



Care Focused Purchasing, Inc.
Transforming Health Care

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Providers and Performance Measurement: Helping Patients and Providers

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Care Focused Purchasing commissioned this white paper to give providers—particularly doctors and hospitals—a framework to understand how performance measurement and transparency can help them to improve patient outcomes, improve patient relationships, support their professional goals, and strengthen their market positions.

Introduction

Physicians are central to ensuring quality health care given their role as the key decision maker in determining what services patients receive. In fact, the vast majority of health care spending (~80%) is the result of direct care by a physician or care provided on a physician's order, illustrating the enormous power physicians hold in the health care system. The traditional fee-for-service payment structure perpetuates physician control of health care dollars as doctors are reimbursed for each service they provide.

Purchasers of care (employers, government and health insurers) have watched health care costs rise faster than inflation over the past 40 years. While advances in medical technology and patient care have dramatically improved the lives of millions of Americans, as is evidenced by the recent health care reform legislation (Patient Protection and Affordable Care Act with amendments made by the Health Care and Education Reconciliation Act), our health care system is under significant scrutiny. A decade after the Institute of Medicine's (IOM) report, *To Err is Human*, quality measures tracked by the Agency for Healthcare Research and Quality (AHRQ) showed only small annual gains, while patient safety measures actually declined.ⁱ

Our fragmented health care system often fails to meet the IOM's aims of safe, timely, effective, efficient, equitable and patient-centered (STEEEP) care, despite physician efforts and increasing spending. Errors and omissions occur in the midst of highly complex and intensive inpatient care, as well as in outpatient care settings for patients with routine conditions. It is therefore not surprising that health outcomes in the United States are often worse than those in other developed and even developing countries. More importantly, research repeatedly demonstrates the huge variation in care from place to place around the country and within markets as well.

Health care providers (physicians and the hospitals and health care systems with which they are affiliated) take pride in their achievements and reputation, and are committed to quality improvement to address these gaps in care. However, as stated by IOM's President Dr. Harvey Fineberg, "the only way to know whether the quality of care is improving is to measure performance."ⁱⁱ

Payers (employers and health insurance companies), in response to these dynamics, are beginning to use performance information in purchasing decisions, as well as making that information available to members covered by the benefit plans they fund. The trend towards performance measurement, public reporting, and incentive structures means physicians must explore new business models to have the greatest impact on improved

health care for their patients, while ensuring a financially viable practice. This changing medical landscape is posing new challenges to how physicians have traditionally been assessed, recognized and reimbursed. There are, however, clear advantages of performance measurement systems, most importantly for the patients who are receiving more effective care, but also for providers who may professionally benefit.

The Importance of Performance Measurement to Care Focused Purchasing

Initially formed in 2003, Care Focused Purchasing, Inc. (CFP) is an innovative coalition composed of employers and health insurance carriers committed to lowering cost trend and improving quality by increasing the transparency of information in the health care system. CFP members believe that a more transparent, rational market for health care could reduce cost pressures, correct quality defects, and reverse decreases in consumer confidence that jeopardize the current system.

As purchasers of healthcare, CFP employer members and health plan partners want to encourage the use of providers that excel in providing high quality, cost-efficient care. We believe that market forces, driven by transparent and consistent provider performance information, will align incentives for providers with their customers' needs, improve individual responsibility for health management, and lead to even greater freedom of choice.

We pursued our goal of building a market that rewards better physicians, better hospitals, and better treatment options through three key tactical objectives:

- Development, from existing sources, of industry standard provider performance metrics
- Aggregation of non-financial claims data to enable the most robust and credible application of the performance metrics
- Deployment of aggregated data by partnering carriers to help in provider education, network management, and consumer decision support

We've seen a moderation of health care trend over the past couple of years. The focus of many employers on quality and efficiency, which in turn influences carriers and providers to expand their efforts in this area, is one of the key factors that have resulted in more favorable trends. Our application of these measures to two data aggregation runs provided important learnings for future efforts to perform large-scale provider measurement.

The current health care market

The health care system is unique and unlike any other consumer driven market. A traditional competitive market involves multiple buyers and multiple sellers with interchangeable products or services being offered. Under a system of transparency of both price and quality, buyers and sellers are free to choose whether or not to enter into a given transaction without time pressure and with access to all necessary information to make prudent decisions on their own.

