability of clinical benchmarks.

This policy paper introduces the general issue of healthcare transparency and proceeds to focus on price and clinical performance transparency—with particular emphasis on issues related to physicians and their relationships with healthcare patients/consumers. It offers an overview of significant issues and activities related to this subset of transparency, reviews current ACP policy and provides new policy recommendations where required.

Catalysts of Modern Healthcare Transparency

The work of Ernest Codman is often cited as the starting point of healthcare transparency in this country.[11] In the early part of the twentieth century, he promoted the "end result idea" which highlighted the importance of hospitals following-up with all their patients and publicly reporting the results of their interventions to promote quality improvement, physician learning and patient choice. While Codman's work serves as the foundation of the current healthcare transparency movement, it was a 2001 IOM report that significantly energized current efforts in this area. This report reflected the need for increased transparency to improve overall healthcare quality—specifically recommending the increased availability of information to patients and their families that allow them to make informed choices when selecting a health plan, hospital or clinical practice, or choosing among alternative treatments.[12] Furthermore, it recommended that this include information describing performance on safety, evidence-based practice and patient satisfaction. This view was further highlighted in a subsequent IOM report that called on programs within the federal government to "lead by example" through collaborating on the development and implementation of a standardized, national set of performance indicators for health care quality; recognizing and rewarding hospitals and physicians who deliver improved care; and publicizing data comparing the quality of care delivered by individual providers.[13]

The call by the IOM for increased public information to inform healthcare choices was reinforced by Regina Herzlinger and others proponents of Consumer-Driven Health Care (CDHC).[14] This market driven approach to facilitate increased quality and efficiency in healthcare services highlights the importance of consumers taking increased responsibility for the financial consequences of their healthcare choices, while at the same time having access to essential information on the price and quality of available healthcare services through public reporting. CDHC advocates promote the use of high deductible

insurance plans to protect consumers from high cost catastrophic risk, but believe that the more routine costs of healthcare should primarily be shouldered by the consumer to encourage informed shopping for high quality, low cost healthcare services. Others have questioned the validity of the CDHC approach, contending that the healthcare is not a homogenous commodity and does not perform like markets of other goods and services.[15] Factors such as the timing of many healthcare decisions (e.g. emergency situations), the fact that many healthcare services are required as opposed to discretionary, the involvement of multiple healthcare professionals in the treatment of many episodes of care, and the general complexity of healthcare price and quality reporting, all contribute to potentially making healthcare a different type of market.

Influenced by the CDHC movement, the G.W. Bush Administration took several policy steps in support of this market-driven approach. Beginning in 2003, a series of tax incentive provisions were passed into law to promote high-deductible insurance plans coupled with savings accounts (health savings accounts) in which individuals could shelter funds used for qualified healthcare expenditures. In February 2006, Allan Hubbard, the Director of President Bush's National Economic Council, called in the major provider groups and requested the introduction of greater transparency into the healthcare system—particularly price transparency. This was quickly followed by a Presidential executive order that directed federal agencies and sponsored federal health insurance programs including Medicare, the Department of Defense, the Department of Veterans Affairs and the Federal Health Benefit program to increase their transparency in pricing and quality information.[16]

The Consumer-Purchaser Disclosure Project was organized in 2003 by a coalition of leading employers, consumer and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information.[17] This vision was subsequently expanded to ensure that all Americans have access to publicly reported health care performance information to facilitate the selection of hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. The activities of this collaborative have served as a stimulant for public reporting efforts throughout the country.

Ethical and Professional Catalysts of Healthcare Transparency

Several sections within the ACP Ethics Manual clearly support the concept of transparency within the patient-physician relationship.[18] Under the "disclosure" section, physicians are expected to disclose whatever is considered material to the patient's understanding of his or her situation including the costs and burdens of treatment, the experience of the proposed clinician, the nature of the illness and potential treatments, and procedural and/or judgment errors made in the course of care. It is also expected that this information is provided in a manner that the patient can comprehend. Similarly, the "informed consent" section highlights the duty of the physician to provide adequate information to allow the patient to make an informed judgment regarding their care. Within the "changing practice environment" section, physicians are obligated to interact honestly, openly and fairly, not only with patients, but also with other clinicians, insurers, purchasers, government, health care institutions, and health care industries. Finally, the ethics manual promotes disclosure of any financial arrangements with industry or other providers that may in any way compromise their objective clinical judgment or the best interests of patients or research subjects. The College, in collaboration with the American Board of Internal

Medicine and the European Federation of Internal Medicine, developed in 2002 a physician's "Professionalism Charter" that also includes principles that promote transparency including obligating the physician to be honest with their patients and to empower them to make informed decisions with their patients about treatment.[19]

Price Transparency:

