GRADING HEALTH CARE

The Science and Art of Developing Consumer Scorecards

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Lessons from the Oregon Consumer Scorecard Consortium Demonstration Project

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Foreword

It is a pleasure to introduce this truly innovative and timely volume on the art and science of developing consumer scorecards. We are currently witnessing a phenomenal growth of scholarly and market-initiated activity related to the development of consumer information materials and health plan scorecards. This activity has been encouraged by an environment in which health care goods and services are rapidly being transformed into market commodities.

Consumer information projects are proliferating at all levels of the health care system from individual health plans to regional, state, and federal efforts. Included is the federal sponsorship of the Consumer Assessment of Health Plan Survey (CAHPS), a five-year initiative being sponsored by the U.S. Department of Health and Human Services Agency for Health Care Policy and Research. The recent endorsement by President Clinton of a Consumer's Bill of Rights in Health Care is yet another manifestation of the growing importance of this dynamic area of health policy.

Underpinning all these efforts is the belief that for a health care market to perform optimally, informed and value-conscious consumers are required. In spite of economic theory holding that markets are optimized by symmetrical relationships between producers and (individual) consumers, most existing efforts at quantifying, measuring, and reporting quality and value in health care have been focused on the information needs of volume purchasers such as large employer groups and the federal and state governments.

I was fortunate to have participated in the Oregon Consumer Scorecard Project in an advisory capacity. It was clear from the outset that Drs. Hanes and Greenlick and the project staff were breaking new ground as they set out to better understand the information needs of consumers and how those needs could be translated into useable information for decision-making purposes. The literature was lean and the need for enlightenment great.

The unique contribution of the Oregon Consumer Scorecard Consortium effort is its focus on the information needs of the system's heaviest users—individuals with significant chronic health conditions and disabilities. The strength of the material presented in this volume is its ability to relate in understandable and engaging ways how the marriage of art and science is possible in scorecard development, even in the present volatile and politically charged environment. The authors provide concrete examples of the many challenges and opportunities they faced in their work, taking the reader through the background thinking and experimentation, and the lessons learned from all aspects of scorecard development.

Grading Health Care offers lessons to be applied and tips to be used for a broad range of audiences. Health plan managers will be interested in this book because of the numerous examples of theory-to-practice that can inform their internal quality improvement efforts. The book is a good introduction to the underlying science of developing consumer satisfaction surveys and quality performance monitoring activities. State policymakers will benefit from the discussions of managing multiple and varied stakeholder interests in pursuit of the common goal of quality improvement in health care. The book is filled with helpful hints about managing the disparate interests of key stakeholders ranging from state bureaucrats to health plans to consumer groups.

We can anticipate that for at least the next several years, consumer information projects will continue to flourish as we test market principles in the delivery of health care. The promise and the limitations of the scorecard methodology are honestly discussed in this volume. Most policy analysts and health care providers agree on one issue: quality standards in health care must not be sacrificed for the sake of efficiency and cost containment. A major question, if not the major issue in this trade-off, is how well a market-driven health care system is serving the needs of its customers. To be attentive to those needs requires new consumer-oriented measurement tools and reporting mechanisms. *Grading Health Care* makes an important contribution to moving this agenda forward.

Seattle, Washington EDWARD B. PERRIN
March 1998

To our extraordinary progeny: David, Timothy, and Rachel Hanes,
Michael and Vicki Greenlick, and Phyllis Greenlick Tabor

Preface

This book can be viewed as an intellectual journey through uncharted policymaking territory. We, as members of the Oregon Consumer Scorecard Consortium, considered whether it is possible for government to make policy that will benefit consumers of health care. Specifically, we explored the question of whether scorecards can be constructed to help guide consumers in their efforts to choose a health plan, even as the health care landscape in Oregon—and throughout the nation—becomes more and more unrecognizable.

