Wisconsin Collaborative for Healthcare Quality (WCHQ): Lessons learned

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Introduction

In health care, voluntary disclosure of outcome data can add and create credibility, a sense of integrity, and an urgency to improve, both internally and externally. This was the philosophy around which nine physician-led health care organizations and their employer-partners rallied in October 2002 to form the Wisconsin Collaborative for Healthcare Quality (Collaborative). They set out to prove that seven hospitals, six multi-specialty physician groups, four health plans and nine employer-partners from across the state could agree upon the mutually beneficial goal of increased transparency and work collaboratively to achieve it. Together, they produced the first *Performance and Progress Report*, released after one year.

Based on a desire to improve the quality of health care throughout the state, the Collaborative founders agreed that shared learning and public accountability were key for continuous quality improvement. They agreed to develop a set of common measures of health care quality outcomes and publicly report the performance of their health care organizations against those measures.

But there were concerns. Why more public reporting? Why the urgency? How will employers and patients react? These were the questions raised, particularly by the physicians within the founders' health care organizations. Some of their organizations were already represented in other scattered reporting initiatives. Hospitals and ambulatory care centers routinely report charges and other data to the state's Bureau of Healthcare Information and core measures to the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Annually, health plans report their Health Employer Data Information Set (HEDIS).

The answers to why more vigorous reporting was needed came from the nine employer-partners invited to participate in the creation and development of the Collaborative's public report: skyrocketing health care costs, return on their health care dollar, and the findings of the Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. Most of all, the group was calling for a full set of quality and cost measures for use by employers and patients.

As their need for comparative data upon which to make informed, value-based health care purchasing decisions became clear, it became evident to all that if the provider community didn't take the lead in developing it, it might soon be mandated through regulatory means.

Another concern was convincing a broader public that the founders' motives were not to create a report to make themselves look good. The employer-partners stepped in to ensure this would not occur. They are experienced in implementing continuous quality improvement in their work environments. They have proven that continually measuring, comparing, and holding themselves accountable to customers improves quality and contains costs. Their expertise in the principles of quality improvement was solicited and was an important ingredient to the success of the Collaborative and its first public report.

The Performance and Progress Report

Developing a set of measures with common definitions was not easy. To facilitate the process, the Collaborative's Quality Improvement Committee, comprised of the founders' quality directors and managers, was formed. With input from the employer-partners, the committee developed the following criteria as guidelines for selecting measures:

1. Data must be easily available and accessible from sources such as electronic medical or administrative records.
2. Measures must be supported by sufficient evidence in the literature, including peer-reviewed studies, systematic reviews, clinical practice guidelines, and formal consensus procedures.
3. Measures must have potential to generate improvement. For the first report, it was important that a measure demonstrate:

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- variations in processes, interventions, practices, and outcomes that can be addressed through the reporting mechanism
- improved care by other providers or institutions
- capacity for improvement with a reasonable amount of additional resources
- comparisons or benchmarks with the best-in-class health care providers from around the country

4. Measures must be easily interpretable for the reader to attach practical meaning in making health care decisions without significant explanation.

Many of the measures included in the Collaborative's first *Performance and Progress Report* are based on definitions developed by national health care reporting organizations, including JCAHO, National Committee for Quality Assurance (NCQA), National Quality Forum (NQF), and the Leapfrog Group. The initial set of 42 performance measures reported included access; disease specific-data, including cardiovascular disease and diabetes; charges; procedure-specific outcomes; and patient satisfaction.

The culmination of the Committee's work was the publication of the *Performance and Progress Report* in October 2003 (www.wiqualitycollaborative.org). This report was created to represent the entire continuum of care, from the physician's office to the inpatient hospital setting. The centerpiece of the report is the common set of definitions and measures identifying health care quality and cost outcomes. This initial set of 42 measures is organized around the IOM's six aims for improvement: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Lessons Learned

Health care providers, physician groups, and hospitals have traditionally based their marketing strategies on product differentiation rather than measuring quality or pricing. However, reputation rather than solid data was the mainstay of that effort. It was not until recent years that the government demanded public reporting of some hospital data. Although physicians and physician groups are not required to publicly share information, some have been inclined to publicly report data as purchasers and consumers have become more empowered. However, many of those reports were a sample of indicators meant more to boost the image of the reporter rather than inform purchasers and consumers.