While no industry or market truly meets the strict definition of transparency, the automobile industry is a useful example of a competitive marketplace. Consumers can choose among dozens of automakers with many dealerships selling similar products. While cars are not interchangeable, consumers can select from among similar styles of car (e.g., sedan, SUV), and can decide to purchase or lease a new or used car. Public information about cars is widespread and readily available, with numerous print and online publications available with reviews and ratings of different models for safety, reliability, and consumer experience. Prices are clearly posted on each automobile, and extensive advertising and on-line comparison shopping services, make it fairly easy to comparison shop.

Healthcare is obviously different in many ways. While the patient is a small buyer, and has many physicians to choose from for most specialties, hospital choice is more limited, especially in rural areas. In addition, the purchase of a car is usually discretionary. Even if an existing automobile abruptly fails or is damaged, there are short-term options for alternative transportation (public transportation, taxi, rental car, bicycling or walking) so a consumer is not forced into a decision on a moment's notice. Patients facing an urgent need for medical care do not have the luxury of time. A patient cannot carefully consider the options when having chest pain, or renal colic, or while trying to comfort their infant with fever or dehydration.

Additionally, medical services, even when competently delivered, clearly demonstrate variations in the quality of care, and providers are certainly not homogeneous. Perhaps the most glaring exception to the rules of a competitive marketplace is the lack of an arms-length relationship and the lack of information available to consumers. Providers have disproportionate power in the transaction, due to the expert knowledge they possess. Often, the seller (provider) acts as the agent for the buyer (patient). In many markets this would be an obvious (and perhaps illegal) conflict of interest. Patients rely on the professionalism of providers to guide them to the treatments.

Efforts are underway to transform healthcare so it resembles other consumer markets. A recent Commonwealth Fund report *Slowing the Growth of US Health Care Expenditures: What are the Options* outlined six strategies to increase the effectiveness of the health care market, including "better information and greater competition."

What purchasers are trying to accomplish

Purchasers of health care, more so than providers and patients, are perhaps most aware of these marketplace challenges. Insurance companies, employer groups and government agencies must focus their attention on the value they derive from the increasingly expensive health care they buy for their constituents. The quest for the highest quality, cost effective care has driven many purchasers to establish new business models. The Leapfrog Group, for example, resulted from several large employers who came together to address their spending billions of dollars on health care for their employees with no way of assessing health care quality and no means of comparing the providers of that care. One of the first large concerted efforts by purchasers to encourage and demand

dramatic improvement (“leaps”) in the quality of care and patient safety, Leapfrog employers were able to work together to use the way they purchased health care to have an influence on its quality and affordabilityⁱⁱⁱ.

Standardized assessment reports, like Leapfrog, helped to drive a shift in the way insurance companies reimbursed physicians. By 2004, some of the largest health plans in the country covering over 20 million enrollees had pay-for-performance (P4P) programs that incentivized physicians based on cost and quality data. Now, nearly all large health plans include P4P in their provider contracts.

In support of this trend, and to ensure consistency among P4P models, in 2006, Health and Human Services Secretary Michael Leavitt convened a joint summit of purchasers and announced four goals to drive value-driven care: 1) transparency of quality, 2) transparency of price, 3) incentives for high-value care, and 4) interoperable health information technology. The National Business Group on Health, a collaborative of large health care purchasers, has continued to pursue this goal with eValue8, a survey designed for “evaluating health plans based on value, not just on price.”^{iv}

Providers must consider the demand for value-based care. While in the past they may have focused more on patient volume and number of procedures given the fee-for-service reimbursement structure, the P4P trend allows providers to focus more valuable time with their patients to discuss how to improve conditions and outcomes. Ultimately, providers will be rewarded for providing the highest quality of care, and doing so most efficiently. With better results on performance measures, providers can command better pay and will attract more patients.

Provider perspectives on performance measurement

While the pay-for-performance model makes sense theoretically, providers have expressed concern regarding the accuracy and relevance of the data, performance measures, and reporting tools that have been used to drive critical decision-making by purchasers. Just as important, physicians are concerned that public reporting of measurement outcomes will be flawed: based on incorrect data, faulty analysis, invalid measures, or excessively narrow scope. Last, providers want the opportunity to check and correct errors that may occur before they are released to the public.

