Quality, Safety, Efficiency, Standardization and Cost-Containment

By James B. Rosenblum

The Meaning of Health Care Quality

Expanding the definition of standard of care in the rubric of pay for performance.

Competent health care is no longer enough. Now there is a pursuit of quality care, promoted in plans described as "pay for performance," where quality and performance are defined broadly. What is the new definition of quality care and how does it affect the "standard of care" which lawyers are familiar with? To understand this evolution, it is helpful to have a brief review of major concerns and goals of healthcare delivery.

The Attempt to Control Costs and the Threat to Quality

Managed care promised to be the panacea for rising health care costs. In retrospect, the premise seemed to be that, if only a nurse manager oversaw those pesky doctors, unnecessary, costly variations—and inflated medical fees—could be squeezed out of the system, while malpractice suits would prevent sub-standard care. Unfortunately, managed care was a financial and public relations disaster and viewed by many as a failure. Health care costs still threaten to bankrupt government and businesses alike. The term "managed care" became synonymous with cost-containment, limited care and inadequate compensation for the real costs of health care. It was viewed as insurance company-centric and antagonistic to patient needs.

Apart from failing to control costs, managed care seemed antithetical to good care. Studies demonstrated a virtual crisis in medical errors. *See* Kohn, Corrigan, Don-

James B. Rosenblum is a founding partner of Rosenblum & Newfield LLC, with offices in New York City, White Plains, New York, and Stamford, Connecticut. His firm concentrates in civil litigation and administrative proceedings in New York and Connecticut for physicians, hospitals, nursing homes, home health care providers and insurers. He has been a member of DRI since 1999.

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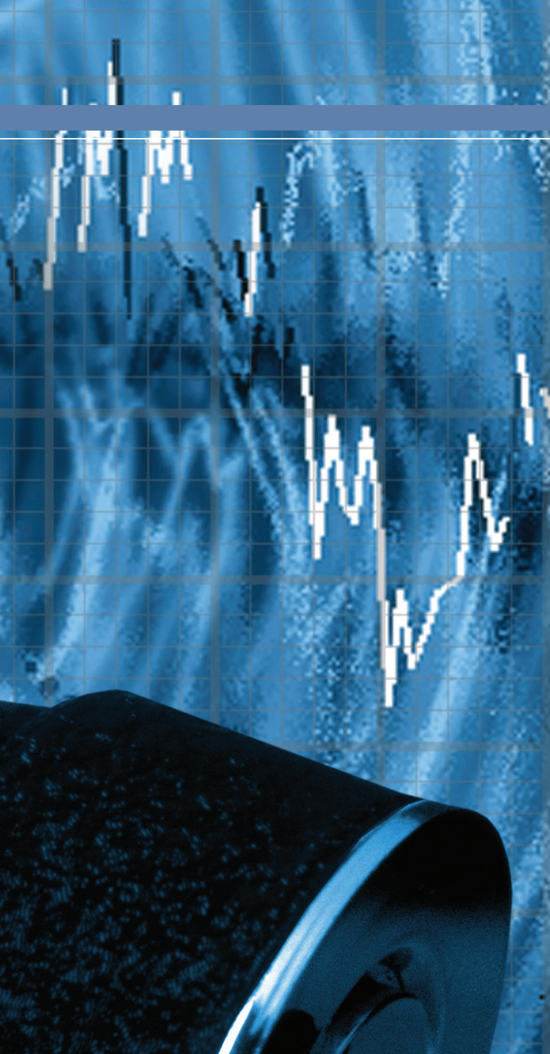

aldson, eds., *To Err Is Human: Building a Safer Health System*, Wash., DC: Nat'l Acad. Press, 2000.

However, costs continue to rise. Therefore, the new paradigm is to try to continue to pursue containment, but to ensure that quality is enhanced, not sacrificed.