Although health care systems are changing throughout the world, the health care delivery system in Oregon has been particularly affected by the forces of change, leaving providers, consumers, and those responsible for policy formulation simultaneously concerned, worried, and hopeful.

As the Oregon Consumer Scorecard Consortium began its journey, the intellectual perspective we embraced was derived from a period often described as the golden age of American medicine: the fee-for-service, private-practice medical care system of the mid-twentieth century. Experiences from the journey have shifted our thinking toward a systems view that is more consistent with the population-based, capitated health care organizations we will all be dealing with in the twenty-first century.

Some among the traveling party were concerned that we had embarked on a fool's mission. The path to a model consumer scorecard that is designed to help consumers make informed choices among health plans was not guided by a road map already in existence. Certainly, we were daunted by the intellectual and practical obstacles we encountered. Although others before us had headed in the same direction, most had returned without reaching their goal.

What we present in this book is a road map, albeit a primitive one, that shows one way to reach the destination we sought: the production of a useful choice and purchasing tool for consumers. The volume also presents a traveler's guide to some of the more interesting scenic attractions along the way. We offer guidance and support for those who choose to undertake the challenge, whether they are naive or well-seasoned travelers.

Most of us in the consortium have come to believe that ours was not a fool's journey. Having now arrived at a stopping place, we think we have produced a thing of real value. We also acknowledge that the idealized consumer-oriented scorecard described throughout this volume has yet to be developed.

However, there is a valid basis for the fears and skepticism that plague many travelers on the scorecard path. There is no clear, direct way to proceed. The practical, hands-on information provided in this volume will be useful to those interested in creating a health plan scorecard for consumers, and it can provide a great deal of technical and common-sense guidance. But it does not contain the full complement of technological tools necessary to develop a model consumer scorecard. Such a tool box does not exist. A consumer scorecard that is tailored to the individualized information needs of consumers will probably not be available for a good many years. We do think it is possible to produce a scorecard that can help consumers in the decision-making process. That is a bold statement—one we could not have made with any degree of assurance when we began the journey described in this book.

The impetus for developing health plan scorecards came from large purchasers, especially employers, whose motives are unclear. Many health care professionals suspect that employers would like to steer their employees to less expensive, rather than higher quality, health care services. However, these same major purchasers believe that specifying the dimensions of quality on which health plans are evaluated will change plans in positive ways, thus increasing the value of the services provided. They further believe that industry norms can be changed or modified with regard to the performance measures included on scorecards.

However, many of us become skilled at directing our learning so that we can pass examinations. Health plan administrators can probably do so as well. The Health Plan Employer Data Information System (HEDIS), which is discussed in chapters throughout this volume, certainly appears to have had this effect. For example, when health plan administrators were informed that their plan would be evaluated on the extent to which the recommended immunization series for two-year-olds was being completed for members, most set out to achieve this objective. By the time the next round of HEDIS measures are released, many, if not most, health plans will probably be reporting two-year-old immunization rates nearing 90 percent. The average health plan had a rate of around 50 percent (an optimistic calculation) at the beginning of the HEDIS process.

There was no such optimism among the consumers we talked with early in our project. In fact, most consumers were skeptical that scorecards could produce useful information for selecting from available health care options. These consumers were particularly skeptical about the health plan performance measures known as HEDIS measures because many did not seem relevant. As one woman in an Oregon focus group reportedly stated, “I don’t care at all what proportion of a plan’s population had a mammogram. What matters to me is if I can get a mammogram how and when I want one.”

As you read this book, you will discover related issues, including the dimensions of health care delivery that are most important to consumers, and you will get a sense of how consumers would like to see a scorecard formatted. You will glimpse the struggles and challenges created by our current methodological limitations and have a peek at the political skirmishes inherent in the creation of a consumer scorecard. Although you should come to appreciate how these problems could vex those who undertake the journey, you will also receive some guidance on making the compromises necessary to achieve progress. And most important, you will come to understand that the choices you make will have consequences.

