



Notes

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Performance and Efficiency Measurement: Implications for Provider Positioning

Health Care Quality Measurement Truisms:

--What gets measured gets done.

--You cannot improve what you cannot measure.

The era of health care measurement is here. Performance measures are now making their inexorable way in the healthcare marketplace zeitgeist, defining a new reality for which physicians and other providers would do well to understand and manage. While most measures have been touted as quality oriented, there is a far less known parallel path of 'efficiency measurement' --- the new way of quantifying provider resource consumption without any explicit link to quality measurement. Both phenomena have arrived on the scene for good reason. Providers, in particular savvy physicians, will take heed and position themselves appropriately for the new grading systems. This AGG Note (1) elucidates the history and policy goals of performance measurement; (2) highlights new Congressionally motivated measurement projects; (3) identifies the major players; (4) speaks to current controversies, including the advent of efficiency measures; (5) describes legal liabilities lurking in these initiatives; and (6) offers some positive, practical approaches physicians might want to consider in light of these developments. (See last page for Links to Resources)

Background

Today's highly intensified focus on health care quality is far more extensive than anyone might have imagined twenty years ago. Pay for Performance (P4P) programs in both the public and private sectors, more report cards on many elements of the health care system, assessments of the state of health care quality from NCQA, the government and others, all speak to the new emphasis on quality. Yet the ability to evaluate, judge, compare and pay for performance all depend on some kind of measurement.

Historically, the old PSROs and later PROs in the mid-70's to the 1980's had variably used, as mandated by federal statute, "norms, criteria and standards" to evaluate the delivery of Medicare services. In 1989, Congress gave to the newly created Agency for Health Care Policy and Research the responsibility to develop clinical practice guidelines, medical review criteria, performance measures and standards of quality. The Institute of Medicine (IOM) got the job of advising the Agency on what the new authority

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meant. Back then, 'medical review criteria' were defined as "systematically developed statements that can be used to assess the appropriateness of specific healthcare decisions, services and outcomes." As a participant in the committee that advised the Agency, I can attest that the IOM struggled with a definition of performance measures; and in 1990 called their definition "provisional", but said measures were "methods or instruments to estimate or monitor the extent to which the actions of a healthcare practitioner or provider conform to practice guidelines, medical review criteria or standards of quality." Nothing has supplanted this definition.

In addition, based on the work of Avedis Donabedian going back to the mid-1960s, most measurement has been focused around three aspects of care: (1) structure - e.g., licensure, safety of the physical environment where care is delivered; (2) process -- what is done during the delivery of healthcare interventions; and (3) outcomes -- what result did the patient experience from the care. Beginning in the early 1990s with the first iteration of HEDIS, the health plan comparison program now operated by NCQA, the patient's experience of care has come to the fore as an additional major focus of measurement as well. Later, in 1998, at the high point of managed care backlash when there were raging debates over whether managed care entities skimmed on care, the President's Advisory Commission Report on Consumer Protection and Quality in the Health Care Industry made quality measurement and public reporting of what was measured, central to the steps to assure quality care was being provided to Americans, no matter the payment mechanism financing their health care services. The Commission found that then current efforts were on one hand too diffuse, counting more than 75 measure sets then in existence, and on the other hand inadequate to the task. The Commission called for the creation of a private Forum on Quality Measurement and Reporting to calm the Tower of Babel effect and standardize measures.

Just a few years later, the IOM's two landmark studies on medical errors and the quality 'chasm'

also focused on the need to have common values brought to bear in the delivery of care ----the so-called STEEEP values --- and promulgated ten rules to redesign the health care system toward that end. Among them were three rules that reflect directly on performance measurement: (1) evidence based decisionmaking; (2) the need for transparency in report cards; and (3) shared knowledge and free flow of information.

In addition, both the IOM and the President's Commission took the position that measurement should initially focus on priority conditions, with special attention to chronic conditions. The health care system, they said, has been oriented around acute care needs and as a result does not facilitate the flow of information over time, offers little recognition or reward for coordinating care and pays mainly for face to face visits. To emphasize priority conditions would improve the feasibility of quality measurement, and both the Commission and the IOM offered standards for selection of the conditions.

