

Commonly Used P4P Definitions

Ambulatory Care - all types of health services provided to patients who are not hospital inpatients at the time service is rendered. Ambulatory care services are provided in many settings, including physician offices, ambulatory surgery centers, independent diagnostic testing facilities and cardiac catheterization centers. (Health Care Quality Glossary, AHRQ)

Ambulatory Care Quality Alliance - the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America's Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), joined together in 1994 to create a collaborative effort for determining, under the most expedient timeframe, how to most effectively and efficiently improve performance measurement, data aggregation and reporting in the ambulatory care setting. The AQA focuses exclusively on implementation issues surrounding measure already developed and endorsed by other organizations. The AQA does not develop measures.

Best Practices Study – an examination of the methods by which optimal clinical outcomes are achieved. (Health Care Quality Glossary, AHRQ)

Clinical Performance Measure – indicates whether or how often a process of care or outcome of care occurs. Clinical performance measures are not clinical guidelines; rather, they are derived from clinical guidelines. (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

Clinical Performance Measure Set – a collection of one or more measures that focuses on a condition or type of care or service. When all the measures of a clinical performance measure set are intended to be used together, they are referred to as a “core” physician performance measurement set. (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

Clinical Performance Measurement – the quantitative assessment of healthcare processes and outcomes for which an individual physician may be accountable.

Clinical Practice Guidelines – standardized specification for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion. Practice guidelines are often developed by medical specialty societies and are essential for performance measure development. Also referred to as: algorithms; clinical criteria; clinical protocols; parameters; preferred practice patterns; protocols; and review criteria. (Health Care Quality Glossary, AHRQ)

Comparison – Using performance measurement information to compare one healthcare provider to another. In order for measures to be valid for purposes of comparison, they require: 1) measures that are precisely defined and uniformly implemented as to their data elements, data element definitions and algorithms for calculations; 2) effective methods for addressing the

impact on measured performance of factors that the individuals or entities being measured cannot reasonably be expected to influence, including risk adjustment or stratification for differences in patients' comorbidities or severity of illness. All physician measures developed by the Physician Consortium are NOT valid for comparison purposes. (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

Data Collection – the process of gathering the information necessary to determine whether a performance measure applies and has been met. The process of getting the necessary information from a patient medical record to the administrator of a pay-for-performance program must comply with the laws of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The process is also referred to as “data abstraction” or “data extraction.”

Efficiency – a performance dimension addressing the relationship between the outputs (results of the care/intervention) and the resources used to deliver the care/intervention. (Health Care Quality Glossary, AHRQ)

Evidence-based measures – measures developed from evidence-based clinical guidelines, using standard processes. In developing guidelines, evidence is ranked by its level of reliability. Level 1 evidence obtained from properly randomized, controlled clinical trials. There are three subcategories in level II evidence including: 1) evidence obtained from well-designed controlled trials without randomization; 2) evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group; 3) evidence obtained from multiple time series with or without the intervention. Finally, level III evidence includes opinions or respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

Feedback – the manner in which the quality data that is collected will be presented to the physician. Feedback reports should provide the physician with information on performance for individual patients and across all eligible patients (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

HEDIS Measures – performance measures developed by the National Committee for Quality Assurance for the purpose comparing managed care health care plans by consumers and purchasers. HEDIS measures focus on access to care and cost. Some physician quality measures available today had their start as HEDIS measures. The letters HEDIS stand for Health Plan Employer Data and Informational Set.

Inappropriate – the expected health risks associated with an intervention exceed the expected health benefits by a clinically meaningful margin. (Health Care Quality Glossary, AHRQ)

National Quality Forum - a voluntary consensus standards setting organization that endorses standards including performance measures, quality indicators, preferred practices or reporting guidelines using a input from a variety of stakeholders, including payers, purchasers/employers and consumer groups. The NQF does not develop quality measures; instead it serves as an endorsing agency for measures developed by other groups, including the Physician Consortium. Under current law, if the NQF has endorsed measures and CMS is interested in implementing measures in that area, CMS must use the NQF measures. Membership in the NQF requires a substantial financial outlay. Because of the financial cost, less than 10 percent of NQF members are physician medical societies.

Objective – a measurable condition or level of achievement at each state of progression toward a goal; objective carry with them a relevant time frame within which the objectives should be met. (Health Care Quality Glossary, AHRQ)

Outcomes – the changes in the current or future health status of individuals or groups of persons that are attributable to previously provided medical care. Outcomes include mortality

and morbidity; physical, mental and social functioning; costs of care; and quality of life. (Health Care Quality Glossary, AHRQ)

Physician Consortium – A physician-led initiative administered by the American Medical Association that provides performance measurement tools to practicing physicians to facilitate quality improvement in patient care. One of the fundamental activities of the physician consortium is to identify and develop physician performance measures. Measures developed by the physician consortium are designed for continuous physician quality improvement, not physician comparison. All medical societies represented in the AMA House of Delegates are invited to become members of the consortium. All 13 member groups of the Alliance of Specialty Medicine are members of the physician consortium. (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

Pilot-Testing – organized trials of specific clinical measures by a small, representative group. Projects focus on 1) testing the reliability and validity of measures; b) demonstrating the feasibility of data collection from physician offices and other practice sites; c) evaluating the use of computer-based and web-based applications; d) increasing physician participation in practice-based research; or e) testing the feasibility of single data collection for physician, hospital, and health plan level analyses. Pilot-testing is an fundamental and essential part of measure development. (Introduction to Physician Performance Measurement Sets, Physician Consortium for Performance Improvement)

Process Measures – characteristics of the use of health services relative to need and the manner with which providers interact with patients providing care relative to some standard. (Health Care Quality Glossary, AHRQ)

Risk Adjustment – the use of severity of illness measures, such as age and other illnesses, to estimate the risk to which a patient is subject before receiving a health care intervention. The purposes of risk adjustments is to ensure that comparisons of performance measures across organization are fair and that observed differences are due to variation in provision of care rather than difference in patient populations served. (Health Care Quality Glossary, AHRQ)

Structural Measures – structure refers to the relatively stable characteristics of the providers of care, the tools and resources they have at their disposal, and of the physical and organizational settings in which they work. Structural measures assess the adequacy of the human, physical, and financial resources required to provide medical care. (Health Care Quality Glossary, AHRQ)