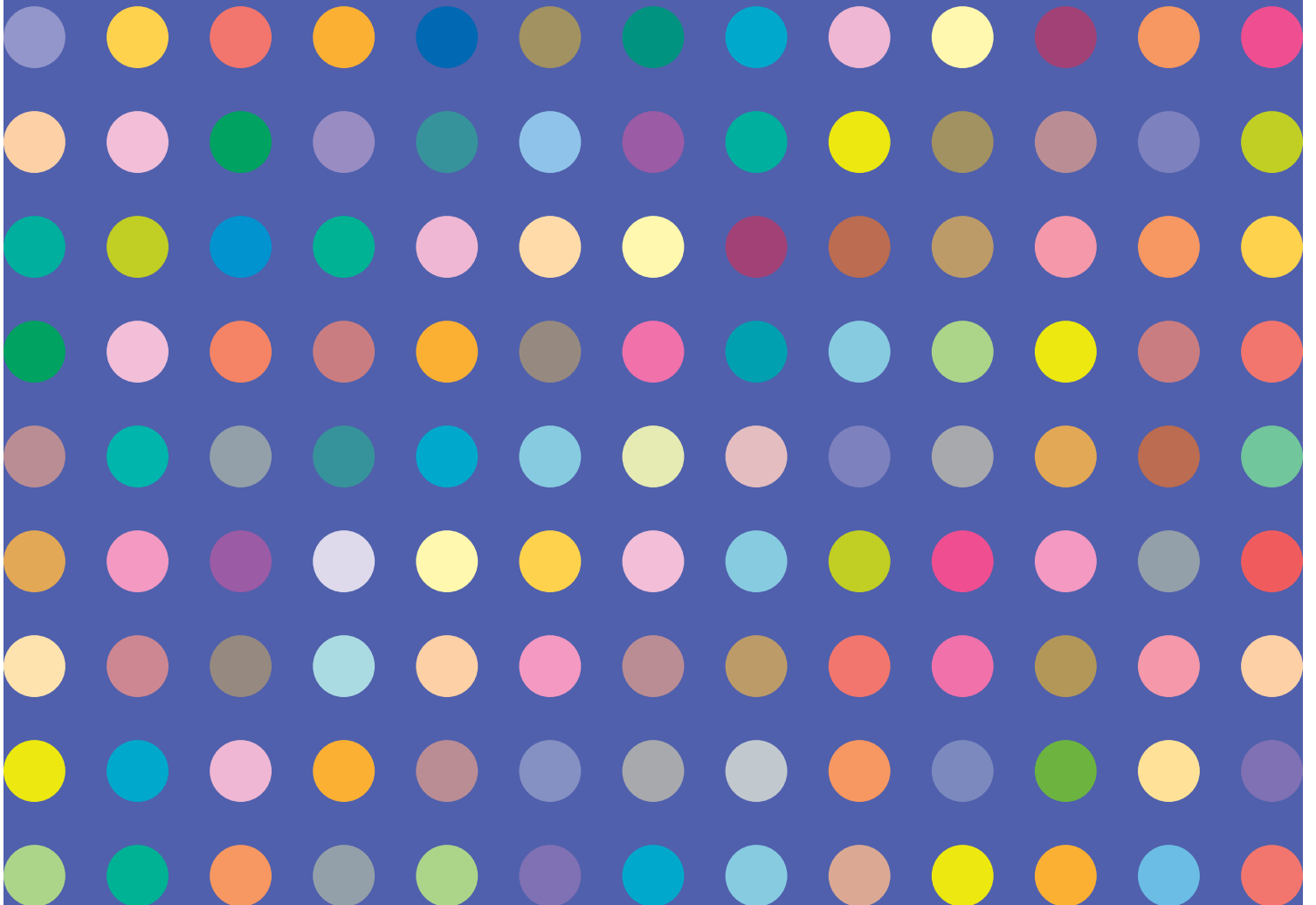


Is Pay for Performance The Key to Quality Improvement?

NATIONAL COMMITTEE FOR QUALITY HEALTH CARE'S
2005 ANNUAL MEETING REPORT

MARCH 10-11, 2005
THE WESTIN EMBASSY ROW HOTEL | WASHINGTON, DC



INTRODUCTION

On March 10-11, 2005, the National Committee for Quality Health Care (NCQHC) hosted its annual meeting, entitled *Is Pay for Performance the Key to Quality Improvement?* This meeting, held in Washington, DC, also served as the 12th anniversary of the NCQHC National Quality Health Care Award. This award is presented in partnership with the Cardinal Health Foundation, its first corporate sponsor, and with *Modern Healthcare* magazine, the award's legacy sponsor.

This report provides highlights and a summary of lessons learned from the meeting's outstanding faculty, who looked at the role of pay-for-performance programs in stimulating quality improvement. Their names appear in alphabetical order below:

- James Adams, MD, Chairman of the Department of Emergency Medicine, Northwestern Memorial Hospital
- Howard Beckman, MD, Medical Director of the Rochester Independent Practice Association
- Regina Berman, RN, MA, Director of Performance Improvement at Hackensack University Medical Center
- Carolyn Clancy, MD, Director of the Agency for Healthcare Research and Quality
- Julie Creamer, Vice President of Operations and Quality, Northwestern Memorial Hospital
- The Honorable Danny K. Davis (D-IL), member of the U.S. House of Representatives
- Richard O. Davis, Ph.D., Executive Director of the Center for Innovations and Quality Patient Care at Johns Hopkins Medicine
- Suzanne Delbanco, PhD, Director of The Leapfrog Group
- James Dwyer, D.O., Executive Vice President and Chief Medical Officer at Virtua Health and Co-Chair of the NCQHC Task Force on Performance Measurement
- Edward J. Giniat, National Sector Leader, Health Care, for KPMG, LLP
- Debra Hadley, Executive Director of Cardinal Health Foundation
- Dean Harrison, President and CEO of Northwestern Memorial Hospital
- Andrew Hine, Director of Health Advisory Services at KPMG in the United Kingdom
- Brent James, MD, M Stat, Vice President of Medical Research and Executive Director for the Institute for Healthcare Delivery Research at Intermountain Health Care
- Herb Kuhn, Director of the Center for Medicare Management at the Centers for Medicare & Medicaid Services
- Charles S. Lauer, Publishing and Editorial Director of *Modern Healthcare* magazine
- Jerod Loeb, PhD, Executive Vice President of the Joint Commission on the Accreditation of Healthcare Organizations
- Catherine E. McDermott, President and Chief Executive Officer of NCQHC

- Bruce D. McWhinney, Pharm.D, Chair of NCQHC and Senior Vice President of Clinical Affairs at Cardinal Health, Inc.
- Gary Mecklenberg, President and CEO of Northwestern Memorial HealthCare
- Arnold Milstein, MD, MPH, Medical Director at the Pacific Business Group on Health
- Michael Ortwine, Manager of the Center for Healthcare Quality and Evaluative Studies at Blue Cross Blue Shield of Michigan
- Robin Osborn, Vice President and Director of the International Program in Health Policy and Practice at The Commonwealth Fund
- Leonard Schaeffer, Chairman of the Board, Wellpoint
- Curt M. Selquist, Company Group Chairman and Worldwide Franchise Chairman at Johnson & Johnson Healthcare
- David Stevens, MD, Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality
- Scott Wallace, President and CEO of The National Alliance for Health Information Technology
- Dan Wolterman, President and CEO of Memorial Hermann Healthcare System
- Gary Young, JD, PhD, Professor of Health Services at Boston University and Associate Director of the Center for Organization, Leadership and Management Research at the Department of Veteran Affairs

Chapter I

THE ABCS OF PAY-FOR-PERFORMANCE PROGRAMS

This chapter reviews the “basics” of pay-for-performance (P4P) programs, including what they are and why, when, and how they are currently being used. It summarizes the theory and reality with respect to their impact, offers overall guidance on making P4P programs more effective, and provides case examples of several prominent P4P initiatives.

What Is Pay-for-Performance?

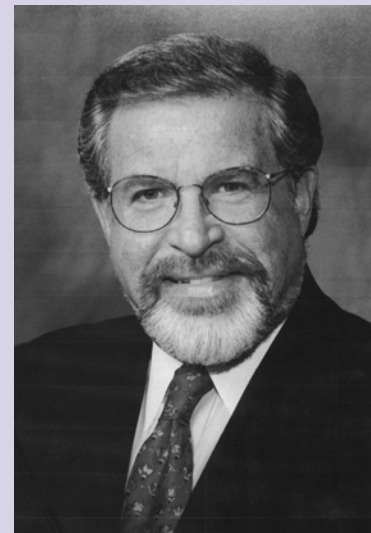
While P4P programs can mean different things to different stakeholders, they appear to have three primary characteristics:

- A financial incentive with a wide array of structures that can vary considerably across programs.
- Predefined performance targets that relate to efficiency, productivity, and/or quality. While P4P programs that reward efficiency and productivity have been around for many years, newer programs focus on quality.
- Accountability, which holds individuals, teams, or entire organizations, responsible for achieving or exceeding performance targets.