The advent of quality measures has been obvious over the last four years. However, as health care costs have risen, far less obvious has been the use of "efficiency measures". These little known software programs are widely used by health plans to identify provider resource consumption. Loosely described, they take claims data, link the claims submitted to the program's definition of an episode of care and measure those who use less resources (ie. cost less) against those who use more. While typically conducted in secret, there are efforts now to make this comparative information about their performance known to physicians in the states of Washington and California and to hospitals in Tennessee and elsewhere. The point is to both favor less costly providers and educate those who don't measure up. These efficiency-focused software programs are generally not explicitly linked to quality measures.

So, today we have a developing national strategy to confront the longstanding but largely unconsummated promise in quantifying health care in order to be able to improve it, with the addition

of efficiency measurement. The fact that there remains significant policy debate has not stanchied Congressional action on point.

Congressional Initiatives*

The Medicare Modernization Act of 2003 was a major leap forward in public performance measurement policy. Probably the most direct action on performance measurement was the Congressionally enacted 0.4% Medicare reimbursement penalty to be imposed on any hospital that failed to report quality data to the previously administratively created 'voluntary' hospital quality reporting initiative.

In addition Congress set into motion more than six demonstration projects entailing measurement. A five year Medicare Health Care Quality Demonstration project was enacted to encourage delivery of improved quality by use of incentives for improved safety, appropriate use of best practice guidelines, reduced scientific uncertainty through examination of variations in the utilization and allocation of services, and outcomes measurement and research, along with encouraging shared decisionmaking between providers and patients. None of these efforts can bear fruit without performance measurement.

In the Medicare Care Management Performance Demonstration, Congress created another pay for performance program for physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and 'evidence based outcomes measurement'. Physicians have to report electronically on clinical quality and outcomes measures established by the Secretary of HHS. Additional demonstration projects on home health, adult day care, chronic care improvement and the chronically ill all entail performance measures to some degree.

* A longer article on much of this topic, with citations to resources is available at "The Performance Measures Ball: Too Many Tunes, Too Many Dancers?" HEALTH LAW HANDBOOK, 2005 ed., WestGroup, <http://www.gosfield.com/PDF/Ch4Gosfield.pdf>

So the public programs are squarely in the performance measurement game. The government is not alone, however.

The Major Players

Going back to the Commission Report, and bolstered by the National Technology Transfer and Advancement Act (NTTAA) of 1995, the National Quality Forum (NQF) was created as a public-private enterprise with a voluntary membership of more than 250 entities, including CMS. They represent and are structured into four major stakeholder perspectives including (1) consumer and patient groups; (2) purchasers; (3) providers and health plans; and (4) research and quality improvement organizations. But it is the impact of the NTTAA which gives NQF its power. That law requires federal agencies and departments to use technical standards that are developed or adopted by voluntary consensus standard bodies. An OMB Circular specifies in significant detail how consensus standards will be developed and how federal agencies may participate with bodies developing them.

As a result, NQF is the major clearinghouse through which parties seeking government application of their measures bring them to be endorsed by the consensus process which NQF offers. There are rules about how measures are put forth for consideration, the scientific support for them, the process for their review and consideration, how they are endorsed, what happens when there are disagreements, and the like. NQF has now published measures on hospital care, ambulatory care, nursing home care, safe practices, adult diabetes care, serious reportable events, consumer focused measures of mammography center quality, evidence based substance abuse treatment practices, cancer care, patient safety in medication use, standardizing cardiac surgery and prevention and care for deep vein thrombosis, and more. (www.nqf.org) The JCAHO operates a voluntary hospital performance measurement exercise through their ORYX program which entails hospitals selecting

from approved lists, measures they will report and around core sets. The initial list reflects in large part measures from the PRO Sixth Scope of Work. Measure-set vendors get approved for specific measures and the hospitals report their data to them. They then submit that data to the JCAHO.

CMS not only has its own hospital reporting initiative alluded to above which is a 10 measure starter set, its Premier Hospital Quality Incentive Demonstration, a hospital P4P project, has another list of 34 measures. These incorporate all 10 of CMS's own starter set of hospital measures, 27 measures from NQF, 24 from the PRO Seventh Scope of Work, 15 from the JCAHO core measures and 3 used by the Leapfrog Group in its patient safety focused efforts. The PROs (now called QIOs) have still another set of core measures for hospitals, home health agencies and nursing homes. They also have physician measures associated with diabetes treatment in the office, screening mammography and adult immunizations.