To assure providers that performance measurement programs will be developed in a fair and reasonable way, the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs was developed to outline standards for measurement and reporting. Leading consumer, labor and employer organizations who share the conviction that public reporting of physician performance is integral to improving the health and health care of patients have endorsed this effort. The Patient Charter complements the Physician Charter developed by the American Board of Internal Medicine Foundation, which asserts “physicians must 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 responsible for health care delivery.”^v

The implications of the Patient Charter are that measurement efforts will be more transparent and open to outside review. Measures will be more consistently applied, across different efforts and locations, and will maintain usability for consumer decision making. By equipping providers with information about how measures are being used, they can provide input into the process and can address imperfections that might arise in their own ratings. In the end, performance measurement will be more accurate, more relevant, more helpful to consumers, and will allow providers to focus on what is most important—improving their own role in providing quality and cost effective care for their patients.

In addition to the Patient Charter, standards for measuring performance have been established by the New York State Attorney General Andrew Cuomo’s Office. Cuomo and his team reached agreements in 2007 and 2008 with health plans, and set forth an “agreement concerning physician performance measurement, reporting and tiering programs” to ensure accuracy, transparency and oversight. This included similar provisions to the Patient Charter, such as: measures of quality were defined as those meeting the IOM’s goals of STEEEP; performance includes measures of cost-efficiency; there must be full transparency in the methods used to create performance scores; national standard measures, including those endorsed by the National Quality Forum, were preferred; physicians must be informed of their performance scores in advance of the public, and have the opportunity to appeal; and measures of efficiency must use episodes of care with risk adjustment and full disclosure. Through adoption of the Patient Charter and the New York agreement, standards for performance measurement programs have been established, and guidelines are in place for other states to follow.

Despite the creation of such standards, some large provider organizations have used contract provisions to prevent disclosure of their performance data. These “gag rules” may require advance permission before any data related to a particular provider or provider comparisons can be made public. Other stipulations, such as “product participation” clauses or “guaranteed inclusion” provisions are used by some powerful provider organizations to ensure that they are immune to any negative effects of measurement programs.^{vi}

Such contract provisions have obstructed the transition to transparency. Limiting public access to information has the potential to harm the consumer/patient and purchaser by perpetuating substandard care. In addition, a health care model that reimburses providers based on factors other than quality has led to physician shortages (and surpluses) in some specialties or geographic areas.

Standardization of a performance measurement system accomplished through a variety of collaborative approaches may enable payers and providers to feel confident about the presented data, and will reduce unnecessary costs related to data collection and analysis. The Council of Medical Specialty Societies encourages providers to play a critical role in the development of performance measurement programs, outlining the following recommendations for physicians and their societies:

- Develop the evidence base for clinical practice guidelines from which the performance measures are generated
- Develop the decision support that informs quality improvement subsequent to performance measurement
- Exert leadership in advancing scientifically valid and expertly designed assessment initiatives
- Fight for standardization of measures
- Devote resources, expeditiously, to the development of useful and valued performance measures for the important clinical areas in their field of medicine
- Share information with colleagues and members about developments in performance measurement and the use of these measures
- Support their members in data collection, especially through activities that support the use of electronic health records and the development of helpful and useful standards for information technology
- Include the concept of performance assessment in any and all continuing education activities
- Develop methodologies to integrate performance, as measured through the use of reporting of carefully designed and valued measurement sets, into ongoing Board certification

With standardized and accurate methodologies in place, providers have a strong appreciation for performance measurement and the performance feedback that results.^{vii} There is therefore great potential for performance measurement reports to result in improved quality care.

Ben Yandell, Chief Quality Executive at Norton Healthcare in Louisville, KY stressed the importance of clinical data for quality assessment at a 2007 public hearing in Washington, D.C. Yandell claims “public reporting is not just for the public” and identified hospital administrative and medical staff as the primary audiences of such information. Yandell asserted that attention and transparency creates a sense of urgency to bring about improvement. And while Yandell claims the health care field is not ready for a comparative shopping guide for consumers, the public already benefits from the heightened attention to quality that has resulted from performance measurement efforts.^{viii}

Developing performance measurement systems

Providers must accept the challenge of adding their voice to the performance measurement movement and can ensure that clinical performance measures are based on medical evidence from scientific literature review or from an existing (rigorously evidence based) clinical guideline.^{ix} Outcome and process measures must be valid indicators of health care quality. Dr. Alan M. Garber, Professor of Medicine, Economics, and Health Research and Policy at Stanford University asserts “evidence based clinical guidelines, which have the credibility that comes from a combination of impartiality and deep clinical and scientific expertise, are attractive in this regard.”^x