The New Paradigm: Patient-Centric/Consumer-Oriented Care to Promote Quality

Today's buzz words are "consumer-oriented"/"patient-centric" care. The big question for this new approach is, "What does the consumer want?" The question seems simplistic, however, since health care providers were supposed to know what patients want ever since they started caring for patients. Further, "consumers" include employers and governments, which are still concerned about cost. Further, quality is linked with standardization of care, efficiency, and other criteria.

Packaging Consumerism: Pay for Performance

One approach towards promoting consumerism is called Pay for Performance ("P4P"). Providers have always supposed to have been compensated for performance. So, what is new or different? One might think that it really means improved performance, or higher quality. In some cases, it probably has this meaning. However, where operated by health insurance plans, and governmental agencies seeking to promote all-encompassing health care reform, "quality" includes multiple goals, *i.e.*, safety, efficiency, standardization, and cost-containment, which may conflict with each other. Consequently, pay for performance has become a controversial approach towards health care, raising the same confusion, suspicion, and concerns that managed care has raised in the past. Similarly, it is difficult to know exactly what the term quality entails. It is not clear whether it is really a new paradigm, or simply a new marketing term.

Traditional Ways of Evaluating Quality Care

To understand how P4P has affected the definition of "quality," it is helpful to understand how quality care has traditionally been defined. Quality has been evaluated in different arenas, by different groups and with different criteria. Patients judge physicians as to whether they are compassionate, gentle, prompt, and give patients good news. In courtrooms, juries evaluate whether care was reasonable under the circumstances of the case, as defined by medical experts. Jurors also apply subjective criteria, *e.g.*, are doctors nice, intelligent, kind and thoughtful. Medical care is also judged by physicians in different settings. Younger physicians are judged by basic skills, such as eliciting medical histories, performing physical exams, the propriety of testing, consideration of probable diagnoses, knowledge of the anatomy and physiology, and the propriety of treatment. Medical care is judged by providers in hospital peer review settings. Similar criteria are used, with the added component of effectiveness in interacting and communicating with other members of the health care team. Physicians are also judged by their colleagues in regulatory settings, which may apply a more fundamental standard—*i.e.*, risk to the public. Physicians are also judged by their colleagues for their research or teaching skills

The traditional basis for judging care has been training, experience, medical books and articles, and the rationale for treatment. Treatment could vary in terms of quality and cost, but still be deemed reasonable.

In a sense, quality was tantamount to competence and reasonableness.

Clinical Care Guidelines and Standardization of Practice Patterns

An early development that tried to address the cost of care without adversely affecting the quality of care was assessing whether there were unnecessary and costly variations in care. Consequently, there has been an attempt to promote a coherent, cost-effective approach to care by determining which practice patterns optimized care and optimized cost-effectiveness. These resulted in clinical care guidelines. As stated by L. Gregory Pawlson, MD, Sarah Hudson Scholle, Dr PH, and Anne Powers, PhD, in the *American Journal of Managed Care*, (Oct 2007):

> The use of clinical performance measures for public reporting and accountability has grown rapidly in the last decade. Spurred on by the Institute of Medicine (IOM) report, "Crossing the Quality Chasm," and further accelerated by programs in public and private sectors, use of clinical performance measurement has reached a broad audience. These efforts have increased attention on clinical performance measurement both in the hospital sector and with physicians through the implementation of the Physician Quality Reporting Initiative (PARI).

See http://www.ajmc.com/Article.cfm?Menu=1&ID=3384.

Clinical care guidelines have been spurred primarily by Agency for Health Care Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research), the research arm of the U.S. Department of Health and Human Services. Issuing periodic National Health Care Quality Reports, the AHRQ's mission is to "identify the most effective ways to organize, manage, finance, and deliver high-quality care, reduce medical errors, and improve patient safety." *See* www.ahrq.gov. Medical societies, of course, are also involved in publishing guidelines based in part on evidence-based medicine, and also

based upon a consensus of experts. These guidelines have been supplemented by those from many other sources, including medical specialty groups like the American Academy of Physicians and the American College of Obstetrics and Gynecology.

