



## **ACCF Principles to Guide Physician Pay-for-Performance Programs**

### **For the delivery of Cardiovascular Care**

*Approved by the ACCF Quality Strategic Oversight Committee*

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ACCF recognizes the importance of and supports the concept of paying for performance to inspire greater focus on improving care delivery systems. However, ACCF believes physician pay-for-performance programs should be designed to support and facilitate the quality improvement process and strengthen the patient-physician relationship rather than solely reporting performance and outcomes (quality assurance). Whereas, the former application can serve to unify multiple participants in the healthcare system to improve patient care and realize the full potential of American healthcare system, the latter can be divisive and impede a coordinated effort to improve care.

ACCF supports pay-for-performance programs and has developed the following principles to guide the development of such programs. Physician pay-for-performance programs should (be):

- ❖ **Built on evidence-based, well established and proven performance measures.**
- ❖ **Provide adequate incentives for investments in structure, best practices, and tools that can lead to improvement and high quality care.**
- ❖ **Reward process, outcome, improvement, and sustainability.**
- ❖ **Assign attribution of credit for performance to physician in ways that are credible and encourage collaboration.**
- ❖ **Favor the use of clinical data over claims based data.**
- ❖ **Set targets for performance through a national consensus process.**
- ❖ **Address appropriateness.**
- ❖ **Not be punitive.**
- ❖ **Audit performance measure data.**
- ❖ **Establish transparent provider rating methods.**
- ❖ **Not create perverse incentives.**
- ❖ **Invest in outcomes and health services research.**

Each of these points is elaborated upon below.

1. **Built on evidence-based, well established and proven performance measures.** Pay-for-performance programs should be anchored in valid and reliable measures of performance. The ACCF is a member of the National Quality Forum and supports NQF efforts in the identification of valid and reliable measures of performance. Measures to be used in pay-for-performance programs should have the following characteristics:
  - Credible. Developed in accordance with a credible methodology and possessing important attributes (e.g. actionable, valid, and feasible) such as that outlined in “American College of Cardiology and American Heart Association Methodology for the Selection and Creation of Performance Measures for Quantifying the Quality of Cardiovascular Care.”

- Current. Based on current practice guidelines and performance measures and updated in a timely manner in response to changes in these documents (to guard against the ongoing institutionalizing of payment policies that do not reflect current science).
- Comparable. Be comparable from period to period (for the same provider) and from provider to provider (i.e. risk-adjusted) inasmuch as that is possible given the need to update them to account for new knowledge and science.
- Risk-Adjusted. Be adjusted for patient severity of illness and comorbidities with the method of risk adjustment validated.
- Data Standards. Data standards and specifications for collection of the measures should be clearly defined and consistent across measure sets to help ensure reliable comparisons of data and reduce the cost and burden of data collection. Where possible, these standards and specifications should be consistent with ongoing clinical trials and other data collection efforts already underway. ACC/AHA Clinical Data Standards should be used to supplement the measure specifications. Employ attributes of risk models, as described in the American Heart Association Scientific Statement on Standards for Statistical Models Used for Reporting of Public Outcomes. This includes the use of hierarchical modeling for comparison of outcome measures.

2. **Provide adequate incentives for investments in structure, best practices, and tools that can lead to improvement and high quality care.** Pay-for-performance programs should provide adequate incentives to encourage investments in sustainable quality improvement (QI) systems. Recognition programs should support both the clinical and business case for investment in change such that the incentive covers the true cost of delivering quality care. It is important that payers recognize that active participation in quality improvement programs represent a significant investment in staff time, training, process change and technology (equipment and software). The size of the incentives should correspond to the resource commitment necessary to build the structures and implement the process protocols required to improve care.

- Structure. The upfront investment required to implement a QI system should be recognized as an investment which needs adequate performance incentives and rewards.

*Data Collection.* Participation in data collection, self-analysis and data reporting requires building an infrastructure (e.g. electronic health records, chart reviews, registry participation, staffing support).

*Benchmarking.* Benchmarking is an essential feature of data analysis. It is important for practices and institutions to have reliable and objective benchmarking against which to compare their performance. There is an increasing array of disease registries that serve this purpose.

*Interdisciplinary Committee and QI Leaders.* To be successful, QI programs should involve an interdisciplinary committee, designated leaders and a system for regular meetings and action plans driven by periodic data analysis.

- Best Practices. Payment should provide sufficient incentives to justify the efforts and expense of committing the resources for implementation of local adaptation of best practices and tools proven to support high quality care. Programs should consider providing additional incentives to physicians who champion implementation of regional quality improvement programs.

*Case Studies*. The evidence supports the concept that certain process improvements are tightly linked to improved outcomes. Where possible, physicians and their care teams should be offered case studies of best practices and access to resources based on those cases allowing them to enhance their own care delivery systems. Payers in collaboration with physician organizations should be encouraged to support the exchange of best practices that can provide examples of pathways to excellence in care.

*Tools*. A number of resources have been developed that support the delivery of high care. Standing orders, discharge instructions, and care management plans are examples of tools that can support process changes. For example, a prospective data collection tool can serve as an effective memory aid and communication tool while also supporting documentation of comprehensive and complete delivery of quality care.

### 3. **Reward process, outcome, improvement and sustainability.**

- Process. Measuring processes of care (e.g. provision of evidence-based medication in eligible patients) offers specific opportunities to improve the quality of care and focus attention on improvement. This is especially true in an ambulatory care setting which is not a closed system and where outcomes may be realized over a number of years and providers.
- Outcome. Outcome measures are subject to factors that can be influenced by the physician (e.g. medical management), but are not completely under the physician's control (e.g. genetic background, co-morbidities, patient adherence). Proper risk-adjustment and other key methodological attributes (such as used of hierarchical modeling for outcome measures) are required for these measures. In addition, incentives should encourage practices to develop systems to improve patient compliance.
- Improvement and Sustainability. To emphasize the importance of the quality improvement approach, payers should recognize improvement – the change over time in performance as the result of quality improvement activities - independently and in addition to measurement of process and outcome at a single point in time. Those places that start at a low level should be given credit for improvement. Those places that start at a high level should be given credit for sustaining the performance.