Ideally, measurement criteria must be compared against the strongest evidence available, such as randomized controlled trials. If such scientific data are not available, performance measures can be created through what is available, combined with a collaborative consensus process in which key stakeholders can review existing evidence and create a standard by which to measure care.^{xi}

Once a performance indicator is created, it is necessary to test it as a measure to ensure its validity, acceptability, feasibility, reliability, and sensitivity to change. For example, will an indicator detect changes in quality of care when it occurs? Performance measure developers conduct rounds of pilots to test and refine such measures, and create written specifications for scoring and analysis.^{xii}

It is critical to keep in mind that a poorly designed measure can do more harm than good, and that measuring outcomes relies on patient adherence rather than simply physician performance. According to David M. Eddy, MD, PhD, Senior Advisor for Health Policy and Management at Kaiser Permanente “when the main health outcome for an important condition are infrequent, delayed, weakly controllable, or heavily confounded, blind adherence to outcomes will produce inaccurate results...the solution is to use more process measures.”^{xiii}

Once proven, indicators are often submitted to the National Quality Form (NQF) for review and endorsement. NQF evaluates measures for their suitability based on four sets of standardized criteria: importance to measure and report, scientific acceptability of measure properties, usability, and feasibility. It is likely a provider will be more accepting of their performance being measured against a process that is scientifically proven, based on the best available evidence, involved key stakeholders, and was endorsed by an independent entity.

On occasion, private companies may develop their own set of proprietary quality measures, derived from evidence in the medical literature. After testing, these measures may be licensed to provider and payer organizations for performance improvement efforts. If successful, the measure will be widely adopted by many organizations, becoming a *de facto* standard measure.

While a proven process exists to create performance measures, the process by which data is collected and analyzed against measures is less rigid. Because the NQF stipulates that the data should be available in electronic form, performance is often measured against claims data. The benefits of claims data is that it is inexpensive and readily available to payers, and can provide overview information about the patient and the clinical encounter from which they are generated. Claims data are, however, an abbreviated summary of the clinical encounter and therefore do not capture all relevant information. Medical record data is more detailed, but it is also more expensive, takes longer to collect, and is non-standardized.

The anticipated implementation of electronic medical records (EMR) in the future means clinical data will be more effectively and efficiently captured in a standardized format.

Organizations with EMRs can take advantage of the available data for performance measurement purposes now, and may be eligible for government incentives. For many provider groups, however, the goal of full EMR implementation is likely years away.

CFP's approach to developing a set of provider measures

One of the key objectives of the CFP organization was to develop and promote an industry-standard set of comprehensive hospital and physician performance metrics, focused on efficiency and quality. CFP developed its first set of performance metrics (CFP Measures Version 1.0) in 2005 with an update in 2007 (CFP Measures Version 2.0).

To develop the CFP Measures sets, CFP relied on measures that had already been defined by organizations such as NCQA and physician specialty associations, and where possible, reviewed and endorsed by organizations such as the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA). In some instances, CFP also licensed the use of existing measures, including Joint Commission core hospital measures, Leapfrog hospital measures and NCQA physician measures. For both physician and hospital efficiency measurement, CFP licensed resource use measurement methodologies from 3M and Symmetry.

The measures implemented by CFP were vetted and approved for inclusion by CFP's Expert Panel which is a panel of national experts in provider performance measurement that assures CFP's approach to the measurement of quality and efficiency of care reflects state-of-the-art measures and methodology. The original Expert Panel was formed in 2004 and was comprised of nationally-recognized leaders across the full continuum of performance profiling including health services research, quality and efficiency measurement, clinical application of measures, and performance improvement at the health plan level. Many of the original academic members participated in the 2007 Expert Panel Process and were joined by new academic and clinical experts who were able to add a broader spectrum of knowledge to the group.

The CFP Expert Panel selected measures using the following criteria:

- The measure must be a valid, broadly accepted standard for quality and/or cost efficiency, as approved by the academic and clinical expert panel with significant input from carrier and employer representatives.
- The measures can be determined using claims data or other readily available data sources, can be implemented by the health plans, and will be considered useful by the health plans, providers, employers, and consumers.

During the development of CFP Version 2.0 Measures, the Expert Panel organized its work to address all four quadrants of CFP Version 1.0 Measures (physician efficiency, physician quality, hospital efficiency, and hospital quality). They reviewed the existing design and considered modifications for CFP Version 2.0 Measures based on current industry knowledge and state-of-the-art methods in measurement of quality and efficiency.