In contrast, the Collaborative took an approach that some would consider risky. Their willingness and commitment to be open with one another and be transparent to the public is, in fact, a significant improvement for purchasers and consumers. This is evidenced by the condition the founders placed upon themselves to report all logistically possible agreed-upon indicators.

Lesson: Because founders did not have the option of picking and choosing which measures to report, the need for previously described well-defined and accepted criteria for measure selection was proven.

It is common for providers to doubt the results of performance measures when the results are negative. Objections such as "but my patients are different" or "my circumstances are unique" are common to all practice types and sizes. As a learning collaborative, no such allowances were made.

Lesson: Contrary to conventional thinking, it was demonstrated that provider/patient experiences were more alike than different.

There is always a need for case-mix adjustments, and this will be included in future reports. However, the founders felt it was important to publish the first report even before appropriate refinements could be determined. Driving internal quality improvement was felt to be more important than waiting for perfectly equitable risk-adjustment methodologies to be applied.

Lesson: As a result of publicly reporting data that was not yet risk-adjusted, the founders experienced a spike in urgency for staff-driven quality improvement initiatives within their respective organizations.

Use of Data to Drive Internal Improvement—The true work of the Collaborative is to use the publicly reported data to drive internal process improvement and have a positive influence within the health care industry. Measuring, comparing, and publicly reporting performance outcomes enables leadership to identify which areas need attention or immediate improvement, with the added benefit of inspiring performance improvement throughout the organization. They may find it necessary to rethink parts of the strategic plan. In fact, several of the Collaborative's founders have done just that and are using their performance on the publicly reported measures to drive certain aspects of their strategic plans, and, through drill-down, systematic internal improvement.

The report only tells part of the story, however. Any individual report represents only a snapshot in time, perhaps providing a skewed view of organizational performance.

Lesson: A long-term perspective of data over time is necessary to maximize the value of participation. For that reason, it is important to provide departments with baseline performance, then follow up with trended data to track performance and improvement over time. Some organizations might even provide individual performance values to providers compared to other internal peers in an effort to further drive process improvement.

The Spirit of the Collaborative—Because comparable data is the goal,

consistently agreed-upon rules about decision-making were necessary. Purchasers participated in the Collaborative's consensus-building model. This two-way communication between providers and purchasers resulted in two positive outcomes. The first was continuous, direct, and timely feedback about what is important to the purchasers. The second, and no less important, was the providers' ability to teach purchasers how health care quality indicators can identify best practices and thus, demonstrate the relationship between cost and quality. This true partnership should ultimately benefit the patients.

Another lesson learned was how to collaborate in spite of physical distance and the varying characteristics among the participating institutions and individuals. Informal sharing of ideas proved to be as important as formal meetings. Many offline but open discussions and communication channels were opened and continuously used. The ability to engage in these exchanges proved critical for delivering a report of this magnitude in just one year's time.

Lesson: One should not underestimate the amount of communication and coordination required to continually review standards and amass the resources for data to be captured and accurately reported.

Wisconsin Collaborative for Healthcare Quality

MISSION: The Wisconsin Collaborative for Healthcare Quality is a voluntary statewide consortium of quality improvement-driven healthcare organizations learning and working together to improve the quality of health care in the State of Wisconsin. We will accomplish this by agreeing to a set of common measures of healthcare quality outcomes and by publicly reporting performance of our healthcare delivery organizations against these measures.

