Health Policy
NEWSLETTER
Vol. 25, No. 1 | WINTER 2012

Physician Profiling in Primary Care in Emilia-Romagna Region, Italy: A Tool for Quality Improvement

According to the American Academy of Family Physicians (AAFP), physician profiling is an analytic tool that, via epidemiological approaches, supplies physician groups with information on physician practice patterns across various quality of care dimensions.[1] The desired benefit of profiling is that analyzing and comparing patterns of care will raise provider awareness of quality and will help stimulate improvement by reducing the variation in performance among physicians through audit and feedback.[2]

Primary care lies at the core of the Italian National Health Service (NHS), which maintains universal coverage to all citizens either free or at minimal charge at the point of service.[3] In each of the 21 regions of Italy, Local Health Authorities (LHAs) are responsible for the delivery of primary care provided by general practitioners (GPs) to a geographically designated population. Traditionally, GPs have worked in solo practices. However, in the last ten years, in an effort to increase coordination of care the Italian NHS has introduced substantial reforms seeking to encourage collaborative arrangements among GPs. Since 2006, in order to build on earlier national reform, the Emilia-Romagna region--a large region located in northern Italy with a population of about 4.6 million inhabitants--has required GPs in the 11 LHAs of the region to join a Primary Care Team (PCT). A PCT includes, on average, 15 GPs; the GPs, many of whom remain in solo practice, act in full autonomy, but are part of clinical networks designed to provide patients with integrated delivery of healthcare. As such, in the team GPs are mandated to collaborate and share information and, by means of clinical governance, to engage in improving the quality of healthcare services provided to patients. GPs elect a member as the team coordinator, who is in charge of organizing meetings on a regular basis to discuss care activities within the LHA healthcare initiatives.

To facilitate the role of the team coordinator and promote collaboration and the sharing of information among GPs, the Emilia-Romagna region established a tool to supply each PCT with data on the quality of care offered to their population. To this end, using the regional healthcare administrative database (an anonymous comprehensive and longitudinal database linkable at the patient and provider level)[4] in 2007 the Emilia-Romagna region and Thomas Jefferson University began collaborating to provide PCTs with patient quality data via "profiles."

The profiles were initially developed and tested for the 21 PCTs of the LHA of Parma and subsequently for the 23 PCTs of the LHA of Reggio Emilia before being launched in 2009 in all 216 PCTs of the Emilia-Romagna region, reaching a total of 3,215 GPs. The profiles, distributed to the PCTs on an annual basis, describe the demographic information and morbidity data of the PCT population, furnish data on healthcare resources used by PCT patients, including hospital care, outpatient pharmacy data, and specialty care, and provide information on a number of quality indicators related to the activities in several clinical areas provided by the GPs. A scientific advisory committee including clinicians and representatives of all LHAs, coordinated by the Emilia-Romagna region and Thomas Jefferson University representatives, annually reviews and updates the content of the profiles and monitors the project.

How are the profiles being used? Every year the profiles are presented to the team coordinators in educational sessions; in turn, they are mandated to introduce the profile data to their peers in the team. The team coordinators are assisted by a group of professionals selected in each LHA called "facilitators," trained to help the physicians review and interpret the data. Then, the GPs in each team are asked to identify at least one critical area of the profile data and initiate quality improvement activities in their practice accordingly, and when appropriate, review guidelines with specialists and hospital clinicians.

Through an agreement with the LHA, GPs may receive financial incentives to participate in the activity of the PCT profile. It is important to note that the profiles are not meant to be "punitive;" rather, the profiles are intended to promote teamwork and coordination, ingrain a culture of quality and encourage clinical discussion in the PCT in order to improve the organization and delivery of the services to the population .[5] It is too early to say whether the PCT profile has achieved its objectives; however, preliminary results in the two LHAs of Parma and of Reggio Emilia, early adopters of the profiles, are promising. Performance for the quality indicators has overall improved. For instance, the proportion of AMI patients receiving beta-blockers and statins in the ambulatory setting after hospital discharge has increased to about 90% in 2010 from approximately 70% in 2007 before the intervention. In addition, GPs seem to have a positive view of the profiles. A focus group recently conducted in both LHAs showed a substantial agreement among GPs on the usefulness of the profiles to reflect on their daily activities and foster a culture of quality; to increase the colloquium within the PCT; and to encourage reviews of current practice and reach uniform clinical behavior.

As the profiles are currently implemented in all 216 PCTs in the region, the hope of the Emilia-Romagna region is that these results will be replicated in all Local Health Authorities. The use of physician profiling in primary care in Emilia-Romagna associated with a no-punitive strategy appears to be an effective way to help clinicians as they strive to improve the quality of care they provide to their patients. ■

Continued on next page

For information on quality indicators, their specifications, and related literature visit the Emilia-Romagna regions website at: http://www.regione.emilia-romagna.it/prim/
For more information on this research contact: vittorio.maio@jefferson.edu

Health Policy
NEWSLETTER

Vol. 25, No. 1 | **WINTER 2012**

Vittorio Maio, PharmD, MS, MSPH,[1]
Andrea Donatini, MSc,[2] **Eric Jutkowitz, BA,**[1]
Stefano Sforza, MS,[2] **Stefano Del Canale, MD, PhD,**[3]
Maria Beatrice Bassi, MD,[4] **Massimo Fabi, MD**[3]**,**
Maria Lazzarato, MD,[5] **Daniela Riccò, MD,**[4]
Antonio Brambilla, MD,[2] **Daniel Z. Louis, MS**[6]

1. Jefferson School of Population Health, Thomas Jefferson University, USA
2. Health Care Authority, Emilia-Romagna Region, Italy
3. Local Health Authority, Parma, Italy
4. Local Health Authority, Reggio Emilia, Italy
5. Local Health Authority, Imola, Italy
6. Center for Research in Medical Education and Health Care, Thomas Jefferson University, USA

REFERENCES

1. American Academy of Family Physicians. Physician Profiling, Guiding Principles. Available at: http://www.aafp.org/online/en/home/policy/policies/p/physicianprofiling.html Accessed November 26, 2011.

2. Goldfield N, Gnani S, Majeed A. Primary care in the United States. Profiling performance in primary care in the United States *BMJ*. 2003; 326(7392):744–747.

3. Lo Scalzo A, Donatini A, Orzella A, Cicchetti A, Profili S, Maresso A. Italy:Health system review. *Health Systems in Transition*. 2009;11(6)1-216

4. Louis DZ, Yuen EJ, Maio V, Rabinowitz C, Robeson M, Smith KD, Gonnella JS. A population-based longitudinal health care database in the Emilia-Romagna Region, Italy: A resource for planning and research. *Health Policy Newsletter*.2005;18(2):6

5. Lilford R, Mohammed MA, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute medical care: avoiding institutional stigma. *Lancet.* 2004;363:1147-54.