Growing Interest in P4P Programs

- Burdened with skyrocketing costs and questionable quality, private purchasers forming coalitions at community or regional levels to encourage market adoption of P4P programs.
- The public sector is also encouraging a shift toward P4P. The current Administration has set an ambitious goal for the adoption of new and emerging technologies to develop and use electronic medical records (EMRs). The Medicare Modernization Act (MMA) and new Medicare programs are also provided a boost to quality measurement and P4P demonstration projects.
- The provider community is focusing on P4P initiatives. The American Medical Association (AMA) has developed a set of principles related to P4P programs. Hospitals and health systems are working with the Joint Commission on the Accreditation of Healthcare Organizations and others to develop P4P programs.

One national study found 78 such programs in 2004, double the number from a year earlier. These programs, which affect 35 million health plan members, are being put in place primarily by health plans (either HMOs or PPOs), although the Centers for Medicare & Medicaid Services (CMS) are developing some programs. While most of the programs target hospitals or primary care physicians, a sizable minority (33 of the 78 programs in 2004) include specialists as well.



*Leonard Schaeffer,
Chairman of the Board,
WellPoint, Conference
Keynote Speaker*

Why Is Interest Growing in P4P?

Traditional methods of compensating providers—fee-for-service, capitation, and salary—all have severe limitations, and none has been shown to be a strong catalyst for quality. While there is no perfect system, P4P programs are seen as a way to produce better results in three areas:

Area #1: Slowing the Growth in Expenditures, and Increasing Value

- There is an urgent need to slow the growth in health expenditures, which are rising much faster than wages, leaving fewer and fewer Americans earn enough money to pay for health insurance.
- Purchasers have become frustrated with the rapid rise in costs, and some are looking toward a “business case for quality”—that is, that the savings realized from aggressive quality improvement initiatives and P4P programs will more than offset the costs of these implementing programs.
- P4P programs hold the promise of increasing adherence to best practices, which should lead to reduced healthcare spending and better value. A well-publicized 2003 study by RAND found that patients receive appropriate care only 55 percent of the time. After evaluating Medicare claims data, John Wennberg and his colleagues at Dartmouth concluded that more care and higher spending does not result in better outcomes for Medicare patients. The researchers believe that the same findings apply to the commercially insured population.

Area #2: Improving Quality and Saving Lives

P4P programs hold out the promise of stimulating improvement in quality care. By encouraging adherence to recommended guidelines, P4P programs can help to minimize errors and the possibility of harmful consequences that lead to unnecessary deaths today. For example, P4P programs can encourage providers to follow recommended testing and procedures for diabetes, hypertension, colon cancer screening, and vaccinations to older citizens.

Area #3: Encouraging Adoption of Information Technology

Some P4P programs include explicit incentives designed to encourage provider adoption of information technology (IT), which many experts see as being a critical first step to lasting quality improvement cost reduction. However, in many cases, financial incentives have not been enough to encourage IT adoption.

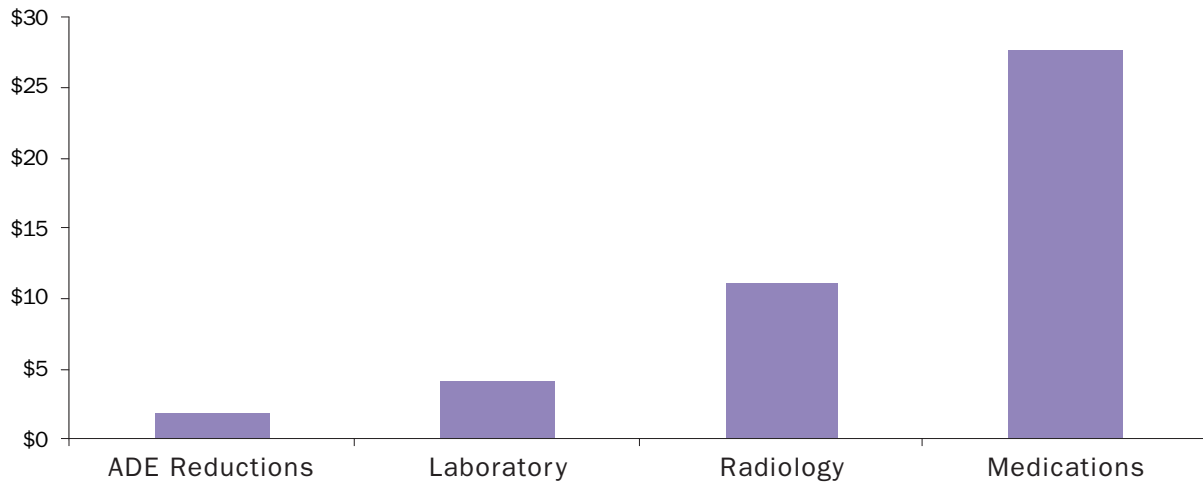
Through increased use of computerized clinical decision support systems, patient reminder systems, electronic prescribing, computerized physician order entry (CPOE), and other technologies, greater investments in IT should improve quality, reduce costs, and increase efficiency.

Will P4P Work? The Theory and Reality

Evidence from the manufacturing sector on P4P is encouraging, showing that P4P programs help to boost productivity, efficiency, and quality. Unfortunately, the evidence from healthcare is fairly limited, and the results are mixed. Few studies have been conducted, and even fewer have been done well. Those studies that do exist do not provide clear-cut results with respect to the impact of P4P. The *Rewarding Results* program

INCENT HEALTH IT ADOPTION

Nationwide adoption of CPOE will save an estimated \$44 Billion per year



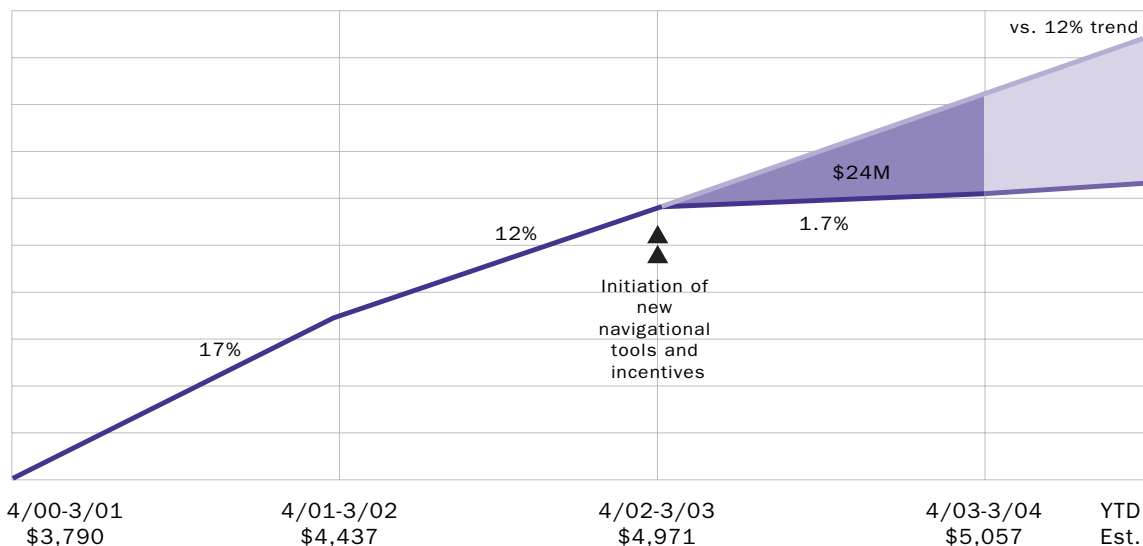
Note: Chart refers to computerized provider order entry in ambulatory settings; ADE = Adverse Drug Event *Source: California HealthCare Foundation, 2004*

sponsored by The Robert Wood Johnson Foundation (RWJF) may, in time, provide some answers on P4P.

