

MICHIGAN STATE MEDICAL SOCIETY

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MSMS Principles on the Release of Physician-Specific and Physician Group Data

Collection, analysis, and release of physician- specific and physician group data should be aimed at improving patient health and education and should utilize methods that will increase the knowledge base of physicians, consumers, government and employers about the quality of care and the impact of health behaviors and social conditions on health. Quality, patient safety, efficiency, appropriateness of care, patient satisfaction and cost all are important dimensions of care for measurement and improvement. For this purpose, physician groups include physician organizations, independent practice associations, and less formal self-aggregations of physicians.

The Michigan State Medical Society advocates that physicians, hospitals, employers, payers, government entities, and others collaborate in the collection, analysis, and/or release of physician-specific and group health care data, and adhere to the following principles:

- Any effort in collecting and analyzing physician- specific and group health care data should allow for a fair process of physician collaboration, including those whose practice will be measured, in the development of measurements and reports, review of databases, analysis, and ongoing refinements for accuracy.
- Physician-specific and group health care data shall be objective, valid, and accurate, and are to be used for the education of physicians, as well as consumers, employers and government officials. In programs in which public release is the goal, it is critical that validated and accepted methodologies of risk adjustment be used. The exact specifics of the risk adjustment methodologies must be released. Data should be used to construct educational programs, to identify areas that merit further investigation, and to improve the process of care.
- Risk adjustment factors relevant to the specific outcomes must be used, including, when appropriate: age/sex, health risks specific to the outcomes, case mix adjustment, severity adjustment, benefit level/structure, practice specialization, other relevant risk factors, and the impact of chance variation. Depending on the outcome being measured, data may also need adjustment for geography, socioeconomic status, family/social support, health behaviors such as smoking, substance abuse, diet and exercise, and/or job-specific risk factors. All-payer models of data collection and analysis will help overcome small-number variation.

- Physicians under review and relevant physician organizations shall be provided an adequate opportunity to comment on proposed physician-specific health care data projects and disclosures of their outcomes prior to publication or release.
- Physician groups, physician organizations and payers should collaborate to create the most efficient and effective way to aggregate all payer, all patient data to provide a comparative view of the physician's practice to guide process improvement.
- Effective safeguards to protect against the dissemination of skewed, preliminary, unadjusted, or misleading results shall be established.
- Reliable administrative, technical, and physical safeguards to prevent the unauthorized use or disclosure of physician-specific or group health care data shall be developed and implemented. Consistent with Michigan law, such safeguards shall treat all underlying physician-specific and group-specific health care data and all analyses, proceedings, records, and minutes from quality review activities on physician-specific and group-specific health care data as confidential quality improvement documents, and provide that none of these documents shall be subject to discovery, or admitted into evidence in any judicial or administrative proceeding.
- The quality and accuracy of physician-specific and group health care data shall be evaluated by conducting periodic medical record audits and maintaining a mechanism to ensure continuous updating of data under review.
- Any aggregated analysis and use of data should be evaluated periodically to assess the impact on quality and efficiency.

(Revisions to the January 2005 version as proposed by the MSMS Committee on Quality, Efficiency and Economics)