STRATEGIC INNOVATIONS FOR AFFORDABLE, SUSTAINABLE HEALTH CARE:

A Model for Health System Reform

*Environmental Scan*

Performance Measurement and Health Care Quality
Table of Contents

Performance Measurement and Health Care Quality ............ 1

Performance Measurement .................................................. 1
  National Performance Measurement Systems ....................... 3
CMS Hospital Compare ..................................................... 3
Joint Commission .............................................................. 4
Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality (AHRQ) ......................... 4
HEDIS, National Committee for Quality Assurance (NCQA) ........ 5
NCQA Quality Dividend Calculator (QDC) ................................. 6
The Leapfrog Group .......................................................... 6

National Health Equity and Cultural Competency Performance Measurement ............... 7
National Quality Forum (NQF), Measuring and Reporting Cultural Competency ............ 7
CAHPS Cultural Competency Item Set .................................... 8
The Joint Commission: Hospitals, Language, and Culture ................................. 8
Evidence-Based Medicine (EBM) ........................................... 9
Employers Support For Primary Care .................................... 10
Payment Systems Impact on Quality ...................................... 11
Pay for Performance (P4P) ................................................... 12
California P4P Program, Integrated Healthcare Association (IHA) ......................... 13
## Performance Measurement and Health Care Quality

### Introduction
Quality of care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.\(^1\)

Pay for Performance refers to incentives that reward providers for achieving objectives established by a purchaser; these objectives may include improvements in efficiency, data submission, quality improvement, and/or patient safety.\(^2\)

### Performance Measurement and Health Care Quality

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Measurement</strong></td>
<td>Performance measurement and public reporting have been identified as potential levers to improve health care quality and reduce costs. On the national level, the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), the Joint Commission, and others have been accrediting, measuring, and reporting on the performance of health plans and hospitals for more than a decade. In addition, some states are collecting and reporting on performance information regarding procedures, health plans, medical groups, hospitals, and other entities. In 1999, the National Quality Forum (NQF) was created in response to a need to facilitate collaboration in multiple performance measurement systems. <strong>NQF organizes its work into the following categories:</strong> (\text{o} ) Patient and Family Engagement, (\text{o} ) Population Health, (\text{o} ) Care Coordination,</td>
<td>Several initiatives attempt to connect a nationally recognized group of measures. While there is development of performance measures across all care areas, the evidence has not definitively shown an improvement in health care quality, reduced costs, or return on investment. <strong>R</strong>eturn on Investment (ROI) studies have proven difficult to conduct. For example, four sites studying quality based purchasing in an Agency for Healthcare Research and Quality (AHRQ) study did not conduct an ROI analysis. Factors cited included difficulty of isolating the effects of its P4P initiative, small sample sizes, and the short history of the programs.(^3)</td>
<td>National accreditation measures are standard across markets. However, there are wide differences across markets in the type and number of local or state level performance measures. National measures include the HEDIS (Health Plan Employer Data and Information Set) for health plans and the Joint Commission and CMS measures for hospitals.</td>
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## PERFORMANCE MEASUREMENT AND HEALTH CARE QUALITY

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<td>o Palliative and End of Life Care,</td>
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<td>o Overuse,</td>
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<td>o Health Information Technology,</td>
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<td>o Disparities, and</td>
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<td>o Safety.</td>
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### Other Comments

- AHRQ supports resources on public report cards, including the Web-based Report Card Compendium, which is available on AHRQ’s TalkingQuality.gov site, http://www.talkingquality.gov. The compendium provides a searchable database of over 200 report examples.\(^4\)
- In 2007, through its Aligning Forces for Quality (AF4Q) program, the Robert Wood Johnson Foundation launched a major initiative focusing on the measurement and improvement of health care quality in 20 communities around the country.
- Since 2008, the AHRQ has chartered 25 value exchanges in health care markets around the country with the chartering value exchanges (CVEs) program, some of which also participate in the AF4Q program.\(^5\)
- Many health plan report cards rely on HEDIS and CAHPS (Consumer Assessment of Healthcare Providers and Services) indicators.
- The Consumer-Purchaser Disclosure Project is a coalition of more than 50 consumer, labor, and employer organizations that works to advance publicly reported, nationally standardized measures of clinical quality, efficiency, equity, and patient centeredness for health plans, hospitals, medical groups, physicians, other providers, and treatments. The Disclosure Project is supported by in-kind contributions of participating organizations and by a grant from the Robert Wood Johnson Foundation.\(^6\)
- Other initiatives include the High-Value Health Care Project, an initiative of the Quality Alliance Steering Committee that is supported by the Robert Wood Johnson Foundation and the Engelberg Center for Health Care Reform at the Brookings Institution; and the National Priorities Partnership, which is convened by the National Quality Forum and has 32 partner organizations.
## Performance Measurement and Health Care Quality