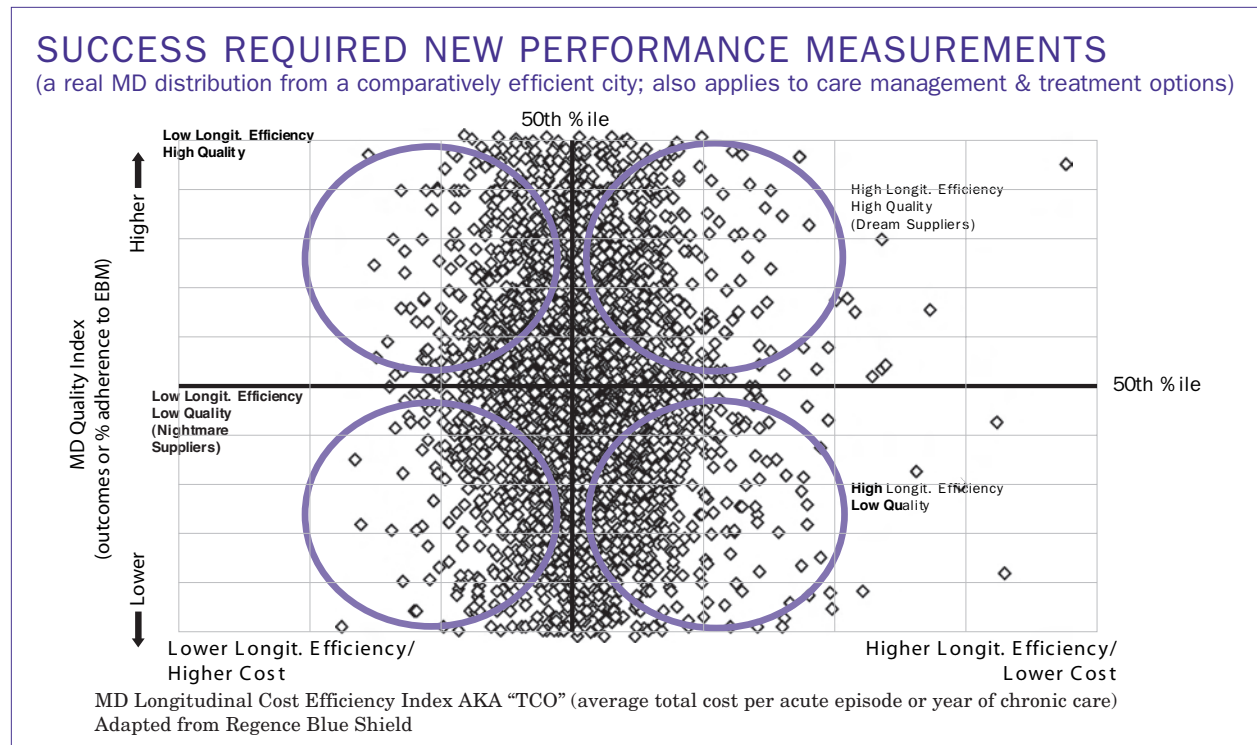
In the meantime, some anecdotes of success do exist. For example, the initiation of new navigational tools and incentives helped to lower the growth in per capita healthcare spending for 120,000 low-wage hotel workers in Nevada (see chart below). The key to success was to encourage the workers to seek out high-value providers.

ACTUAL REDUCTION IN SPENDING TREND WITHOUT QUALITY COMPROMISES: OUTSWIMMING THE SHARK IN NEVADA

Per Capita Health Care Spending (Low Wage Hotel Workers in Nevada)



The hotel-worker example is illustrative of the larger theory of how P4P programs can work. As shown in the chart below, there is wide variation in the efficiency and quality performance of physicians—the key is to migrate consumers to the “dream suppliers” in the upper right quadrant.

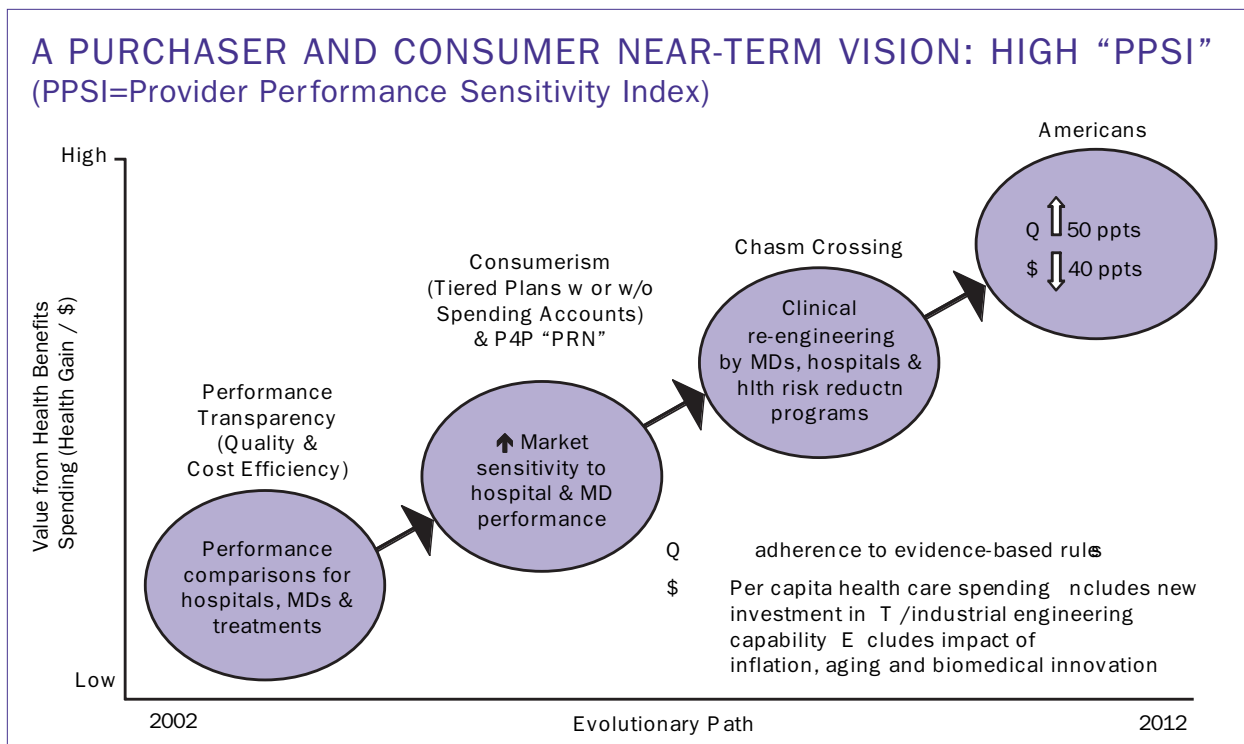


The hope is that, over time, other physicians will improve their performance as a way to prevent consumers from switching providers. For example, hiring additional assistants and investing in training may lead to significant increases in productivity, patient satisfaction, and provider satisfaction, along with dramatic reductions in costs and waiting times.

Played out across the entire country, experts estimate that ultimately the quality of healthcare could improve by 50 percentage points, while costs could fall by 40 percentage points. As depicted in the chart below, the evolutionary path to this end-state begins with performance comparisons across hospitals, physicians, and treatments. Then as consumerism and P4P become more prevalent, there will be increased market sensitivity to physician and hospital performance, which will in turn encourage providers to embark on the hard work of clinical re-engineering.

It is important to note, however, that P4P represents only one of the tools that keep this evolutionary path going. Transparency in performance measurement, consumerism, and clinical process re-engineering are also critical components. But P4P programs have their place, and may be particularly effective with respect to the following:

- Jump-starting provider prioritization of performance management and investment in required infrastructure, including industrial engineers and IT.
- Motivating provider oligopolists that have no capacity to take on new patients at this point.
- Overcoming the practical, psychological, and ethical limits of consumerism.



Making P4P Work

The Agency for Healthcare Research and Quality (AHRQ) and RWJF supported a survey of over 2,500 randomly selected physicians at two *Rewarding Results* demonstration sites. The survey elicited roughly 850 responses. Also as a part of this work, telephone interviews were conducted with 46 physician practice leaders at three demonstration sites. This research helps to identify a set of design and implementation issues related to P4P programs. Key issues include:

- **Provider awareness of the incentive:** Many providers are confused because many P4P programs are overly complex; and many providers deal with multiple programs. The various payment algorithms, which often included multiple components, criteria, and quality targets are often confusing and frustrating.
- **Financial salience of the incentive:** It is not yet clear how much of a financial incentive is needed to motivate behavior change, even though 10 percent of total income has been widely suggested as a rule of thumb. Because most providers care for patients of multiple payers, the total amount of the incentive may depend on how many eligible patients the provider sees from the payer that is sponsoring that particular P4P program. The timing of payments may also be an issue. Infrequent payments (e.g., once-a-year) may cause providers to “forget” about the quality targets. Finally, the relative emphasis on quality within the P4P program is important, since most programs are designed to reward not just quality, but also utilization, patient satisfaction, efficiency, and investments in IT.
- **Clinical relevance of the quality target:** Quality targets must be thoroughly researched and scientifically tested and validated to have provider “buy-in.” Because some quality targets are based on HEDIS (Health Plan Employer Data and Information Set) standards originally designed for health plans, providers may feel that they have

little control over performance on these measures. Providers also are wary if target measures are constantly changing.