A significant feature of guidelines is that they are advisory, not mandatory. They are supposed to inform treatment, not restrict it. Medical judgment and individualization of care were still supposed to prevail. Therefore, the test of "good" care was whether it was reasonable under the circumstances.

Part of the process of evaluating practice patterns was not only to determine what procedures were cost-effective, but also which ones led to better, safer outcomes.

Disease Management Regimens

Clinical care guidelines usually address specific aspects of treatment. Meanwhile, recommendations for management of specific diseases falls under the rubric of disease management.

Evaluating Care by Assessing Outcomes

Part of the process of evaluating practice patterns was not only to determine what procedures were cost-effective, but also which ones led to better, safer outcomes. Consequently, results matter. If one hospital has a higher infection rate than another, it implies that one of the hospitals has better infection control patterns. The ACRQ has also taken the lead in outcomes research in conjunction with their formulation of guidelines.

Evaluating Care by Adverse Outcomes

A related type of concern about "outcomes" involves an evaluation of the reasons for adverse outcomes, which raise heightened concerns that treatment leads to sub-standard results in particular cases. Many state health departments require that so called "sentinel" events be reported to them, and that investigations be conducted to determine the cause and preventive techniques. On February 12, 2008, the Department of Health and Human Services published proposed regulations under the Patient Safety and Quality Improvement Act (PSQIA) to establish a framework by which hospitals, doctors, and other health care providers may voluntarily report information to Patient Safety Organizations (PSOs), on a privileged and confidential basis, for analysis of patient safety events.

"Never Events"

Another type of P4P plan, promoted by the Center for Medicare and Medicaid Services (CMS) is a bit of a euphemism. It involves non-payment for bad results, described as "never events," on the theory that they should never happen.

Evaluating Care by Achievement of "Excellent" Outcomes

Another approach to evaluating care has been to determine which methods lead to "excellent" outcomes. Consequently, there are so-called "centers of excellence" that seek to promote practice patterns that purportedly yield not only good results, but results that are superior. However, the concept of "excellence" is not clear. Once again, it may include good results that are "very" cost effective, or possibly shorter recovery periods or more cost-effective care, or a combination of these factors.

Efficiency and Quality Care

There are several major economic criteria for evaluating and paying for health care, including efficiency, cost to consumers, and income to providers. Each subject is complex. Only some highlights will be addressed here.

Reimbursement, *i.e.*, the amount providers are compensated, is determined by diagnostic and treatment codes that try to standardize payment based upon various criteria, including customary billing and the complexity of treatment.

Efficiency is usually described in terms of utilization review. The central goal is to ensure that care is provided as efficiently as possible, and whether resources used are truly necessary. For example, longer hospital stays were associated with better care and more concern about patients. However, this became viewed as over-utilization, and much "in-patient" care has been replaced by out-patient or ambulatory care.

Cost-Containment Component of Quality Care

Another component of "quality care," broadly defined, is whether the practice patterns reduced costs while still achieving good outcomes. Just as care could be rated as "excellent" in terms of quality, care has also been evaluated in terms of whether it was more cost-effective than other practice patterns.

Organizations Promoting P4P Plans

Because health care is such big business, there is no shortage of organizations involved in this work and no shortage of variations in these plans and the way they are implemented. Some organizations are public, some are private but non-profit, and some are private and for profit. Some purport to be consortiums of diverse stakeholders. A leading private, not-for-profit organization is the National Central for Quality Assurance (NCQA), which accredits and certifies health care organizations. The NCQA has devised extensive performance management tools, referred to as Health care Effectiveness Data and Information Set (HEDIS®). The NCQA also seeks to evaluate how well health plans measure and report the quality and cost of physicians and hospitals, through its Physician and Hospital Quality Program. The National Quality Forum (NQF) is a private, not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

A prominent consortium of purportedly diverse "stakeholders," *i.e.*, employers, providers, and "industry experts," is Bridges to Excellence, which describes itself on its website as follows:

> Bridges to Excellence is a not-for-profit organization developed by employers, physicians, health care services, researchers, and other industry experts with a mission to create significant leaps

> in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients and deliver safe, timely, effective, efficient, equitable and patient-centered care.