While CFP is proud of the progress made in promulgating performance measures, the group is not adamant that this particular set of measures be used universally. CFP supports the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs and has a vested interest in finding methods to measure performance, as well as effective ways to disseminate the information, that will meet the needs of all participants in the health care market place.

Our objective with this white paper is to provide health care administrators and practitioners with a point of view regarding what they stand to benefit from the use and dissemination of such measures. The following sections describe these potential benefits.

Putting measures to use

Although there is no formal national framework for promulgating measures, they typically get disseminated through a series of steps. As mentioned previously, measures come into use first through meeting the development requirements and after gaining acceptance for use by major organizations, such as academic researchers, a regional or national collaborative, or another large player.

Many of the organizations conducting performance measurement related to quality are professional societies, non-profits collaborative groups or accrediting organizations, for-profit groups (payers, purchasers or health informatics firms), and government. For example, the AHRQ creates and maintains measures related to patient safety, quality of care, avoidable hospitalization, and utilization (HCUP). Other groups are exploring cost efficiency, as well as quality, such as Thomson Reuters, 3M, WebMD, Verisk, Focused Medical Analytics, and Ingenix.

Depending on the focus area, there are three methodologies for performance measurement:

- *Percent compliance*, in which case the denominator is the number of times that a provider has the opportunity to provide an element of recommended care to a patient who was a candidate for that care and the numerator is the number of times the care was provided.
- *Actual vs. expected performance*, in which case a provider is measured based on how often they provided care to someone who should have received it adjusted for case mix or other relevant factors.
- *Performance against a benchmark*, in which a provider's performance level is compared against the best in class; studies have found that the use of benchmarks has significantly enhanced the effectiveness of physician performance feedback.^{xiv}

Performance measures offer a system for physicians to obtain meaningful results with their patients, even when their patient population is not identical to others. Efficiency data using episode software automatically adjusts for case mix (the types of patients that a particular provider treats), and, to a moderate degree, severity (how sick patients are). When applied to comparable groups of physicians (that is, those within the same specialty), case mix adjustment will ensure providers can be validly compared to each other and the best practices. The results will yield valuable insights into provider

performance level and opportunities for improvement. Proper adjustment also minimizes physician fears that they will be unfairly compared to their peers, should they have a different mix of patients.

How performance measurement improves care

The quality improvement (QI) cycle is a series of steps aimed at finding a problem, planning an approach to addressing that problem, testing that approach, and measuring its impact. The cycle is then repeated. While different organizations have created various names or schemes for a QI process, they all follow this basic pattern.

For clinical performance improvement, a similar QI process is adopted. However, the process is informed by best practices and evidence-based guidelines. In addition, a benchmarking process takes place in which providers are compared against their peers, and all are measured against top performers.

This process can be illustrated in the example of improved care for patients with heart failure. First, a care process must be established that ensures physicians provide the interventions that are evidence-based and shown to have the best outcomes for congestive heart failure. Such interventions – for example, clinical processes, choice of pharmaceuticals, and effective patient education—could be included in a quality measure. However, unwarranted variation may occur, even for well-trained clinicians.

There are clear benefits to adhering to clinical performance guidelines. First, they increase consistency and therefore reduce unwarranted variation in care. Additionally, evidence-based guidelines may help with patient management since it is likely standard steps are already identified for providers. Because the guideline serves as a checklist to ensure important steps are not inadvertently omitted, guideline adherence not only reduces medical errors, but also helps avoid complications and unnecessary tests and procedures. Ultimately, this will result in improved, and less expensive, care.

With cycles of QI, the clinical process can be changed and tested, seeking closer adherence to the guideline.

Providers should compare their performance against others to set the highest expectations for themselves and aim for the best outcomes for their patients. Ideally, physicians should compare themselves against the very best performers. By comparing yourself to the best practices, it is easier to hone in on the specific differences in practice that might account for the differences in outcomes. Contact with providers of the best practices is strongly encouraged to provide lessons beyond what can be found in the data alone.

More than likely, it is not that the providers using best practices have better evidence based guidelines than their peers. Most often it is that they excel in their adherence to executing the steps identified in the guideline. Perhaps their office has a better system of professional education so that all physicians and nurses are trained in the guideline and how to use it. They may have better office processes in place, either high tech or low tech, to facilitate compliance with the guidelines. These providers may offer better

education and communication with patients and their caregivers to help ensure full patient engagement and thereby benefit from better outcomes. As we will explore, patients play a critical role in the performance measurement process.

