

# THE PATIENT CHARTER: A Way To Enhance The Rigor And Relevance Of Physician Reporting Programs?

By Ann Greiner and Michelle Johnston-Fleece



In the spring of 2008, physician groups, health plans, consumer organizations and employers agreed upon a set of national principles to govern physician reporting programs. Embodied in the "Patient Charter," these principles constitute an initial consensus among stakeholders who have historically differed around a voluntary approach to reporting on physician performance. The New York State Attorney General's office and the threat of lawsuits brought these parties to the table and helped to foster a possible truce around proliferating but contentious efforts to measure physician performance. This agreement holds out the promise that future physician report cards will more consistently meet high scientific standards and be both more transparent and more meaningful to patients and physicians. Tracking the issues surrounding public reporting is important to the American Board of Internal Medicine (ABIM) as the organization considers how to enhance transparency of physician information, one of four priorities in its strategic plan.

## PROBLEMS ASSOCIATED WITH PROLIFERATING PHYSICIAN REPORTING PROGRAMS

Public reporting on physician performance is a growing trend. In 2008 alone, Angie's List and Zagats joined the ranks of HealthGrades, various websites such as RateMDs.com and numerous health plans in varied efforts to assess, rank and report on physician quality and/or cost performance. Many of these initiatives were developed to support consumer information needs and to respond to the growing desire for enhanced accountability, but they have been met with organized resistance by physician groups and criticism by independent experts. The problems identified by these groups include faulty methodologies, reporting systems focused solely on cost or anonymous web comments, statistical errors and a lack of transparency, among other concerns.

State and county medical societies have taken varying actions in a number of regions to challenge health plans' physician reporting and tiering programs, including catalyzing public outcry (Missouri, Texas, Tennessee); filing lawsuits to stop or delay reporting efforts (Massachusetts, Connecticut, Washington); and participating in the development of legislative and regulatory actions to govern implementation of such programs (New York, Colorado).

## A SHARED GOAL: PROTECTING PATIENTS

Concerns about physician reporting programs reached a high pitch in the summer of 2007 when the Office of the Attorney General (AG) of the State of New York threatened to file a lawsuit against UnitedHealthcare, which was planning to introduce its physician "Premium Designation" program in New York. Other health plans operating physician reporting programs in the state received similar warnings from the New York AG's office.

Initially, the AG's office intended to stop these programs because, in its view, the programs lacked consumer protections. The problems for consumers included little to no information about how ratings were developed; confusion over being forced to change doctors when a long-time doctor was no longer designated a preferred provider in their network; and concern about the potential for conflict in health plans' reporting programs, particularly those that might steer consumers to choose physicians based on cost alone. The AG office's actions were also a response to urgent concerns about the programs raised by the physician community.

When leaders of the Consumer-Purchaser Disclosure Project – a coalition of over 60 consumer, labor and purchaser organizations – became aware of the New York AG's threatened lawsuit, they decided to get involved in order to make ratings more informative and valuable for consumers. "We believe that when these efforts are properly executed they can provide consumers with information to make better decisions

The Patient Charter specifically references the Physician Charter,<sup>1</sup> which has been adopted by 130 physician organizations across the globe and was developed by the ABIM Foundation, ACP Foundation and European Federation of Internal Medicine. The Physician Charter focuses on a set of core principles of professionalism that includes improving quality of care and just distribution of finite resources.

Specifically, the Physician Charter calls upon physicians to "actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems..."

The Patient Charter holds out the promise of more physician involvement in developing reporting programs and may build confidence in the physician community that these programs are valid and useful in helping physicians to improve quality.

<sup>1</sup> <http://www.abimfoundation.org/professionalism/charter.shtm>

## ABIM FOUNDATION'S MISSION:

To advance medical professionalism and physician leadership in quality assessment and improvement.



“WE ACKNOWLEDGED THAT SOME OF THESE PROGRAMS WERE DONE POORLY AND INACCURATELY, BUT WE DID NOT WANT TO THROW THE BABY OUT WITH THE BATHWATER.”

– PETER LEE, CO-CHAIR, CONSUMER-PURCHASER DISCLOSURE PROJECT AND EXECUTIVE DIRECTOR FOR NATIONAL HEALTH POLICY, PACIFIC BUSINESS GROUP ON HEALTH

“THE NEW YORK ATTORNEY GENERAL’S OFFICE NOT ONLY BROUGHT EVERYONE TOGETHER, THEY HAD THE POWER TO MAKE SOMETHING HAPPEN.”

– NANCY NIELSEN, MD, PHD, PRESIDENT, AMERICAN MEDICAL ASSOCIATION

about care and give doctors the kind of feedback they need to improve the quality of the care they deliver,” said Debra Ness, Co-Chair of the Consumer-Purchaser Disclosure Project and President of the National Partnership for Women & Families.