See www.bridgestoexcellence.org.

Another consortium is The Leapfrog Group, which describes its goals as follows:

> The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information [and rewards] hospitals that have a proven record of high quality care.

See www.leapfroggroup.org.

Types of P4P Plans

There are several different models for P4P plans. One model is a so-called tiering or ranking program. Another type is a bonus plan where physicians are presumably rewarded for meeting specified clinical standards. A third type involves non-payment for failing to meet specified criteria.

Ultimately, all plans have ranking systems whereby providers are evaluated and rewarded based upon not only quality and safety, but also cost. As stated in "Payer Trend: 'Tiering' Physicians and 'Steering' Patients," by Trevor J. Stone and Drew Sullivan, in *Family Practice Management*, (Nov/Dec. 2007), (American Academy of Family Physicians):

> Health insurers' practice of rating physicians' performance based on the cost and quality of the care they provide, often referred to as "physician profiling" or "economic credentialing," is nothing new. In the past, payers used the practice to justify terminating high-cost physicians from their networks. More recently, payers have used computer programs to analyze physicians' claims data and assess both the quality of their performance and their cost-efficiency relative to their peers.

Plans also place a high priority on efficient operation, which may be antithetical to accurate measurement of care. Thus, many plans use of claims data may not fairly reflect treatment actually rendered or the rationale for treatment. They also use clinical care guidelines, but in contrast to guidelines that are discretionary, P4P guidelines are mandatory in the sense that failure to comply with guidelines may be viewed as a departure from the requisite standard of care, regardless of the patient's actual needs.

Finally, in trying to accomplish all these goals, the plans are extremely complex. There is often limited opportunity for providers and patients to understand how different plans work, how the goals are weighted, and how providers are actually rewarded for performance.

Tiering, Ranking, Profiling and Economic Credentialing

Although all plans involve some type of ranking, some plans are explicitly described as tiering, ranking, profiling or economic credentialing. As stated in "Payer Trend: 'Tiering' Physicians and 'Steering' Patients,"

> A growing number of payers are also using the data to guide the development of "tiered networks" that encourage patients to choose selected providers. Payers use their cost and quality ratings to divide physicians into two or more groups ("tiering") and make the ratings apparent to patients, for example, by putting a star next to the names of the "better doctors" in their plan directories. "Steering"—offering patients lower co-payments or co-insurance percentages for office visits with "high-performing" physicians—is an emerging strategy that health plans have not commonly applied to their primary care networks.

Trevor J. Stone and Drew Sullivan, in *Family Practice Management*, American Academy of Family Physicians (Nov/Dec. 2007).

Tiering plans can adversely impact physician income insofar as insurers publicize the rankings and steer patients towards a certain group of physicians, with smaller deductibles or publicized ratings. Thus, "good" doctors may be penalized by the diminution of their practice, for not meeting cost guidelines.

Bonus Plans

Another type of plan provides rewards for meeting specified criteria. They are different from tiering insofar as they don't steer patients away from "inefficient" physicians to more "cost effective" physicians. However, bonus plans are similar to tiering plans insofar as physicians who provide quality care are nevertheless deprived of compensation to which they are entitled by virtue of that care if they do not meet all the criteria—including economic criteria—of the plans. Therefore, the emphasis may be placed on economic constraints, not promoting quality care. Measurements are also likely to be inaccurate because they use claims data and guidelines reflexively, without regard to the true quality of care. The plans are therefore deceptive in the sense that they promise to reward "quality" care, but really reward and may overemphasize cost constraints.

