Transparency in Medical Group Practices
Physician Quality Performance Profiles
Issued June 28, 2006

Abstract
The Institute of Medicine’s (IOM’s) landmark 2001 report, “Crossing the Quality Chasm: A New Health Care System for the 21st Century,” declared that the fragmented health care system in the United States needs fundamental change. “Between the health care we have and the care we could have lies not just a gap, but a chasm,” said the highly influential IOM report. The IOM laid out a framework for moving toward an “environment that fosters and rewards improvement.” Among the suggested attributes for a revamped health care system is public disclosure of medical practices’ and individual physicians’ performance regarding quality, patient satisfaction and efficiency. This position paper sets forth MGMA policy on how medical group practices can best work with other stakeholders to make such performance information available to patients and others.

Background
Since 2001, a groundswell of public and payer support has pushed to make information on physician performance on measures of clinical quality, patient satisfaction and efficiency easily available to the public. Consumers have a legitimate interest in learning about the quality of care delivered in their community.

Clinical Performance Measures
Measures designed to assess the clinical performance of individual physicians and physician groups are developed and validated through existing organizations. The American Medical Association-convened Physician Consortium for Performance Improvement has developed (to date) more than 93 evidence-based performance measures on 16 clinical topics. The consortium brings together technical experts from multiple medical specialty societies to develop evidence-based clinical performance measures and ensure that their implementation can be consistent and accurate.

The consortium’s work is guided by the following principles:

- Measures must be based on medical evidence and represent substantial potential for improvement between current clinical practice and evidence-based optimal practice.
- Measures must be relevant to physicians and their patients, and accurate and consistently reproducible across health care organizations and clinical settings.
- Measures must be tested for validity. Each measure should include specifications that describe its intent and targeted population, definitions of sampling procedures, definitions of data elements and instructions for collecting data.
- The results of the measures should be risk-adjusted and easily interpreted by clinicians.
• Measures must be feasible to collect, adaptable to various settings and not impose unreasonable cost burdens on practices.

Performance measures from the consortium and other sources are considered for validation by the National Quality Forum (NQF), a private, nonprofit organization that Congress has charged with endorsing consensus-based national standards for measurement and public reporting of health care performance data. NQF-endorsed measures must provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient.

**Patient Satisfaction Measurement**
The Agency for Health Care Research and Quality has developed a series of patient satisfaction survey instruments, collectively called Consumer Assessment of Healthcare Providers and Systems. These surveys, designed to assess satisfaction with health plans, hospitals and medical groups, allow patients and consumers to evaluate their experiences with health care.

**Efficiency Measures**
The AQA (formerly the Ambulatory Care Quality Alliance) is working to develop a standard, statistically valid method to measure how a physician’s use of health care resources to treat a patient within an episode of care compares with expected average costs.

**MGMA Position**
MGMA supports quality improvement activities that focus on improving patient care, outcomes, satisfaction and the cost-effective use of resources.

Quality improvement programs that are initiated outside the medical practice (such as those conducted by health plans, accrediting bodies or public agencies) should comply with the following the guidelines:

• Before physician performance profiles on different domains of care are made public, medical practices and their administrators must be able to review all relevant data and make appropriate corrections.

• Measures used in such programs must be consistent across all organizations involved. To ensure consistency, only measures that have been created through the Physician Consortium for Performance Improvement and approved by the NQF should be deployed. Nothing will hamper quality improvement efforts more quickly than having multiple programs collecting and reporting different measures. The resultant chaos would force medical practices to focus on meeting competing administrative requirements rather than improving medical care.

• Medical practices must not be solely responsible for funding the costs associated with patient satisfaction surveys. Instead, all parties interested in using the resulting data should help defray the cost of statistically valid survey methods, which would otherwise be cost-prohibitive for most medical practices.

• Efficiency measurement must be restricted to areas where there is both information on the cost of care delivered (including pharmaceuticals, especially if prescription drugs represent the standard of care for the diagnosis) and information on performance of clinical care measures. Efficiency measurement should be limited to specific episodes of care and be risk-adjusted for each patient. Payers using efficiency
measurement should make their methodology and data sources easily accessible to physicians being measured, and to their administrators.

**Members of MGMA in their professional roles are encouraged to:**

- Implement or review internal quality improvement or benchmarking activities that incorporate clinical performance measures developed by the Physician Consortium and endorsed by NQF.

- Review physician performance profiles that are either submitted to the practice by third parties or compiled internally to ensure they are reliable and accurate.

- Use MGMA resources, such as the “Pay-for-Performance Toolkit,” to better understand the possible uses of information collected for physician profiles.

**For additional information related to this topic, please consult the following resources**

MGMA’s position paper “Principles for Pay-for-Performance Programs and Recommendations for Medical Group Practices”
[http://www.mgma.com/about/MGMApositions.cfm](http://www.mgma.com/about/MGMApositions.cfm)

AMA-convened Physician Consortium on Performance Improvement
[http://www.physicianconsortium.org](http://www.physicianconsortium.org)

Agency for Healthcare Research and Quality (AHRQ)
[https://www.cahps.ahrq.gov/content/cahpsOverview/OVER_Intro.asp](https://www.cahps.ahrq.gov/content/cahpsOverview/OVER_Intro.asp)

Institute of Medicine report “Crossing the Quality Chasm”
[http://www.iom.edu/CMS/8089/5432.aspx](http://www.iom.edu/CMS/8089/5432.aspx)

The Commonwealth Fund

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**About MGMA**

MGMA, founded in 1926, is the nation’s principal voice for medical group practice. MGMA’s nearly 20,000 members manage and lead more than 12,000 organizations in which more than 242,000 physicians practice. MGMA’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. MGMA headquarters are in Englewood, Colo.

For feedback or questions, please contact MGMA Communications Department at communications@mgma.com, 303.799.1111, ext. 871, or visit mgma.com.