### 4. **Assign attribution of credit for performance to physicians in ways that are credible and encourage collaboration.**

- Physician Group. Consider physician group measurement (e.g. by practice group or hospital affiliation) rather than individual physician level measurement to avoid small population issues, encourage group quality improvement initiatives, and support a team approach to care.

- Multiple Providers. Incentives should be structured to encourage collaboration between physician groups, especially between specialty and primary care groups. Attribution of care for individual patients to physicians should account for the fact that multiple providers will deliver the care being measured.
5. **Favor the use of clinical data over claims based data.** While it may be argued that a number of performance measures (e.g. medication and lab based measures) appear to be amenable to retrospective claims based data collection, reporting of measures solely based on claims (administrative data) will negatively impact the validity and reliability of the measures in the sets. Claims data will not capture the complete patient and care attributes (e.g. disease severity, co-morbidities, complications) nor provides enough information for adequate exclusions or rigorous risk adjustment.
- Physician review and correction. All reports, including those based on administrative data, should be subject to physician review and correction prior to use in any program.
  - Routinely supplement report data. Physician or physician groups should be allowed to routinely supplement or supersede report data, especially claims-based information, with additional clinical data on quality collected prospectively without the need to follow an appeals process.
  - Validation. Reports, particularly those based on administrative data should be validated, such that misclassification rates against the gold standard (e.g. clinical data) are low.
6. **Set targets for performance through a national consensus processes.** These processes should include mechanisms to deal with the following:
- Sites which begin from different starting points.
  - Sites which face differences in socio-demographic case mix and other factors which may affect (among other things) patient compliance with physician recommendations for care and hence ability to meet measure goals. This is particularly relevant for outcome measures.
  - Sites which have local resource constraints.
7. **Address appropriateness.** Pay-for-performance programs should address not only what should be done and rewarded, but what should not be done (and not rewarded); that is, there should be explicit consideration of what behaviors are to be *discouraged* as well as what behaviors are to be *encouraged*. These decisions should be based on solid clinical evidence. Where there is not sufficient evidence, then clinical studies should be encouraged to determine the appropriate standard of care.
8. **Not be punitive.** Pay-for-performance programs should emphasize success and reward achievement but not penalize practitioners for less than top performance.
- Patterns of care. Payment enhancements should be rewarded based on patterns of care, not case-by-case specific care. Pay-for-performance programs should be based on a quality improvement model – looking at patterns of care across populations – as compared to a quality assurance model, which looks at care on a case by case basis.
  - Local resource constraints. There must be some mechanism to consider and deal with local variation (for example, opportunities to adhere to ACC/AHA performance measures may be limited in communities that have limited access to technology). Consideration should be given to help such areas to obtain those technologies.

- Efficient targeting of resources. Efforts should be made to reward efficiency in improving care for populations of patients. Thus, a group that effectively offers a suite of disease management services preferentially to those most in need will have more marginal improvement in their patient population, perhaps, than one who invests resources without differentiation.
  - Physician performance. Physician performance should be evaluated and reported based on a comparison to baseline standards of care agreed upon at the onset of any pay-for-performance program. The benchmarks should be achievable by all providers over a specified period of time.
9. **Audit performance measure data.** The data used for pay-for-performance based programs should be submitted to an objective third party, and audited by an objective third party. For example, pay-for-performance programs could use the model of some disease registries such as ACC's National Cardiovascular Data Registry which includes an auditing component and standardized quarterly reports feeding back to providers their performance data. Physician-reported data should be audited, as well.
  10. **Establish transparent provider rating methods.** The provider rating method, including detailed measurement specifications and algorithms used to combine scores from individual measures and/or group providers into performance tiers, should be publicly disclosed. Such disclosure recognize that there may be variations in the methods by which entities transform results from provider performance measurement into provider ratings based on differences in populations, care interventions by third parties (e.g. disease management organizations), performance incentives, negotiated rates, and other considerations. Measurement program rules should be clearly delineated and disseminated prior to implementation. Furthermore, where possible, prior to implementation the participation of physician groups in the establishment of pay-for-performance incentives should be encouraged to ensure 'buy-in', participation, and successful implementation of these programs. If data is to be reported publicly, it should adhere to principles such as that outlined in the American Heart Association Scientific Statement on Standards for Statistical Models Used for Reporting of Public Outcomes.
  11. **Not create perverse incentives.** Pay-for-performance programs should be designed in such a way so as not to create perverse incentives, such as excluding sicker patients from a physician's panel.
  12. **Invest in outcomes and health services research.** The ACCF recognizes that there are areas in which the evidence-base is inadequate or where measurement feasibility questions remain. These areas may be unsuitable for quality-based reimbursement at this time. However, where practicable, the ACCF encourages investment and participation in clinically-rich data collection efforts to enable analysis of the relationship between processes and outcomes, and thus, optimization of care in those uncertain areas. In addition, there should be support of implementation research, i.e. the study of pay-for-performance itself, including its' efficacy and safety.
    - Evaluation and assessment. Pay-for-performance programs should undergo periodic assessments to test for intended and unintended impacts on access, costs, quality, health outcomes, physician and patient satisfaction. This could be in the form of a research document that assesses the implications of pay-for-performance and potentially compare pay-for-performance versus other quality improvement approaches.