A Commonwealth Fund survey of American healthcare opinion leaders indicated that 91 % believed that having information on the cost of care provided by physicians and hospitals before they received that care is important. Types of price transparency vary widely. The Congressional Budget Office (CBO) outlines specific types of price transparency, including providers publicizing the list and transaction prices for particular health care services for the various payers, insurers making available to their subscribers the rates that they have negotiated with physicians and hospitals, and government agencies publicly reporting the average prices for common health care services.[20] The CBO has also called for increased transparency related to letting employees understand that employment-based health insurance is ultimately financed through lower take-home pay—an issue of some relevance in recent healthcare reform discussions.[21] The American Medical Association (AMA) recently reported another transparency issue regarding a trend for hospital-based systems to bill patients an additional "facility" fee for outpatient appointments to capture various regulatory and administrative costs without clearly informing the patients beforehand of this additional charge—at least two states, Wisconsin and New Hampshire, are considering bills that would require telling patients about facility fees in advance.[22]

The most readily available provider cost data at this time is from hospital settings fueled both by the transparency efforts of the Bush Administration and a series of well publicized law suits calling attention to hospitals allegedly billing uninsured patients a much higher price than the prices negotiated by the health plans.[23] In 2006, CMS began posting hospital-specific charges and payment data for thirty common elective procedures and hospital admissions. The CMS effort has expanded to include information and charges for ambulatory surgery centers (ASCs), and hospital outpatient departments.[24] Furthermore, a growing number of states (e.g. New Jersey, Florida, and California) have released publicly available web-sites over the past several years providing comparisons of hospital cost information.[25]

In contrast to the hospital setting, the public availability of physician price information is minimal and may be a result of several factors including the complexity of providing meaningful physician price data and the fact that most individuals are covered by comprehensive insurance policies that provide limited incentives to address cost when seeking physician care. Aetna was the first health plan to report prices paid to physicians for medical procedures and medical tests[26], although it must be noted that physician negotiated payments are different than the cost of the intervention to the patient. In 2007, CMS began reporting aggregate, regional physician charges and payments for a number of procedures.[27] Also, a number of private entities collect and report cost and certification data at the individual physician level. For example, HealthGrade sells reports on individual physicians that include information on the average charges, out-of-pocket costs and health insurance payments for fifty-six pro-cedures, in addition to data of individual physicians' board certification and education.[28]

While the issue of transparency in price information delivered by providers for a healthcare service seems straightforward, in actuality it is quite complex. This complexity is found in all healthcare sectors (e.g. hospitals, pharmaceuticals), but this analysis will focus on the transparency of prices charged by physicians for their services. Several authors have recognized the issue of price transparency complexity[29,30,31] and ACP has reflected many of these concerns in a letter to the Director of President Bush's National Economic Council that stated:[32]

- Physician fees for a specific service or procedure have little relationship to the total cost of care. Knowing how much an internist charges for a "typical" office visit, for instance, does not tell the patient anything about what level of office visit may be required, what tests or procedures may have to be ordered, or what other costs could be incurred for referrals to other physicians or health care facilities
- The costs associated with an entire episode of care would be a more relevant indicator—but such cost of care measures are still very much in their infancy. To be meaningful, those measures would have to encompass the services of multiple healthcare professionals and sites of service, as well as pharmaceutical, radiological, and laboratory costs, rather than just the cost of care provided by a single physician
- Physicians often have a single retail "fee" for each service, but the amount they charge—and the amount they actually collect from the patient—is a function of a specific contract signed with a particular insurer
- Some physicians practice in more than one setting or in the employment of more than one employer, so an individual physician may have a different set of fees for each setting and/or employer, meaning the physician may have multiple fees for the same service
- Telling patients what a physician's retail fees are for common procedures still does not let patients know what they will have to pay out-of-pocket—unless insurers also disclose how much they reimburse for a given service, including the patient's co-pay or co-insurance for covered services, in advance
- Comparing prices could be misleading unless patients also have comparative data on the quality of care provided

The incentive for most Americans to consider price issues when seeking physician care is also quite limited. Most individuals and families are covered through their employer by a comprehensive healthcare policy and it is primarily the responsibility of a designated health plan to address costs and negotiate provider fees. While the typical employee experiences cost issues when comparing premium costs of available plans, their current risk at point of care is limited to relatively small deductibles and copayments. Thus, research indicates that most consumers rely on physician referrals and word–of-mouth recommendations from family and friends when choosing a provider and the use of price information is minimal—in one survey being 5.1 % for individuals seeking a new primary care doctor and 1.1 % for a specialist seeker.[33]

There is recent evidence of increased interest by healthcare plans and others to provide price information regarding the cost of care; including care provided by physicians.[34,35] For example, a review of a series of yearly consumer surveys conducted by EBRI and the Commonwealth Fund reflects a trend towards the increased availability of information provided by health plans on the cost of care provided by doctors.[36,37] The cost information typically provided is

not practice specific, but is generally the average cost of physician services in a particular geographic area for consumers to use as a benchmark.[38] In a recent survey of health plans, only one had a web site customized to allow the individual to obtain price information based on the enrollees specific deductible, co-payments and out-of-pocket maximum—but others are interested in developing similar capabilities.[39] Furthermore, a new website has been offered that lists physicians who are willing to post their prices and negotiate with patients.[40] This increased interest in providing physician cost information is likely in reaction to the significant increase over the past several years in individuals covered by CDHC plans (estimated to be 8 million in 2009)[41], an increase in individuals relying on the private insurance market who generally experience higher out-of-pocket costs and more limited coverage than individuals covered by group employer-based plans[42], a shifting of healthcare costs from employers to employees,[43] and the continued high number of uninsured and underinsured individuals.[44,45] Ginsburg has highlighted those situations in which "price shopping" can be more useful that include services that are less complex, non-urgent, post-diagnosis, bundled, and not part of the benefit structure of a health plan.[46]

Is Increased Price Transparency Always Beneficial?