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<td><strong>Case Example 1</strong></td>
<td>The medical conditions available on Hospital Compare include heart attack, heart failure, chronic lung disease, pneumonia, diabetes in adults, and chest pain. Several surgical procedures in five areas are included. The five areas are heart and blood vessels; abdominal; neck, back, and extremities (arms and legs); bladder, kidney and prostate; and female reproductive.</td>
<td></td>
<td>The CMS performance measurement system for inpatient quality is not limited by market.</td>
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### National Performance Measurement Systems

**CMS Hospital Compare**

In December 2002, the American Hospital Association (AHA), the Federation of American Hospitals (FAH), and the Association of American Medical Colleges (AAMC) launched the Hospital Quality Alliance (HQA), a national public-private collaboration to encourage hospitals to voluntarily collect and report hospital quality performance information. The initiative grew into a consumer accessible website called Hospital Compare (www.hospitalcompare.hhs.gov), where consumers can search for hospitals in a specific geographic area and compare those hospitals according to performance, outcome, and structural measures related to certain medical conditions and surgical procedures.

- Over 4,000 hospitals voluntary participate in Hospital Compare, and since 2007, have received a 2% increase in Medicare payments as a result.
- Membership in the Hospital Quality Alliance (HQA) now includes the CMS, the Joint Commission, the AHA, the FAH, the AAMC, the American Medical Association, the American Nurses Association, the National Association of Children’s Hospitals and Related Organizations, American Association of Retired Persons (AARP), American Federation of Labor and Council of Industrial Organizations, the Consumer-Purchaser Disclosure Project, the Agency for Healthcare Research and Quality, the National Quality Forum, the Blue Cross and Blue Shield Association, the National Business Coalition on Health, America’s Health Insurance Plans, National Association of Public Hospitals and Health Systems, Society for Critical Care Medicine, Wisconsin Collaborative for Healthcare Quality, and the U.S. Chamber of Commerce.

**Other Comments**

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## Performance Measurement and Health Care Quality

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<th>Joint Commission</th>
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<td><strong>Case Example 2</strong></td>
<td><strong>Joint Commission</strong></td>
<td>One reason that hospitals seek Joint Commission accreditation is because it provides deeming authority for Medicare certification. The CMS designation means that hospitals accredited by The Joint Commission may choose to be “deemed” as meeting Medicare and Medicaid certification requirements. CMS has consistently found that The Joint Commission’s standards for hospitals meet or exceed those established by the Medicare and Medicaid program. Hospitals seeking Medicare approval may choose to be surveyed either by an accrediting body, such as The Joint Commission, or by state surveyors on behalf of CMS.</td>
<td>In 2002, accredited hospitals began collecting data on standardized—or “core”—performance measures. In 2004, the Joint Commission and CMS began working together to align measures common to both organizations. These standardized common measures are called “Hospital Quality Measures.”</td>
<td>The Joint Commission’s accreditation process, and performance measurement, is applicable in any market.</td>
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### Other Comments