Informing and involving patients

Performance measurement programs are the means by which public reporting mechanisms are developed, offering consumers a tool to make informed medical decisions. For the most part, patient perspectives on quality have focused on the interpersonal aspects of care, rather than health care outcomes.^{xv} Within a more transparent health care system, patients will have choices never before offered, which may seem helpful while simultaneously they may feel overwhelming. It is therefore necessary to educate patients about the many factors that comprise quality care so they can put measurement data to use.

Currently, consumers have limited information about physicians and hospitals. In most states, a patient can verify a doctor's licensure and board certification, and check on any official disciplinary action taken or malpractice suits lost. Beyond these limited resources, information about providers is inconsistent and often hard to find. A variety of private websites, such as HealthGrades, publishes an online report card on a particular physician for a fee. Often the report card contents are similar to state and health plan information on the doctor's training, and may include patient reviews.

More information is available to patients about hospitals. Their accreditation status with the Joint Commission is readily available, and the Center for Medicare and Medicaid Services (CMS) Hospital Compare offers ratings on patient experience and care for select conditions. More information can be found at the previously-mentioned Leapfrog Group website related to IT systems, staffing, selected outcomes and patient safety. Many states and health plans also offer ratings of hospitals, sometimes using the sources already cited as well as a variety of measures from AHRQ National Quality Measures Clearinghouse or the National Quality Forum (NQF).

With limited access to information, patients have relied upon word of mouth or a personal recommendation when making health care choices. However, research has shown that when patients are presented with relevant data about practice performance, consumer choice is influenced, a fact that demonstrates how critical public reporting will be to the future of the health care marketplace.

Initially, the rise of Internet access and public sharing of quality and cost information did not change consumer behavior related to health care. A recent study by the Center for Studying Health System Change found that only 11% of patients used online rating tools, while the remaining used traditional sources when choosing a primary care physician: 50% from relatives or friends, 38% from doctors or other clinicians, 35% from health plans.^{xvi} A RAND study found similar results.

There is evidence, however, that suggests the public is starting to better understand and use quality ratings in making health care choices while simultaneously information is

becoming more widespread through public and private sites. Therefore, as consumer choice is increasingly driven by the available performance ratings, providers must prepare to work within a new system of care.

Undoubtedly, a correlation exists between the engaged patient and better health care outcomes. Engaged patients benefit from greater trust in their physicians, increased knowledge of their condition, and better interaction that enable them to address problems and issues. Such engagement requires effective patient-physician communication, as well as access to accurate information to help guide patient decision-making. This includes explicit information that will help patients choose their provider, learn about their condition, and make decisions about their treatment choices.

Providers can help achieve the IOM goals of STEEEP - Safe, timely, effective, efficient, equitable, and patient centered care – by facilitating active involvement of patients in their care. Knowing the variation in care measured through performance indicators related to cost and quality, patients can make informed choices and the best providers can be better rewarded. For many providers, this poses a challenge to the traditional doctor-patient relationship, yet it opens the door to better communication, greater trust and improved satisfaction and outcomes.

Performance measurement programs yielding results

While limited, studies have demonstrated the value performance measurement programs have on improving quality and facilitating cost savings.^{xvii}

For example, Minnesota-based HealthPartners, a large nonprofit health care organization created a measurement initiative in which they tracked performance on individual measures and calculated a composite score for a set of critical aspects of care received by the patient for a given condition. Across its 630,000 members, HealthPartners demonstrated improvements for all composite measures. In addition, as a result of performance tracking, HealthPartners' overall preventive care rate rose from 44% in 1997 to over 70% in 2004.^{xviii}

Rochester Independent Practice Association (RIPA), a large nonprofit physician organization in NY representing 3,000 practitioners also engaged in a performance measurement initiative. They created a physician profiling program among their 900 primary care and 20 specialty providers. RIPA created individual provider performance reports three times per year that includes data from three areas, weighted as follows: patient satisfaction (20%), quality of care comparing practice patterns with recommended care (40%) and efficiency (40%). This profiling program, which cost RIPA \$1.2 million (\$0.33 PMPM) saved the organization \$1.4 million by 2005, and demonstrating improvement in both individual practitioner performance, as well as benefits to the entire practice.^{xix}

