The Use of Performance Measurements to Improve Physician Quality of Care

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Executive Summary

Performance measurement, the objective assessment of how well physicians adhere to evidence-based standards to achieve desired outcomes, is increasingly being applied in the health care sector to improve the quality, safety, and accountability of medical care. Performance measures---if done right---have great potential to assess physician performance, improve the quality of patient care, enhance the coordination and management of care, and reward physicians who meet or exceed the benchmarks set by performance measures. However, if applied in a bureaucratic, arbitrary, or punitive manner, performance measurement can hinder quality and harm patient care, undermine the physician--patient relationship, and cause physician frustration and career dissatisfaction.

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 115,000 doctors of internal medicine and medical students. The College has a long-standing commitment to improving the quality of care. Since its founding, the College's mission has been to enhance the quality and effectiveness of internal medicine by serving as a forum for shared peer knowledge and best practices. More than 30 years ago, ACP pioneered the use of evidence-based clinical practice guidelines through its Clinical Efficacy Assessment Project (CEAP). In response to internists' growing need for point-of-service decision aids, ACP developed the Physicians' Information and Education Resource (PIER), an electronic tool based on the best available knowledge and updated periodically. Most recently, ACP's Board of Regents established a new program to critically review, develop, and disseminate physician clinical performance measures.

Evaluating physician performance to improve quality of care is not a new subject for the College. What has changed is the government's and market's demand for better information on which to make health care choices---not surprising when recent reports of avoidable medical errors and geographic and socioeconomic variances in the quality of care are considered. The impact has been a heightened demand for comparative provider performance data, helping raise the bar on quality by bringing professional accountability to the health care marketplace.

The goal of this paper is to present the College's policy position about performance measures and to summarize some general principles about how responsible, equitable, and effective physician performance information can be developed, used, and disseminated. A glossary of the many acronyms listed in this paper is provided at the end of the document.

The College's position on physician performance measurement can be summarized as follows:

Position 1: The goal of physician performance measurement should be to foster continuous quality improvement of clinical care to meet or exceed evidence-based national standards of such care.

Position 2: Physician performance measures should be evidence-based, broadly accepted, and clinically relevant. These measures should assess and focus on those elements of clinical care over which physicians have direct and instrumental control (as opposed to systems constraints). They should be built on statistical methods that provide valid and reliable comparative assessment across populations.

Position 3: Any data collection required to support performance measurement should be feasible, reliable, and practical. Data collection should not violate patient privacy or add to the paperwork burden experienced by physicians. Should performance measurement data collection impose additional costs on physicians, these costs should be supported by the health system and not the physician.

Position 4: The College supports demonstration projects on public reporting of performance measures to provide patients with information to make educated choices about their physicians and other health care professionals. Acceptable demonstration projects should include the following elements:

a. Physician participation in the demonstration projects is voluntary.

b. Physicians have a key role in determining the design of the demonstration projects, selection of the measures, and data collection and reporting systems that will be used.

c. Physician-specific performance data are disclosed only after physicians participating in the project are provided an opportunity to review and comment on such data; data are fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, and severity of illness; number of comorbid conditions; and other features of a physician's practice and patient population that may influence the results); and patient identifiers are removed to ensure that patient privacy is protected.

Position 5: Information technology tools should be used whenever possible to facilitate data acquisition for performance measures and to minimize any manual data extraction to support such measurement.

Position 6: The College supports demonstration projects to evaluate the use of incentives, including financial incentives, to reward physicians who meet or exceed performance standards. Any financial incentives related to performance measurement should be directed at positive rather than negative reward.

Position 7: The College will lead the critical review, development, and dissemination of physician clinical performance measures and the development of public policies to support the appropriate use of performance measures.

Background

The Role of Performance Measurement in Clinical Practice

Measures of physician performance are generally used to assess whether an individual physician's provision of care is consistent with norms of care on the basis of the best evidence available. In its 2002 report, the ACP Task Force on Performance Measures defined performance measurement as an effort to convert the recommendations of clinical practice guidelines or other authoritative research into well-defined measures, which can then be used to assess how physicians meet these recommendations or guidelines (1). Assessment of physician performance can focus on either processes or outcomes of care; can be measured in terms of quality of care, cost savings, or beneficiary and provider satisfaction; and can be reported internally or publicly.