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<td>CAHPS Ambulatory Care Surveys include: CAHPS Health Plan Survey, CAHPS Clinician &amp; Group Survey, CAHPS Surgical Care Survey (developed by the American College of Surgeons and the Surgical Quality Alliance), ECHO Survey (The Experience of Care and Health Outcomes Survey asks adult health plan enrollees about their experiences with behavioral health care and services provided by either managed behavioral health care organizations or managed care organizations), CAHPS Dental Plan Survey (originally developed for the TRICARE dental plan), CAHPS American Indian Survey (developed for the Choctaw Nation Health Service), and the CAHPS Home Health Care Survey. Supplemental Items Sets include CAHPS Item Set for Children with Chronic Conditions, CAHPS Item Set for People With Mobility Impairments, CAHPS Item Set for Addressing Health Literacy, CAHPS Health Information Technology Item Set, and the CAHPS Cultural Competency Item Set. At the request of the CMS, the CAHPS Consortium is developing several surveys of patients’ experiences in health care facilities. Facility surveys include the CAHPS Hospital Survey, CAHPS In-Center Hemodialysis Survey, and CAHPS Nursing Home Surveys. The CAHPS Consortium is comprised of Federal agencies and private research organizations. AHRQ works closely with the Centers for Medicare &amp; Medicaid Services (CMS), which has funded the development of several of the CAHPS surveys. AHRQ also contracts with Westat to support the work of the Consortium and assist users of CAHPS products through the CAHPS User Network. Westat also manages the National CAHPS Benchmarking Database.</td>
<td>Case Example 4: HEDIS, National Committee for Quality Assurance (NCQA) The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across eight domains of care. HEDIS measures address a broad range of health issues, including: - Asthma Medication Use, - Persistence of Beta-Blocker Treatment after a Heart Attack, - Controlling High Blood Pressure, - Comprehensive Diabetes Care, - Breast Cancer Screening, - Antidepressant Medication Management, - Childhood and Adolescent Immunization Status, and - Advising Smokers to Quit.</td>
<td>HEDIS is applicable in all markets. In some markets it has become standard across plans. In other areas it has been less broadly adopted.</td>
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**Other Comments**