Staff from the AG’s office, health plan leaders and the American Medical Association all highlighted the critical role that leaders from the Consumer-Purchaser Disclosure Project played in helping to educate the stakeholders involved and, ultimately, in shaping the resulting agreements. The firsthand knowledge they brought to the table about the kind of information patients are seeking about their physicians and their understanding of the intricacies and complexities of physician measurement were noted in particular.

“It was clear that making this effort a success would rely on bridging the needs of consumers with the concerns of physicians, and the business realities of payers,” said Ness. “I’ve had a window into how physicians view reporting programs – and where they seek improvement – through my role as an ABIM Foundation Trustee, and via our ongoing dialogue with ABIM about these very issues,” she added.

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### **BUILDING MULTI-STAKEHOLDER CONSENSUS**

Over the second half of 2007, health plans and other stakeholder groups met with the AG’s office to discuss how physician reporting programs could be improved.

These conversations were informed by the input of independent experts, informal “shuttle diplomacy,” and proposed criteria drafted by the Consumer-Purchaser Disclosure Project. The AG’s office described itself as agnostic with respect to the ultimate merits of reporting programs, while underscoring its primary motivation for getting involved – ensuring that consumers are protected.

The first agreement was struck by the AG’s office with CIGNA, followed by Aetna, Empire Blue Cross Blue Shield, Excellus, UnitedHealthcare, Health Insurance Plan of Greater New York (HIP), Group Health Incorporated (GHI), Independent Health and MVP/Preferred Health.<sup>2</sup> Eventually, all New York health plans either operating or considering operating a physician reporting program signed agreements with the AG’s office to ensure that the ratings were fair, rigorously derived and available to consumers. Further, where relevant, these plans agreed to apply the same reporting criteria to their plans across the country.

As individual agreements with specific health plans were reached, the leaders of the Consumer-Purchaser Disclosure Project concluded that it would be a waste of time and money for states across the country to structure their own agreements with organizations that sponsor physician reporting programs. They felt that not only would such efforts undermine existing work to develop a common standard, numerous agreements would be confusing to consumers and make it difficult to provide guidance about what should be expected from such programs.

As a result, the leaders of the Consumer-Purchaser Disclosure Project developed the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness and Independent Review” (the Patient Charter),<sup>3</sup> which parallels many of the criteria included in the New York agreements. The Patient Charter benefited from input by leading physician groups and the nation’s major health plans and from attempts to strike a balance between standardizing physician reporting programs and allowing for innovation in the development of performance measures.

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<sup>2</sup> The agreements are available on the AG’s website, linked within relevant press releases: [http://www.oag.state.ny.us/bureaus/health\\_care/HIT/doctor\\_ranking.html](http://www.oag.state.ny.us/bureaus/health_care/HIT/doctor_ranking.html).

<sup>3</sup> To download the Patient Charter and to get up-to-date information on Patient Charter activities and endorsements, see the Consumer-Purchaser Disclosure Project website: <http://healthcaredisclosure.org/activities/charter/>



The Patient Charter commits health plans and other sponsoring organizations to adopt and publicly report the Charter elements, to align their reporting programs with national quality measures and to make their measures and methodology fully transparent. It also requires that health plans retain – at their own expense – an independent, nationally recognized standard-setting organization to review health plan programs against the Patient Charter criteria every three years.

The criteria for reporting programs can be grouped under four main principles:

**1. Programs should be fair and have input from physicians**

- Physicians/physician organizations are involved in the development of reporting programs, including the underlying methodology
- Physicians are given reasonable prior notice before release of information and the opportunity to correct inaccurate results
- Physicians are provided with information from these programs to inform changes and improvements in their own practices

**2. Measures should be meaningful to consumers and reflect diverse clinical activities**

- Measures are directed at the Institute of Medicine's six aims and, where feasible, include patient experience, and are reflective of consumer health and information needs
- Reporting programs may not solely rely on cost-efficiency information and they must reveal the proportionate weighting given to cost and quality elements
- Consumers/consumer organizations must be involved in the development of these programs, the programs must provide consumers with appropriate context for understanding and using the ratings and they must have a clearly defined consumer complaint process

**3. Measures and methods should be both transparent and valid**

- Measures and related ranking methodologies are made available to the public, with key elements assessed against national standards, e.g. risk/severity adjustment
- Information about the comparative performance of physicians is made accessible to consumers and the rationale/methodology related to the unit of analysis is made available
- Any limitations on the usefulness of the results are publicly communicated, and the overall program is regularly evaluated, including a review of any unintended consequences
- Sponsors of reporting programs are encouraged to aggregate data and to align and harmonize measures where possible to reduce redundancy and burden for providers