WCHQ Founding Sponsors

Bellin Health in Green Bay; Dean Health System and St. Marys Hospital Medical Center in Madison; Medical College of Wisconsin and Froedtert Hospital, Milwaukee; Gundersen Lutheran in La Crosse; Marshfield Clinic and St. Joseph's Hospital in Marshfield; ThedaCare in Appleton

WCHQ Employer-Partners

The Alliance
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Appleton Papers
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Sentry Insurance
The Trane Company
Wisconsin Manufacturers & Commerce

WCHQ 2003 Performance & Progress Report Hospital/Clinic/Health Plans

Location	Hospital	Clinic	Health Plan
Fox Valley	Appleton Medical Center	Theda Clark Medical Center	ThedaCare Touchpoint
Green Bay	Bellin Hospital	Bellin Touchpoint	
La Crosse	Gundersen Lutheran Medical Center	Gundersen Lutheran	Gundersen Lutheran Health Plan
Madison	St. Marys Hospital Medical Center	Dean Health System	Dean Health Plan
Marshfield	Saint Joseph's Hospital	Marshfield Clinic	Security Health Plan
Milwaukee	Froedtert Memorial Lutheran Hospital	Medical College of Wisconsin	No associated health plan

Next Steps—Even before the first *Performance and Progress Report* was made available publicly, the Collaborative began planning its next steps. In January 2004, the Collaborative signed a contract with Madison-based MetaStar, Inc., to serve as the independent auditor of the initial set of 42 measures to ensure the integrity and validity of the comparative data for subsequent reports. With that and the overall process for reporting in place, the Collaborative invited health care providers from throughout the state, willing to report on its 42 measures and submit to the data audit and validation process, to participate in the Collaborative and report outcomes in the next *Performance and Progress Report.*

Each of the founders' organizations has begun the data audit and validation process with MetaStar. New Reporting Entities will begin the process in mid-May. The process includes completion of a Baseline Assessment Tool (BAT) used to identify the strengths and opportunities for improvement in each organization's process of data capture, transfer, and entry; data integration; and reporting. Once analysis of the BATs is completed, on-site visits will take place to determine each reporting entity's ability to report, and final data submission will take place. The inclusion of additional health care reporting entities, along with the data auditing and validation process, will greatly expand the scope and value of

the Collaborative's next *Performance and Progress Report*. To accommodate that expansion, the next report will be Web-published, interactive, easily accessible to the public, and available during the first quarter of 2005.

Concurrently, the Collaborative is in the process of refining existing measures and developing new measures to be included in subsequent reports. The role of additional reporting entities in the development of new measures will be of great benefit. In particular, methodologies by which to move to reporting outcomes for all patients rather than only certain payer groups are being investigated. In alignment with the Collaborative's mission to improve outcomes, a formal plan for collaborative improvement opportunities is in development.

In addition, leaders of the Collaborative and the Wisconsin Hospital Association's CheckPoint initiative agree on the need for embracing a complementary and coordinated working relationship to facilitate the collection and dissemination of information in a way that is meaningful for consumers and purchasers of health care and useful and efficient for providers generating the data. To that end, the two organizations are in the process of aligning their efforts to define, develop, and report a common set of evidence-based hospital, clinical, and safety measures. A longer-term goal of this complementary and coordinated relationship might be a single Web site that becomes the primary source from which consumers and purchasers can access all measures of health care quality and safety performance data across the spectrum of care (outpatient and inpatient) and track improvement over time.

Summary

The Wisconsin Collaborative for Healthcare Quality demonstrated that seven hospitals, six multi-specialty physician groups, four health plans and nine employers from across the state can agree upon goals and work collaboratively to achieve them. Together they created:

- A public/private partnership to define common measures of health care quality that make sense to purchasers/consumers
- A report that allows all health care providers to compare data against the measures reported, and evaluate their own performances
- A tool that enables purchasers to educate their employees in making informed decisions in choosing and interacting with health care providers
- A forward-looking approach for determining what effective, reasonable health care will be in the future

The Collaborative has become a learning organization, expanding its capacity to create the quality improvement results to which its participants aspire.