- CAHPS results are included in Quality Compass, an interactive, Web-based comparison tool that allows users to view plan results and benchmark information.
- HEDIS measures are one component of the NCQA Health Plan Accreditation process. More than half of the health maintenance organizations (HMOs) in the nation, covering three-quarters of all HMO enrollees, have been reviewed by NCQA. Additionally, CMS extends
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<td><strong>Case Example 5.</strong> <strong>NCQA Quality Dividend Calculator (QDC)</strong></td>
<td>Deeming authority to NCQA for Medicare Advantage (MA), Medicare’s managed care program. This authority allows NCQA to review MA organizations on behalf of CMS in six categories: Access to Services, Antidiscrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, Provider Participation Rules, and Quality Assurance.</td>
<td>Evidence is not available regarding impact of intervention.</td>
<td>This innovation is applicable in all market settings.</td>
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<td><strong>Case Example 6.</strong> <strong>The Leapfrog Group</strong></td>
<td>The QDC can be used to assess the impact of health care quality on productivity and absenteeism in an organization related to the following conditions: alcohol abuse, asthma, hypertension, heart disease, child immunization (chicken pox), depression, diabetes, and smoking.</td>
<td>Evidence is not available regarding impact of intervention.</td>
<td>This innovation is applicable in all market settings.</td>
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<td><strong>Case Example 6.</strong> <strong>The Leapfrog Group</strong></td>
<td>Leapfrog advocates four leaps in hospital quality, safety, and affordability. These include: o Computer Physician Order Entry (COPE); o Evidence-based Hospital Referral (HER); o ICU Physician Staffing (IPS); and o Leapfrog Safe Practices Score (The Leapfrog Hospital Survey).</td>
<td>There is some concern that too few hospitals are participating in the Leapfrog Hospital Survey to document clinical and financial improvements using the methods. There is some evidence that little change has resulted in hospital operating decisions. Some surveys have indicated that despite a small increase in the number of consumers using performance data to guide their health care selections, the majority have not changed the way they make health care decisions.</td>
<td>The Leapfrog Hospital Survey is applicable to urban and rural hospitals.</td>
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<td>The Leapfrog Hospital Survey assesses hospital performance based on four quality and safety practices endorsed by the NQF. Any hospital in the U.S. is welcome to complete the Leapfrog Hospital Survey and the Leapfrog Safe Practices Leap is comprised of 17 of the 31 NQF-endorsed practices.</td>
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| **Other Comments**                   | • The Leapfrog Group is comprised of a consortium of major companies and other large private and public healthcare purchasers that provide health benefits to more than 37 million Americans in all 50 states.\(^{16}\)  
• The Leapfrog Hospital Survey, Leapfrog's hallmark public reporting initiative, was launched in 2001 and is now in its fifth version.  
• Leapfrog Hospital Surveys are used by purchaser members to inform their employees and their purchasing strategies.  
• In 2009, 1206 hospitals across the country completed the Leapfrog Hospital Survey.\(^ {17}\)  
• Leapfrog Hospital Survey ratings are posted on their website and free to the public; participation by hospitals is voluntary. | | |
<p>| <strong>Case Example 1:</strong> National Quality Forum (NQF), Measuring and Reporting Cultural Competency | The NQF-endorsed framework for cultural competency establishes a conceptual model to identify and organize preferred practices and performance measures based on a set of seven interrelated domains (and multiple subdomains) that are applicable to all settings and providers of care. Specifically, the seven primary domains for measuring and reporting cultural competency are: Leadership; Integration into Management Systems and Operations; Patient-Provider Communication; Care Delivery and Supporting Mechanisms; Workforce Diversity and Training; Community Engagement; and Data Collection, Public Accountability, and Quality Improvement. | The 45 practices endorsed by NQF are intended to improve the quality of care through cultural competency. They are intended to serve as the basis for identification and/or development of quality measures that can be used for public accountability for the delivery of culturally competent care.(^ {18}) Given that the measures are not yet developed, there is no evidence regarding their efficacy. | Given that the measures are not yet developed, applicability to markets is not yet determined. |
| <strong>Other Comments</strong>                   | | | |</p>
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<td><strong>Case Example 2</strong></td>
<td>This item set asks patients to report on their experiences with issues such as language access, health literacy, trust, shared decision making, patient-provider communication, and discrimination. These items will be available for use with the CAHPS Clinician &amp; Group Survey. If time and resources permit, the team will also adapt the items for use with the CAHPS Health Plan Survey.</td>
<td>The CAHPS Cultural Competency Item Set is not yet available, so no evidence exists regarding its efficacy.</td>
<td>The CAHPS Cultural Competency Item Set is not yet available, so no evidence regarding its market applicability exists.</td>
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<td><strong>CAHPS Cultural Competency Item Set</strong></td>
<td>The CAHPS Team is completing work on a new set of supplemental items designed to capture the cultural competency of health care providers from the patient’s perspective.</td>
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<td>Other Comments</td>
<td>The CAHPS Cultural Competency Item set is shaped by work of The Commonwealth Fund. This work emphasizes aspects of culturally competent care from the patient’s perspective. It categorizes measures in the following quality domains: Patient-provider communication, shared decision-making and respect for patient’s preferences, experiences leading to trust or distrust, experiences of discrimination, and linguistic competence.</td>
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<td><strong>Case Example 3</strong></td>
<td>The project explores how diversity, culture, language, and health literacy issues can be better incorporated into current Joint Commission standards or drafted into new requirements.</td>
<td>At the earliest, any implementation of the proposed requirements would occur in January 2011. So, there is no evidence regarding the actual measures. However, the research framework is based on the Joint Commission’s ongoing Hospitals, Language, and Culture: A Snapshot of the Nation (HLC) study. The HLC study is being conducted in partnership with The California Endowment.</td>
<td>Implementation is scheduled for January 2011, so there is currently no information regarding market specifics.</td>
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<td><strong>The Joint Commission: Hospitals, Language, and Culture</strong></td>
<td>The Joint Commission, with funding from The Commonwealth Fund, is developing proposed accreditation requirements for hospitals to advance effective communication, cultural competence, and patient-centered care.</td>
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<td>Other Comments</td>
<td>The Joint Commission, in collaboration with the National Health Law Program is developing an implementation guide to prepare Joint Commission surveyors and accredited hospitals for the potential release of proposed requirements to advance effective communication, cultural competence, and patient-centered care.</td>
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### PERFORMANCE MEASUREMENT AND HEALTH CARE QUALITY

