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Payment for Quality: Guiding Principles and Recommendations

Principles and Recommendations From the American Heart Association's Reimbursement, Coverage, and Access Policy Development Workgroup

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Abstract— Payment-for-quality programs are emerging in the wake of rising healthcare costs and a demonstrated need for quality improvement in healthcare delivery in the United States. These programs, also known as “pay-for-performance” or “pay-for-value” programs, attempt to realign financial incentives with the quality of care delivered. The American Heart Association’s Reimbursement, Coverage, and Access Policy Development Workgroup provides in this statement a set of principles and recommendations for the development, implementation, and evaluation of these programs. The statement also suggests future areas for research around the realignment of financial incentives to improve both the quality of care delivered and patient outcomes. (*Circulation*. 2006;113:1151-1154.)

Key Words: AHA Scientific Statements ■ patients ■ quality of health care ■ delivery of health care
■ payment for health care

The American Heart Association (AHA) and its division, the American Stroke Association (ASA), are dedicated to improving the quality of care available to patients suffering from or at risk of cardiovascular diseases, including stroke. Heart disease, stroke, and other cardiovascular diseases remain the No. 1 causes of death in the United States and are the leading causes of permanent disability.¹ Approximately 70 million Americans suffer from some form of these cardiovascular diseases.¹ In 2005, cardiovascular diseases cost the United States an estimated \$394 billion in medical expenses and lost productivity.¹ The AHA is committed to reducing this disease burden by improving the quality of care delivered in the United States and ensuring that this care is patient centered, is of the highest quality, and ultimately improves patient outcomes.

Payment-for-quality, also known as pay-for-performance, programs are growing in response to variations in the quality of health care and rising healthcare costs. This movement in both the private and public sectors attempts to realign payment for care with the quality of the care delivered.

Current payment policies are not effectively structured to reward improvements in the quality of care. Payment-for-quality programs take many forms, such as bonuses to physicians for satisfying certain performance measurements or incentives to physician groups for implementing health information technology, or, conversely, can include financial disincentives for not meeting quality benchmarks. Payment-for-quality programs have been rapidly implemented despite limited evidence about the effectiveness of this strategy to best benefit patients.

The 2001 Institute of Medicine report, *Crossing the Quality Chasm*, suggested 6 dimensions of health care for which improvement is needed to better meet patient needs. The Institute of Medicine proposed that health care be safe, effective, patient centered, timely, efficient, and equitable.² As such, payment-for-quality programs should strive to properly align financial incentives to improve these dimensions of health care. The goal of any payment-for-quality program should be to reduce the burden of disease on patients.

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Payment-for-quality programs should be examined thoroughly and should include evaluation mechanisms before they can be determined to be a good solution to the dual problems of rising healthcare expenditures and inadequate quality of healthcare delivery. Several aspects of payment-for-quality are not well understood, including whether the use of these programs improves patient outcomes. A wide range of potential negative consequences of payment-for-quality programs also should be investigated—for example, the increased administrative burden that physicians may face and the concern that payment-for-quality programs may drive physicians away from the practice of medicine. Payment-for-quality programs should not worsen health or healthcare delivery disparities, such as those across economic, educational, racial/ethnic, or geographic lines. It is important for any payment-for-quality program to include mechanisms for evaluating the program's outcomes, both intended and unintended.

Measurement of quality is best accomplished through the analysis of clinical data as opposed to administrative or claims data. Payment-for-quality programs should strongly encourage providers to obtain clinical data; one of the ways this can be done is through the adoption of health information technology. However, some settings may lack the infrastructure for data collection, and administrative data may be the only data available. If administrative data are used, then these measures should be validated against higher-quality clinically derived data. Payment-for-quality programs should invest in the infrastructure necessary to obtain clinical data on all patients and should balance incentives for the development of infrastructure and data collection against incentives for quality-of-care measures.

Recognizing that payment-for-quality programs are being widely explored and implemented but acknowledging the insufficient data supporting the effectiveness of payment-for-quality programs, the AHA recommends the following 4 principles to guide the use of payment-for-quality programs.