**4. Measures should be based on national standards, wherever possible**

- The primary source of measures for the reporting programs is the National Quality Forum (NQF); where they do not exist, measures endorsed by AQA, accrediting bodies or federal agencies may be used
- Supplemental measures also may be used where national standards do not yet exist or existing measures are unduly burdensome, but these measures should follow NQF criteria to the extent possible

As of July 9, 2008, 42 organizations had endorsed the Patient Charter, including: AARP, the National Partnership for Women & Families, the AFL-CIO, the Leapfrog Group, the Pacific Business Group on Health, the National Business Coalition on Health and various physician specialty groups including the American Association of Family Physicians, the American Medical Association, the American College of Cardiology, the American College of Physicians and the American College of Surgeons. Health plans that have adopted the Patient Charter include America's Health Insurance Plans, American Association of Preferred Provider Organizations, Aetna, BlueCross BlueShield of Tennessee, CIGNA, Geisinger Health Plan, UnitedHealthcare and WellPoint.

"THE PATIENT CHARTER STANDS ON THE SHOULDERS OF THE NEW YORK AGREEMENTS. THE MAJOR DIFFERENCES BETWEEN THE TWO DOCUMENTS INCLUDE THE MULTIPLE STAKEHOLDERS WHO HAVE SIGNED ON TO THE CHARTER – REPRESENTING A SIGNIFICANT BOOST FOR TRANSPARENCY – AND THE IMPLICIT CONSENSUS THAT THE BROADER COMMUNITY IS WILLING TO TRY A VOLUNTARY MARKET-BASED APPROACH."

– SAM HO, MD,  
EXECUTIVE VICE PRESIDENT  
AND CHIEF MEDICAL  
OFFICER, UNITEDHEALTHCARE



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## LESSONS LEARNED AND IMPLICATIONS

A commitment to include data on quality (rather than cost alone) in any rankings, the inclusion of criteria on transparency of methods and the recommendation that health plans engage an outside, independent organization to review their programs helped to build consensus around both the New York agreements and the Patient Charter.

Linda Lacewell, Counsel for Economic and Social Justice at the Office of the Attorney General of the State of New York, explored how best to structure ongoing monitoring of the New York agreements by getting input from various consumer, physician and health stakeholders. “The conversations kept stressing that what is needed is an independent intermediary who is credible to the various parties to play an oversight role,” said Lacewell. “The health plans selected and we approved NCQA [National Committee for Quality Assurance],”<sup>4</sup> she added.

The Patient Charter also includes a role for a monitor but does not specify any particular independent reviewer. Instead, the document details the characteristics a qualified vetting organization should possess, including multi-stakeholder input into standards, a public comment process and field testing of the standards prior to implementation.<sup>5</sup> “We learned through this experience that we need to be sensitive to what consumers *and* doctors need in physician reporting programs,” said Peter Lee, Co-Chair, Consumer-Purchaser Disclosure Project and Executive Director for National Health Policy, Pacific Business Group on Health. “In the past, many employers weren’t as tuned in as we should have been to physician concerns. These conversations forced us to take a step back and make sure the plans representing our employers were taking proper aim before they fired.”

Previous misfires have made physician groups wary. “We’re not clamoring for report cards,” said Nancy Nielsen, MD, PhD, President of the American Medical Association. “That said, we want patients to have good information and we would like to have a different and better relationship with plans than we have had in the past. The involvement of an outside, independent organization helping to enforce the agreed upon criteria might get us there.”

While it is too soon to assess the success of either the New York agreements or the Patient Charter, the various stakeholders are hopeful that these standards will stave off legislative and regulatory efforts in states that could result in multiple standards in communities across the country. A proliferation of different standards could hamper both innovation and the consistency and usefulness of quality reporting data. Many of the leaders involved in establishing the Patient Charter have indicated that this kind of agreement would not have been possible even a few years ago, and underscored the historic nature of specialty society endorsement. They have also expressed cautious optimism that the effort might serve as a model for multi-stakeholder cooperation on future issues in healthcare.

The true test of this agreement will be health plans across the country implementing the Patient Charter criteria, independent organizations verifying that they have met the applicable criteria, a reduction in physician organization pushback – regulatory, legislative or otherwise – surrounding these efforts, and consumers beginning to seek out these new standards. Dr. Nielsen concluded, “we’re willing to try this on a voluntary basis and see how it works.”

<sup>4</sup> NCQA has recently established a website (<http://nyrxreport.ncqa.org>) to report on their examinations of health plan reporting programs in New York.

<sup>5</sup> In August 2008, the Consumer-Purchaser Disclosure Project endorsed NCQA and its Physician Hospital Quality certification program as one way for measurement sponsors to have their programs assessed against the Patient Charter.

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