Dennis S. O'Leary, M.D.
President
Joint Commission on accreditation of Healthcare Organizations

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Principles for the Construct of Pay-for-Performance Programs

In recent years, thought leaders and policy-makers have directed increased attention to strategies for achieving system-wide improvements in quality, safety and efficiency that will lead to larger-scale, more rapid changes in professional and provider behavior than has been experienced to date. To achieve such extraordinary progress, they have chosen to promote and leverage experimentation in programs that offer structured incentives for practitioners and providers to achieve benchmarks of performance. The hope is that by offering positive rewards – both for reaching thresholds of performance and for making continuous strides in improving quality health care – high quality care will be delivered on a more consistent basis and cost-effective manner. Further, it is widely recognized that financial rewards are among the most powerful tools for bringing about behavior change.

However, pay-for-performance programs are operating in a complex reimbursement environment that often creates – by omission or commission – barriers to reaching the goal of consistent, high quality care for all patients. For example, payment systems frequently do not recognize the nuances of care delivery, nor do they always pay fairly for important aspects of care, such as activities that support patient education, continuity of care, or integration of services. At the same time, reimbursement is often made for services of low or no value to the patient, and these services represent opportunities for system-wide savings.

Many new programs that are seeking to harness payment policy to transform health care delivery are either already operative or in development. However, alignment of payment policies to support the provision of safe, high quality care is a complex undertaking. Such policies must be credible, must minimize unintended negative consequences, and most importantly, must be transparent and attentive to ethical considerations. It is important to recognize as well that non-financial incentives can also be used to drive positive behavior changes.

Despite the proliferation of pay-for-performance programs, they are largely untested, yet a variety of important considerations must be taken into account in both the design and implementation of programs aimed both at rewarding medical excellence and at providing strong incentives for continuous quality improvement. It is important that these programs be well-designed, make every effort to encompass all affected stakeholders for whom the incentives must be aligned; and be designed and implemented in a manner that engenders, maintains, and continually promotes trust among all of the participating parties. Many of the programs will have significant effects on the way quality and safety-related performance is reimbursed, and on the priorities that providers and practitioners will place on their own day-to-day activities. Therefore, the Joint Commission is offering a set of principles to guide the development and refinement of these programs. The design and evaluation of these programs should lead to a national dialogue on how best to utilize incentives and financial investments in our country's health care system so that quality and safety are paramount considerations.

Lastly, it is important to note two evolving areas that relate to the effectiveness of pay-for-performance programs. First, the optimal success of these programs rests on broad-scale implementation of an electronic health infrastructure that can efficiently collect, transmit, and

facilitate analyses of the data necessary for the credible operation of these programs. Second, the ability to drive appropriate cost savings in the health care system depends upon considerable consensus building over how to define and measure service "efficiency." This is an area that needs immediate attention.

Alignment of payment programs to support the provision of safe, high quality care is a complex undertaking if it is to achieve fair reimbursement for necessary services; promote desired behavior change; and avoid unintended consequences. The focus on payment policies should always be on the effects such policies ultimately have on the patient and on the provision of patient-centered care. Therefore, the following principles are offered to guide the development and refinement of these programs.

Principles

A. The goal of pay-for-performance programs should be to align reimbursement with the practice of high quality, safe health care for all consumers.

- Payment systems should be designed to sufficiently recognize the cost of providing care in accordance with accepted standards of practice and should guard against any financial disincentives to the provision of safe, high quality care.
- Reward programs should encourage qualified clinical staff to accept patients where complexity, risk, or severity of illness may be considerations.
- Performance incentives should be aligned with professional responsibility and control.

B. Programs should include a mix of financial and non-financial incentives (such as differential intensity of oversight; reduction of administrative and regulatory burdens; public acknowledgment and reporting of performance) that are designed to achieve program goals.

- The type and magnitude of incentives should be tailored to the desired behavior changes. Rewards should be great enough to drive desired behaviors and support consistently high quality care.
- A sliding scale of rewards should be established to allow for recognition of gradations in quality of care, including service delivery.
- The reward structure should take into account the unique characteristics of a provider organization's mission.

C. When selecting the areas of clinical focus, programs should strongly consider consistency with national and regional efforts in order to leverage change and reduce conflicting or competing measurement. It is also important to attend to clinical areas that show significant promise for achieving improvements because they represent areas where unwarranted differences in performance have been documented.

D. Programs should be designed to ensure that metrics upon which incentive payments are based are credible, valid and reliable.

- Quality-related program goals should be transparent, explicit and measurable.
- Metrics should be evidence-based or, in the absence of strong science, be based on expert consensus.
- Metrics should also be standardized, and have broad acceptance in the provider and professional communities.
- To the extent possible, measures should be risk adjusted to account for population differences.
- There must be credible and affordable mechanisms to audit data and verify performance.
- The measurement set should be constructed to achieve the desired results with the minimum amount of measurement burden.
- Attention should be paid to including standardized measures of patient perception of care whenever possible.

E. Programs must be designed to acknowledge the united approach necessary to effect significant change, and the reality that the provision of safe, high quality care is a shared responsibility between provider organizations and health care professionals.

- Incentive payments should recognize systemic drivers of quality in units broader than individual provider organizations and practitioner groups and encourage improvement at these aggregate levels.
- Incentive programs should support team approaches to the provision of health care, as well as integration of services, overall management of disease, and continuity of care.
- Incentive programs should encourage strong alignment between practitioner and provider organization goals, while also recognizing and rewarding the respective contributions of each to overall performance.

F. The measurement and reward framework should be strategically designed to permit and facilitate broad-scale behavior change and achievement of performance goals within targeted time periods. To accomplish this, providers and practitioners should receive timely feedback about their performance with an opportunity for dialogue as needed. Rewards should follow closely upon the achievement of performance.

G. Programs should reward accreditation, or have an equivalent mechanism that recognizes health care organizations' continuous attention to all clinical and support systems and processes that relate to patient safety and health care quality.

H. Incentive programs should support an interconnected health care system and work to implement the adoption of "interoperable" standards for collecting, transmitting and reporting information.

I. Programs should incorporate periodic, objective assessment into their structure. The evaluations should include the system of payment and incentives built into the program design, in order to evaluate its effects on achieving improvements in quality, including any unintended consequences. The program and, where appropriate, its performance thresholds should be re-adjusted as necessary.

J. Provisions should be made to invest in sub-threshold performers who are committed to improvement and are willing to work themselves or with assistance to develop and carry out improvement plans. Such investments should be made after considering both the potential for realistic gains in improvement relative to the amount of resources necessary to achieve that promise, and what is a reasonable timeframe for achieving program performance goals.