While performance measures can be used in many areas, the dividing line is generally drawn between the internal and external dimension. Measures applied internally focus on quality improvement and carry a greater degree of flexibility. Measures applied externally are synonymous with accountability and demand a much higher degree of scrutiny. Used in this fashion, accountability measures are frequently used as the basis of higher physician reimbursement. In other words, accountability acts as an incentive for higher quality, which is recognized through financial reward. Accountability and its relationship to physician reimbursement are the primary focuses of this paper.

A performance measurement system can ensure physician accountability by establishing minimum expectations about clinical performance. At the same time, performance measures can also stimulate internal improvements in quality by identifying physician needs for professional development. Under certain circumstances, performance measures can identify physicians whose practice does not adequately follow the standards of the profession.

Measures of performance used publicly can reward those physicians who consistently meet universally accepted norms of care. Rewards can come in various forms: higher payments, bonuses, reduced administrative and recertification requirements, or simply recognition. Regardless of the type of reward, incentives often are a critical component of a successful performance measurement system and are increasingly advocated by payers and purchasers alike. Incentives motivate physicians to focus on how their individual performance can be improved, thereby stimulating overall quality improvement.

Health care in the United States is currently fragmented and uncoordinated across settings. Performance measurement systems present an opportunity to establish evidence-based norms of care. In addition, valid and accepted indicators can be used as proxies to reflect the general state of health care. By pointing to disparities in care, indicators have the potential to raise the overall floor of acceptable practice standards.

Why Are Performance Measurements Needed?

A series of major national reports, from the U.S. Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the Institute of Medicine (IOM), and the U.S. Department of Health and Human Services, have drawn attention to the fact that health care is too often inappropriately used, is of poor quality, and is unsafe (2). In 2000, the IOM report, *To Err is Human* (3), pointed out that approximately 98,000 preventable deaths occur each year

because of medical errors. In the summer of 2003, the *New England Journal of Medicine* reported results from the Community Quality Index Study (4), which found that patients were receiving only about 55% of recommended care across various conditions and treatments. The study concluded that "the gap between what we know works and what is actually done is substantial enough to warrant attention" (4). Finally, the National Committee for Quality Assurance's (NCQA) 2003 report on the state of quality blamed 57,000 avoidable deaths and 41 million sick days per year on a failure to follow best practices and concluded that too few health care organizations allow themselves to be monitored (5). In *Crossing the Quality Chasm* (6), the IOM encouraged health care organizations and professionals to work to develop systems of care that increase the safety and effectiveness of health care. Measuring physician performance is one such way to accomplish the goals set forth by the IOM and to track progress in improving the delivery of care.

Current Use of Performance Measurements

A substantial number of quality measures have been developed by organizations with broad scope and expertise in quality measurement and assessment. The most commonly used are the Health Plan Employer Data and Information Set (HEDIS®), developed by the NCQA; the Consumer Assessment of Health Plans (CAHPS®), developed by the Agency for Healthcare Research and Quality (AHRQ); the Center for Medicare and Medicaid Services' (CMS) Outcome and Assessment Information Set (OASIS), used to measure home health quality; and the risk-adjusted cardiovascular disease mortality measures used by New York and Pennsylvania (7).

The Physician Consortium for Performance Improvement (The Consortium), which includes experts from more than 50 national medical specialty societies, such as the American Medical Association (AMA), ACP, AHRQ, and CMS, develops and tests evidence-based, clinical performance measures and outcomes reporting tools for physicians. Measurement sets have been developed for adult diabetes, chronic stable coronary artery disease, prenatal testing, asthma, and preventive care and screening. These measures provide physicians with useful information to identify opportunities to improve patient care (8).

As one component of its program for ongoing maintenance of certification, mandated in 1998, the American Board of Medical Specialties (ABMS) offers an opportunity for voluntary submission of physician performance data. Data are pooled by specialty so that performance can be compared against peers for quality improvement purposes. Physician willingness to participate in this voluntary activity reflects both professional responsibility and accountability (9). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also integrates performance measurement data into its accreditation process to support quality improvement efforts through its ORYX® initiative.