- **Scope of control:** Individual physicians may not feel that they have complete control over performance since they may be dependent on other providers (e.g., nurses, technicians) to achieve high-quality performance. In some cases a team-based incentive may be preferred.
- **Fairness:** Those systems that pay only for achieving an absolute threshold level of performance may be perceived as unfair by low performers that are working quickly to improve. Systems that reward measured improvement may be perceived as unfair by consistently high performers who feel they have little room for improvement. In addition, providers are concerned about being penalized for seeing sicker patients, highlighting the need for performance adjustments based on patient mix. As a result, multiple approaches to P4P may be necessary.
- **Unintended consequences:** There are provider concerns that any P4P program may result in an emphasis on those areas being measured by the program and inadequate attention to other important clinical and process areas.

Case Studies of P4P Programs

As noted, P4P programs are varied. This section profiles the programs being explored by CMS and three private sector organizations--Blue Cross Blue Shield (BCBS) of Michigan, Excellus BCBS (in partnership with the Rochester Independent Practice Association or RIPA), and Wellpoint.



Herb Kuhn, Director, Center for Medicare Management, CMS

CMS

CMS currently has four major demonstration programs underway, two for hospitals and two for physicians.

- **Hospital Quality Initiative (HQI):** This voluntary program covers 10 indicators in three disease categories. The MMA of 2003 provides an incentive for hospitals to participate (participants receive the full market basket update; there is a 0.4 percent decline for non-participants), which encourages almost all hospitals to take part in the program. In the spring of 2005, consumer-friendly data from this project was made available to the public on CMS' *Hospital Compare* web site, <http://www.hospitalcompare.hhs.gov/>.

- **Premier hospital quality program:** This program covers 34 indicators in five disease categories. Roughly 300 hospitals participate, with performers in the top decile getting a two-percent bonus; and those in the second decile receiving a one percent bonus. In year three of the program, those in the two lowest deciles will lose

one and two percent, respectively. The goal is to reduce variations across institutions and encourage improvement over time.

- **Physician group practice demonstration:** Launched in early 2005, this program includes 10 physician groups that will be rewarded based on their performance on

measures related to care management. Participating groups will put two percent of their fees at risk. The goal is to share the savings generated from better care management with the groups that improve their performance.

- **Chronic care improvement program (CCIP):** This population-based disease management program is intended to improve care and reduce costs for the 15 percent of individuals with multiple chronic conditions who consume roughly 75 percent of health expenditures. Under CCIP, physician groups will have up to five percent of their fees at risk. The initial response has been overwhelming.

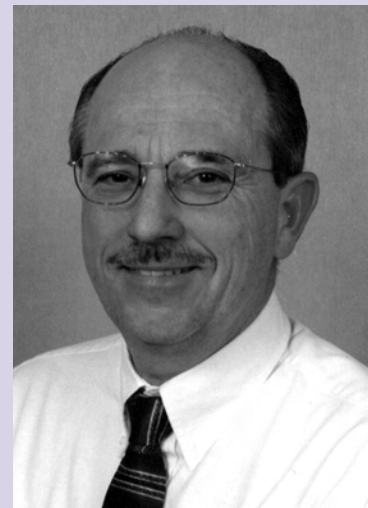
Looking ahead, CMS plans additional P4P demonstration projects, including other disease management programs and a program to reward those who excel in caring for patients with end-stage renal disease. By trying many different models, CMS is making clear its emphasis on paying differentially for quality and to signal its commitment to engaging the stakeholder community in a rigorous attempt to “get P4P right.”

BCBS of Michigan

BCBS of Michigan has had a P4P program in place for hospitals since 1988. The program, known as the Participating Hospital Agreement Incentive Program, is a part of BCBS of Michigan’s contracting process with the hospitals. At present, 86 of the state’s 135 hospitals participate in the program, which provides a percentage add-on to standard diagnosis-related group (DRG) payments. The maximum add-on is four percent. Even though the program is run by BCBS, payouts are based on performance across all payers. Hospitals self-report the data, with BCBS maintaining the right to audit the information. The program is based on three primary components:

- **Quality**, which accounts for 60 percent of the payout. Areas measured include acute myocardial infarction (AMI), congestive heart failure, pneumonia, and surgical infection prevention. Specific measures are set up within each of these four areas, with the level of payout determined by where a hospital’s performance falls within the pre-set range.
- **Patient safety**, which accounts for 30 percent of the payout. Areas measured include having a culture of safety, medication safety practices, patient safety practices, and patient safety technology, including implementing diagnosis-specific standing orders in three clinical areas and implementing at least one high technology tool (e.g. bar coding, CPOE) each year.
- **Overall health of the community**, which accounts for 10 percent of the payout. Areas measured include smoking control and physical activity and nutrition.

A hospital’s overall score is the sum of its score in each of the three components. Hospitals that meet or exceed all performance thresholds, and/or that meet or exceed the upper end of an established range for performance, receive a score of 100 percent, and qualify for the maximum 4.0 percent payout. In 2003, the typical hospital scored around 80 percent, and



*Michael Ortwine, Manager,
Center for Healthcare
Quality & Evaluative
Studies, BCBS Michigan*

qualified for a 3.2 percent incentive. In 2004, that figure increased to roughly 3.4 percent, with roughly 10 hospitals getting the full 4.0 percent. The incentive payment is a part of every DRG payment. There is no ceiling on the dollar amount that can be paid. On average, BCBS has paid between \$34 and \$36 million a year to the 86 participating hospitals.

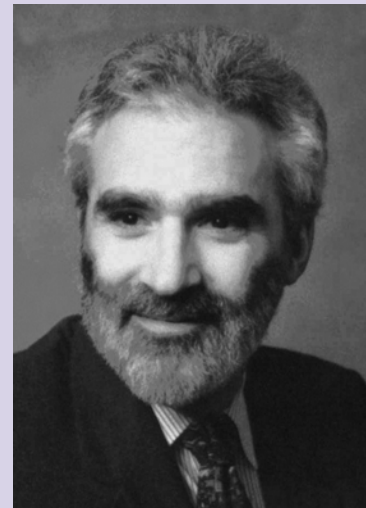
Excellus BCBS and Rochester Independent Practice Association

Excellus BCBS is a not-for-profit healthcare financing and delivery company based in Rochester, New York. Excellus' HMO product is served by a 3,000-practitioner exclusive IPA, which includes the Rochester Independent Practice Association (RIPA).

Excellus began a P4P program in 2002, and in 2004, the P4P program was restructured as a withhold model, with 10 percent of payments being withheld in Excellus' managed care product. Payouts are made to individual physicians based on performance in satisfaction (20 percent), quality (40 percent), and efficiency (40 percent). Ranges of acceptable performance have been established in each area. Those meeting the minimum standard receive the minimum payout, those exceeding the top threshold receive the maximum, and those whose performance falls within the range receive a payment between these two levels. Payouts tend to vary dramatically, with strong performers receiving much more in payouts than they had withheld, while weak performers receive less than was withheld.

As a participant in this program, RIPA has learned some valuable lessons:

- **Anticipate the stages of physician change:** Physicians will quickly go from denial to “blind fury and silent rage.” Over time, they will move through the anger, agitation, and bargaining stage, and only then will they reach acceptance. In addition, any failure to deliver what was promised can result in a backward progression—i.e., a return to the anger and rage phases.
- **Incorporate best practices for measuring performance:** These include enough recent data to develop a statistically reliable sample; restricting comparisons to truly comparable physicians; employing robust case-mix and severity-of-illness adjustments; attributing episodes of care only to those with significant involvement; and distinguishing between differences in utilization and cost per unit when reporting on efficiency.
- **Engage in P4P for the long haul:** These programs require more IT resources and time than usually anticipated. Substantial efforts are needed to train and to get physicians to accept the programs.
- **Engage the practitioners:** Data should be transparent and profiles should include actionable suggestions to improve outcomes. Performance targets need to be realistic, and quality measures need to be medically meaningful to providers. The program should be constantly adjusted based on practitioner feedback.