Issues Raised by P4P Plans

Promising to Do It All: Quality, Safety, Efficiency and Cost

Trying to legitimately balance quality, safety, efficiency and cost may be the impossible dream. Simply defining quality is difficult. Quality may be antithetical to cost-containment. The more time spent with patients, the costlier the care. The more tests that are performed, the costlier the care. Consider the Bridges to Excellence mission statement: to coordinate assessments by groups with highly diverse interests, including *"employers, physicians, health care services, researchers, and other industry experts"* to create significant "leaps in the quality of care" by "recognizing and rewarding" health care providers who demonstrate that they have implemented *"comprehensive solutions in the management of patients"* and deliver *"safe, timely, effective, efficient, equitable and patient-centered care."* The mission, in short, is to create an ideal world that purports to ignore inherent conflicts in health care.

Further, the implication of P4P plans is that "reasonable care" is not "quality" care. It implies that reasonable includes poor care, quality care, and something in the middle. "Reasonable care" was traditionally the gold—or at least legal—standard in court, because it takes into account different criteria and the need for individualization. P4P plans use "guidelines" but they use them differently than the way they are supposed to be used. Good guide-

lines should articulate criteria for consideration, not supplant individualization of care. However, for P4P plans the measure of quality may be the guidelines themselves, not patient needs. Thus, P4P quality care creates a conflict between legal standards and reimbursement standards and, at the very least, creates cacophony and confusion, rather than clarity.

All plans have ranking systems whereby providers are evaluated and rewarded based upon not only quality and safety, but also cost.

Apart from the traditional legal standard of reasonable care, the idea that physicians need a bonus as an incentive to "perform" as physicians, seems incongruous. What does it say about physicians who are not eligible for bonuses, that they are "non-performing," like a financial asset that fails to appreciate?

According to a study published in the November 2007 *Journal of Health Care for the Poor and Underserved:* as described in an article in the American Academy of Family Physician's *News Now*:

> Pay-for-performance, or P4P, programs, as currently constructed, may not always result in healthier patients. So says Katie Coleman, M.S.P.H., lead author of a recently published study that examined a performance-based compensation system for providers at a network of federally qualified health centers located in under-served communities throughout Chicago and surrounding suburbs.
>
> Although P4P programs hold promise, they certainly are not the "cure-all" for what ails the American health care system, said Coleman in an interview.... Coleman said findings from the study, "The Impact of Pay-for-Performance on Diabetes Care in a Large Network of Community Health Centers," were broadly consistent with those from other current literature—namely, that in cases where a P4P program is aimed at a chronic condition, physicians "process measures improve, and outcome measures often don't."

Noting that physician incentives alone are not enough to effect necessary changes to improve patient care, Ms. Coleman said:

> "The shame is that P4P has been heralded as the silver bullet that will solve all of our health system woes... but it 'takes two to tango.'" The other piece of any good quality improvement initiative—and the direction in which health care policy-makers need to refocus their efforts—is a system "where the patient has to take control and is empowered to manage the illness, especially in the case of a chronic disease that lasts several years, a decade or even a lifetime."

The study recommends that " paying physicians to deliver high-quality care on a per-test basis helped the low-performers to improve, and it also rewarded the high-achievers," because "there's been a lot of debate in P4P circles that if you set a threshold where you're only going to pay out a bonus if 85 percent of a physician's panel gets a certain test, then it only incentivizes the people who are already pretty high-performing," and leaves out the people that really need help at the bottom of the spectrum. *See* Sheri Porter, *Meeting Quality Measures Doesn't Necessarily Improve Outcomes*, American Academy of Family Physicians, *News Now*, American Academy of Family Physicians, November 21, 2007.