The NCQA, in conjunction with the American Diabetes Association (ADA), runs the Diabetes Quality Improvement Project (DQIP), which is a voluntary performance measurement program that has attracted nearly 1,800 physicians since its inception in 1997. To be recognized by the program, individual physicians must submit clinical data, such as hemoglobin A_{1C} levels or average blood sugar levels, for a sample of their diabetic patients. Physicians whose patients meet specific measurement targets are then recognized by name and their addresses are posted on the NCQA's Web site (10).

With help from the American Heart Association (AHA), the NCQA also launched a heart/stroke care program in the summer of 2003, with more than 40 participating physicians.

Measurements relate to patients' blood pressure, lipid and cholesterol levels, the use of aspirin or other antithrombotics, and smoking cessation advice and status. Although few of the initial group of physicians have seen financial gains from this program, they have been eager to participate and welcome a chance to demonstrate better quality (10).

The CMS has taken steps toward improving quality by sponsoring the development of performance measures for several types of providers and implementing several demonstration projects to test quality incentives (11). Through its Quality Improvement Organization (QIO) program, CMS has developed numerous quality measures and an infrastructure to assist providers to improve quality (11). The program has led to improving care in both inpatient and outpatient settings and identifying measures that could be used for financial incentives. While hospitals and physicians are not required to participate in QIO data collection efforts, many do participate, illustrating the desire of health care professionals to participate in quality improvement (11).

More recently, CMS launched the Doctors Office Quality (DOQ) project, a 3-year collaborative initiative to define quality measures that assess clinician performance in providing ambulatory care for beneficiaries with chronic diseases. The Consortium and NCQA assist the project by providing CMS with evidence-based performance measures and reporting tools. The project evaluates patient care in three areas: 1) clinical quality; 2) systems of care (for example, the system for follow-up of abnormal laboratory results); and 3) patient experience of care (11). The DOQ project is committed to developing individual physician-specific report cards and has selected diabetes as the first condition for evaluation. Although both process and outcome measures are under consideration, no decisions have been made.

Performance measures linked to quality incentives commonly are used by health plans. Health plans' interest in performance measurement stems partly from their managed care philosophy---to provide care at the lowest cost while still ensuring sufficiently high quality levels to attract business---and partly from the fact that CMS requires health maintenance organizations (HMOs) to compile data evaluating the quality of care provided to Medicare patients.

The Hawaii Medical Service Association (HMSA), the state's Blue Cross Blue Shield plan, has one of the most well-known and successful quality incentive programs for physicians in its preferred provider organization (PPO) network. In 2002, the PPO program distributed a total of $9.3 million in bonuses to 1,800 physicians in the 2,300-physician network. More than 24 physicians received bonuses of $13,000 or more. The average bonus was just more than $5,000, and the lowest bonus received by 325 physicians was $500. The program's popularity among physicians is partly related to their input. Plan officials meet with different specialty groups who recommend specific quality indicators. The incentive plan relies on more than 50 quality indicators (12).

The largest quality incentive payment program to date can be found in California. The program, brokered by the Integrated Healthcare Association (IHA), encompasses six of the state's largest health plans. Included in the IHA is the state's largest independent provider association, which recently reported to have received $3.9 million in 2003 in quality incentive payments. This is an average of just less than $2,000 for each individual physician, representing a 30% increase over the pay-for-performance bonus payments that the association received the year before. The IHA recently contracted with the NCQA to begin issuing quality report cards on participating medical groups in September 2004. Also in 2004, the formula used to calculate medical group bonuses will shift so that investment in information technology, which now accounts for 10% of the total bonus payments, will be increased to 20% (13).

The Bridges to Excellence program, which consists of a coalition of large national employers, including General Electric and the Ford Motor Company, is another initiative to monitor quality and link pay to performance. The program pays bonuses of $100 per patient to physicians who have been recognized by NCQA for their quality diabetes care. Employers can afford the additional expense because the program produces savings in the long run (10).