While there appears to be a trend towards increased availability of price information to inform healthcare decisions, there is some evidence that this increased availability may not always lead to increased healthcare value in the marketplace. For example, research indicates that in situations in which healthcare services are highly concentrated, there is a likelihood that the increased availability of price information will lead to higher prices and/or less price variability.[47] In these situations, particularly with hospitals and specialty practices, providers now with access to competitor price information can use their leverage to make sure they are being paid at the same rate or higher than their competitors. Furthermore, many consumers equate higher prices with quality[48], which serves to inhibit physicians seeking patients to lower their prices. Finally, Berenson and Cassel, in a commentary on the trend toward Consumer Driven Health Plans, cautions that encouraging a competitive environment where physicians attempt to attract healthcare shoppers (patients) through the display of price (and quality) information may have the deleterious effect of increasing reliance on commercial ethics as opposed to professional ethics as the guiding force in patient-physician interactions.[49]

College Policy on Price Transparency and Recommendations

The College, while recognizing the complexity of this issue, has publically supported the goal of transparency in healthcare pricing.[50] This position is consistent with the profession's ethical responsibility to be honest with their patients and to provide them with information necessary to make an informed decision. It is also consistent with the long-standing policy of the College to encourage its members to discuss fees with patients in advance of rendering services with the qualification that the fee charged for an office visit or other service does not necessarily predict the total cost of care. The following policy recommendations expand and refine the College policy on price transparency:

1. **The College supports the goal of price transparency for services and products provided by all healthcare stakeholders to patients/consumers.**

Physicians and all providers of healthcare services and products, including health plans and members of the healthcare product industry, should publicly provide accurate price information to healthcare patients/consumers. This policy also reflects the importance of health plans, including point-of-service and indemnity plans, clearly indicating the amount allowed for different services under a patient's coverage, so the patient can accurately assess their out-of-pocket costs. The availability of reliable and valid price information facilitates the patient/consumer in making informed healthcare decisions—decisions consistent with their needs and circumstances. It also fosters trust in the patient-physician relationship and health care system in general. This general support for the concept of price transparency is contingent on the prince information being reported meeting an number of important criteria, including the information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other healthcare professionals referenced; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations. These criteria are expanded upon in the following policy recommendations.

2. **The College recommends that any methodology used to publicly report price is also transparent, and contains adequate protections to ensure the reporting of reliable and valid price information.**

This recommendation highlights the importance of processes to ensure the reporting of accurate price information that facilitates trust in the information by the patients/consumers using the information and by the healthcare professionals whose price information is being reported. Beside the availability of a clear description of the data development process (process transparency) , such processes should include the availability of the information for review by the physician or other healthcare professional prior to public reporting, and a reasonable appeals process to address potential data inaccuracies. These processes are further elaborated in the discussion of College recommendations regarding performance transparency below.

3. **The College recommends that price information provided to patients/consumers should be readily available, presented in a manner that is easily understood and reflective of its limitations.**

This recommendation highlights the need for price information provided to be disseminated in a manner that promotes ease of access, is presented in a comprehensible format or manner that fosters effective use by the patient/consumer, and accurately reflects the limitations of the information provided. For example, the price for a physician office visit will not accurately reflect the potential for the costs of additional services and/or diagnostic tests that may be necessary to effectively complete the treatment or consultation. This limitation should be made clear in any attempt to publicly report physician office-visit costs. The Commonwealth Fund states that for patients, price transparency should include the total expected out-of-pocket costs for the duration of a treatment plan – including, if necessary, the estimated hospital bill, all physician bills and bills for follow-up care.[51] Another example regarding the need to define the limitations of the price data being reported addresses the public reporting by health plans of the negotiated rates for various procedures. Patients/consumers must understand that this information may not reflect the actual costs to the patient/consumer based on their policy design, deductibles and co-payments.

4. **The College recommends that any formal governmental or private sector requirement for price transparency minimize the administrative burden on the participating physicians or other healthcare professionals.**

This recommendation acknowledges the excessive administrative burdens already being placed on physicians and other healthcare professionals. While full price transparency is a goal, it must also take into account the complexity of the price reporting issue (e.g. a practice may have multiple fee schedules based upon negotiations with different payers) and the administrative burden required from the practitioner to fulfill the requirements.

5. **The College recommends that price should never be used as the sole criterion for choosing a provider or any clinical intervention. Price should only be considered along with the explicit consideration of the quality of services delivered and/or the effectiveness of the intervention.**

This recommendation highlights that price alone is a poor indicator of the potential value of a healthcare service or product. The price information must be evaluated with consideration of the quality /effectiveness of that service or product to be meaningful in making an informed healthcare decision.