The CMS Physician Group Practice Demonstration, a physician P4P program, focuses on chronically ill Medicare beneficiaries and has a separate set of measures. While there is overlap in various places among the measures for specific provider segments, and sometimes the priority conditions are recognized across sets, *even within CMS the measures from project to project are not the same.*

In general in the market, there are far fewer physician measure sets by comparison with hospital measures, and they vary as well, even though they generally address some or all of the priority conditions. The Bridges to Excellence P4P program pays based on some HEDIS measures and other NCQA adopted process and outcomes measures around diabetes and cardiac care. They also measure infrastructure development in the practice. The Integrated Healthcare Association in California uses measures drawn largely but not exclusively from HEDIS. NQF has endorsed additional physician measures jointly proposed by NCQA and the AMA's Physician Consortium for Performance Improvement. The American College of Physicians, American Academy of Family

Physicians, AHIP, the managed care lobbying group, and AHRQ convened another consensus group now called the Ambulatory Care Quality Alliance which has issued an additional initial set of physician performance measures.

AHRQ, the quality research and technology assistance branch of DHHS, has issued still another set of hospital quality indicators.

The Leapfrog Group has led the way with hospital focused patient safety measures which hospitals voluntarily report, for consideration and comparisons in the buying decisions of purchasers and health plans.

The Institute for Healthcare Improvement (IHI) in Boston has taken a different tack entirely, promulgating system level measures which focus on a health system's overall performance on core dimensions of quality rather than addressing specific clinical conditions and measures of processes and outcomes associated with them. For example, they focus on adverse drug events per 1,000 doses in a hospital; work days lost per 100 employees; hospital specific mortality rates; patient satisfaction; percentage of patients dying in the hospital; days to third next available appointment; hospital specific standardized reimbursement and more. These measures, says IHI, point to issues which should be examined more closely to improve quality and safety without reference to specific conditions.

The basic point here is that there are a myriad of performance measures and measurers with which providers must contend. There are so many, in fact, that AHRQ has created a National Quality Measures Clearinghouse reports on five domains of measurement (www.qualitymeasures.ahrq.gov) which means not all measures sets extant are captured. Yet, searching for 'diabetes' alone produces 91 measures.

The diversity of measures, the nuanced nature of the differences among them -- even when they address the same conditions -- are essentially unexplained. The struggles for primacy among

the measurers, including government agencies, speaks to the policy dynamism at work here, but does not prevent operational application of them in ways relating to payment, network participation and exclusion, tiering of providers, and likely more with time. Some of the policy controversies raise very practical concerns for those who are being and would be measured.

Policy Controversies

There are four fundamental controversies swirling around quality performance measurement and one overarching one pertaining to efficiency measurement.

1. The *content in relation to application* of quality measures is the first problem area. There have been longstanding assertions that measures are tainted because they are created by self-interested parties. That problem is somewhat abating today given the broadly representative nature of many of the measures promulgators. The debate continues, though, as to whether measures ought to differ -- both in content and rigidity --- based on their applications. Some argue that truly granular individual physician focused measures are useful only to internal quality improvement efforts in a group, hospital or smaller non-public setting, but should not be publicly reported because of the potential implications of small numbers reporting.

2. The *burden of measurement* is a real concern, especially given the plethora of measures in play. As the American College of Physicians has noted, health plans use multiple measures for the same phenomenon, such as HEDIS measures, an internal measure from claims data, and abstracts from medical records all to report on childhood vaccination rates. Burden reflects ease of reporting which turns on the source of data. There is tension in not imposing too much burden to produce the data as from medical records, versus whether, claims data, (which is more easily accessed) is reliable for quality purposes. Some of the burden issue would mitigate if providers had reliable electronic records from which to call data. Real time access by measurers would eliminate this

problem. Then there is the problem that health care entities that are measured will perform to meet the measures perhaps at the expense of other important quality endeavors.

3. *Comparability* is a major issue since, besides using data for internal improvement, a major point of the whole enterprise is to be able to compare performance among the subjects of measurement. The oldest problem is whether the measures are appropriately refined to reflect adequate risk adjustment. Are the patients really sicker? Inaccuracy is another yet different problem created by insufficient sample size, data sets, and confounding factors the measures cannot capture. Without standardized specifications for measures these problems exacerbate.