While there is no question that interest in performance measures has grown, more work is needed in terms of the development of indicators. Disease-specific measures are only available for some conditions, many of them related to a few prominent chronic diseases, such as asthma, hypertension, congestive heart failure, and diabetes. (7)

Considering the preceding discussion of the need for and current application of performance measurements, the College envisages the role of performance measurement in clinical physician practice to be the following:

Position 1: The goal of physician performance measurement should be to foster continuous quality improvement of clinical care to meet or exceed evidence-based national standards of such care.

Establishing an Environment Most Suitable for Performance Measurements

Choosing the Most Appropriate Measures

Developing appropriate performance measures is time-consuming and difficult. Although evidence-based knowledge and clinical guidelines have proliferated, crucial gaps remain in the applying that knowledge in daily practice (7). Because of a limited number of evidence-based performance measures and a lack of consensus on criteria for rating them, health plans and providers often use multiple measures for the same phenomenon. One particular plan uses both a HEDIS® measure and an internal measure based on both administrative data and chart abstraction to report childhood vaccination rates (9).

Defining quality is also problematic. According to the Employee Benefit Research Institute, “quality is a multidimensional concept: It can be viewed narrowly (as clinical effectiveness) or broadly (as all attributes of medical care that patients value)” (14). The College has acknowledged in the past that balancing the disparate elements of quality is one of the most controversial tasks in developing a measurement system. Even when individuals agree on the disparate attributes of care that determine its quality, they may disagree about the relative importance of each attribute (15).

Position 2: Physician performance measures should be evidence-based, broadly accepted, and clinically relevant. These measures should assess and focus on those elements of clinical care over which physicians have direct and instrumental control (as opposed to systems constraints). They should be built on statistical methods that provide valid and reliable comparative assessment across populations.

Determining at what level to set the floor on standards requires thoughtful analysis. The bar must be set at a point that will not dissuade participation. The use of measures should not be a disincentive for physicians to treat particularly sick people. It should be made clear to

physicians that the ultimate goal of using performance measures is not punitive but rather to foster continuous quality improvement in the delivery of health care.

Only rigorous statistical methods provide valid and reliable comparative assessments of performance. Since physicians do not necessarily have control over all aspects of care, comparative assessments of performance must also focus on those elements of care that physicians are capable of controlling.

Measures of process (as opposed to outcomes) are often more suitable for assessing the performance of internists and other specialists who deal with chronic conditions (16). Measures of process assess adherence to recommendations for clinical practice on the basis of evidence or consensus. To a greater extent than outcome measures, process measures directly identify specific areas of care that may require improvement. They also can be interpreted more easily than outcome measures, since case-mix adjustments are not as critically important (17). However, if these process measures are to be used for accountability, they have to be evidence-based.

Data Collection and Reporting

Position 3: Any data collection required to support performance measurement should be feasible, reliable, and practical. Data collection should not violate patient privacy nor add to the paperwork burden experienced by physicians. Should performance measurement data collection impose additional costs on physicians, these costs should be supported by the health system and not the physician.

To ensure reliable and valid data, performance assessment must include uniform specifications for data collection. In setting these standards, quality performance measurement systems should not measure "what can be easily measured" but "what is clinically important" (16). At the same time, since data collection is both time-consuming and costly, the different environments in which physicians practice must be recognized. Data collection requirements from a solo practice differ from those of a large group practice (16). More importantly, data collection should not violate patient privacy.

Physicians simply cannot endure additional costs or supplemental constraints on their time. They are already subject to excessive paperwork, which limits the amount of time they can devote to patients in a system where current federal payment policies undervalue the cost of providing primary care. Practice-based electronic health information systems should first be in place before data can be collected for measurement purposes to ensure that physicians are not further inconvenienced by performance measurement. The costs of implementation should not be borne by the individual physician but rather should be supported by the health system. If at all possible, in the early stages of implementation, performance measures should be based on data collected as a routine part of care or on data that have already been collected (11).

Well-accepted measures and standardized methods of data collection already exist. Measures for Medicare + Choice plans often overlap with private accreditation requirements, and CMS uses information already collected for payment and care management purposes to measure nursing home and home health agency performance (11).