The Minnesota Medical Association also issued a report complaining about the purported quality measurements. It stated that "insurers don't take into account different patient populations, effectively penalizing doctors who treat sicker, poorer patients," according to Dr. David Luehr, who chairs the MMA's quality committee. *Minneapolis Star Tribune* (11/19/08, Chen); Minneapolis-St. Paul Business Journal (11/20/08, Orrick).

Ranking Providers and Compensating Them by Their Rankings

All plans that treat providers differently necessarily rank providers, and there is an economic component to ranking. A "good" provider in the eyes of health insurance plans is one who meets the plan's criteria. In "tiering" or "ranking" plans, this may result in encouraging patients to see so-called higher performers. Even in bonus plans, some providers receive bonuses if they meet the plan's objective, based upon the plan's measurements, and some providers do not, even where quality care is provided. In many cases, moreover, the criteria for the rankings may be either unclear or based upon criteria that do not really reward quality care.

Determining How Providers Are Evaluated

Apart from not knowing what the major priorities are, another factor complicating P4P plans is that it is often difficult to determine how providers are rewarded. However, because these plans try to achieve so many different goals, and because the goals are likely to be conflicting, provider rankings may be obscured in a statistical morass. These criteria may also be used to conceal from patients and their employers, the true priorities of such plans. Patients and employers may perceive the plans as promoting quality, but the plans may really emphasize cost-containment, or they may have inadequate measures of care.

Use of Over-Simplified Data That Does Not Accurately Reflect Quality Care

Different data can be used to evaluate health care. In medical peer review assessments, data usually includes clinical records. In courtrooms, clinical records are supplemented by testimony of providers and non-treating experts. This process can take weeks—after months of pre-trial discovery and depositions. Insurance companies traditionally use claims data on standardized claims forms that list diagnostic codes and treatment codes. In contrast to the data used in other settings, claims data is sparse and does not fully explain the nature of the care or the rationale for treatment.

Accurately comparing care rendered to care that should be rendered is another problem. In court, it may take weeks to evaluate medical care after years of pre-trial discovery. Health insurers, meanwhile, have to evaluate thousands of interactions. To do this as efficiently as possible, they rely upon the data they are accustomed to receiving and capable of processing, namely, claims data, which is also referred to as administrative data. However, claims forms, with diagnostic and treatment codes, do not

accurately reflect all the significant reasons why treatment was or was not rendered. A patient with a sore throat may not receive a throat culture for various medical reasons not stated on the claim form. If there is a rule that sore throats generally require throat cultures, and there is no claim for a throat culture, the provider may be penalized for "failing" to provide treatment that, in fact, was not indicated. As stated in "Comparison of Administrative-only Versus Administrative Plus Chart Review Data for Reporting HEDIS Hybrid Measures," by L. Gregory Pawlson, MD; Sarah Hudson Scholle, DrPH; and Anne Powers, PhD, in the *American Journal of Managed Care*, vol 13, #10, p. 553 (Oct 2007):

> These efforts assume that measurement of clinical performance at the medical group or physician level will be sufficiently accurate to allow ranking or tiering. At the level of physician ambulatory care practice, there are 3 main sources of data for performance measurement: patient surveys, medical charts, and electronic data commonly referred to as administrative data. (The term "administrative" should, strictly speaking, only be used to refer to data, such as claims or demographic information, which is used for administration purposes. However, current usage of the term often includes data that are clinical, such as laboratory results. We will use the term "electronic data" to include both broadly defined administrative data, as well as data flowing directly from electronic medical records.) While valuable in their own right, surveys of patient experiences of care are relatively expensive and difficult to administer and are not sufficient to address the technical quality of clinician performance.

The conclusion in Dr. Pawlson's study is that "administrative data alone do not appear to provide sufficiently complete results for ranking health plans on HEDIS quality-of-care measures with hybrid specifications." The results suggest that "reporting of clinical performance measures using administrative data alone should include prior testing and reporting on the completeness of data, relative rates, and changes in rankings compared with the use of combined administrative data and chart review."