Performance Transparency:

Types of performance transparency vary based on the perspective of the healthcare stakeholder. Provider performance transparency broadly refers to the public availability of information related to:

- clinical quality—measure of the extent to which services provided meet recognized consensus or evidence-based structural, clinical process or positive health outcomes benchmarks or guidelines.
- resource use—measure of service intensity or frequency typically expressed as cost to a payer (e.g. Medicare) in per capita or per episode units.
- experience of care—measure of the patient's view of the care received from a provider. Typically, these are obtained through survey techniques that assess a wide variety of issues related to the patient's experience of receiving care from the provider such as waiting times, perceived thoroughness and degree of communication and responsiveness.

Other examples of healthcare performance information that can be reported in a transparent manner include the efficiency of health plans in administrating submitted claims or the degree the health plan uses premiums to pay for medical services (medical loss ratio) or the effect of a particular procedure or product compared to an alternative (comparative effectiveness information).

The previously referred to Commonwealth Fund survey of American healthcare opinion leaders indicated that 95 % believed that having information on the quality of physician and hospital care is important.[52] While few patients seeking care appear to actually consider either price or performance quality information at this time, quality issues are seen as significantly more important than price. A survey of patients seeking primary care physicians found that 23 % of consumers used quality information when choosing a primary care physician,

while cost information was used by only 5.3 %.[53] A recent Employee Benefit Research Institute (EBRI) consumer survey found that for those health plan enrollees who received information on provider cost and quality, quality information trended to be used more often than cost.[54]

The underlying foundation of any performance transparency effort is the evidence and processes used to develop the measures reflecting the performance. The College,[55] as well as many other bodies including the IOM[56] and AQA,[57] has outlined the qualities of a good performance measure, which include that the measure be:

- reliable, valid and based on sound scientific evidence
- clearly defined
- based on up-to date, accurate data
- adjusted for variations in case mix, severity and riskbased on adequate sample size to be representative
- selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
- reflective of processes of care that physicians and other clinicians can influence or impact
- constructed so as to result in minimal or no unintended harmful consequences (e.g., adversely impact access to care)
- as least administratively burdensome as possible
- related to clinical conditions prioritized to have the greatest impact
- should be easily understood by patients/consumers and other uses
- should be developed, selected and implemented through a transparent process

The last bullet highlights an issue that is often neglected when discussing healthcare performance transparency. That is, the processes and evidence base used to develop the measures should be readily available and easily understood by the relevant stakeholders. This "process transparency" is required to promote trust in the measures, increase provider cooperation, help ensure accuracy in the measurement process and help users of the information form a clearer idea of what is actually being measured.

Currently, there are multiple healthcare organizations engaged in the development of performance measures. These include The Joint Commission, the National Committee for Quality Improvement (NCQA), and the American Medical Association's Physician Consortium for Performance Improvement. Measures developed by these bodies are typically submitted for endorsement by the non-profit, National Quality Forum (NQF) based on a consensus process. The NQF's membership includes a wide variety of healthcare stakeholders, including consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and healthcare research and quality improvement organizations.

Two of the first major efforts towards transparent quality reporting in the U.S. were the publication in 1984 of hospital mortality rates by the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS)[58] and the reporting by the New York State Department of Health beginning in 1989 of mortality and other clinical data related to hospital and surgeon performance on coronary artery bypass graft (CABG) surgery.[59] Due to methodological criticism directed at the so called "death list", HCFA rapidly discontinued this early effort, while the New York CABG reporting continues to this day in an expanded fashion. CMS has

continued to be a leader in providing quality reports on many of its participating providers, now including health plans, hospitals, nursing homes, home health agencies, and renal dialysis centers through its web-based Compare initiatives.[60] The National Committee for Quality Assurance (NCQA) has made available since 1993 comparative quality information on health plans through its Health Plan Employer Data Information Set (HEDIS). State governments, private purchasers, coalitions, and others currently offer additional public healthcare reporting programs. Most of these performance transparency efforts have focused on hospital and other institutional providers—the efforts towards transparency in physician performance reporting have been more limited and are taking longer to develop. The current availability of physician performance information is not only limited to the general public, but physicians report that they rarely have sufficient comparative data on the quality of the care they provide or the quality of care provided by other physicians to whom they refer patients.[61]

In 2006, Medicare began a Physician Voluntary Reporting Program (PVRP) as a first step towards increasing physician performance transparency and increasing value within the program. The program originally consisted of "36 evidence-based clinically valid measures that have been part of the guidelines endorsed by physicians and the medical specialty and are the result of extensive input and feedback from physicians and other quality care experts."[62] There was no financial incentive for this reporting, but participating physicians were promised confidential feedback on their performance. The 2006 Tax Relief and Health Care Act (TRHCA) expanded this reporting program, relabeled it as the Physician Quality Reporting Initiative (PQRI) and linked it to an incentive payment.[63] Currently, physicians under the PQRI can earn up to 2% of their total Medicare billings for voluntarily reporting on measures of clinical quality. For 2009, physicians could choose from a total of 153 different structural, process and outcome measures; with most physician specialties needing to report on at least 3 measures to receive the incentive payment.