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<td><strong>Evidence-Based Medicine (EBM)</strong></td>
<td>EBM is operationalized through the reporting of evidence-based measures to organizations like the Joint Commission, CMS, and others that tie accreditation and pay-for-performance to the implementation of specific evidence-based measures. Guidelines or protocols may be provided. A guideline is a systematically developed statement to assist practitioners and patients in choosing appropriate care for specific clinical conditions. A protocol is a plan, or set of steps, to be followed in a study, investigation, or intervention. Evidence-based medicine impacts both the information patients receive about their medical conditions and health care, and their shared decision-making choices and skills.”</td>
<td>• EBM is a key dimension underlying consumer decision tools in health care. Although most of the focus has been on developing clinical provider decision tools; e.g., care protocols, this activity is necessary in order to create health care decision tools that have value to the consumer. • There is some controversy in EBM as to the extent that EBM either implies or explicitly requires an evidence hierarchy. For example, some hold that EBM prioritizes randomized controlled trials and systematic reviews of randomized trials above observational studies, physiological studies, and unsystematic clinical observations. As Sackett, et al. write, “because the randomised trial, and especially the systematic review of several randomised trials, is so much more likely to inform us and so much less likely to mislead us, it has become the ‘gold standard’ for judging whether a treatment does more good than harm.” They also hold that EBM is not restricted to randomised trials and meta-analyses. It involves tracking down the best external evidence with which to answer clinical questions.</td>
<td>EBM applies to all markets.</td>
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<td>Other Comments</td>
<td>• The Cochrane Collaboration is a worldwide endeavor dedicated to tracking down, evaluating, and synthesizing randomized clinical trials in all areas of medicine. The Cochrane Collaboration established a consumer website that links patients to articles on how to understand health research and the consumer’s role in health research and to the consumer version summaries on the effects of health care. • UpToDate is an evidence-based (proprietary) electronic resource for clinicians that includes a free, evidence-based information section for patients. Zynx is another EBM tool for physicians.</td>
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Evidence-based medicine is the practice of supporting clinical decision making with systematic research, while taking into account the personal values, uniqueness, and the specific concerns of each patient.
### Employers Support for Primary Care

**Primary Care** is care provided by personal physicians—family physicians, general internists, and general pediatricians—who are responsible for the entire health of an individual or family. Primary care is the patient’s entry into the health care system and the medical “home” for ongoing, personalized care.

This approach seeks to reduce costs and improve quality. The National Business Group on Health’s workgroup on primary care was formed to develop strategies for employers to increase support for primary care. Its priorities for action are patient-centered medical homes, health information technology (IT) for practice transformation, payment policies that recognize the value of primary care services, and educational and loan programs that encourage physicians and other health professionals to work in primary care.

The Patient-Centered Primary Care Collaborative, a coalition of major employer and physician groups, represents more than 300,000 primary care physicians (PCPs). Its goals are to help transform how primary care is organized and financed to provide better patient outcomes; more appropriate payment to physicians; and better value, accountability, and transparency to purchasers and consumers.

Individual employers are sponsoring demonstration projects. For example, the IBM Corporation has a patient-centered primary care initiative.

- Research studies (dozens) demonstrate that a strong primary care foundation to the health system can reduce costs and improve quality.
- People with a PCP rather than a specialist as a personal physician had 33% lower annual health care spending and 19% lower mortality; cost and mortality data were adjusted for age, sex, ethnicity, health insurance status, reported diagnoses, and smoking status. Other studies confirm that patients with a regular PCP have lower health care costs than those without.
- For Medicare patients, hospitalization rates were 80% higher in areas with a shortage of PCPs than in other areas.
- People with PCPs are more likely than those without PCPs to receive preventive services, to have better management of chronic illnesses, and to be satisfied with their care.
- States with more PCPs per capita have lower total mortality rates, lower heart disease and cancer mortality rates, and higher life expectancy at birth compared with states that have fewer PCPs, adjusting for other factors such as age and per capita income.

This innovation is applicable to all markets.

