

Physician Performance Measurement Implementation Rules

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... many critical considerations

- Intent of measurement
- Reporting options
- Accuracy of “claims-only” measures
- Stakeholder engagement
- Electronic and medical record data requirements and considerations
- Data pooling
- Accuracy of performance results
- Integrating cost and quality of care measurement
- Risk adjustment
- Auditing
- Benchmarking
- Linking measures across performance domains
- # of quality measures for different physician specialties
- Defining peer group comparisons
- Physician attribution
- Requisite number of observations
- Patient inclusion options
- Analysis time periods
- Data collection and sampling methods
- Composite scoring for quality measures
- Methods for evaluating physician cost of care performance
- Specifications for quality of care measures

... too little time today

... Focus of comments here

- **Performance Domains & Data Sources**
- **Establishing physician “accountability”**
- **Minimizing chance of being “wrong”**
- **Measuring cost-of-care**

Identifying Allowable Data Sources

	Electronic data: <ul style="list-style-type: none"> - Med., Lab, Pharm. Claims - Lab Values - Retrievable codes from EMRs/PMS 	Paper medical Records	Survey of patients	Survey of practice personnel
Clinical quality	<input checked="" type="checkbox"/>	?		
Cost of Care	<input checked="" type="checkbox"/>			
Care Experience			<input checked="" type="checkbox"/>	
Practice infrastructure				<input checked="" type="checkbox"/>

Critical issues: data sources

- **Understanding trade-off between accuracy and feasibility for data sources**
 - Defining allowable and non-allowable data sources
 - Data source substitution
- **Defining key data source attributes**
 - Quality of source data – comprehensiveness of source data for all patients
 - Quality of data linkage across multiple data sources (MD/practice identifier)

Establishing Physicians' Accountability

- **Logic & algorithm: which physician is accountable for which patient and quality event?**
- **Different rules for quality, cost, experience?**
 - Rules based on administrative assignment
 - Rules based on “time under care of physician”
 - Rules for primary vs. specialty care
 - Rules based on “proportion of costs”
- **Balancing multiple concerns**
 - Attribution rule ↔ patient sample size ↔ # of measured physicians ↔ # of measured patients ↔ accuracy of attribution

Handling “chance of being wrong”

- **Reasons for lack of accuracy/reliability**
 - Sample size (# of pts in denominator)
 - Measure properties
 - Patient variables (gender, age, SES, severity)
- **Options**
 - Sample size requirements
 - Estimating error – confidence intervals (for each measure) – more complicated when dealing with “composite scores”
 - Taking patient variables into account
 - Logic
 - Limiting comparisons across different specialties
 - Statistical adjustments/stratified reporting

Measuring cost of care

- **Linking quality and cost measurement**
- **Issues of patient-mix differences between practices loom large**
 - **Proprietary tools available (episode and person-risk adjustments)**
 - **Risks and benefits of using tools (Transparency, “Upcoding”, different diagnostic behaviors)**
 - **Dealing with unit price and utilization differences**
- **Standardization needs remain**
 - **Outlier costs, attribution, risk adjustment, comparison groups,**

Technical assistance

- **Aligning Forces is making technical assistance available**
 - Each community will need to carefully weight the options (sometimes without a lot of empirical findings guiding decisions)
 - Experience/conventions you can draw from – some care codified
 - Looking forward to working with your communities on the wide-scale implementation of these efforts

Contact

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