

# Efficiency in Health Care: What Does it Mean? How is it Measured? How Can it be Used for Value-Based Purchasing?

## Highlights from a National Conference

Appendix A updated as of 11/06/06

---

*Co-sponsored by*  
The Agency for Healthcare Research and Quality and  
The Employer Health Care Alliance Cooperative (The Alliance)

*May 23-24, 2006  
Madison, Wisconsin*



*Prepared by*  
**AcademyHealth**



This report was prepared with support from  
the Agency for Healthcare Research and Quality  
Knowledge Transfer and Application Support Contract #290-04-0001

**Efficiency in Health Care:  
What Does it Mean? How is it Measured?  
How Can it be Used for Value Based Purchasing?**

**Highlights from A National Conference Co-sponsored by  
The Agency for Healthcare Research and Quality, and  
The Employer Health Care Alliance Cooperative (The Alliance)  
Madison, WI May 23-24, 2006**

**Table of Contents**

Table of Contents	Page ii
Conference Goals and Themes	Page 1
The Problem – Defining, Measuring and Achieving Efficiency	Page 2
Brief Overview of Presentations	Page 3
Diverse Stakeholder Views	Page 5
Measurement Challenges	Page 5
Issues for Further Discussion	Page 6
Research and Development Needs	Page 7
Conclusion	Page 9
Figure 1: A Typology of Efficiency	Page 10
Appendix A: Summary of Presentations	Page 11
Appendix B: Conference Overview and Agenda	Page 21

This report was prepared by AcademyHealth under AHRQ contract #290-04-0001. Liza Greenberg, R.N., M.P.H., of Health Policy Consulting, wrote the report under the direction of Daniel Campion at AcademyHealth. The views expressed are those of the conference participants and the author and do not necessarily represent the official views of the Agency for Healthcare Research and Quality, The Alliance, or AcademyHealth.

AcademyHealth wishes to thank all of the conference participants for sharing their ideas and perspectives. We are especially grateful to planning committee and core staff who worked on the project and helped prepare this summary report, including Irene Fraser, Jan De La Mare, Steve Seitz, John Bott, John Freedman, David Hopkins, Chris Queram, Enrique Martinez-Vidal, Liza Greenburg, and Daniel Ferranti.

For further information, contact any of the following organizations:

**U. S. Department of Health and Human Services**

Agency for Healthcare Research and Quality

540 Gaither Road, Rockville, MD 20850

Telephone: (301) 427-1350

Fax: (301) 427-1255

[www.ahrq.gov](http://www.ahrq.gov)

**The Employer Health Care Alliance Cooperative**

P.O. Box 44365, Madison, WI 53744-4365

Telephone: (608) 276-6620

Fax: (608) 276-6626

[www.alliancehealthcoop.com](http://www.alliancehealthcoop.com)

**AcademyHealth**

1801 K Street, NW, Suite 701-L

Washington, DC 20006

Telephone: 202.292.6700

Fax: 202.292.6800

[www.academyhealth.org](http://www.academyhealth.org)

**Efficiency in Health Care:  
What Does it Mean? How is it Measured?  
How Can it be Used for Value Based Purchasing?**

**The Agency for Healthcare Research and Quality  
The Employer Health Care Alliance Cooperative (The Alliance)  
Madison, WI May 23-24, 2006**

***Conference Highlights***

In May 2006 the Agency for Healthcare Research and Quality (AHRQ) co-sponsored a conference with the Employer Health Care Alliance Cooperative (The Alliance) to discuss current activities under way to measure efficiency in health care delivery. This document summarizes key issues and themes raised at the conference. An appendix to the document includes summaries of conference presentations. The PowerPoint slide presentations from the conference are available at: <http://www.alliancehealthcoop.com/>

**Conference Goals and Themes**

Public and private purchasers of health care are using market power to drive quality improvements and to moderate cost increases. While great advances in quality measurement for value based purchasing have been realized over the last several years, scientific evidence on efficiency measurement is lagging behind.

