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# THE HEALTH REPORT

## Guidelines for Measuring, Reporting, and Rewarding Physician Performance



MASSACHUSETTS  
MEDICAL SOCIETY

# IMPROVING THE QUALITY OF HEALTH CARE

**I**ncreasingly, physicians are being judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care. Quality improvement programs that have these goals should utilize the following criteria:

- Use objective, well-validated, and clinically important measures of quality
- Ensure accurate and timely assessment of these measures
- Include physicians in both primary care and medical specialties
- Provide for timely review of reports by involved physicians prior to public release
- Ensure that reports released to the public can be easily and accurately interpreted
- Make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible
- Use appropriate incentives to reward superior performance and stimulate continuous improvement in the quality of care being provided
- Promote and facilitate the adoption of information technology (IT) tools including electronic health records (EHRs)

## Measuring Quality

- Many quality measures used today, including Health Plan Employer Data and Information Set measures, represent “low-hanging fruit” and are of marginal clinical importance. They provide a starting point, however, until better measures can be implemented. Such data should not be used in the physician peer-review process. Physician peer review should be conducted in accordance with the Society’s “Model Principles for Incident-Based Peer Review for Health Care Facilities.”
- Technical barriers to accurate and timely measurement of quality need to be confronted. As sources of data, claims data have the advantages of being readily available, relatively low in cost, and inclusive of important parameters such as diagnostic and procedure codes. Shortcomings include delays in obtaining access to the data, inaccuracies, and inadequate information on the clinical needs of patients and socioeconomic indicators that may affect outcomes. Uniform availability of EHRs is central to improved measurement. The development of such systems should be a high priority.
- The costs of quality measurement can be considerable. Costs should be justified by tangible evidence of resulting improvements in health care quality and/or savings in the costs of health care. Measures of cost should include the added clerical burdens on physician practices or managed care organizations.

## Patient-Physician Relationships

- Quality-measurement programs should be directed at supporting and improving patient-physician relationships. To these ends, they must reflect the vital importance of sound medical judgments as well as adherence to defined guidelines.
- **Programs should protect and improve access to high quality health care for all patients. Program developers should be especially sensitive to minimizing barriers to access among patients who are disadvantaged by reason of ethnic, cultural, and socioeconomic barriers, or who have especially complex medical conditions, and should take positive steps to improve access to care for such patients.**

- Programs should aim to achieve equity in quality assessment for patients and their physicians, regardless of the setting in which care is delivered or the location of the population served (for example, inner city or rural areas). This challenge will be particularly difficult in practice settings that lack the needed infrastructure, including EHRs.
- Programs should be “risk-adjusted” to reflect the important effects of patient non-adherence on performance outcomes. This is especially important when patient adherence is not reasonably under the control of the physician.

## Public Reporting of Physician Performance

- The public expects and deserves valid reports on the performance of all health care providers: medical practices, managed care organizations, hospitals, nursing homes, and other services.
- Reports for public release must meet high standards for accuracy and statistical validity. They should receive timely review by involved practices prior to release, and should be corrected for discovered errors or risks of misinterpretation. Particular attention should be given to ensure that physicians are held accountable only for care for which they are responsible.
- Reports that compare performance of physicians or practices to each other or to benchmarks must avoid using arbitrary cut points that designate practices as being “superior,” “above average,” “average,” or the like. Instead, performance should be rank-ordered according to the quality measure under consideration. Ranking should be based on clinically important and statistically significant differences.
- Reports must pay careful attention to differences in sociodemographic and socioeconomic classes and cultural divides that may affect patient attitudes toward health care and adherence to recommendations of their physicians.

## Paying for Performance (P4P)

- Use of incentives to reward superior physician performance or improvements in performance over time make intuitive sense. Solid evidence is needed, however, to establish that these rewards actually contribute to higher quality and more cost-effective health care. Evidence that supports the value of such incentives in health care is, at present, limited.
- Criteria, methodology, and background data for P4P on measures of quality and cost should be transparent to all involved. Practices involved with these incentives should have an opportunity to review their data and, preferably, begin improvement prior to the implementation of the incentives.
- Requirements to achieve P4P goals should be made known to physicians in a timeframe that will allow them to safely alter the care they deliver in order to meet the goals.
- Incentives should seek to move practices to the “next level” in terms of acquiring essential structural components (for example, tracking systems or EHRs) that will improve processes or outcomes of care.
- P4P pilots should use incentives of sufficient magnitude to influence physician behaviors. Results should be carefully monitored to ensure the intended objectives are met and unexpected detrimental effects have not been introduced.
- P4P incentives will be most effective in improving patient care if they are aligned and standardized across payers, physician practices, and hospitals.
- Funding of P4P initiatives should come from additional resources. Financial incentives should not come from a redistribution of current physician and other health care provider reimbursement.

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