Principles

1. Promote health care that is safe, effective, patient centered, timely, efficient, and equitable. Payment-for-quality programs should be designed, implemented, and evaluated to ensure that financial incentives are aligned with the delivery of high-quality care that is in the best interests of all patients. Quality-of-care measures should be updated in a timely manner. Programs should be reevaluated periodically and be responsive to changes in evidence-based research, including consensus-based treatment guidelines. Payment-for-quality programs should be coordinated with the demands of the marketplace to provide incentives that are aligned with the cost of providing improved care for the maximum number of patients.
2. Use rigorous methodological approaches to measure quality of care. Quality-of-care measures should be risk adjusted, standardized, and evidence based. Rigorous methods should be used to measure quality, and these methods should include defining data standards and providing for consistency of measures. Quality measures should be based on clinical data to the greatest extent

possible. If administrative data are used, then quality measures should be validated against higher-quality clinically derived data. Use of the highest-quality methodological approaches will minimize the likelihood of misrepresentation of quality. The alignment of incentives with these measures should be transparent. The AHA is committed to the science of quality improvement, including evidence-based clinical practice guidelines,^{3–6} data standards,^{7,8} performance measures,^{9,10} and methodological standards for developing all of these.^{11–14}

3. Promote quality-of-care systems and quality infrastructure. Financial incentives should be aligned to support systems-focused healthcare delivery. Programs should encourage the coordination of care across specialties, providers, and facilities. Incentives for implementation and maintenance of health information technology should be explored, so that at a minimum physicians and hospitals can comply with reporting requirements. At the same time, payment-for-quality programs should address the burden of documentation on the healthcare delivery system and base levels of increased compensation on the costs of the development and operation of new systems. Payment-for-quality programs should balance incentives for developing infrastructure and data collection against incentives for developing and maintaining quality-of-care measures.
4. Implement evaluation mechanisms. Payment-for-quality programs should include evaluation mechanisms that determine whether program goals are achieved or whether inadvertent adverse consequences result. Monitoring of the program is needed to build an evidence base for payment-for-quality program outcomes. Evaluation is also necessary to ensure that payment-for-quality programs do not increase disparities (eg, racial/ethnic, socioeconomic, regional) in health care and do not have unintended consequences either at the patient (eg, impact on populations such as older persons with multiple comorbidities) or provider (eg, administrative burden placed on physicians and hospitals) level.

Research Needs

The AHA encourages additional research into the realignment of financial incentives to improve quality of care. New evidence may indicate how payment-for-quality programs could guide quality improvements in health systems as well as patient outcomes. At this time, data are insufficient to demonstrate the effectiveness of payment-for-quality programs to improve the quality of health care or patient outcomes. Much research is still needed to understand the benefits and risks of payment-for-quality programs. Examples of potential research needs include but are not limited to the following:

1. longitudinal evaluations of patient outcomes from payment-for-quality programs,
2. longitudinal cost-effectiveness studies of payment-for-quality programs,
3. analyses of the effectiveness of providing financial and nonfinancial incentives to patients to improve quality,
4. determination of the actual costs of system redesign and

- operation needed to improve quality,
- 5. evaluation of optimal systems for recording processes of care and outcomes to ensure quality, and
- 6. comparison of payment-for-quality with other approaches to quality improvement, such as point-of-care decision

support and multifaceted quality interventions such as collaborative care models.

This statement will be revised and updated as additional data on the effectiveness of payment-for-quality incentives become available.

Writing Group Disclosures

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This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit.

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Correction

We would like to acknowledge the authorship of J. Sandy Schwartz, MD, with regard to the AHA Policy Recommendation, “Payment for Quality: Guiding Principles and Recommendations: Principles and Recommendations From the American Heart Association’s Reimbursement, Coverage, and Access Policy Development Workgroup,” which appeared in the February 28, 2006, issue of the journal (*Circulation*. 2006;113:1151–1154). His name was mistakenly omitted from the print and electronic versions of this article.

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