### Other Comments

Health Employer Data and Information Set (HEDIS) performance measures are heavily weighted toward such primary care items as preventive services and chronic disease management.
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<td><strong>PAYMENT SYSTEMS IMPACT ON QUALITY</strong></td>
<td>Changing payment systems to incentivize quality seeks to alter providers’ behavior indirectly. The end goals are improving quality and managing costs. Fee-For-Service (FFS) payment puts the provider at risk for the cost of processes within each service, but there is no limit on the number of services. Providers get paid regardless of quality or outcomes. The advantages of episode-of-care-payment include the flexibility for providers to decide how care is delivered within the episode and the incentive it creates to eliminate any unnecessary services within the episode. If the services of multiple providers are covered by the same episode-of-care payment, there is also an incentive for those providers to coordinate their services. Capitation models or payment are designed to control the number of episodes of care as well as the cost of individual episodes. In this model, providers have a strong incentive to avoid patients who are more costly to treat.</td>
<td>- It has become clear that under existing reimbursement structures, current market forces are insufficient to ensure either higher-quality or more cost-effective care. The evidence tends to compare FFS to capitated systems of payment. Quality is often disappointingly poor for both FFS and capitated arrangements. The majority of studies of outcomes uncovers no difference between FFS and HMOs. There is little evidence of any consistent difference in clinical quality between FFS and HMOs.</td>
<td>State governments and nonprofit regional health improvement collaboratives are playing a growing role in forging consensus on new payment systems among multiple payers. Without this collaboration, aligning multiple payers is challenging, because antitrust laws and policies at both the federal and state levels limit the ability of multiple payers to discuss and agree on changes in payment systems. Financial incentives must be sufficiently large and clear in order to have an impact on quality.</td>
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<td><strong>Other Comments</strong></td>
<td>Fee-for-service is where a predetermined amount is paid for each discrete service provided. Episode-of-care payment is paying a single price for all of the services needed by a patient during an entire episode of care. If services of multiple providers are covered by the same episode-of-care payment, this is called bundling payments. Capitation is when a provider (or a group of providers, working in a coordinated fashion) receives a single payment to cover all of the services their patients need during a specific period of time, regardless of how many or few episodes of care the patients experience. In comprehensive care payment, a provider or group of providers would receive a single payment to cover all of the services their patients need during a specific period of time (such as a year). However, this payment would be adjusted based on the health of the patients and other characteristics that affect the level of services needed. A provider would receive a higher payment if he or she has more patients with severe rather than mild heart disease, but the payment would not depend on what kinds of treatment patients receive.</td>
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PAY FOR PERFORMANCE (P4P)

Pay for Performance (P4P) refers to incentives that reward providers for achieving objectives established by the purchaser. Following the Principal-Agent model, existing payment mechanisms do not reward providers for higher quality as do prices in most other markets. In health care, purchasers are not able to contract for a given level of provider quality.46

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<td>Pay for Performance (P4P)</td>
<td>This approach seeks to reward quality and efficiency via payment incentives. Ideally, P4P should reward high quality, give all providers incentives to improve, and create a payment gradient between high-and low-performing hospitals.47 Emerged from dissatisfaction with reimbursement methods that reward quantity rather than the quality of health care services.48</td>
<td>• The empirical foundations of Pay for Performance in health care are rather weak.49 However, one systematic review of the literature did find partial or positive effects of financial incentives on measures of quality in five of six studies of physician-level financial incentives and seven of nine studies of the provider group-level.50 There is a paucity of demonstrable return on investment (i.e., evidence of net savings).51 • According to one report, the modest P4P incentives in the CMS Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration have succeeded. However, there is little evidence that small (2-5%) payment incentives are likely to drive individual specialists to changing practices, such as joining accountable care organizations.52 • There is no empirical evidence suggesting how large a payment gradient needs to be to stimulate quality improvement.53 • Possible unintended consequences may include gaming, where participants find ways to maximize measurable results without actually accomplishing the desired objective; crème skimming of healthier patients for treatment; and the multitasking problem – where compensation based on available measures will distort effort away from unmasured objectives.54 • Limitations of P4P initiatives include: defining and unifying measures across the vast number of reporting initiatives, risk adjustment for clinical outcome measures, resource burdens on smaller versus larger hospitals, and the need for data on the effectiveness of P4P in improving care processes and outcomes.55</td>
<td>• P4P initiatives work better in more integrated markets.56 Unilateral, small-scale bonus arrangements will be insufficient to motivate substantial changes on the part of physicians and hospitals.57 • Because the U.S. health care system is characterized by a large number of overlapping contracts among payers (i.e., health plans and government programs) and providers, financial incentives introduced by any one payer must be a relatively large percentage of total reimbursement to justify any quality improvement effort with substantial fixed costs.58</td>
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Other Comments