Position 4: The College supports demonstration projects on public reporting of performance measures to provide patients with information to make educated choices about their physicians

and other health care professionals. Acceptable demonstration projects should include the following elements:

a. Physician participation in the demonstration projects is voluntary.

b. Physicians have a key role in determining the design of the demonstration projects, selection of the measures, and data collection and reporting systems that will be used.

c. Physician-specific performance data are disclosed only after physicians participating in the project are provided an opportunity to review and comment on such data; data are fully adjusted for case-mix composition (including factors of sample size, age/sex distribution, and severity of illness; number of comorbid conditions; and other features of a physician's practice and patient population that may influence the results); and patient identifiers are removed to ensure that patient privacy is protected.

Programs designed to provide feedback motivate physicians to improve performance, especially when the physicians recognize that their own performance is being compared with that of their peers. However, a thoughtful approach to the objective of reporting is critical to ensuring that report cards only serve to maintain standards and stimulate quality improvement and not punish physicians (16). Although physicians recognize the utility of external assessments and understand that report cards provide patients and purchasers with a more informed choice about physicians, they also recognize that only rigorous statistical methods provide valid and reliable comparative assessments of performance. Physicians would exhibit less resistance to report cards if these were based on valid and reliable data, specifically data over which the physician has direct and instrumental control.

The most thoroughly scrutinized reporting effort is New York's cardiac surgery program, which has published provider-specific outcome reports since 1989. The program has been associated with reductions in operative mortality at almost twice the rate of the national trend. In just 4 years, state deaths from cardiac surgery decreased 41% (11). At the same time, physicians with better outcomes have experienced greater market share, poorly performing physicians have left the state, and more than a third of cardiologists reported that the data have affected their referral to surgeons "very much" or "somewhat" (2).

Reporting has also been widely tested by CMS for quality information on Medicare + Choice plans, hospitals, nursing homes, and home health agencies (11). Reporting is used by CMS to encourage providers and plans to improve care but also to provide information to help consumers choose well-performing providers (11). According to a Medicare Payment Advisory Commission (MedPAC) report, the results from these efforts have been encouraging, because scores on specific measures continue to improve and requests from providers for technical assistance in data collection have increased dramatically (11).

The CMS has found it difficult to publicly release information comparing individual physicians on the basis of quality. Because available measures for these settings are limited, CMS provides feedback to physicians---rather than to the public---through its QIO program, charged with improving the quality of hospital and physician services. This program has led to better care in inpatient and outpatient settings and to the identification of measures that could be used to apply financial incentives in the future (11).

While public disclosure seems to have an effect on physician behavior, patients have, for the most part, displayed apathy in response to available quality data. Although patients seem to want more information about their providers and they increasingly turn to the Internet for health care information, little evidence suggests that they use these data for informed decision making (7). In the New York study (11), for example, patients did not seem to use the information to choose higher-scoring providers. Therefore, a critical aspect of developing performance measures should be to understand how patients use evidence about physicians' performance to make choices about their care. Perhaps patients would use the evidence if data were presented in a more simplified, easy-to-understand manner; perhaps few patients will ever rely on quantitative data, opting for more personal, qualitative data instead (7). Still, once consumers become more informed decisionmakers, volume tends to shift to higher-performing providers (2). This, in turn, stimulates incentives for continuous quality improvement.

Information Technology

Information technology, including electronic health records, decision-support systems, computerized physician order entries, registries, and information retrieval functions, plays an essential role in facilitating the use of performance measures. Point-of-service tools, particularly clinical information systems, can facilitate disease management by sending physicians alerts, reminders for preventive services, and warnings of potential drug interactions and providing periodic patient status reports. Electronic health records and registries support collecting data for assessing physician performance. Together, these tools can integrate evidence-based clinical guideline recommendations with patient data from multiple sources (18).

Position 5: Information technology tools should be used whenever possible to facilitate data acquisition for performance measures and to minimize any manual data extraction to support such measurement.

The challenges of applying advances in information technology to improve clinical quality include funding of these complex systems, adapting them to traditional practice, and applying the enormous amount of information suddenly generated. The IOM report *Crossing the Quality Chasm* (6) highlighted the inadequacy of current information support systems for physicians who treat chronically ill patients. For example, electronic medical record software must take into account confounding patient factors, such as comorbid conditions (19). Electronic systems must also ensure that personal patient information is used for its intended purpose and protected from unauthorized use. Finally, information technology systems must recognize that adoption of health information technology lags significantly among physicians in solo and small groups compared with larger physician practices.