4. Whether all of this measurement will actually *improve care* is also debated. Since there is a very strong preference in today's world for consensus measures and against regulatory imposition of measures, the measures themselves may report on matters which are essentially either very low hanging fruit, or not truly meaningful to improving quality. There is some evidence that only those performing at the lowest tiers of measurement change their behavior in response to public reporting of measures. As to internal uses, there is some evidence that profiling physicians does motivate changed behavior and improvement. Yet, benchmarking within a class of under performers has been referred to as striving to become 'the cream of the crap.'

The primary concern with respect to efficiency measures is the extent to which they *reflect evidence based medicine*. To quantify resource consumption in terms of high users and low users for an episode of care is simply a more sophisticated way of targeting providers for exclusion from networks, disadvantageous tiering and otherwise. The real question is the extent to which low resource consumption is consistent with high quality care in accordance with evidence based medicine. The cheapest care is no care at all.

There is no question that an understanding of

comparative resource consumption can facilitate provider appreciation of the financial impacts of their care, but in today's environment, efficiency measures which are used completely apart from quality measures will produce inappropriate results. In addition, how proprietary software programs define an episode is not standardized which raises additional issues where different payors in a market score the same provider differentially. Appropriate *principles in measuring efficiency*, have been addressed by the Bridges to Excellence program in a new white paper devoted specifically to this subject.

Legal Issues

The legal issues associated with quality and efficiency performance measurement group around (1) the construction of measures, and (2) their applications.

It is unclear at this time whether there is, in fact, a standard of care for the construction of performance measures. Although the IOM and the President's Commission have spoken to factors that are important in creating measures, these have not risen to a legal standard of care. Because of the requirement in the NTTAA that federal agencies look to voluntary consensus standard organizations, NQF's work may well have different legal standing by comparison with unendorsed measures, even though, because it is a purely consensus driven process, its measures could reflect less science and more political acceptability.

The applications of performance measures are where the rubber hits the road. Hospital medical staffs may use them to limit, restrict or terminate clinical privileges. Similarly, health plans use them for bonus payments or payment denials, network construction and tiering of networks. Because of the potential implications for those who score badly, it is likely that there will be legal challenges raised to the construction of the measures, the process by which they are applied, and the mechanisms to appeal their implications.

The fact of performance measurement is likely to

create new forms of liability. Some would argue that for services which are typically overused, widespread use of measures may increase liability for physicians. A plaintiff's lawyer might argue an overutilizing physician should have used a more conservative approach to care. Under-utilizing physicians, however, might be able to justify not providing unnecessary care using a combination of efficiency and performance measure data. Physician anxiety regarding disclosure of data demonstrating poor performance will likely provoke additional legal battles when the effects of measurement really touch on the physician's business, such as when he is denied bonuses or excluded from preferred networks. The accuracy of the data relied on/and the legitimacy of the process by which it is applied will also likely be challenged. Some payors are already adopting contract provisions which truncate provider rights to challenge their measures-based determinations. A different kind of liability may arise where providers say they use internal measures, but data which is collected is not reviewed and acted upon. This would be particularly problematic for hospital boards which do not investigate data which is routinely made available to them.

Clinical Integration

In light of the clear movement towards a more quantified environment, providers, and particularly physicians, would be well advised to position themselves to score well. In this regard, the antitrust protected opportunity offered by the Federal Trade Commission and Department of Justice in 1996 in the form of clinical integration is relevant. This opportunity is potentially the most potent technique made available to physicians to improve the quality of their care, enhance their professional quality of life, and position themselves to be able to bargain collectively with payors for enhanced reimbursement.

In the near term, it will be more difficult for providers to obtain differential and better reimbursement from any payor in the absence of data supporting a rationale for differential payment. Therefore, provider positioning to

produce data that speaks to relevant measures in any market will be important. Other data demonstrating distinction from the overall class will also be useful. Performance measurement alone, however, is not a sufficient reason to clinically integrate.