• With the advantages and disadvantages, it is evident that there is no perfect P4P payment strategy for every setting. The decision about which P4P strategy to use likely depends on the goal of P4P (to improve quality among low-performing providers or to maintain quality among high-performing providers), the distribution of performance within and across providers (whether it is highly variable or uniformly high), the percentage of payment available for P4P programs, and the overall level of performance.59

• Key elements of P4P programs include: individual vs. group incentives, paying the right amount, selecting high-impact performance measures, making payment rewards all high-quality care, and prioritizing quality improvement for underserved populations.60
### PERFORMANCE MEASUREMENT AND HEALTH CARE QUALITY

<table>
<thead>
<tr>
<th>INTERVENTION AREAS AND Case Examples</th>
<th>What does the intervention intend to address?</th>
<th>What is the research evidence regarding impact of intervention?</th>
<th>How applicable to which types of markets?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS and Premier Inc., a nationwide organization of not-for-profit hospitals teamed on a P4P initiative where hospitals are scored and ranked by condition measured. Top-tier hospitals (in top 10%) receive a 2% bonus on its Medicare payments; hospitals in the next decile receive a bonus of 1%.</td>
<td>• Performance on the clinical quality metrics improved by an average of 3% annually, while performance as measured by patient satisfaction surveys stagnated. A survey of physician and plan leaders by Cheryl Damberg and colleagues reported that the majority felt that the P4P program had motivated improvements in the data systems and measurement capabilities but that no “breakthrough” quality improvement had been achieved.</td>
<td>The medical group structure of managed care in California theoretically resolved the three thorniest problems besetting episode initiatives in other contexts: small numbers, attribution, and inconsistent benefit designs.</td>
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<td>Bridges to Excellence (BTE) is a multilateral effort backed by a group of large employers to offer new financial incentives for physicians to improve health care quality in several target markets (Boston, Cincinnati/Louisville, and Albany/Schenectady). Three distinct initiatives were launched by BTE, including the Diabetes Care Link, the Physician Office Link, and the Cardiac Care Link. Each “link” comprises a broad set of measures, each of which is accorded points toward an overall score.</td>
<td>• Adoption of the P4P-specified types of information technology (IT) increased annually by 7%.</td>
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**Case Example 1:**

**California P4P Program, Integrated Healthcare Association (IHA)**

Launched in 2003 for 6 California health plans, 6.7 million enrolles, and 230 physician groups.

- Although P4P principles were adopted by Medicare and by private insurers across the nation, the CA program remains the largest in terms of dollars distributed.62

This program changes the incentives to providers from quantity of services provided to a combination of quality and efficiency. The episode of care is the unit of analysis—and episode of care is a series of health care services related to a particular condition or event.63

Other Comments

- The highly regulated HMO product in California had very similar levels of consumer cost sharing across competing health plans; thus, differences in the number of episodes per patient and in the average cost per episode would not be driven by differences in benefit design. 65

- Physician organization-based health care system – advantage for measuring efficiency in that organization as the unit of observation overcome the small numbers that preclude valid episode measurement at the individual physician level. (The IHA technical committee decided that a physician organization must have at least 30 patients experiencing a type of episode during a year for the episode results to be valid for statistical purposes.) 66


3 Ibid., AHRQ. (2007).


**Mission**
Altarum serves the public good by solving complex systems problems to improve human health, integrating research, technology, analysis, and consulting skills.

**Vision**
Altarum Institute demonstrates and is sought for leadership in identifying, understanding, and solving critical systems issues that impact the health of diverse and changing populations. Altarum is acknowledged as a valued, collaborative, and collegial institute of the utmost competence and integrity.

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