Physician resistance to using information technology often stems from the cost and administrative hassles associated with its adoption. Resistance may also be because of the lack of standardization and reluctance to risk investing in a technology that may soon become obsolete. Physicians may be more willing to try information technology if it can potentially provide a measurable return on investment or if financial assistance is provided. Offering incremental payments, tax credits, or other federal incentives may be an effective way to encourage physicians to purchase information technology that will promote quality improvement (20).

Financial incentives, such as payments for e-mail exchanges with patients, can change physician attitudes to information technology (7).

The ACP's Medical Informatics Subcommittee is looking at ways to ease the burden of performance measures on practicing physicians through using information technology. Electronic medical records systems are expected to eventually have measurement tools embedded for smooth reporting (21). As this work continues, standardized, interoperable electronic data formats mandated by the Health Insurance Portability and Accountability Act (HIPAA) may help ease data collection problems by reducing paperwork and improving administrative uniformity.

The subject of information technology is discussed further in the College's paper, *The Paperless Medical Office: Digital Technology's Potential for the Internist*.

Incentives

For years, performance measures have been used by health care organizations as an internal tool to assess and improve quality. However, performance measures alone are often insufficient to change physician practice and promote quality improvement. Pairing measures with incentives offers a way to manage performance and improve quality. Major purchasers, including Medicare and large health plans in California, are now looking to link reimbursement with physician performance to improve quality, reduce medical errors, and control costs.

Incentives come in various forms but can most easily be categorized as either financial or nonfinancial. Financial incentives include provider or consumer payment differentials and reduced malpractice insurance premiums. Nonfinancial incentives include public disclosure and flexible regulatory oversight. Flexible regulatory oversight encourages providers to improve quality of care by offering less burdensome regulatory requirements to those who demonstrate high levels of performance or effort. In turn, providers' costs of complying with government or purchaser requirements are reduced (11). The CMS uses flexible oversight through its Medicare + Choice program by allowing health plans that have reached a certain level of performance on a required quality measure to opt out of quality improvement programs for 1 year. In 2003, several plans took advantage of this option; they had demonstrated high mammography screening rates the previous year (11).

While less commonly used, incremental payment to investment in technology has been used by some organizations to promote quality improvement. The federal government similarly could provide incentives through tax credits for physicians to invest in information technology that will support quality improvement (20). Reduced malpractice insurance premiums and/or lowered ceilings on potential claims for physicians who use certain types of quality-improvement infrastructure are other types of incentives. Physicians with high performance ratings may also gain leverage in negotiations with health plans.

Position 6: The College supports demonstration projects to evaluate the use of incentives, including financial incentives, to reward physicians who meet or exceed performance standards. Any financial incentives related to performance measurement should be directed at positive rather than negative reward.

The IOM report *Crossing the Quality Chasm* concludes that "to achieve the aims of the 21st century health care system. . . it is critical that payment policies be aligned to encourage and

support quality improvement" (6). Payment systems are often aligned with performance to promote quality care (commonly known as "pay-for-performance" or "payment differentials"). Those who make the necessary changes to improve quality are rewarded with a bonus or higher payment. In its 2003 study, MedPAC concluded that paying providers differentially based on their quality performance seems to encourage quality improvement (11). For example, the Employers Coalition on Health in Rockford, Illinois, provided monetary bonuses for physician groups that improved care for their diabetic patients. After 1 year, the coalition raised the bar for the bonus from 60%to 65% of patients meeting target hemoglobin levels (11). Financial incentives do not necessarily have to be large in value to be effective. In the recently launched Bridges to Excellence initiative, physicians told employers that a sum of $1,000 was enough to engage them in performance measurement efforts (11).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 incorporates considerable federal support for developing uniform performance measures and financial incentives as a way to improve quality of care. The legislation establishes a 3-year Medicare Care Management Performance Demonstration Project under which the federal government will work with the IOM to develop a set of quality standards and a plan to reward physicians for good performance. Physicians who provide care to a specified minimum number of eligible beneficiaries may participate if they agree to use health information technology and report electronically on clinical quality and outcomes measures. Participating physicians who meet or exceed the agreed-upon performance measures will receive higher Medicare reimbursements on a per-beneficiary amount. The amount of payment may vary according to differential levels of performance or improvement. To further enhance quality, Medicare preferred provider organizations will be required by 2006 to provide data on how well they provide care to continue participating in the program. The legislation also promises hospitals 0.4% higher reimbursements for each Medicare beneficiary treated if they voluntarily provide CMS with quality data.