*Howard Beckman, MD,
Medical Director, Rochester
Individual Practice
Association*

- **Do not rush the program:** Upfront planning is critical to ultimate success. Pilots can be used to test measures for accuracy and reliability, to educate practitioners about what is expected, and to evaluate the display of results.

Wellpoint

Wellpoint, one of the largest managed care organizations in the country, has developed partnerships with physicians and hospitals on quality incentive programs within its PPO, HMO, and Medicaid products.

- **PCP programs:** These programs typically include measurement of widely accepted clinical outcomes where interventions lead to improvement. They also evaluate adherence to evidence-based medical procedures, generic prescribing rates, use of technology and streamlined administrative processes, and patient satisfaction.
- **Specialist programs:** Early initiatives have been developed in obstetrics/gynecology, cardiology, and orthopedics, using measures similar to those in the PCP programs.
- **Hospital programs:** These P4P programs focus on acute care hospitals that have full-service cardiac facilities. These programs typically include measures related to patient safety, clinical outcomes, and patient satisfaction. The goal is to continuously improve the quality of Wellpoint's network hospitals by using a comprehensive set of metrics based on best hospital practices and national guidelines. Wellpoint uses an independent third party to evaluate data on all hospital patients (not just Wellpoint members). To encourage performance improvement over time, financial incentives are made a component of the contract renewal process, with reimbursement rate increases being tied to quality improvement.

Chapter II:

STANDARDIZED PERFORMANCE MEASUREMENT: THE KEY TO EFFECTIVE P4P

P4P programs will not be effective without credible, validated performance measurement that is based on accepted, standardized indicators that facilitate comparisons of performance across organizations and/or individuals.

What Is Standardized Performance Measurement?

Standardized performance measurement refers to the measurement of what care is provided and how well it is provided through the use of a set of common measures. The primary objectives of the effort are to aid consumers in making decisions and to stimulate quality improvement among hospitals, physicians, and other providers by comparing their performance to that of their peers. Additional objectives of standardized performance measurement include higher levels of customer satisfaction; improved job satisfaction; enhanced community reputation; and better financial results.

CONSUMERISM AND P4P IN THE UK NATIONAL HEALTH SERVICE

A 2003 survey of 2,000 British adults found that reforming the United Kingdom's National Health Service (NHS) was the most important issue facing the country. Prime Minister Tony Blair's *NHS Plan 2000* called for radical change at every level, with consumerism and P4P programs being an integral part of the revised system. Key elements include:

- Foundation Trusts (i.e., self-standing hospitals) that are autonomous of the Department of Health, and have the ability to create joint ventures, borrow capital for new services, and retain surpluses.
- National, fixed pricing, with a direct relationship between activity and funding via a “payment-by-results” system.
- Patient choice, with patients having at least five providers to choose from at the point of referral, and at least one being an independent provider.
- Five-year contracts with the independent sector for electives and diagnostics, either separate from or in partnership with NHS. By 2008, it is expected that 15 percent of elective activity will be provided by the independent sector.

In addition, NHS will also embark on the following changes:

- **A national program for IT** that will link over 30,000 general practitioners and all 300 NHS hospitals in a single, secure NHS network. The program is expected to cost at least six billion British pounds over the next decade, although the costs may balloon well beyond this level.
- **Workforce reform**, including significant increases in staffing and salary, and the tying of compensation to performance and productivity.
- **Clinical service redesign**, with a focus on the provision of evidence-based services. While incentive systems have not yet been developed to reward adherence to best practices, such linkages will be made in the future.

The NHS reforms are already having a beneficial impact. Competition between state and independent providers has created a first-time surplus in capacity, allowing consumers to access care more quickly and to choose among providers based on quality performance and reputation. Performance information is already available to the public for hospitals and specialties to help guide these choices. As consumers migrate to the better performers, unpopular and/or inefficient organizations are either being taken over by other organizations or they are closing.



Robin Osborn, MBA, of The Commonwealth Fund moderated the panel on Pay for Performance: The US and Abroad

Public and Private Sector Role in Facilitating Standardized Measurement

Both the public and private sector are playing an active role in facilitating the transition toward standardized performance measurement.



*Carolyn M. Clancy, MD,
Director, Agency for
Healthcare Research and
Quality*

The Public Sector's Role: Agency for Healthcare Research and Quality

The Agency for Healthcare Research and Quality (AHRQ) has the mission of promoting quality by disseminating evidence-based research and translating that research so that it can be used in the everyday practice of medicine. By statute, AHRQ may not set standardized measures; instead, much of that work is being conducted by the National Quality Forum (NQF), a consensus-driven, public-private partnership that endorses standardized measures for adoption by the public and private sectors.

An example of AHRQ's reliance on standardized performance measurement is the agency's recently released 2004 *National Health Care Quality Report* and the accompanying report on healthcare disparities. Based on trends in performance against standardized measures, AHRQ concluded that the quality of healthcare improved modestly (roughly three percent) between 2002 and 2003, with the greatest gains occurring in the nursing home sector, which improved by 14 percent. Interestingly, nursing home performance data have been published on

CMS's *Nursing Home Compare* web site since 2002. This publicly reported, standardized performance measurement system may have had an impact on the magnitude of the improvement.

AHRQ has also played a prominent role in developing a series of CAHPS® surveys, including H-CAHPS for hospitals. H-CAHPS results will be posted on the *Hospital Compare* web site of CMS. A recent survey conducted by AHRQ in conjunction with the Kaiser Family Foundation found that more than half of consumers are concerned about quality and safety and are dissatisfied with their healthcare. The survey also found that consumers are increasingly turning to comparative, standardized measures of quality to help them make healthcare decisions. One in five consumers used such information in 2004, up from 12 percent in 2000.

The Private Sector Role: The Leapfrog Group

The private sector, consisting primarily of employers and other large purchasers of healthcare services, is playing an important role in promoting standardized performance measurement. The Leapfrog Group, a coalition of more than 160 large healthcare purchasers (most of which come from the private sector) collectively represents more than 36 million Americans and purchases more than \$65 billion in healthcare services each year.

Leapfrog's mission is to trigger giant "leaps" forward in the safety, quality, and affordability of healthcare by supporting informed decisions by those who use and pay for healthcare; and by promoting high-value healthcare through incentives and rewards. Leapfrog is a national organization with a regional approach to change. Twenty-eight roll-outs

have been implemented in geographic areas that have demonstrated leadership, competitive healthcare markets, and a concentration of healthcare stakeholders from Leapfrog members. The Leapfrog Group adheres to three pillars for improving quality:

Pillar #1: Standard Measures and Practices

There are four initial quality and safety “leaps” where the evidence is strong that implementation will lead to improved quality:

- Computerized physician order entry or CPOE
- ICUs that are covered by physicians trained in critical care medicine (CCM), either with live staff or via tele-monitoring, or risk-adjusted outcomes comparisons in the ICU
- Evidence-based hospital referral in selected procedures where volume is associated with better outcomes, or risk-adjusted outcomes comparisons
- Leapfrog quality index, a rolled-up score of the remaining 27 NQF-endorsed safety practices

Leapfrog is trying to promote consolidation around a single set of measures by keeping NQF measures at the core of its activities. The goal is to reduce the reporting burden on plans and providers, and to enable apples-to-apples comparisons. If NQF measures are not available in an area, Leapfrog will turn to accrediting organizations, specialty societies, or other bodies as sources of measures until such time that NQF makes formal recommendations.

Pillar #2: Transparency

Reporting results should be routine and results should be used to make healthcare purchasing decisions. The Leapfrog Group publishes information for consumers and purchasers on hospital patient safety practices; and through a web site, consumers and purchasers can compare the performance of individual hospitals in a given geographic region on the four safety leaps.

Pillar #3: Reimbursement Incentives and Rewards

The Leapfrog Group has published a compendium of 90 incentive and reward programs around the country. Many of these programs target hospitals and physicians, and roughly a quarter include the Leapfrog safety leaps. Just over half of the programs use financial incentives, with the rest having some sort of reward or public recognition of strong performers.

The Leapfrog Group is developing its own national incentive and reward program modeled after the CMS program with Premier hospitals (see page 8). The program, which can be implemented by health plans, purchasers, and purchaser coalitions, focuses on improvement in both effectiveness and efficiency in five high-volume, high-cost clinical areas: AMI, community-acquired pneumonia, coronary artery bypass graft (CABG) surgery, percutaneous coronary interventions, and newborn/delivery. The program relies on NQF-endorsed measures that hospitals are already reporting.