More recently, empowered by a MedPAC recommendation[64] and provisions in the 2008 Medicare Improvements for Patients and Providers Act (MIPPA),[65] Medicare is beginning to phase in the confidential reporting back to physicians of their quality and resource use information. This process began in 2009 with the providing of physicians with confidential feedback on their resource use in 12 geographic regions, The methodology CMS is using to collect the resource data is based on recent MedPAC reports indicating that available, proprietary "episode groupers" can successfully attribute resource use to providers and can provide risk adjusted and stable cost data for care delivered during a defined episode.[66] The proprietary nature of the these episode groupers, which make it difficult for assessed physicians to evaluate the accuracy of the reported data, is a "process transparency" issue that CMS is currently attempting to address.[67] Besides attempting to make the process transparent, other general principles guiding this effort include that the measurement process be actionable, risk adjusted, allow for physician input, use multiple measures and provide substantial physician outreach and education.[68] The number of regions involved will be gradually expanded and the addition of quality measures to this confidential physician feedback is scheduled to begin in 2010. Furthermore, the MIPPA legislation called for the names of physicians who successfully report their quality data through the PQRI program to be placed on the Medicare website, although the values of the reported quality measures remained confidential. The trend appears for CMS to eventually publicly report this physician information as they currently do for other Medicare providers.

This intent was confirmed by quality provisions in the recently passed 2010 Patient Protection and Affordable Care Act,[69] which requires the Secretary to make available to the public , through standardized internet sites, performance information summarizing data on quality measures including for physicians and other clinicians. The legislation outlines a rigorous and open process for measure selection that includes input from the health stakeholders.

In addition to measuring and public reporting of structural, clinical process and outcome information, there has been increased recent interest in the measuring and reporting of patient experience of care information. The Agency for Healthcare Research and Quality (AHRQ) has been very influential in this area through their establishment of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program.[70] This public/private initiative has developed standardized, field-tested surveys of patients' experiences based upon the best available scientific methods with significant multi-stakeholder input. The measures have been endorsed by the NQF and assess patient experience within health plans, hospitals, and ambulatory settings, including physician offices. The tools are publicly available. The CAHPS program sponsors a national benchmarking database to allow for users to compare their results to various reference groups. Currently, only the health plan database is fully developed. Current users of the ambulatory surveys include regional collaboratives such as the Aligning Forces for Quality sites and AHRQ's new Chartered Value Exchanges that promote the availability of information to the public, member boards of the American Board of Medical Specialties, and a growing number of individual health plans and medical groups. This experience of care measure is typically combined with additional clinical performance measures by these different groups.

The last several years has also seen a significant raise in the number of web sites on which patients/consumers can provide subjective ratings of the care received from their physicians—similar in format to previously successful restaurant and consumer product/services rating sites. There are now approximately 40 such physician rating sites currently available on the web.[71] Patients/consumers typically provide global ratings on such areas as punctuality, helpfulness, professionalism and quality and these ratings are often combined into an overall score. Anecdotal comments may also be made. These measures, in comparison to the CAPHS methodology, can be considered a less rigorous means of obtaining physician experience of care information. They also do not meet a number of measurement and reporting criteria reflected in ACP policy. The medical community has been quite critical of these websites contending that they do not provide an accurate view of the physician's performance and they can be very damaging to the physician's reputation. Problems frequently cited with these rating sites include:

- ratings are typically anonymous and there is often no attempt to ensure that the rater has actually seen the physician that was rated
- rating sites are often easily manipulated either in a positive or negative direction as a result of the anonymous nature of most sites
- ratings are often based on a small sample size that negatively affects the reliability of the results
- ratings are based on a methodology that has not been adequately validated
- rated physicians typically cannot respond to inaccurate ratings or comments, either because of the anonymity provided by the process or limitations resulting from federal and state health information privacy laws

- ratings, which are subjective, are rarely combined on these sites with more objective measures of physician quality (e.g., A patient's subjective view of the quality of a physician's services may be quite different from a measure reflecting the degree the physician met clinical process or outcome benchmarks.)

Physician Profiling and Tiering

The past decade, fueled primarily by the goal of large employers to increase the value of their healthcare purchases for their employers, has seen a rapid increase in health plans measuring and reporting the quality (and costs) of their participating physician providers. The information is often presented in the form of physician ranking or tiering programs based on claims and other available administrative data. While in most cases the information is presented for use by enrollees to inform their decision-making, several plans have used this data to pay high performing physicians a bonus, or to reduce co-payments for those enrollees that choose a high performing physician. Each of these programs uses different methodologies to form these rankings including different databases (metrics), sample-size requirements for data inclusion, and the relative emphasis of cost vs. quality measures. Many of these early efforts have come under substantial criticism by physician (and consumer) groups for reasons including:

- Lack of transparency in the processes used to develop the rankings
- Limited or no involvement of rated physicians in the development of the ratings process
- Limited or no opportunity of rated physicians to assess the accuracy of the data used to develop the ratings
- Concerns that the claims and administrative data used to develop the ratings did not accurately reflect physician performance
- Overemphasis of cost measures in the ratings relative to clinical quality ratings
- Significant variation in the metrics and processes used by the different health plans leading to situations in which a provider would receive a high performance rating under one plan and a low performance rating under another
- Presentation of the rating results in a manner that either did not accurately reflect the characteristics being measured, or could not be reasonably interpreted by the plan enrollees