As the nation's single largest purchaser of care, Medicare is in a pivotal position to lead efforts to improve quality through using financial incentives. Medicare's market share is large enough that even small incentives could impact providers. In addition, the private sector will probably follow the lead of a successful and tested federal model, as demonstrated by the historic implementation of the prospective payment system (PPS).

The specialty of internal medicine requires a more equitable way to reimburse services rendered. Current federal physician payment policies discourage physicians from entering primary care specialties by undervaluing the evaluation and management of patient care. Medicare updates have not kept pace with the increasing costs of running a primary care practice, and primary care physicians receive lower aggregate reimbursement from Medicare and other third-party payers than do other specialist physicians. Financial incentives represent an opportunity for internists to be recognized and compensated for the coordinated care they provide to patients with multiple and chronic diseases. Financial incentives allow physicians the chance to "get off the fee-for-service treadmill" and to reclaim control of the payment system (10).

In a system where performance is motivated by incentives, particularly financial incentives, attention must be paid to possible adverse consequences. Continual monitoring of such a system is necessary to detect misreporting and other unacceptable behavior such as cream-skimming. Rewarding providers based on inaccurate (or worse yet, fraudulent) data could reinforce poor or undesirable performance, rather than improve quality (7). To build trust and

enhance participation in the system, financial incentives should reward, rather than penalize, physician performance.

ACP's Role in Implementing Performance Measurements

Position 7: The American College of Physicians will lead the critical review, development, and dissemination of physician clinical performance measures and the development of public policies to support the appropriate use of performance measures.

Leadership is vital to realize the vision set forth in the IOM's *Crossing the Quality Chasm* (7). The College will play a crucial role in educating different stakeholders about the strengths and limitations of physician clinical performance assessment. A critical part of this effort will be promoting the positive aspects of physician performance assessment, such as enhancement of professional development, the clear differentiation between the majority of excellent physicians from the few who provide unacceptable care, promotion of "best practices" resulting in overall improvement of care, proper alignment of patient needs with physician capabilities, and enhancement of patient trust (9). However, ACP will also continue to work collaboratively with stakeholders to identify and remove weaknesses from current strategies (9).

The College will develop performance measures only under exceptional circumstances, when doing so is relevant to College interest and membership and when no other credible source is available (22). Instead, ACP will evaluate existing performance measures based on stringent evidence-based criteria and promote the development of appropriate and feasible performance measures through a public--private process. Examples of this partnership are the College performance measurement affiliations with the American Medical Association, JCAHO, American Board of Internal Medicine, NCQA, National Quality Forum, and the DOQ project. Physicians must play an integral role in these efforts to ensure that measures are clinically relevant and broadly accepted (19).

Although professional societies have been heavily involved in developing practice guidelines, insufficient attention has been given to their application in practice (23). The application of performance measures requires a system structured so that "doing the right thing" becomes automatic (23). The College is poised to take a leading role in developing such a system. The ACP will actively encourage Congress and private organizations to fund demonstration projects that evaluate efforts to implement performance measures in the clinical setting and will actively participate in developing and monitoring these projects. Finally, ACP will continue to collect feedback from practicing internists to assess whether quality of care and outcomes improve because of performance measures.

Conclusion

This paper outlines the milieu in which physicians of internal medicine would like to practice---a system that ensures the highest quality of care through transparency, accountability, and credibility. The College understands that achieving this goal will require system-wide changes, which can only proceed if society, as a whole, is willing to commit to achieving quality care.

The current system has many impediments that deter physicians from achieving the goals outlined in this paper. Some of the largest purchasers of health care often fail to reward and even penalize physicians who make changes to improve quality. Meanwhile, physicians who make investments to improve quality and decrease costs do not necessarily enjoy the resulting savings. The current system simply does not encourage physicians to deliver high-quality care.