There are many reasons which we have described for physicians to come together to standardize and simplify their professional lives (www.uft-a.com). Performance measurement and efficiency measurement is another. To the extent that otherwise competing physicians can share experiences so as to learn from each other and help their practice colleagues who are not scoring as well can only benefit both the physicians and the quality of care they render to their patients. Physicians and their business 'significant others' -- hospitals and plans -- should organize their fundamental activities around five basic principles: (1) standardize to the science as much as possible; (2) simplify administrative and clinical procedures to save time and reduce the risk of errors; (3) make all systems physicians must use clinically relevant; (4) engage the patients in these endeavors; (5) embrace efforts to fix accountability at the locus of control. (See, Gosfield and Reinertsen, "Doing Well By Doing Good: Improving the Business Case for Quality" June, 2003, www.uft-a.com).

Application of these principles can reduce fraud and abuse liability, malpractice liability and likely would produce better scores on measurement scales as well. But, a substantial motivation for physicians will be the opportunity created by these undertakings to bargain collectively over rates.

Although financial integration is one mechanism by which otherwise competing physicians can come together to bargain collectively on fees, clinical integration does not require unifying the business. Rather, otherwise competing physicians can come together in the interests of furthering quality. Although not a strict "safety zone" which provides protection if you comply with its principles, the clinical integration opportunity is one which has been offered by the FTC and DOJ in their description of the characteristics of a clinically

integrated network.

To qualify as clinically integrated, a network of otherwise competing physicians must be engaged in quality relevant activities through the use of protocols and/or clinical practice guidelines to standardize their delivery of care. They must be engaged in internal review and profiling of the participating physicians. There must be investment in infrastructure either with time or money or both.

Based on their internal review they must take corrective action against physicians who do not measure up and they must share their data with payors. In order to clinically integrate safely so that collective bargaining over fee for service payment is legitimate, the fee bargain must be ancillary to the real reason the physicians have come together. This means that unless there is a good reason to come together and act in a clinically organized, standardized way, the collective activity may run afoul of the anti-trust laws.

Getting Started

Physicians who are considering how to organize around these principles should understand there is no one way to do it. However, logic leads to the following steps:

1. Identify within the market other physician groups of good reputation who share these values and begin to discuss how to clinically integrate.
2. Identify performance measures activities within the specific market.
3. Identify among those measures the range of conditions applicable to the specialty of the integrating practitioners.
4. Begin by identifying a few clinical conditions around which common documentation standards might be developed.
5. Implement the documentation standards among the physicians. When the records have been created in this standardized way for a month, pull

five patient records for each physician participating and analyze the extent to which documentation conformed with clinical practice guidelines and how, using the relevant measures that drove the project, the physicians scored.

6. Analyze the results.

7. Consider process improvement for those who did not score well and benchmark against the high performers and analyze what makes them successful.

8. Do this again for additional conditions until a significant bulk of data has been created and a standardized process is in place.

There is no defined parameter as to when there is sufficient clinical integration to be able to bargain collectively. In addition, there is no obligation the clinical integration be complete across the practices. To bargain for higher rates for the treatment of specific conditions can begin in this way, and expand over time.

Conclusion

The advent of measurement both of clinical performance and efficiency is yet another goad to physicians to consider reordering the way they do business. Taking into account the demands of the marketplace as well as the clinical needs of patients will be critical to the success if not survival of physician practices in the foreseeable future. Savvy practices will explicitly position themselves proactively around these demands.

Links to Resources

WA efficiency measurement initiative

“Measuring Provider Performance: An Online Learning Forum” -

<http://www.regence.com/research/>

TN reporting initiative

“BlueCross, hospitals group publishing quality reports” – August 8, 2005

http://www.bizjournals.com/industries/health_care/

hospitals/2005/08/08/nashville_story6.html?f=et163

CA reporting initiative

“Blue Shield of California Launches First Physician-Driven Efficiency Program in the State”

- http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=AAHP_HEA.story&STORY=/www/story/08-04-2005/0004082766&EDATE=THU+Aug+04+2005,+12:34+PM

A critique regarding efficiency measurement:

“Episode Treatment Groups (ETGs): A Patient Classification System for Measuring Outcomes Performance by Episode of Illness” -

<http://www.thedeltagroup.com/Corporate/Pubs/ETGs.pdf>

Bridges to Excellence - “Provider Efficiency White Paper”

http://www.bridgestoexcellence.org/bte/white_paper_release.htm

The government’s statement on clinical

integration: “Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures” -

<http://www.ftc.gov/reports/hlth3s.htm#8>.