

Measuring Quality: Influencing Our Future

In Brief: In the July/August 2008 issue of *The Physiatrist*, the Academy introduced a series of articles about the quality movement by explaining its background and potential impact. The following article, the second installment in the series, explains the concept of measurement and one type of system being used for measurement. Quality articles have been developed by Karen L. Andrews, MD, assistant professor of PM&R at the Mayo Clinic in Rochester, Minnesota, and chair of the AAPM&R Practice Improvement Committee; and Lisa Kaplan, JD, director of health policy and practice services at AAPM&R.

QUALITY MEASURES OUTLINE appropriate methods of treatment, raise awareness of existing practice, measure the quality of care, and act as important drivers to identify opportunities for improvement.

The health care industry is moving to measure and report the quality of health services and the cost to provide them. Every facet of the industry – hospitals, individual physicians, insurance companies and the government – is working to define what constitutes appropriate and accurate measures, to decide how this information should be made public, and to plan for the likelihood that payment will be tied to measures if it isn't already.

Doctors have raised concerns about being measured by systems that lack oversight and consistency. It is critical for physiatrists to understand that practices and efficiency will be measured, and it is in our best interest to ensure that the right elements are being measured.

Aiming at quality improvement

In 2001, the Institute of Medicine's Committee on the Quality of Health Care in America issued a report in which they stated that there is a need to approach

health care in a different way, one that focuses more directly on providing safe, effective, patient-centered, efficient, and equitable care.¹ The report identifies six specific aims for measuring and reporting quality improvement: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. To meet these ends, organizations, professional associations, payers, regulators, accrediting bodies, and consumer groups have begun to make significant changes in their respective agendas. Some of the initiatives undertaken include paying for performance, reporting on performance, and measuring quality. Despite these efforts, progress is slow, and reliability on the methodologies remains low. Most importantly, disagreement still exists within the health care industry about the best way to achieve these initiatives.

Many quality measures were developed early in the quality improvement movement. For these early initiatives, the risks and rewards from measures were nominal. The goal was for local improvement, and results were not publicly reported. Many of these measures may not be scientifically sound enough for the high-stakes environment created by pay for performance and public reporting. Although public statements of lives saved or errors prevented abound and likely influence health care purchasing decisions, consumers lack tools to evaluate the validity of such statements.

Rewarding quality: Pay for Performance

One way that insurers and the Centers for Medicare and Medicaid Services (CMS) are trying to improve quality is by developing pay for performance (P4P) programs. P4P is an emerging movement in health insurance in which providers are rewarded for quality of health care services. P4P is a strategy to pay providers for higher-quality care as measured by selected evidence-based standards and procedures. Goals of P4P include

encouraging performance improvement and promoting better outcomes and patient care coordination. P4P relies on a combination of quality measures that includes clinical outcomes, clinical processes, structural factors, and patient satisfaction. All of the data is collected and then "measured" by comparing it to a standard. Incentives, including bonus payments and feedback reports, are paid based on how one does compared to the defined standard or measure.

Currently, more than 100 P4P projects exist nationally.² Employers, private payers, Congress, and CMS are all moving forward with P4P programs or variations of it.

The measures used to assess quality and cost effectiveness in P4P programs vary greatly. Many programs use a variety of measures which include looking at how often patients receive evidence-based treatments combined with utilization, patient satisfaction, and cost. Administrative measures, such as using patient registry systems and electronic medical records, are also taken into account.

Reporting quality: PQRI

CMS sees P4P as a way to improve quality and cut costs. The 2006 Tax Relief and Health Care Act (or TRHCA) required the establishment of a physician quality reporting system that included an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of the 2007 reporting period. CMS named this program the Physician Quality Reporting Initiative (PQRI).³ Currently, physicians can report on 119 individual quality measures, of which 117 are clinical measures and 2 are structural measures. The structural measures apply broadly across specialties and document that the provider has adopted either a qualified electronic medical record or a qualified

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e-prescribing system.

For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data for services furnished during the reporting period of January 1-December 31, 2008, will earn an incentive payment of 1.5% of their total allowed charges for the Physician Fee Schedule covered professional services furnished during that same period. The program is authorized to continue through 2009 and 2010, with the incentive payment for those years expected to increase 2%, with no applied cap.

2007 PQRI results

On July 15, CMS announced payment of more than \$36 million in bonus payments to many of the more than 56,700 health professionals who satisfactorily reported quality information to Medicare under the 2007 PQRI. This marked the completion of the first reporting period and the first time payments were made. Physicians, physician group practices, and other PQRI-eligible professionals were rescheduled to receive their payments by August 2008. The average incentive amount for individual professionals is more than \$600, and average incentive payment for a physician group practice is more than \$4,700, with the largest payment to a physician group practice totaling more than \$205,700.

More than 109,000 professionals participated in the 2007 PQRI; based on data provided by CMS in late February 2008, this means an estimated 17% of clinicians who could participate in PQRI did so. Of those, more than 56,700 physicians and other eligible professionals met statutory requirements for satisfactory reporting for the 2007 reporting period and are receiving incentive payments.

The 2007 reporting period received participation in all 50 states, including Washington D.C., Puerto Rico, the Virgin Islands, and Guam. Of all the participating states and territories, health professionals in Florida and Illinois are receiving the highest incentive payments for the 2007 reporting period. In Florida, health professionals will receive a total of more than \$3 million and in Illinois, a total of more than \$2 million. For more information visit the CMS Web site at www.cms.hhs.gov. ■

Stay tuned...

Health care experts say that performance ratings are here to stay. More urgent questions center on how to balance assessment of quality with cost. In the next issue, we'll take a look at the entities developing performance measures.

References:

1. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New System for the 21st Century*. Washington D.C.: National Academy Press, 2001.
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3. Centers for Medicare and Medicaid Services. "Physician Quality Reporting Initiative." P.L. 109-432. <http://cms.gov/pqri>.

aapm&r

American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life™

330 North Wabash Avenue
Suite 2500
Chicago, Illinois 60611-7617
phone 312/464.9700
fax 312/464.0227
info@aapmr.org
www.aapmr.org