Developing ambulatory care physician performance measures

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Major US corporations and consumer groups are demanding more accountability for their health care expenditures. In response, the federal government, specialty boards, and state medical boards are evaluating ways to implement objective measures of quality. Many dermatologists already choose to participate in quality measurement and improvement activities. More will need to, as recertification and relicensure requirements change. Dermatologists need measures that are specialty-specific, as measures developed for primary care physicians are generally not appropriate for a dermatologic practice. (J Am Acad Dermatol 2008;59:505-13.)

THE NEED FOR MEASURES

Physician performance measurement offers the opportunity and challenge of quantifying some aspects of the quality of patient care. The opportunity is in the ability to identify which aspects of care are not being performed at optimal rates, including underuse or overuse of services, and may also identify disparities in care. Challenges include the inability to measure some of the most important aspects of quality, such as complexities of the physician-patient interaction. No single set of standardized measures can substitute for clinical judgment, life-long learning, compassion, and understanding. Still, studies have demonstrated that US citizens do not consistently receive recommended care and the public is increasingly demanding some measures of accountability in health care, both at the hospital level and individual provider level.[1,2] Congress passed the Tax Relief and Health Care Act of 2006 establishing the Physician Quality Reporting Initiative (PQRI) for Medicare and the medical profession has taken the lead in developing the majority of performance measures being used in this program.[3] Many measures already existed for primary care physicians, but few have been developed for assessing specialty and subspecialty care. Dermatologists who choose to participate need performance measures that are specialty-specific. This article describes an effort led by the American Academy of Dermatology (AAD) in collaboration with leading measure developers to create clinical performance measures for the dermatology specialty.

Demands for greater transparency of quality data that allow for informed consumer decisions are being heard from multiple perspectives, including the public and private sector. Physicians need quality data to identify areas for improvement in their practices. Specialty boards are increasingly using performance measures for board recertification and some states may require performance improvement activities for relicensure. Employers are also pushing

Abbreviations used:

AAD:	American Academy of Dermatology
AHRQ:	Agency for Healthcare Research and Quality
AMA:	American Medical Association
AQA:	the former Ambulatory Care Quality Alliance
CMS:	Centers for Medicare and Medicaid Services
IOM:	Institute of Medicine
NCQA:	National Committee for Quality Assurance
NQF:	National Quality Forum
PCPI:	Physician Consortium for Performance Improvement
PQRI:	Physician Quality Reporting Initiative

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for greater accountability for their health care dollars. The list of large corporations calling for quality measures now includes General Electric, BellSouth, Boeing, UPS, Xerox, Bristol-Myers Squibb, General Motors, Johnson & Johnson, Marriott, Motorola, the Pacific Business Group on Health, Honeywell, and Proctor and Gamble.[4] Both the public and corporate United States are pushing for objective measures of quality, and momentum is building.

In response to the demand for information on health care quality, national organizations with broadly representative membership have been formed to further development of standard measures of health care quality. Three of the largest measure developers include the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI); the National Committee for Quality Assurance (NCQA); and the Joint Commission. The PCPI comprises more than 100 national medical specialties and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its member boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality (AHRQ); and Centers for Medicare and Medicaid Services. The AAD has been an active member of PCPI since its inception in 2000.

Other groups in quality measurement efforts include the National Quality Forum (NQF), the Hospital Quality Alliance, and the AQA (formerly the Ambulatory Care Quality Alliance), which are multistakeholder organizations with membership representative of all sectors of society and are positioned to endorse and select performance measures for widespread implementation as national measures.[5-7]

PRINCIPLES OF MEASURED DEVELOPMENT

It would be naïve to believe that any set of quality measures could capture the full scope and breadth of aspects that determine quality in medical care. Medicine remains an art and care must be individualized based on individual patient needs. Measures are not meant to dictate how a physician practices medicine, rather, they are meant to promote quality by encouraging "best practices" endorsed by both private practitioners and academic physicians.

To guide its measure development efforts, the AMA-convened PCPI has established basic principles or desirable attributes of performance measures.[8] Similar principles have been outlined by the Institute of Medicine (IOM), the AQA (formerly the Ambulatory Care Alliance), and the NQF.[5,7,9] The major principles are as follows: measures are intended to promote quality, but cannot substitute for judgment; measures are not clinical guidelines and do not establish a standard of medical care; and measures must be supported by current, vetted, evidence-based guidelines of care. Further, to ensure measures address health care priorities, there should be published evidence of a gap in care and the measures should address a disease state that causes considerable morbidity and mortality. Measures should be designed so as to minimize the potential for perverse incentive (an incentive to abandon needy patients to perform well on measures) and take case-mix information into account to avoid penalizing physicians who care for sicker patients and more complex diseases. Finally, measures should be evidence-based, actionable by the entity being measures (eg, the individual physician), and meaningful to users.

Evaluation of performance may be based on patient outcomes (outcome measures), the consistent performance of specific behaviors (process measures), or the successful creation of infrastructure to promote quality (structural measures).[10] Measures may address coordination of care between providers, continuity of care, risk assessment, early intervention, or appropriate use of services. Process measures are strongest when they address bundles of steps to be accomplished. To promote greater participation in performance measurement, the incentives offered should be sufficient to offset the expense of implementation and the burden of reporting should be minimized by the use of technology whenever possible.

OVERVIEW OF PQRI

The PQRI was established by Congress as one means of promoting reporting of quality data. The Tax Relief and Health Care Act of 2006, P.L. 109-432, established the PQRI Program for 2007 and 2008.[3] The PQRI was in response to the IOM report on pay for performance (Rewarding Provider Performance: Aligning Incentives in Medicare), which was part of the Quality Chasm series, "despite more than a decade of efforts to establish total quality management and continuous improvement programs...health care organizations have not made quality improvement a business strategy...among the complex reasons for this lack of progress, two are crucial: the failure to align incentives and achieve integration across care settings and the lack of a business imperative to improve quality—the lack of a business case for quality."[11] This report identified the key issues of safe, effective, patient-centered, timely, efficient, and equitable health care but most importantly created physician payment incentives linked to evidence-based guideline recommendations to improve