

EVALUATING PERFORMANCE: Evolving Approaches To Evaluating Performance Measurement Programs

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URAC

Overview

- URAC Background Information
- Draft Provider Performance Measurement & Public Reporting (PMR) Standards (as of 12/29/08)
- Related Draft Public Reporting Companion Workbook
- Evaluation of P4P Programs – An Auditor’s Perspective

About URAC

MISSION

- To promote continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education.

STRUCTURE

- Non-profit, independent entity
- Broad-based governance
 - Providers ○ Purchasers ○ Labor
 - MCO's ○ Regulators ○ Consumers
- Expert advisory panels (volunteer)

STRATEGIC FOCUS

- Consumer Protection and Empowerment
- Improving and Innovating Healthcare Management

URAC Board Member Organizations



America's Health Insurance Plans

Industry Trade Groups



Public



American Medical Association
Physicians dedicated to the health of America



Provider Organizations



Other



About URAC

- URAC's accreditation programs and other quality benchmarking activities cover a large array of clinical and IT services
- Uses a modular approach to quality assessment with dozens of various accreditation and certification programs
- URAC currently accredits about 2,700 different health care programs operating in all 50 states and internationally
- Accredited activities cover over 140 million Americans
- Is now recognized in 38 states, Washington, D.C. and four federal agencies

URAC's Full Range of Accreditation Programs

- Clinical:
 - Core Accreditation
 - Health Care Management
 - Health Utilization Management
 - Case Management
 - Comprehensive Wellness
 - Disease Management
 - Health Call Center
 - Independent Review
 - Workers' Compensation UM
 - Health Care Operations
 - Health Plan
 - Health Network
 - Health Provider Credentialing
 - Medicare Advantage Deeming
 - Other
 - Claims Processing
 - Credentials Verification Organization
 - Consumer Education and Support
 - Vendor Certification
- Health Information Technology:
 - Health Web Site
 - Peer Reviewed Health Content Provider
 - HIPAA Privacy
 - HIPAA Security
- Pharmacy Quality Management Programs:
 - Pharmacy Benefit Management
 - Drug Therapy Management
 - Specialty Pharmacy
 - Mail Service Pharmacy
 - Workers' Comp Pharmacy Benefit Management

Provider Performance Measurement & Public Reporting (PMR) Standards (as of 12/29/08)

- Developed 2008: Standards plus Workbook
- Influences: Disclosure Project and NY Attorney General
- All content still draft:
 - Public comment phase
 - Beta test phase
 - Finalization
 - Board approval



PMR 1 – Disclosure of Provider Performance Information to Consumers

- Public reporting regarding physicians or other providers
- Clear and easily accessible information for consumers
 - Measures
 - Attribution Level
 - Context
 - Disclosure of limitations of data
 - Performance ratings only one factor in choosing provider
- Inclusion of consumers in the development

PMR 2 – Consumer Complaints and Comments

- How can a consumer register complaint or comment regarding public ranking or quality information?
- How does the organization provide notice (verbal/written) of the outcome of the complaint – including explanation of the outcome?
- How does the organization track and analyze complaints?
- Summary report to the organization's quality management committee or designated entity

PMR 3 – Criteria for Selecting Performance Measures

- Involves providers in selecting developing measures
- Uses a hierarchy to select accurate, reliable and valid measures:
 - National Quality Forum
 - Multi-stakeholder national groups
 - Other national groups
- Uses measures that are:
 - Clearly delineated
 - Risk adjusted, particularly for outcome and efficiency measures

PMR 4 – Disclosure of Performance Information to Providers

- 45 days prior to release of performance data to public, disclose to providers:
 - Provider participation in the development process
 - Data sources for the ratings
 - Process to request a review of their own performance results, including how to obtain individual patient-level data used in the calculations
 - Methodology and measures, including approach to attribution
- Define and disclose the process for making material changes to the measures over time
- 45 days notice of material changes