Skepticism regarding the performance rating programs resulting from these substantial criticisms fueled a series of legal actions; the most publicized being the 2007 investigation by the New York Attorney General of the physician rating practices of a number of large health plans.[72] The resulting settlement required the plans to ensure the significant inclusion of quality measures (and not just cost) in the ratings determinants; use established national standards to measure quality, including measures endorsed by the National Quality Forum (NQF) and other generally accepted national standards; use measures to foster more accurate physician comparisons, including risk adjustment and valid sampling; disclose to consumers on how the program is designed and how doctors are ranked; and provide to consumers complaint and to physicians appeals processes. The settlement also required the plans operating in New York to nominate and pay for an independent ratings examiner, who must be a

national standard-setting organization, to oversee compliance with all aspects of the settlement. The NCQA was subsequently selected to serve as the independent rating examiner.[73]

Around the same time, the previously referred to Consumer-Purchaser Disclosure Project announced a comprehensive national agreement with leading physician groups, including the ACP, and health insurers on principles to guide how health plans measure doctors' performance and report the information to consumers called the Patient Charter for Physician Performance Measurement, Reporting and Tier Programs.[74] This Charter ensures that measurement is based on sound national standards and methodology; measures and methodology are transparent and valid; measures are meaningful to consumers and reflect a diverse array of physician clinical activities; consumers and physicians are provided with input opportunities on the measurement and result reporting processes, and protections are provided to physicians that ensure accurate information is used and reported. This Charter, and the New York settlement, has guided the establishment of regulations to promote sound provider quality information reporting in several states throughout the country (e.g. Colorado[75], Maryland[76])

The College recently approved a policy statement pertaining to health plan physician rating programs.[77] The statement highlights the belief that the Patient Centered Medical Home (PCMH) practice model, rather than rating physicians to establish tiers and/or "high performance" networks, is a better way to improve the quality of care provided to patients and the physician role in ensuring efficient use of health care resources. While the ACP does not endorse health plan programs that rate physicians, the College policy statement aims to promote fair treatment of internists and other physicians in the programs that exist. The elements of the policy are very consistent with the Disclosure Project's Patient Charter and are organized under the following general principles:

- Delivering a high quality of care should be the primary focus of programs that rate physicians to establish tiers/high performance networks.
- Program ratings should only be based on factors that are within control of the physician.
- Practicing physicians should be involved in the development, implementation, and evaluation of programs that rate physicians to establish tiers/high performance networks.
- Health plans should make the methodology for determining physician ratings transparent.
- Health plans should make their quality improvement efforts known to physicians and patients.

Additional specific elements of this policy statement include:

- Programs should not base physician ratings used to establish tiers/high performance networks solely on cost and health plans should clearly identify the degree to which any rating is based on cost.
- Programs to rate physicians to establish tiers/high performance networks should:
    - Use a sample size for evaluating a specific physicians' performance that provides statistically significant results and ensures that the evaluation is based on conditions the physician commonly treats.

- ❍ Use data that are fully adjusted, as appropriate for case-mix composition, including factors for sample size, age/sex distribution, severity of illness, and number of co-morbid conditions; and other pertinent features of a physician's practice and patient population.
- ❍ Use based on current data, updated as needed to present a timely representation of the a physician's performance.
- ❍ Provide physicians the opportunity to review plan-determined ratings that are available in a user-friendly format before they are finalized and used.
- ❍ Provide a process for physicians to appeal incorrect ratings pertaining to quality and/or cost. consistent with the positions included in the 2007 ACP position paper, "Developing a Fair Process through which Physicians Participating in Performance Measurement Programs can Request a Reconsideration of Their Rating."
- ❍ Use rankings based on a larger universe of patients than those attributable to a single health plan—to provide a broader representation of the physician's performance.

- o Health plans should provide educational feedback derived from determining quality and cost scores, including how an individual physician compares to peers, on a routine and timely basis and in a standardized, user-friendly format.
- o Health plans should disclose to patients/consumers how the program is designed and how physicians are ranked and provide a process for consumers to register complaints about the system.
- o Quality of care scores should be prominent in health plan efforts to use tier/high performance network programs that steer patients toward specific physicians.

A recent series of papers[78,79,80,81] have examined health plan efforts to categorize physician performance on quality and cost measures and has determined that the reliability of these ratings is often too low to make meaningful distinctions among providers. Physicians are categorized, but the probability of miscategorization is high. Factors related to this reliability-related problem include sample size, method of attribution, level of analysis (e.g. group or individual provider), and case mix of population. This data highlights the importance of patients/consumers and other users of these categorizing efforts being informed of their current limitations.