Gregory Pepe, Counsel to the Connecticut State Medical Society, described problems of P4P data measurement by saying, "…the data collected by health insurance companies is not reliable for the assessment of quality or efficiency." He also stated:

> First and foremost, data collected by health insurance companies is almost always collected [in furtherance] of the administration of the plan. That is, the principal objectives are to determine the eligibility of a patient to receive certain health care services, and to determine the proper payment for those services. As a result, the data is received by the health insurance companies in formats that are not always geared to an assessment of quality and efficiency, because it is almost always uncoupled from the clinical information that makes the data relevant.
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> …
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> Second, the data collected by health insurance companies is woefully inaccurate. An IPA that our firm represents tells of a health plan that had 100 patients assigned to an IPA physician member who had been dead for 6 years. Physicians routinely have patients attributed to them who have never been seen by the physician.

Action, published by Connecticut State Medical Society, (Feb 2008, p. 11).

Administrative Burdens

P4P also enhance already substantial administrative (paper-work) demands upon providers in verifying compliance with P4P requirements and explaining reasons for deviating from these requirements. Disputes can also produce administrative hearings or litigation. The Minnesota Medical Association ("MMA") issued a report complaining about different criteria used by different plans which tie physician performance to bonuses and rankings, and complains that they "create a heavy administrative burden" and do not "reward doctors for investing in information technology and for coordinating care for those with chronic disease." Another concern is that pay-for-performance programs that health insurers say help raise medical quality levels also create confusion and unnecessary administrative work for providers," according to the report. One complaint by the MMA is that "the nine pay-for-performance programs used by Minnesota Patient Rights/Quality of Care insurers each have subtle differences and often measure performance differently." Minneapolis Star Tribune (11/19/08, Chen); Minneapolis-St. Paul Business Journal (11/20/08, Orrick).

Lack of Contractual Remedies

The typical remedy where someone's rights are at stake is to negotiate them and crystallize them in a contract. However, payors are likely to have a one-size-fits-all take-it-or-leave-it contract, giving providers little room to negotiate.

Lack of Meaningful Procedures for Enforcement of Rights

Providers and patients alike may also lack effective means of enforcing their rights. Some insurers may try to squelch criticism and dissent by creating "internal" appeals processes of decisions, where they are judge and jury and can impose their views. If patients or providers try to seek external review, some insurers may seek to limit discovery of important information, claiming that the insurer's procedures are proprietary and not discoverable.

Proposals to Enhance Transparency and Integrity of P4P Plans

The New York Attorney General

The New York Attorney General targeted tiering plans promoted by United Health Care, Aetna and Empire Blue Cross. The attorney general and the insurers negotiated agreements that sought to address problems by enhancing transparency and promoting fairness in evaluating physicians. They "reform" doctor ranking programs by "compelling insurers to fully disclose to consumers and physicians all aspects of their ranking system." A November 13, 2007, press release by the AG's office states that insurers must retain an oversight monitor, known as a Ratings Examiner ("Rx"), to oversee compliance with all aspects of the agreement and report to the attorney general every six months. Insurers must also ensure that rankings for doctors are not based solely on cost and clearly identify the degree to which any ranking is based on cost. They will use established national standards to measure quality and cost efficiency, including measures endorsed by the National Quality Forum (NQF) and other generally accepted national standards. They will also employ

several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling. They will disclose to physicians how rankings are designed, and provide a process to appeal disputed ratings.