*Suzanne Delbanco, Ph.D.,
Executive Director, The
Leapfrog Group*



*Scott Wallace, President
& CEO, National Alliance
for Health Information
Technology*

The Role of Technology in Standardized Performance Measurement

Information technology (IT) is a catalyst for the development of a consumer-centric healthcare system; and it is no surprise that it is a “hot” topic in Washington, DC, with a variety of important activities underway.

ONCHIT (Office of the National Coordinator for Health Information Technology)

Created a year ago under the leadership of David Brailer, MD, this office serves as a single point of focus for healthcare IT activities within the federal government. ONCHIT is driving the IT discussion and debate, having released a framework for IT development in June 2004 and a request for information (RFI) on what a national health information network (NHIN) should look like. They received 57 responses, which varied widely. ONCHIT is expected to make a decision on the RFI in the next several months.

CCHIT (Certification Commission for Health Information Technology)

CCHIT will certify technology products to help accelerate adoption by providers. The hope is that certification will provide confidence to providers as they consider investing in products such as electronic health records (EHRs). The commission will ensure that certified products meet standards for interoperability with other HIT products.

The Commission is made up of three constituencies (providers, purchasers, and vendors), along with several at-large stakeholders and government liaisons (such as ONCHIT). It is organized into four work groups—functionality, security, interoperability, and certification processes. The effort is voluntary, and will focus, at first, on products for physicians’ offices. Vendors are free to submit or not submit their products for certification. The initial criteria to meet certification is scheduled for release in the summer of 2005. The plan is to provide vendors with a clear roadmap so that they understand the minimum requirements for certification in advance, and can adjust products accordingly.

CSI (Commission on Systems Interoperability)

The Commission has an advisory role and will make recommendations for Congress and the Administration. Its charter is to be consistent with ONCHIT and may not engage in activities that are the responsibilities of other government agencies. CSI is focusing on three areas:

- Consumer benefits to encourage consumers to demand IT
- Provider issues, such as what to do with obsolete systems that are still being used
- Financial dimensions, including financial models that will support adoption and use of IT

Standardized Measurement in Action: Intermountain Health Care

Few organizations have had as much success in improving quality and reducing costs than Intermountain Health Care (IHC). Standardized performance measurement is the key to the organization's success.

IHC's leadership acknowledged that the organization's "business" is clinical medicine, and that the financial/administrative approach to improving quality must give way to a new approach that focuses on re-engineering clinical processes. IHC dubbed this new effort "clinical integration"—the integration of clinical processes under a management umbrella.

"You manage what you measure. The measurement system is the central nervous system for the organization. It's how you communicate about performance and how you hold people accountable."—Brent James, MD, M Stat, Vice President of Medical Research, Intermountain Health Care



Clinical Integration Organized Around Work Processes

IHC's leaders discovered that roughly 10 percent of identified work processes (62 of 600) accounted for 90 percent of the organization's work. Moreover, these 62 processes naturally grouped into a handful of clinical areas, including cardiovascular care, neuromusculoskeletal care, surgical specialties, women and newborn care, medical specialties, pediatric specialties, and mental health. The key is to focus on the most important processes.

Over the next several years, additional steps were taken to aid the effort, including integrating management information systems to create an outcomes tracking system, integrating clinical and operations management structure, and beginning to align financial incentives. By 2000, IHC rolled out its quality improvement program across the institution.

The End Result: Better Quality and Lower Costs

IHC's approach has yielded significant dividends in terms of both quality improvement and cost reduction. The many QI projects that have been implemented have yielded over \$20 million in savings while simultaneously improving quality. Some of the best examples of these projects come in the area of maternal/newborn care, where IHC adopted several changes that collectively save the institution nearly \$10 million a year while also dramatically improving quality. Examples of these changes include the following:

- After data revealed that neonatal intensive care unit (NICU) admissions were higher when elective inductions were performed prior to 39 weeks gestation, a new protocol was introduced recommending against this practice.
- IHC developed guidelines calling for measurement and use of Bishop scores for determining when it is appropriate to induce labor. The number of elective inductions performed on women with low Bishop scores (indicating a baby that may not be ready for delivery) fell by roughly 50 percent.

- After discovering that bilirubin levels were not routinely being tested in newborns, IHC adopted a protocol calling for such testing. Testing levels quickly approached 100 percent, which allowed for early identification and treatment of those with excess levels.

The Second Half of the Story: Declining Revenues

Despite IHC’s internal efforts to align incentives, the organization still found that some of its QI efforts were “rewarded” with declining revenues. For example, a protocol related to antibiotic choice for patients with community-acquired pneumonia helped to significantly reduce complications, admissions, in-hospital mortality rates, average length of stay, and overall costs per case. The protocol is estimated to save 76 lives each year. But while IHC’s costs dropped 12.3 percent, its revenues fell even more dramatically (17.5%), primarily because patients were less sick and therefore shifted into DRGs that were reimbursed at lower levels.

This example illustrates a larger problem. As demonstrated in the chart below, the majority of IHC’s (and other hospitals’) revenues are tied to payment mechanisms that provide for lower payments when quality is improved. Under discounted fee-for-service and per-case reimbursement (which comprise 85 percent of IHC’s revenues), certain types of cost-reduction and quality-improvement activities lead to lower revenues and reduced net income.

P4P programs are designed to address this problem. However, any P4P program must provide an adequate level of incentive for improvement, and a few percentage-point bonus is not likely to be enough. Shared-savings models, where any savings generated are divided between the providers and those paying for care, can help to provide a more meaningful incentive. IHC has implemented a handful of these P4P programs. These programs may be difficult to implement, because the payoff from an investment in quality may be several years down the road. This time lag makes it more challenging to figure out how to finance the upfront investment and how to distribute the financial savings when they do accrue.

Improvement to cost structure		Payment mechanism			
		Discounted FFS	Per case	Per diem	Shared risk
Decrease cost per unit		↑	↑	↑	↑
Decrease # units per case					
Decrease other units per case		↓	↑	↑	↑
Decrease LOS (# nursing hours)		↓	↑	↓	↑
Decrease # of cases		↓	↓	↓	↑
		(45%)	(40%)	(0%)	(15%)

A Tool to Assist: NCQHC's CEO Survival Guide

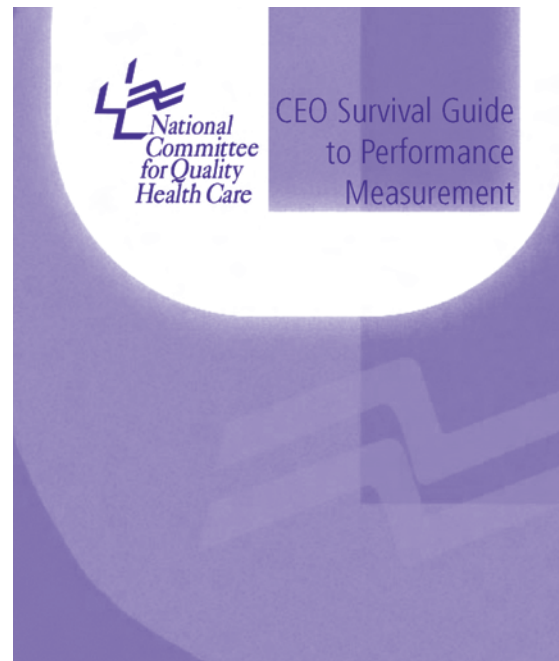
In 2003, NCQHC's leadership decided to mark the organization's 25th year by launching the NCQHC Executive Institute which is designed to study some of the most perplexing and complex issues in healthcare, and to design products directed toward healthcare executives. With initial sponsorship from Roche, Cardinal Health Foundation, and Bard, the NCQHC Executive Institute organizes Task Forces comprised of experts in an identified field or topic, debates and researches the topic, and then produces tools to assist hospital and health system CEOs and other NCQHC members work to ensure quality care delivery. There are two working Task Forces, one on performance measurement and a second on P4P. A third Task Force on Health Information Technology is being formed.

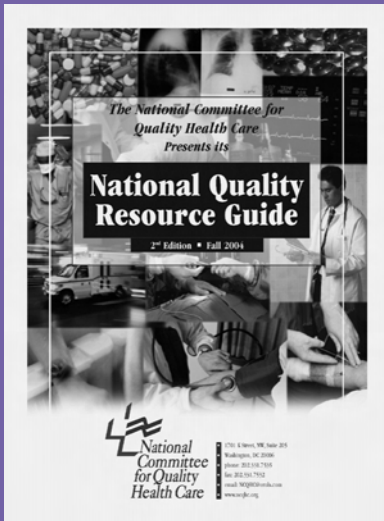
The Performance Measurement Task Force has produced a "survival guide" aimed at the CEOs of hospitals and health systems who are literally being bombarded with information on quality and performance measurement. The *CEO Survival Guide to Performance Measurement* was developed, designed and produced to:

- Make sense of the vast amount of information available on performance measurement.
- Suggest a framework in which hospital and health system executives consider performance measurement as a core component of an organizational strategy. This framework includes the following steps:
 - ✓ Assess the environment, including external (i.e., payer and regulator) initiatives and priorities and internal factors (e.g., relative volumes, financial impact of major clinical conditions, history of sentinel events and malpractice claims).