There have also been recent efforts to address the problem of different health plans and payers evaluating physicians based on varying methodologies, which contributes to physicians being ranked differently by the different health plans. Clearly, the call for the use of national recognized standards and methods helps address this issue, but efforts to develop data aggregation entities in which common data from all participating quality initiatives can be collected and uniformly reported would be a significant improvement. The Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) and the Generating Medicare Physician Quality Performance Measurement Results (GEM) projects, funded by CMS, are testing methods to aggregate Medicare claims data with data from commercial health plans and, in some cases, Medicaid, in order to calculate and report quality measures for physician groups and, to a lesser extent, individual physicians.[82,83] The projects aim to both provide beneficiaries with health care performance information on the physicians who treat them in order to facilitate physician selection and treatment choices and

to provide performance information to the physician groups and/or physicians who treat these beneficiaries to help them improve the quality of care they provide. The Department of Health and Human Services, with the assistance of the Agency for Healthcare Research and Quality, are also promoting the establishment of Chartered Value Exchanges and Community Quality Collaborative to promote increased aggregated reporting of performance data.[84] The College, as part of the AQA and other organizations, has been actively involved in addressing issues related to effective data aggregation and reporting including determining the best methods to collect and aggregate the data, data ownership, patient privacy and effective public reporting methodology.[85]

This effort towards increased standardized performance measures and data collection methodology also directly relates to the issue of administrative burden for physicians and other healthcare professionals. As the demands for increased physician performance data reporting to governmental and private increases, so does the cost and time required from participating practices to comply increase. It is important that these increased efforts be recognized and these demands be minimized.

What are the Effects of Publicly Reporting Performance Data?

Given the call from consumers and the health policy community for the importance of transparent performance (and cost) information, and the significant efforts to develop adequate measures and disseminate the data, it is reasonable to examine the effects of the availability of this information.

As reflected throughout this policy paper, there is currently little evidence that large numbers of consumers are using publicly reporting quality information and "report cards" in their provider selections. This was recently confirmed in a systematic review of available research on the effects of publishing patient care performance data.[86] Little evidence was found to indicate that patients select health plans, hospitals, or physicians on the basis of these public performance reports.

The literature does reflect interest in examining factors that will increase patient use of this information. Factors that have been related to the usability of performance information by consuming patients include timeliness, relevance, ease of use, understandability (i.e. health literacy), degree of dissemination and report design (e.g. degree of cognitive burdensomeness).[87,88,89] Furthermore, consumers need to be educated to realize there are significant performance differences throughout the healthcare system and these differences have a direct effect on the effectiveness and cost of the services they receive.[90]

Although consumers appear not to be taking advantage of the increase availability of provider cost and quality information, a recent review of the available research provides evidence that the public reporting of this information appears to facilitate increased efforts to make quality improvements both in institutions already engaged in quality improvement efforts or that performed poorly on the reported measures.[91] This evidence focuses on hospital and health plan settings, and the research survey found no published studies on the effect of publicly reporting performance data on quality improvement activities among physicians or physician groups. There are several theories on the underlying pathway motivating these quality improvement changes. Berwick and colleagues have outline both a "selection" pathway where concern about market share motivates improvement and a "change" pathway where identification of quality deficiencies is sufficient to motivate the provider to institute change. More recently, Hibbard and colleagues proposed a third possible pathway focusing on the importance to a provider to maintain a high public image or reputation.[93]

Finally, the potential effect of increased public reporting of physician performance data on malpractice liability and insurance costs is an area of concern for some in the physician community.[94] It is an area that has received little critical analysis or research scrutiny at this time.

College Policy on Performance Transparency and Recommendations

The College, in providing its public support of the "Patient Charter for Physician Performance Measurement, Reporting and Tier Programs" developed through the Consumer-Purchaser Disclosure Project, expanded its previous position on public reporting of physician quality data.[95] That position limited such public reporting to demonstration projects that contained the following elements:

- Physician participation in the demonstration projects is voluntary
- Physicians have a key role in determining the design of the demonstration projects, selection of the measures, and data collection and reporting systems that will be used
- Physician-specific performance data are disclosed only after physicians participating in the project are provided an opportunity to review and comment on such data; data are fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, and severity of illness; number of comorbid conditions; and other features of a physician's practice and patient population that may influence the results); and patient identifiers are removed to ensure that patient privacy is protected

The issue of public reporting of physician performance information was also addressed in the ACP policy paper Linking Physician Payment to Quality Care."[96] which stated that performance data should be used for public reporting only after:

- Physicians participating in the program are provided an opportunity to review and comment on such data
- Patient identifiers are removed to ensure that patient privacy is protected

By endorsing the "Patient Charter," the College accepted the broader position that public reporting of physician performance is integral to improving the health and health care of Americans.

The following policy recommendations expand and refine the College policy on performance transparency:

6. The College supports the goal of performance transparency for services and products provided by all healthcare stakeholders to patients/consumers.

Physicians and all providers of healthcare services, including health plans and members of the healthcare product industry, should publicly provide accurate performance information to healthcare patients/consumers. The availability of valid performance information facilitates the patient/consumer in making informed healthcare decisions—decisions consistent with their needs and circumstances. It also fosters trust in the patient-physician relationship and health care system in general. This transparency is also consistent with College ethical and professional guidelines. This general support for the concept of

performance transparency is contingent on the performance information being reported meeting an number of important criteria, including the information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other healthcare professionals being evaluated; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations. These criteria are expanded upon in the following policy recommendations.