PMR 5 – Reconsideration Process for Providers

- Reasonable, prompt and transparent process to address inaccuracies in data or application of measurement methodology
 - Timeline and mechanisms to submit for reconsideration
 - Written responses to providers regarding outcome
 - ✓ Reason for reconsideration decision
 - ✓ Next actions the organization will take based on decision
 - Providers have 30 days to ask for reconsideration – leaves 15 day window for organization to resolve issues and the performance information or ranking remains unpublished until the organization communicates its decision

PMR 6 – Criteria for Using Multiple Measurement Categories

- Categories of measurement must include quality of performance; cost efficiency measures can also be included:
 - If both types reported, calculate and report separately
OR
 - If combined, the individual component scores and their proportion must be disclosed along with combined score
 - In tiered networks, disclose methodology to place provider in one tier versus another

PMR 7 – Public Display of Measurement Categories

- When comparing or ranking physicians or other providers
 - Cost efficiency measures must disclose how providers are compared to the comparison group AND
 - Organizations must disclose the rationale for selecting the comparison group

(Only applicable if using cost efficiency measures, either separately or combined with quality measures to publicly report; does not apply to cost comparison (“shopping tools”) to assist consumers with out-of-pocket cost calculations)

PMR 8 – Data Collection

- Organizations engaged in public reporting of provider performance (rating, rankings or measurement designations):
 - Use the available data for the eligible population
 - Describes the statistical basis of the measures used
 - Describes the confidence intervals for the measures used
 - Adjusts the time frame for the measure as needed to attain sufficient data – multi-year data collection to obtain adequate sample size

PMR 9 – Feasibility Assessment for Data Aggregation

- Organizations have evaluated written documentation addressing the feasibility of aggregating data using an appropriate methodology from various sources outside of the organization for purpose of public performance reporting
 - Within last 3 years from application
 - Who evaluated
 - Minutes acceptable

PMR 10 – Scope of Data Collected

- Data for is collected and aggregated from sources outside of the organization [L]



PMR 11 – Program Evaluation

- Evaluate program at least every two years to assess effectiveness and unintended consequences:
 - Internal review
 - Solicits input from stakeholders



Provider Performance Measurement & Public Reporting Companion Workbook

- Also in draft until after beta
- While designed for this accreditation product, reflects “good practice” for any data aggregation and reporting process (internal performance improvement; feedback to providers not necessarily publicly reported)
- Document set to be completed and uploaded (worksheets to be developed)
- Encouraged to use as part of internal annual quality planning – communication vehicle for an organization’s governance and leadership

Provider Performance Measurement & Public Reporting Companion Workbook

- Each section contains set of 3 to 8 questions with:
 - Question
 - Interpretive Information
 - Points to Remember
 - Evidence Reviewers Will Look For
 - Bright Ideas



Section 1: Structure and History of Program (5 Questions)

1. Overview of the Public Report Card Program
2. Development of the Public Report Card Program
 - Qualifications/background of leaders/staff
 - Internal reviews
 - External reviews
 - Approval of measures used



Section 1: Structure and History of Program (5 Questions)

3. Data collection used in the public reporting program
 - Detailed review of data sources, limitations
 - Does the data support the measures being reported?

4. Episode treatment groups or comparable methodology if used
 - Software product and version
 - Risk adjustment approaches
 - Exclusion criteria

Section 1: Structure and History of Program (5 Questions)

5. If patient/consumer satisfaction surveys are used, how the data is collected to be relevant at the provider level



Section 2: Measurement Methods and Standards

(8 Questions)

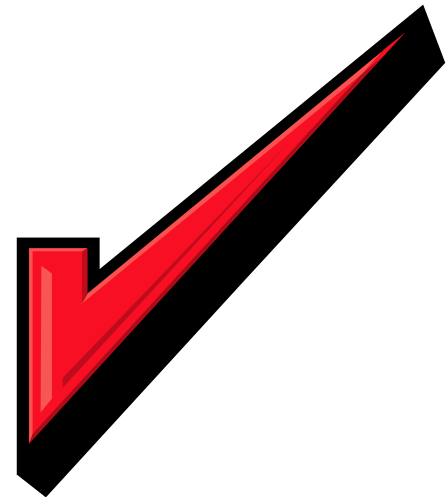
1. Measure Abstract

- Type: assess, cost-effectiveness, detection, prevention, quality of care, satisfaction
- Source of measure (NQF, specialty group, internal)
- Provider specialties included
- Modifications
- Settings
- Threshold for analysis (minimal number of patients/cases)
- Data Source
- Statistical Method (normative comparison to peers or improvement from baseline)