Dr. Richard Davis, Executive Director, Center for Innovations and Quality Patient Care, Johns Hopkins Medicine, and Dr. James Dwyer, Chief Medical Officer, Virtua Health, co-chairs of the NCQHC Performance Measurement Task Force





ADDITIONAL PRODUCTS FROM THE NCQHC EXECUTIVE INSTITUTE

Along with the *CEO Survival Guide to Performance Measurement*, the NCQHC Executive Institute produced the *National Quality Resource Guide*, which profiles the quality initiatives of many respected national healthcare organizations. In addition, the Task Force on Pay for Performance is developing a product to help CEOs better understand P4P initiatives, including how they might affect their organizations' finances and how the incentives relate to performance measurement and QI.

- ✓ Set a clear performance agenda. QI should be a central business strategy of the organization, not a project or initiative.
 - ✓ Choose performance measures that have been vetted nationally. Prime targets for many organizations include heart failure, AMI, pneumonia, surgical infection, and pregnancy-related conditions.
 - ✓ Improve care. The bar for improvement should be set high. In fact, because most measures include clear criteria for who should be excluded, the appropriate rate for a given measure is often 100 percent.
 - ✓ Report results. There is no question that the public reporting of performance has a tremendous impact on hospitals. It changes the way these institutions do business, in part by forcing them to focus on the development of strong data management systems.
- Provide background information that is useful to hospital and health system executives when managing performance. For example, the report provides links to web sites and other resources that provide useful information on performance measurement and improvement (e.g., descriptions of Six-Sigma and other methodologies for QI). The guide also provides a performance measurement checklist to assist CEOs develop an environment for performance measurement.

Chapter III:

THE 2005 NATIONAL QUALITY HEALTH CARE AWARD WINNER

Each year for the past 12 years NCQHC has presented the National Quality Health Care Award at its annual meeting. This award recognizes outstanding provider efforts to ensure quality healthcare delivery the communities it serves. NCQHC is proud to have



Northwestern Memorial Hospital Team

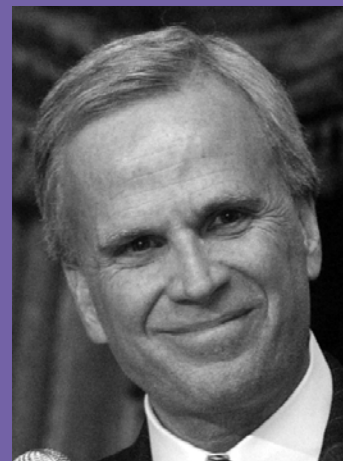
the Cardinal Health Foundation as the award's corporate sponsor, and *Modern Healthcare* magazine as the award's legacy partner.

The 2005 recipient is Northwestern Memorial Hospital (NMH), Chicago, IL. In 1999 NMH replaced its aging hospital with a world-class facility, the product of a \$580 million redevelopment project. The facility has 504 beds, all private rooms large enough for families to stay overnight. In 2007 NMH will open a new, state-of-the-art women's hospital.

NMH's mission is to be an academic medical center where the patient comes first. To live up to this mission, NMH embarks on three key strategies:

- To provide the best patient experience from the patient's perspective. This means providing safe, effective, timely, and convenient care that is coordinated and patient-centered. It also means

“Data and measurement are the universal language of quality improvement. We emphasize transparency in a blame-free culture where everyone gets involved. No one sits on the sidelines.”— *Dean Harrison, President and CEO, Northwestern Memorial Hospital*



providing the best physical environment for care and offering advanced expertise through research and education. Finally, it means being a trusted source of information and working to improve the health of the community at large.

- To recruit, develop, and retain the best people who share the organization's values and achieve results.
- To develop the resources to achieve the mission and vision through exceptional financial performance.

Achieving the Best Patient Experience at NMH

Northwestern is successful in offering patients a positive experience as a result of five key factors.

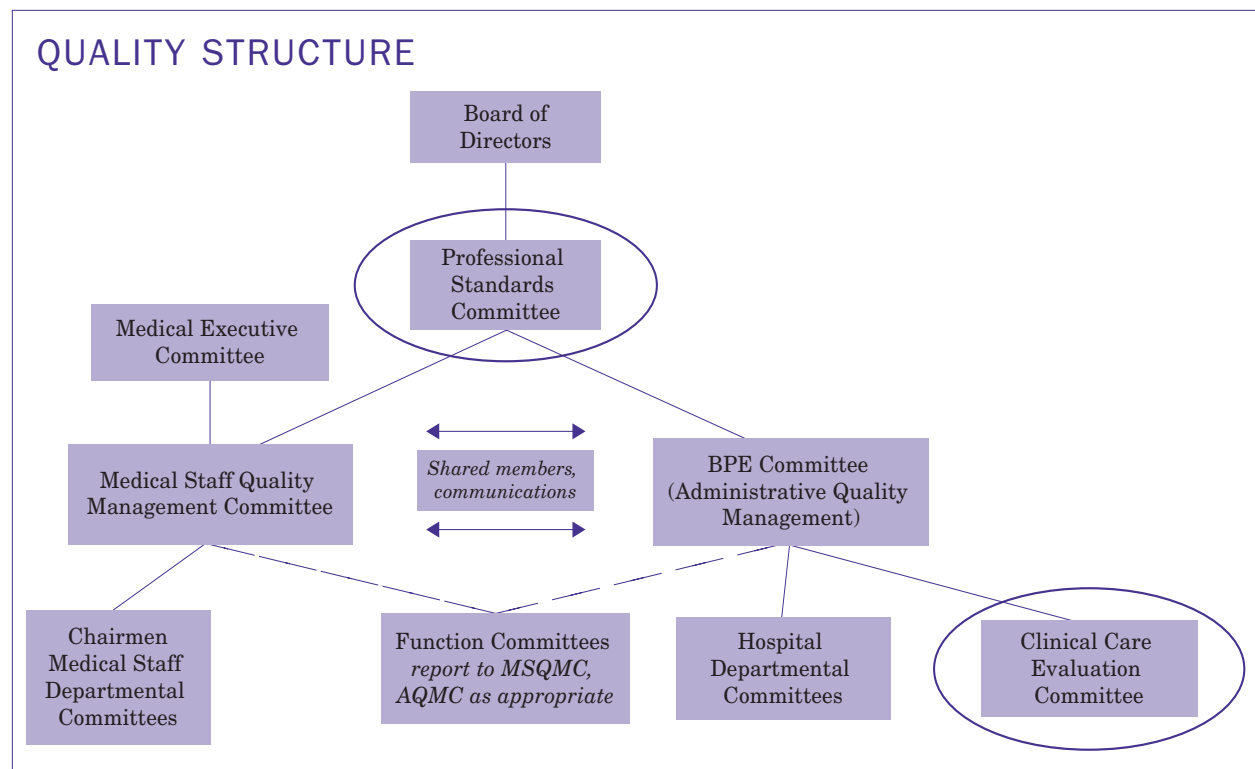
#1. Quality Structure and Leadership

Quality is considered to be good business practice and is hardwired throughout the organization, including in strategic planning and human resource systems and structures. NMH's success begins with strong leaders at the board level and within the hospital and medical staff.

Coupled with strong leadership is having the right structures for quality in place. NMH has established a number of effective committees that oversee QI. For example, the clinical care evaluation committee meets each week to review adverse events and to take immediate action to correct problems through process improvement.



Julie Creamer, Vice President, Operations and Quality, Northwestern Memorial Hospital.