Benefits of Performance Measurement

Unquestionably, a performance measurement process provides benefits for providers and their patients, especially within the shifting landscape of a more transparent and consumer driven health care system. Paul Levy, CEO of Beth Israel Deaconess Medical Center, was innovative in his thinking then he first launched a public reporting program. According to Levy, “for the most part, patients can not really find out very much about a hospital’s quality measures and record on safety. The data that are made available are old...we think those are insufficient which is why we publish the more recent, more accurate clinical data...it presents a summary every quarter of what kinds of harm we have caused to our patients that could have been prevented. We do that because we think it helps people improve our processes of care and our results by knowing where we stand relative to the audacious goals we have set for ourselves.”^{xx}

Distribution of performance measurement results allows patients to become more active participants in the health care discussion because they can be more informed. Similarly, by giving providers explicit comparisons, they are able to identify their strengths as well as opportunities for improvement, and make changes guided by the data. The process will also allow providers to realize that cost and quality are not correlated. Rather, the best providers are often the most cost-efficient, and quality need not be compromised for the sake of cost-efficiency.

Additional Resources and Links^{xxi}

AHRQ, National Quality Measures Clearinghouse

http://www.qualitymeasures.ahrq.gov/resources/measure_use.aspx

AHRQ, Pay for Performance: A Decision Guide for Purchasers, 2006

<http://www.ahrq.gov/QUAL/p4pguide.pdf>

AAFP, Performance Measurement & Pay-for-Performance

<http://www.aafp.org/online/en/home/practicemgt/quality/qitools/perfmeasure.html>

HFMA's Internet Guide: Pay-for-Performance Programs

<http://www.hfma.org/library/reimbursement/pfp/payperform.htm>

URAC, Provider Performance Measurement and Public Reporting Accreditation Program Overview

http://www.urac.org/programs/prog_accred_PPMPR_po.aspx

AMA, Physician Consortium for Performance Improvement (PCPI)

<http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement/pcpi-measures.shtml>

National Quality Forum

<http://www.qualityforum.org/>

Leapfrog Group

<http://www.leapfroggroup.org/>

Bridges to Excellence

<http://www.bridgestoexcellence.org/>

Ambulatory Care Quality Alliance

<http://www.ambulatoryqualityalliance.org/>

Better US health care at lower cost, Arnold Milstein, Issues in Science and Technology, Winter 2010

<http://www.issues.org/26.2/milstein.html>

This article, co-authored by Mercer's Arnold Milstein, identifies several public policy initiatives that would help the US health care system reduce health costs and waste and improve health care quality and outcomes. The policies include standardizing measurements of comparative performance, payer methods for administrative interactions with providers, payment methods that offer providers incentives to improve the value of care and payer incentives for patients to improve the value of care they receive.

The Effect of Performance-Based Financial Incentives on Improving Patient Care Experiences: A Statewide Evaluation, Hector P. Rodriguez et al., Journal of General Internal Medicine, December 2009

<http://www.springerlink.com/content/5g6l61tk75m16004/fulltext.pdf>

In the context of statewide measurement, reporting, and performance-based financial incentives, patient care experiences significantly improved. In order to promote patient-centered care in pay for performance and public reporting programs, the mechanisms by which program features influence performance improvement should be clarified.

Waste Not, Want Not: The Right Care for Every Patient, National Quality Forum, July 2009

<http://www.qualityforum.org/pubs/issuebrief-wastenotwantnot-0906.aspx>

Overuse is a culture-driven problem, and, as with all culture-driven challenges, solutions exist, but they must be robust, and they take time to be successful. Potential solutions include implementing a “shared decisionmaking” approach to healthcare that engages patients as fully equal partners in their own care; implementing information technology systems to ensure that medical decisions are informed by the best possible data; and reforming the healthcare payment system to enhance incentives to provide the right care rather than the most care.

Physicians respond to pay-for-performance incentives: Larger incentives yield greater participation, Francois S. de Brantes et al., American Journal of Managed Care, May 2009

http://www.ajmc.com/media/pdf/AJMC_09May_deBrantes305to310.pdf

Physician participant rates in pay-for-performance (P4P) programs rises sharply as the size of financial incentives increases, these authors report. Their analysis is based on pilot data from P4P programs administered by the not-for-profit organization Bridges to

Excellence.