7. **The College reaffirms and expands upon the qualities of a good performance measure as reported in the ACP policy paper, "Linking Physician Payment to Quality Care."[97] Quality measures used to evaluate physician performance should be:**

- o reliable, valid and based on sound scientific evidence
- o clearly defined
- o based on up-to date, accurate data
- o adjusted for variations in case mix, severity and risk
- o based on adequate sample size to be representative
- o selected based on where there has been strong consensus among stakeholders and predictive of overall quality performance
- o reflective of processes of care that physicians and other clinicians can influence or impact
- o constructed so as to result in minimal or no unintended harmful consequences (e.g., adversely impact access to care)
- o as least burdensome as possible
- o related to clinical conditions prioritized to have the greatest impact
- o should be developed, selected and implemented through a transparent process.
- o easily understood by patients/consumers and other users

8. **The College highlights the importance of "process transparency" in the public reporting of healthcare performance information—the explicit delineation of the methodology and evidence base used to develop the measures being reported.**

This "process transparency" is required to promote trust in the measures, increase provider cooperation, help ensure accuracy in the measurement process and help users of the information form a clearer idea of what is actually being measured.

9. **The College reaffirms the importance of physicians and other healthcare professionals having timely access to assessed performance information prior to public reporting and the availability of a fair and accurate appeals process to examine potential inaccuracies as reflected in the ACP policy paper "Developing a Fair Process through which Physicians Participating in Performance Measurement Programs can Request a Reconsideration of Their Rating."[98]**

The position emphasizes the importance of assuring that physicians are given the opportunity to comment on performance ratings that they believe are inaccurate, or that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public.

A fair reconsideration process helps to ensure the accuracy of the reported information, and thus, facilitates increased patent/consumer trust in the information, increases the willingness of providers to cooperate with the process and helps to minimize unintended consequences that may compromise the care of the patient. This principle reflects the importance of balancing stakeholders' urgent need for useful information with the need for due diligence to ensure that the information provided is valid, reliable, and useful.

10. **The College reaffirms the "ACP Policy Statement Pertaining to Health Plan Programs to Rate Physicians."[99] and recommends that the expansion of public reporting of physician performance differences takes into account the technical capability to report reliable, valid and useful differences.**

The positions expressed in this policy statement, which emphasize the importance of a transparent performance assessment processes; physician involvement in the development, implementation, and evaluation of these programs; the presence of a reconsideration process to examine potentially inaccurate information; and the presence of processes to help patients/consumers understand and interpret these ratings, serve to ensure that physicians and other providers are treated fairly through these programs and further helps ensure that the information provided is reliable, valid and useful. The recent data on the inherent low reliability of the methods used by many health plans to categorize provider performance leads the College to strongly recommend that expansion of these efforts (e.g. increased public reporting) should correspond with the ability to effectively address such issues. This recent data also emphasizes the importance of communicating to users the limitations of these current data sets.

11. **The College supports the use of standardized performance measures and data collection methodology, consensually agreed upon by relevant nationally recognized healthcare stakeholders, in efforts to publicly report the performance of physician and other providers. In addition, the College supports the collection of both public and private data by trusted third party entities so that physician and other clinician's performance can be assessed as comprehensively as possible.**

This position is consistent with principles proposed by the AQA Data Sharing and Aggregation Workgroup.[100] The College is a founding member of the AQA and has played a key role in the development of these principles. This position helps facilitate the provision of meaningful, comprehensive information to patients/consumers and also serves to lessen the burden of data reporting for participating providers. Efforts to achieve these goals should take into account issue of data ownership, patient privacy and effective public reporting methodology.

12. **The College, while recognizing and supporting the increased patient/consumer interest in obtaining and providing physician performance information, does not support the use of web-based physician rating sites that rely on subjective and unvalidated data, and do not meet the College's standards for physician performance measurement.**

The College does not support the use of web-based, subjective physician rating sites that do not meet the its standards for physician performance measurement as reflected by the policy paper "Linking Physician Payment to Quality Care", College policy on physician tiering and profiling, and policy reflected in the College-supported Consumers-Purchasers Disclosure Project's "Patient Charter for Physician Performance Measurement, Reporting and Tier Programs."

13. The College supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers, and to educate these information users on the meaning of performance differences among providers and on how to effectively use this information to make informed health-care choices.

The effort towards increased performance (and price) transparency can only be successful if the information is presented in a comprehensible manner to the patient/consumer. Issues such as "cognitive burdeness", health literacy, and cultural factors must be considered and further research in this area is needed. In addition, patients/consumers must be further educated on how to effectively use this information. These educational efforts can be provided by patient advocacy groups, professional membership groups, health plans and relevant state and local government entities. These efforts could be facilitated through the establishment of a grant program focused on these goals through the Agency of Healthcare Research and Quality (AHRQ). The agency, through its Effective Healthcare Program and related activities, has gained a substantial amount of experience helping patients/consumers navigate our complex health-care system.[101]

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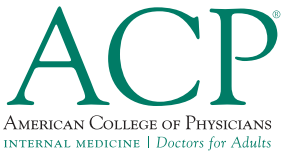

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