The American Medical Association

Recognizing the pitfalls—as well as the promise—of P4P plans, the American Medical Association has issued guidelines for evaluations, including criteria for methodology, accuracy, and transparency. At its June 2005 annual meeting, the AMA House of Delegates amended and approved the AMA Principles and Guidelines for the formation and implementation of pay-for-performance programs. The AMA promises that, "as the pay-for-performance concept becomes more commonplace, the physician community will work to ensure pay-for-performance programs are positively structured and appropriately applied." The AMA believes pay-for-performance programs must be aligned with the following five principles:

- Ensure quality of care
- Foster the relationship between patient and physician
- Offer voluntary physician participation
- Use accurate data and fair reporting
- Provide fair and equitable program incentives

The AMA also issued a white paper acknowledging that health insurers and employer groups "continue to search for new schemes that will help temper increasing health care costs." and describe pay for performance plans as "the latest rage." The AMA recognizes that these programs have the potential to have a positive impact on improving quality of care but, when applied with minimal regard to health care quality and patient safety, also can be disruptive to the patient/physician relationship and cause overall quality to suffer. *See* www.ama-assn.org/ama/pub/category/14416.html.

While the AMA guidelines are noble, however, they are not mandatory and do not require an independent audit to ensure compliance with these goals.

The Consumer Disclosure Project and the Patient Charter

The Consumer Disclosure Project is an informal coalition of multiple organizations, including employers, health care plans, and medical organizations, designed to improve implementation of health care plans, including pay for performance plans, with enhanced disclosure. Its mission statement states that "measurement and public reporting are powerful mechanisms to drive quality and efficiency improvement throughout the health care system." *See* www.healthcaredisclosure.org. Therefore, "purchasers and consumers have embraced a vision of a transparent health care market, in which decision-making is supported by publicly reported comparative information." The organization has developed a Patient Charter to promote "transparency" and achieve an agreement on principles to guide physician performance reporting. The goal is to enable consumers to make more informed decisions based on quality and cost, with adequate guidance about how to use the information, and to promote measurement based upon "sound national standards and methodology."

Conclusions about the Changing Definition of the Standard of Care and Its Impact on Patients and Providers

- Some people believe that the American health care system needs a major overhaul. Whether or not that will happen, there are evolving systems which affect the evaluation of health care. Even achieving the diverse goals described above may be noble but not workable. It is therefore important to prioritize goals.
- The mechanisms by which physicians are evaluated are complex and changing. They must be clearly articulated. Insofar as health insurance is marketed to the public, and health delivery is provided by physicians, evaluation criteria cannot be unduly complicated or hidden under the guise of proprietary information. Some insurers may be inclined to forgo clear articulation of such important information, taking an opportunity to promise "quality," but actually to promote cost-containment. The goal of information sharing is often described as "transparency." However, simply flooding people—with diverse backgrounds—with information, is not sufficient. Transparency must be coupled with clarity.
- The current definitions of "quality" care and "performance" as defined by health insurance plans and the other groups involved in this work, are likely to create rigid guidelines by which physicians are judged and these standards are likely to permeate medical liability cases and regulatory investigations and change the traditional meaning of "the standard of care."
- Meanwhile, the pursuit of standardization appears to be antithetical to the need for individualization of patient care. In that regard, it is not really patient-centric. Further, the traditional definition of "reasonable care," does not include concern about efficiency and cost. New definitions of quality care and "performance" make these more significant criteria for evaluating health care providers.
- There should be consistent methods for evaluating physicians. It does not seem fair to judge the quality of health care one way in court, another way in regulatory proceedings, and yet another way by health insurers. Further, data used to evaluate health care should be accurate. Health insurers use claims data that is too often inadequate and incorrect. As electronic medical records become more common, accurate evaluation should be easier.
- There should be an independent review of health insurance plans which define and reward "quality," to ensure that the insurer's definition of quality conforms to the public definitions of quality. It is true that health insurers, as any businesses, need to be responsive to their constituencies. However, it is not clear whether the constituencies they want to heed are the employers who want to save costs, or the patients seeking quality healthcare
- Finally, it is important to remember that many of the changes described above, like clinical care guidelines, have been implemented. However, there is still concern about lack of "quality" care and "increased costs." Health care reforms need to be approached with a sense of humility and hope, rather than certainty that they will provide a panacea to the many problems that afflict our health care delivery system. FTD