Section 2: Measurement Methods and Standards (8 Questions)

2. Measure Specification

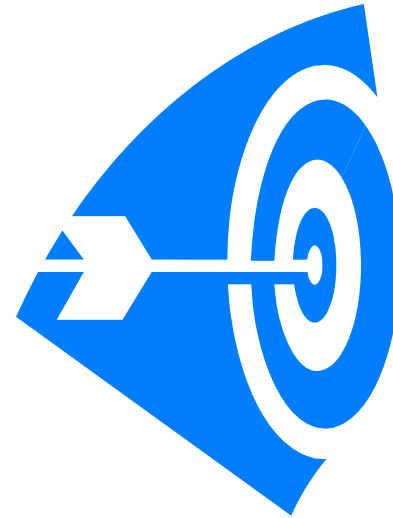
- Measure description/intent
- Code Sets (diagnostic or procedure)
- Timeframe
- Importance
- Scientific acceptability
- Feasibility
- Usability



Section 2: Measurement Methods and Standards (8 Questions)

3. Measure Qualities

- Timely
- Effective
- Efficient
- Equitable
- Patient centered
- Reflects consumers' health needs



Section 2: Measurement Methods and Standards (8 Questions)

4. Unit of Analysis

- Minimum population for reporting
- Treatment if fewer than minim required
- Examples of calculations and rates

5. Composite Scores

- Explanations
- Rules
- Weights
- Calculations



Section 2: Measurement Methods and Standards (8 Questions)

6. Statistical Standards

- Example of full measure's calculations using the statistics applied

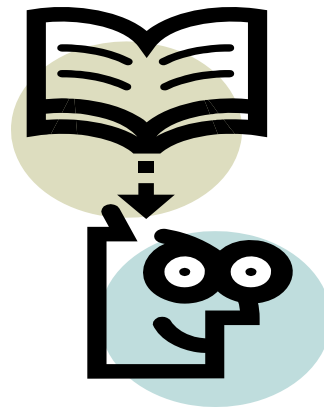
7. Attribution Logic

8. Measure Adjustments

- Exclusion criteria
- How are disputes handled about whether to include a patient/case

Section 3: Transparency of the Public Reporting Program (6 Questions)

1. Sharing program information with providers
2. Sharing scoring/ranking information with providers
3. Sharing information with consumers



Section 3: Transparency of the Public Reporting Program (6 Questions)

4. Description of the public report
5. Description of public guidance on use of the report
6. Feedback from consumers and purchasers



Section 4: Complaints and Review Procedures (3 Questions)

1. Dispute resolution transparency

- Communication Methods
- Dates of most recent communications
- Frequencies of distributions
- Percent providers impacted/reached by methods

2. Dispute resolution process

- Periods of dispute, post-dispute, post-publication
- Numbers of disputes at various stages
- Percent total participating providers/groups at each stage

Section 4: Complaints and Review Procedures (3 Questions)

3. Performance Measurement Program Evaluation

- How?
- Who?
- When?
- Evidence?
- How is data validated internally?
- How are appeals integrated into evaluation?



Appendix A: Question Worksheets

To be developed



Evaluation of P4P Programs – An Auditor's Perspective

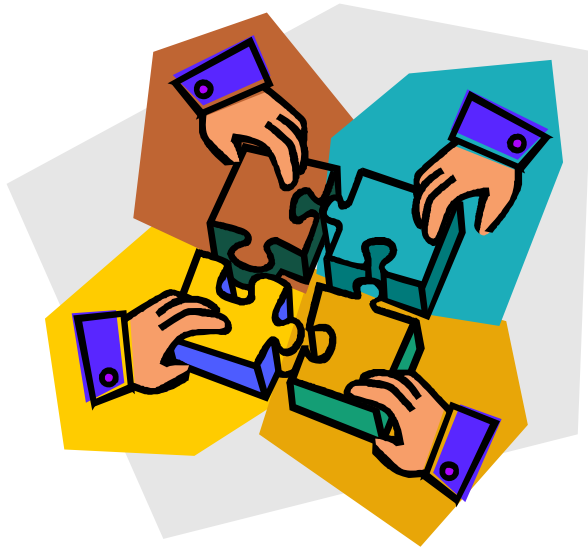
- Overall Program Review
- Review of Specifications
- Review of Communications and Feedback
- Program Oversight and Dispute Resolution