Performance measures offer an opportunity for physicians to regain some control of a payment system that does not adequately compensate them for their efforts (10). At the same time, performance measures directly target the quality deficiencies in our current health care system that are of increasing concern to the public.

The importance of performance measures in tracking our progress toward improving quality of care cannot be overestimated. However, insufficient understanding remains in the value of different approaches to measurement, different systems of data collection and reporting, and different ways to incentivize quality improvement.

The College must take a leading role in developing criteria to evaluate measures of physician performance and ensuring they are based on sound evidence. The College must also be involved in how these measures are applied in practice and how health systems must modified to make measuring performance and improving quality integral parts of the practice of medicine. The College will use its resources and capabilities to provide physicians with the tools necessary to implement such change.

Notes

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Glossary

ABMS	American Board of Medical Specialties---organization of 24 approved medical specialty boards that provides information on issues involving specialization and certification of medical specialists.
ADA	American Diabetes Association
AHA	American Heart Association
AHRQ	Agency for Healthcare Research and Quality---health services research arm of the U.S. Department of Health and Human Services that prrovides evidence-based information on health care outcomes; quality; and cost, use, and access. (Formerly known as the Agency for Health Care Policy and Research.)
AMA	American Medical Association
CAHPS®	Consumer Assessment of Health Plans---AHRQ project that develops comprehensive sets of surveys and reporting tools for assessing the experience of care for children and adults in health care plans.
CEAP	Clinical Efficacy Assessment Project---ACP project responsible for developing clinical practice guidelines based on the best evidence available.
CMS	Center for Medicare and Medicaid Services---arm of the Department of Health and Human Services that administers the Medicare and Medicaid programs. (Formerly known as the Health Care Financing Administration [HCFA].)
Consortium	Physician Consortium for Performance Improvement---provides performance measurement resources for practicing physicians to facilitate implementation of clinical quality improvement programs. Convened by the AMA, it includes methodologic and clinical experts representing more than 50 national medical specialty societies.
DOQ	Doctors Office Quality project---a 3-year collaborative initiative launched by CMS to define quality measures to assess clinician performance in providing ambulatory care for beneficiaries with chronic diseases.
DQIP	Diabetes Quality Improvement Project---a voluntary performance measurement program run by NCQA, in conjunction with the ADA.
HEDIS®	Health Plan Employer Data and Information Set---a tool developed by NCQA to measure performance in key areas, such as immunization and mammography screening rates.

HIPAA	Health Insurance Portability and Accountability Act of 1996---requires the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers and also addresses the security and privacy of health data and protects health insurance coverage for workers and their families when they change or lose their jobs.
HMO	Health Maintenance Organization
HMSA	Hawaii Medical Service Association---the state's Blue Cross Blue Shield plan.
IHA	Integrated Healthcare Association---a California group of health plans, physician groups, and health systems that promotes integrated health care.
IOM	Institute of Medicine---independent institute of the National Academies that provides unbiased, evidence-based, and authoritative information on matters of biomedical science, medicine, and health.
JCAHO	Joint Commission on Accreditation of Healthcare Organizations---an independent, nonprofit organization that evaluates and accredits more than 16,000 health care organizations and programs in the United States.
MedPAC	Medicare Payment Advisory Commission---an independent federal body established to advise the U.S. Congress on issues affecting the Medicare program.
NCQA	National Committee for Quality Assurance---an independent, nonprofit organization that helps the public make informed decisions about health care through the use of accreditation, performance measurement tools, and a comprehensive member satisfaction survey.
OASIS	Outcome and Assessment Information Set---data set developed by CMS that represents core items of a comprehensive assessment for adult home care patients and forms the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI).
ORYX®	The JCAHO initiative that integrates outcomes and other performance measurement data into the accreditation process.
PIER	The Physicians' Information and Education Resource---a Web-based decision-support tool developed by ACP and available to College members.
PMWG	Performance Measures Work Group---a group of experts responsible for assessing the capabilities and functions of performance measures and reports to ACP's Board of Regents.
PPO	Preferred Provider Organization

PPS	Prospective Payment System
QIO	Quality Improvement Organization program---CMS program that has developed several quality measures and an infrastructure to assist providers to improve quality.