#2. Measurement

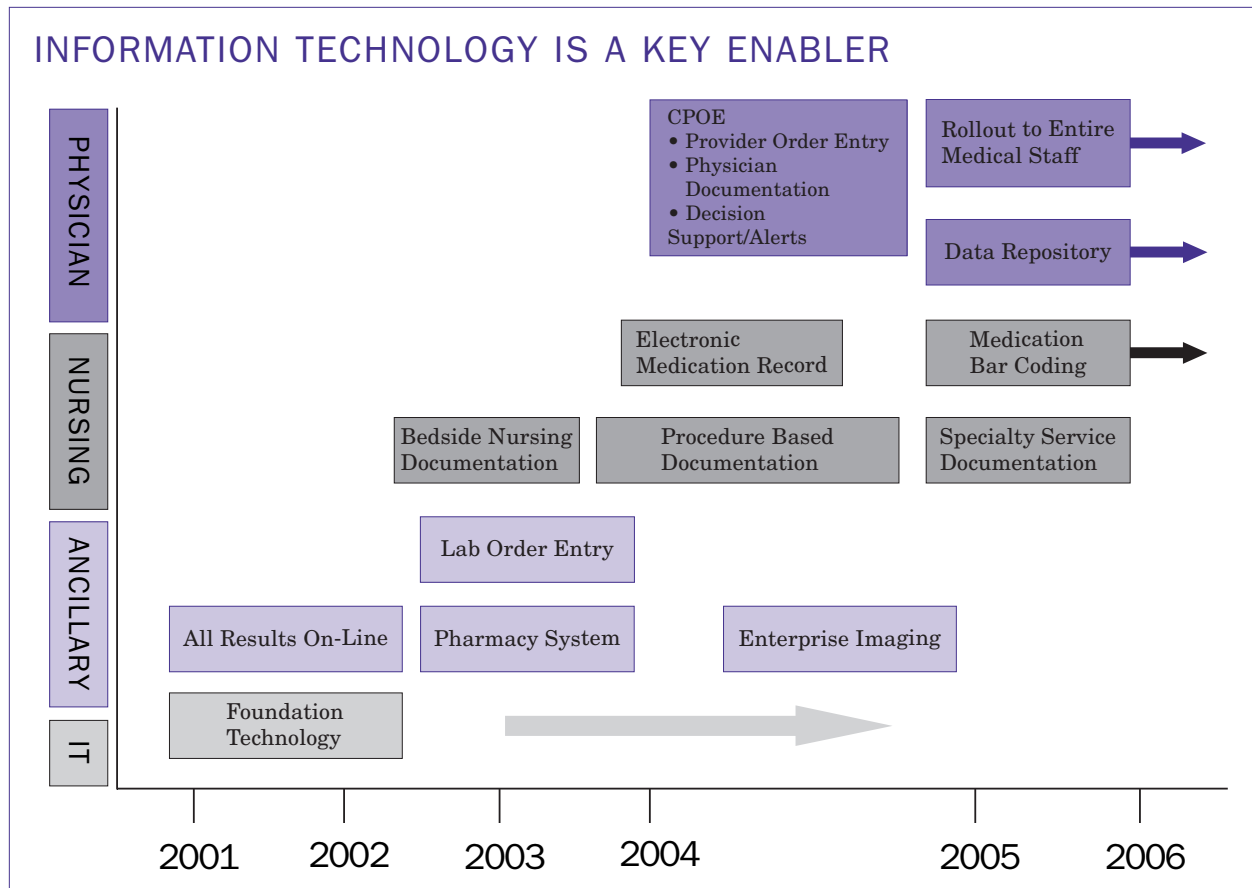
Measurement is the backbone of QI at NMH. Northwestern tracks performance on specific measures within each of the key elements of patient-centered care.

FY 2005 BEST PATIENT EXPERIENCE MEASURES, Q1 UPDATE							
Measure	FY2005 Goal	FY05Q1 Actual	Var	Measure	FY2005 Goal	FY05Q1 Actual	Var
System Wide Measures Severe & Moderately Severe incid. Failure to rescue (per 1000 patients) Death in low mortality DRG's (per 1000 patients)				Patient Satisfaction In-Patient Emergency Department Ambulatory Surgery Unit			
Effective Care AMI- % Compliant with Guidelines CHF- % Compliant with Guidelines Pneumonia- % Compliant with Guidelines CABG- Compliance with Leapfrog Measures AAA- Compliance with Leapfrog Measures Anticoagulation- Effectiveness of Heparin Anticoagulation- Incidence of DVT Cardiac Arrests- # cases CVC Blood Stream Infection Rate GBS-% Compliant with Guidelines SSI – Appropriate and Timely Antibiotic Admin VAP- Infection Rate (per 1000 vent days) Pain- % Compliant with assessment and intervention Pressure Ulcer- % Patients				Safe Care % Orders via CPOE % Med. Orders entered by MD Blood- # Reported Dispensing/ Administration Errors IP Fall Rate (per 1000 patient days) Safe Practices Patient ID'd Properly Verbal Order Readback Safe Use of Abbreviations Hand washing Procedure time out documentation Safety in Surgery Avoiding Adverse Event/ Foreign Body Retained: % Compliant with Policy			
Timely & Convenient Care IP: # Times on Diversion # Hours on Diversion # of Cancelled External Transfers Total # IP Beds (Feinberg) Fein Pt Days OP Access – Appointment in 48 hours PICC Line-% placements w/i 24 hours				Coordination of Care IP D&T- % Seen within 30 min % Patients w/ online MD documentation % Dept mtg MR Compl. Threshold % Dept Compliant w/ Dictation Stds			

#3. Data-Driven Process Improvement

NMH uses performance data in a systematic manner to drive process improvement and has adopted the DMAIC (define-measure-analyze-improve-control) approach to process improvement.

- After discovering that patients were reporting too-high pain levels, NMH developed a “forcing function” within its IT system to remind nurses to assess and address pain levels.
- After well-publicized adverse events related to infant security and organ transplantation occurred at other hospitals, Northwestern embarked on a systematic review of its procedures to ensure safe practices for newborns and transplant recipients.
- After discovering that waiting times were too long in the diagnostic testing center, NMH implemented process improvements that reduced waiting times to 20 minutes or less for 80 percent of patients.
- After discovering that laboratory test turnaround times were too long, NMH brought 29 previously outsourced tests in-house, reducing wait times and saving \$750,000 annually.



#4. IT as a Key Enabler

Northwestern makes heavy use of IT to promote quality. Similar types of “forcing functions” have been used to promote administration of pneumococcal vaccinations to the elderly and to encourage smoking cessation counseling for patients with pneumonia. The organization’s IT plan is laid out in the chart above. As the chart suggests, NMH is promoting widespread adoption of technologies like CPOE to promote quality.

NMH’s IT system also includes customized order sets and protocols, derived from evidence-based guidelines, that help to aid clinical decisionmaking. The IT systems produce reports to individual caregivers and physicians documenting their performance.

#5. NMH Academy Training

NMH has established an in-house academy that provides centralized education and training on important issues. Established as one of the first corporate university structures in healthcare, this academy improves efficiency, effectiveness, and quality at NMH by acting as a catalyst for change within the organization. The academy offers 160 program courses for clinical, professional, and technology staff.

Success in Action: Case Study in Re-engineering the NMH Emergency Department

NMH’s emergency department (ED) faces significant crowding issues. NMH identified three primary opportunities to improve care: shorten wait times, reduce overcrowding, and



*James G. Adams, MD,
Chairman, Department
of Emergency Medicine,
Northwestern Memorial
Hospital*

improve communication with patients and families. Using the DMAIC methodology, the NMH ED teams completed over 30 improvement projects including:

- **Team-based care:** Physicians and nurses were made a part of the same clinical team, with physicians being trained to work with the nurses.
- **Lab technician in the ED:** NMH placed a laboratory technician physically inside the ED to handle all functions (e.g., labeling) on a real-time basis. The improvement has been dramatic.

These and countless other changes like them have led to dramatic improvements in the performance of NMH's ED. For example:

- NMH has set the national benchmark for the amount of time it takes to get a patient complaining of chest pain from the ED door to the catheterization laboratory.
- Patients with life-threatening infections and pneumonia almost always get antibiotics within an hour because of a partnership between the ED and the pharmacy.
- Average wait times have been reduced to almost half.

With improvements like these, overall patient satisfaction with the NMH ED has risen from roughly 75 percent in 2002 to 82 percent in 2004.

CONCLUSION

This conference posed the question as to whether P4P programs are *the key* to QI. The presentations and discussions suggest that P4P is *a key* to QI, but that P4P is not the only tool available to improve care. P4P is likely necessary for, but not sufficient in and of itself to, ensure sustained QI. P4P can play a critical role in aligning the financial incentives of all the stakeholders, but to achieve sustained improvement, other factors must also be present, including effective use of IT systems, a dedicated focus on the patient, strong leadership, and a culture that is committed to continuous improvement.

It is also important to remember that there are several prerequisites that must be in place before P4P programs can work. One is the existence of valid, reliable, standardized performance measures that allow for apples-to-apples comparisons across organizations. The second is a commitment to public reporting of performance information in useable and understandable formats so that all stakeholders can use this information to make healthcare decisions.



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