Overall Program Review – Possible Findings

- Weak or Out of Date Program Description
- Metrics Poorly Defined
- Metrics Out of Date
- Homegrown Measures
- Measures Not Relevant to Provider Groups Being Measured
- Appropriate Peer-To-Peer Comparisons



Overall Program Review – Possible Findings



- Metrics Suffer from Systemic Data Incompleteness
- Measures Limited to Claims Data
- Measures Fail to Use Data Appropriate to Measure (Lab Results, Immunization Registries)
- Program Development Limited to Closed Group of Internal Staff

Review of Measures – Possible Findings

- Homegrown vs. Nationally Recognized and Tested Metrics
- Measures Do Not Meet Industry Standard Requirements:
 - Timely
 - Effective
 - Efficient
 - Equitable
 - Patient Centered
 - Reflects Consumer Needs

Review of Measures – Possible Findings



- Math Errors
- Ranking Errors
- Composite Score Calculations Too Complex
- Attribution Logic Too Complex
- Attribution Logic Not Equitable
- Reasonable Exclusions Not Allowed

Communications and Feedback – Possible Findings

- Measure Specification Detail Not Shared with Providers
- Vague Metrics Make Intervention by Providers Difficult
- Overall Scores Shared with Providers But Not Compliance at the Patient Level
- Incentive Criteria Hard to Follow / Algorithms Too Complex



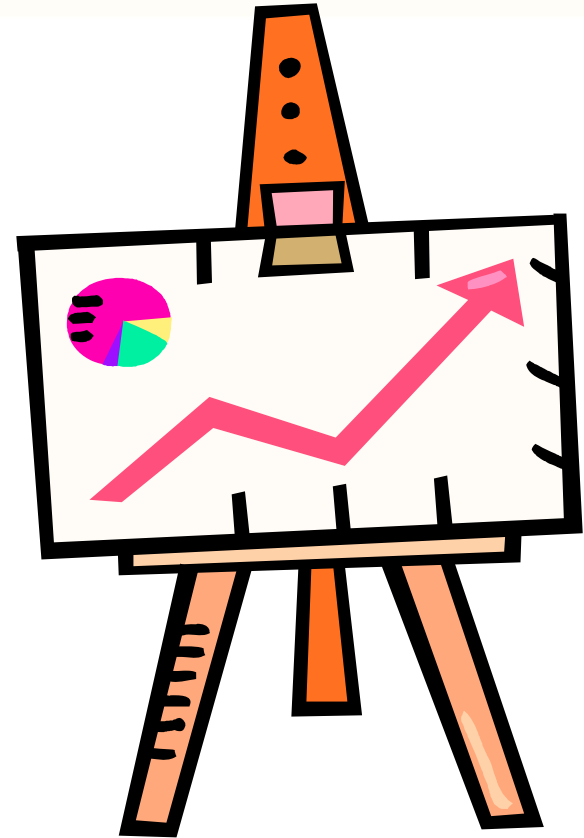
Communications and Feedback – Possible Findings



- Rankings Provided to Consumers Without Explanation
- Web Site Information Out of Date
- Report Card Written in Jargon / Too “Scientific”

Communications and Feedback – Possible Findings

- Only “Low Cost” Providers Identified
- No Guidance on Use of Report / No “Caveats”
- No Solicitation of Feedback



Oversight and Dispute Resolution – Possible Findings



- No Formal Process for Providers to Review Their Scores and Highlight Errors
- No Opportunity to Provide Supplemental Data

Oversight and Dispute Resolution – Possible Findings

- Program Does Not Follow Formal Correction Process
- Program Does Not Have an Internal or External Evaluation Process for Validity or Effectiveness



Follow-Up Contact

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