Middle Ground, David Bennett, Managed Healthcare Executive, March 2009

<http://managedhealthcareexecutive.modernmedicine.com/mhe/P4P/Middle-Ground-Payers-and-providers-collaborate-on-/ArticleStandard/Article/detail/584937>

There is a growing trend among health care payers to increase emphasis on partnership and accountability for quality in their provider business relationships, according to this article. Some health insurers are insisting on pay for performance language in their contracts while providers are becoming more open to the idea of being paid under stipulations of quality. This article highlights the Alternative Quality Contract from BlueCross BlueShield of Massachusetts which is a five-year commitment that aims to change the fundamentals of reimbursement through the emphasis of quality performance.

Baylor Health Care System: High-performance integrated health care, Tom Emswiler et al., The Commonwealth Fund, March 2009

http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/March/Baylor%20Health%20Care%20System/1246_Emswiler_Baylor_case_study_rev.pdf

A committee created by Baylor Health Care System (BCHS) oversaw major improvements in care quality, the Commonwealth Fund reports. Keys to this success included appointing physician champions to encourage peers to adopt best practices, stimulating competition among doctors by posting their outcome results on the intranet, and implementing electronic health records at a cautious pace. These efforts helped BCHS attain the third-highest ranking in the US among 73 systems assessed in a recent report.

Innovations in recognizing and rewarding quality, AHIP, March 2009

<http://www.ahip.org/content/default.aspx?docid=26393>

More than two dozen health plans' physician and hospital pay-for-performance programs are highlighted in this report. The programs recognize and reward providers for achieving national benchmarks and improving quality and performance. The report includes descriptions of programs offered by Aetna, BlueCross BlueShield plans, CIGNA, Geisinger, HealthPartners, MVP Health Care and UnitedHealthcare.

ⁱ .[Ref AHRQ National Health Quality Report 2008]

ⁱⁱ Performance Measurement: Accelerating Improving. Committee on Redesigning Health Insurance Performance Measures, Payment and Performance Improvement Programs. Board on Health Care Services Institute of Medicine of the National Academies. 2006. National Academies of Sciences.

ⁱⁱⁱ leapfroggroup.org accessed 2/2/10

^{iv} [cite eValue8 2008]

^v Medical Professionalism in the New Millennium: A Physician Charter. 2002. ABIM Foundation. In partnership with the [American College of Physicians Foundation](#) and the [European Federation of Internal Medicine](#).

^{vi} [Cite AGO report http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf]

^{vii} Pemberton JK, Kiefe C., Weissman NW: Association of Health Services Research. "Physician perspectives on clinical performance feedback with achievable benchmarks of care. Abst Book Assoc. Health Serv Res Meet. 1998; 15:202-3

^{viii} www.ncvhs.hhs.gov “Hearing Summary” Use of Administrative and Clinical Electronic Data for Quality Assessment. June 19, 2008.

^{ix} Kresowik, RA, Fresowik, TF, Evaluating Evidence in the Development of Performance Measures. Expert Commentary, National Quality measures Clearinghouse.

^x Garber, A M “Evidence-Based Guidelines as a foundation for performance incentives” *Health Affairs*, 24, no 1 (2005): 174-179

^{xi} Campbell, SM, et al. Research Methods used in developing and applying quality indicators in primary care. *BMJ*. Volume 326 12 APRIL 2003

^{xii} [Cite Rubin et al IJQHC article)

^{xiii} Performance measurement: problems and solutions *Health Affairs*, Vol 17, Issue 4, 7-25
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^{xiv} Kiefe, CI, et al. Improving Quality Improvement Using Achievable Benchmarks for Physician feedback. 2001 American Medical Association. *JAMA*. 2001; 285:2871-2879

^{xv} Stulberg, J. Doctor Shopping: Finding a Physician on the Internet. Case Western Reserve University.

^{xvi} (cite CSHSC research brief #9, December 2008).

^{xvii} Pay for Performance. Methematica Inc. Princeton, NJ.

^{xviii} Performance Measurement: Accelerating

Improvement Committee on Redesigning Health Insurance

Performance Measures, Payment, and Performance

Improvement Programs ISBN: 978-0-309-10007-6, 384 pages, 6 x 9, hardback (2006)

^{xix} Performance Measurement: Accelerating

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^{xx} Interview with Paul Levy: How to Protect Yourself in the Hospital. September 29th, 2009

Better Health <http://www.getbetterhealth.com/tag/paul-levy>

^{xxi} V. Additional resources

Links, etc

CMS, NCQA, IHA, IHI, Dr. Foster, NICE, ICSI, MHQP , Niagara, WI alliance, Health partners, Tufts HP, other large HP sites,