This book will help you understand that the journey reported here was made by people in a uniquely constituted group, with representatives from most of the possible interests contained in the field of health policy: consumers, researchers, policymakers, health professionals, and health-insuring organizations. This consortium model gave us the advantage of having a particularly broad perspective as we looked out over the road ahead. It also meant that we had the difficult task of satisfying a large, vocal, and at times unwieldy group. We hope that you will gain insight into the viewpoints, needs, desires, and contributions of this large cast of characters. Much of the richness of our story is reflected in this diversity.

Finally, we are pleased to assure the reader that those on the scorecard journey paid particular attention to two special populations of consumers who are frequently overlooked. First, for a variety of reasons, we focused on consumers who live in rural areas and therefore have limited options in arranging their health care. Second, we focused on individuals who have special health care needs such as serious chronic illness or disabling conditions. These populations are easily overlooked in scorecard development because their numbers are small; yet their information needs are great. The one universal theme expressed by consumers in Oregon, as elsewhere, is that choice information needs to be tailored to "people like me."

We very much enjoyed teaming up with our fellow travelers on this exciting but difficult journey. Our greatest rewards came from the interactions and experiences shared with our traveling companions and with those we met along the way. In that spirit, we offer this work to you.

Portland, Oregon
March 1998

PAMELA P. HANES
MERWYN R. GREENLICK

Acknowledgments

Many individuals made substantive contributions to the Oregon Consumer Scorecard Project. We would be remiss not to acknowledge the many and important contributions of our fellow travelers, particularly the Oregon Consumer Scorecard Consortium members. First and foremost, our thanks go to Vickie Gates, the former Oregon Health Plan Administrator, who had the vision and political acumen to suggest a consortium model as the appropriate vehicle for consumer scorecard development. She provided expert leadership, a quick wit, and lots of road stories along the way. To our friends and colleagues at the Agency for Health Care Policy and Research (AHCPR), Clifton Gaus, former director, and Sandra Robinson, our project officer, we owe a debt of gratitude for having the confidence and belief in the Oregon Consumer Scorecard Consortium to provide needed financial assistance for its journey. To our colleagues at the University of Washington's Rural Health Services Research Center, Ed Perrin and Sue Skillman, we owe much for their sharing of rural health research resources with Oregon to pursue this project. To each of our contributing authors in this volume, their respective accountings of the road trip typify the diversity of our traveling party. Finally, to each member of the consortium who gave countless hours and boundless energy to the endeavor, a hearty thank you.

Members of the *steering committee* were Bruce Bayley, Providence Health Systems; Bruce Bishop, Kaiser Permanente; Ralph Crawshaw, Oregon Health Decisions; Jeff Davis, Marion County

Health Department; Vickie Gates, Oregon Health Plan; Jeannette Hamby, Oregon state senate; David Lansky, Foundation for Accountability; David Lindquist, Oregon Medical Association; Lew Parker, Parker Printing; Ken Rutledge, Oregon Association of Hospitals and Health Systems; Dick Shoemaker, Office of Medical Assistance Programs; Barney Speight, The Benchmark Group; and Mylia Wray, Benova, Inc.

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Members of the *technical committee* were Berhanu Anteneh, Office of Medical Assistance Programs; Diane Bennett, Benova, Inc.; Jonathan Brown, Kaiser Permanente Center for Health Research; Julia Bryan-Wilson, Oregon Health Policy Institute; Ted Colombo, Kaiser Permanente (retired); Tina Edlund, Office of Medical Assistance Programs; Dan Harris, Health Resources Commission; Dawn Hayami, Kaiser Permanente; Judith Hibbard, University of Oregon; Holly Jimison, Oregon Health Sciences University; Diana Jones, Oregon Health Policy Institute and Oregon Health Plan Administrator's Office; David Lansky, Foundation for Accountability; Cindi McElhaney, Physician Association of Clackamas County Health Plan; Scott Page, NW Surgical Associates; David Phillips, Oregon Health Sciences University; Pia Schneider, Blue Cross/Blue Shield of Oregon; Paul Sher, Oregon

Health Sciences University; and Dan Stevens, Center for Outcomes Research and Education.

Members of the *consumer committee* were Becky Adelman, consumer-at-large; Sue Burlison, Office of Medical Assistance Programs; Gloria Colton, consumer-at-large; Ruben Contreras, consumer-at-large; Pat Gardner, consumer-at-large; Vickie Gates, Oregon Health Plan Administrator; Lew Parker, consumer-at-large; Sandra Spiegel, consumer-at-large; Len Torvinen, consumer-at-large; Nicholas Wickliff, consumer-at-large; and Mylia Wray, Benova, Inc.

Finally, we pay particular tribute to Peter Kohler, M.D., president of the Oregon Health Sciences University, and to Judith Ramaley, Ph.D., former president of Portland State University for having the vision and clarity of intent that spawned the Oregon Health Policy Institute in 1993 to serve as an academic resource to policymakers in the state of Oregon.

P.P.H.
M.R.G.

The Editors

Pamela P. Hanes is an associate professor of public health and preventive medicine and associate director of the Oregon Health Policy Institute at the Oregon Health Sciences University in Portland, Oregon. Hanes earned her B.S. in sociology of the family at West Virginia University, Morgantown (1974), her M.S.W. in health policy and administration from California State University at Sacramento (1987), and her Ph.D. in social welfare policy from the University of California, Berkeley (1989). Before joining the School of Medicine faculty at the Oregon Health Sciences University, she was on the faculty in the School of Social Work at the University of Wisconsin, Madison.

Hanes has worked in the field of health policy, health services research, and health program evaluation for the past twenty-five years, analyzing health policies from a variety of vantage points, including service as a principal consultant on health and welfare to the California Assembly Ways and Means Committee, as a program developer and project evaluator for three private foundations in the San Francisco Bay Area, and as an academically based health services researcher and scholar at the University of California, San Francisco, in addition to her tenure in Madison and Portland. Hanes's main research interests have focused on state policy formulation as it relates to access to quality care for vulnerable and otherwise disenfranchised populations. She has conducted numerous studies in the areas of health and disability policy, identifying and analyzing nonfinancial barriers to health care access and measuring the impact of managed care on children with special health care needs and persons with significant physical disabilities. In her research, Hanes has focused on the experience of health and medical care from a consumer perspective. Issues related to the influence of culture, ethnicity, and individual differences have received special emphasis in her work.

Merwyn R. Greenlick is a professor and is chair of the Department of Public Health and Preventive Medicine, School of Medicine, Oregon Health Sciences University. He was, until July 1995, director of the Kaiser Permanente Center for Health Research and vice president for research, Kaiser Foundation Hospitals. Greenlick received his B.S. in pharmacy and his M.S. in pharmacy administration from Wayne State University in Detroit, Michigan, and his Ph.D. in medical care organization from the University of Michigan, with specializations in sociology, social psychology, and research design.

Greenlick has served as research adviser to many projects throughout the country and as an adviser to several foreign government research and medical care projects. He was elected to the Institute of Medicine (IOM) of the National Academy of Sciences in 1971. He has served on a number of IOM study committees and chairs the IOM's committee on community-based drug treatment. He has served on a variety of National Institutes of Health review panels, including the health services development panel. Greenlick was a senior fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford during 1995–96. He currently serves as an adviser to the chair and CEO of the Kaiser Foundation Health Plan.

Greenlick's research has been in the areas of large-scale demonstration projects relating to the organization and financing of medical care and behavioral interventions in disease prevention. He was a co-principal investigator for the Medicare Prospective Payment Demonstration Project ("Medicare Plus"), which provided care to over 7,600 Medicare beneficiaries on a capitation basis. He