AHRQ and The Alliance convened this conference to discuss what it means to measure “efficiency” and how that understanding can be used to support value based purchasing, comparative reporting, and tiering of networks and benefits. The conference included a presentation of the first draft of a “typology” to classify existing measurement activity and to help clarify discussions of efficiency among diverse audiences. Presentations addressed models for measuring both hospital and physician efficiency and strategies for linking performance measures to a variety of incentives.

Specific conference goals were to:

- Review the state of literature on efficiency
- Understand the state of the art thinking on efficiency
- Examine progressive examples of efficiency measurement
- Provide a forum for exchange and create the research agenda

A number of themes, listed below, emerged throughout the two days. Each of these themes is discussed in greater detail in later sections of this report. A summary of presentations is included as Appendix 1.

**The Problem – Defining, Measuring, and Achieving Efficiency**

- Throughout the conference, presenters offered data and information demonstrating that the health care system currently does not operate in an efficient manner. However, it is

challenging to improve efficiency without a consensus on what constitutes efficiency, how to measure it, and what actions must be taken to improve it. A draft AHRQ typology was presented that could help organize various approaches to understanding efficiency. Many conference presenters described approaches to measurement that attempt to quantify the extent of the problem and generate improves. Participants recognized that additional technical and consensus building activity is needed.

- Current measurement activities have employed a variety of definitions for the term efficiency. Stakeholders – including consumers, purchasers, health plans, and providers – will need to reach a common definition of the term “efficiency” if we are to measure it effectively.

#### **Diversity of Stakeholder Views**

- Stakeholders have divergent views of efficiency and goals for efficiency measurement. They also have varying levels of tolerance for the imperfection of measuring and the complexity of communicating the results of efficiency measurement.

#### **Measurement Challenges**

- Measurement of efficiency is challenging due to lack of definition of terms, lack of an agreed upon framework of efficiency, differential access to data, and unresolved technical issues such as sampling methods.

#### **Issues for Further Discussion**

- Stakeholders expressed both urgency and caution in regard to efficiency measurement. Urgency is needed in that the skyrocketing cost of health care is not sustainable if employers are to continue to insure employees. A more rational approach to purchasing health care needs to be found. Caution should be applied in that there are concerns that incorrectly applied or constructed measures could lead to unintended negative consequences for patients and providers that could undermine access to or quality of care.

#### **Research and Development Needs**

- Additional research and development work is needed to build the evidence base and technical capability for measuring efficiency. Participants in the conference identified a number of categories for research and offered some suggestions on priorities.

### **The Problem – Defining, Measuring and Achieving Efficiency**

The Institute of Medicine identified efficiency as one of six necessary attributes for a high performing health care system. Yet evidence is strong that the health care system is not efficient. For example, a recent examination of Medicare spending published in the *Dartmouth Atlas* and presented at the conference demonstrated high variation in health care spending with little impact on beneficiary outcome. Some regions have markedly higher cost (mostly related to use of discretionary services), with no higher patient satisfaction or health improvement. The Dartmouth researchers concluded that Medicare could save 30 percent of spending on cost of care for the end of life if all regions adopted the practices carried out in more efficient regions.

Many conference presenters showed data indicating that cost and quality are not correlated; some lower cost physicians (or hospitals) produce high quality care, while some high cost physicians produce low quality care. This led many of the purchasers, plans and researchers to conclude

that measuring, rewarding and making transparent both cost and quality may lead to improved efficiency without adversely affecting quality.

There is increasing pressure from the purchaser community to measure efficiency. As a number of presentations at the conference illustrated, measurement is moving forward on many fronts. These activities are taking place in spite of limited scientific evidence on validity of measures. We also do not fully understand the implications of publicly reporting efficiency measures and creating consumer or physician incentives around them. The potential for redundant and/or ineffective measurement efforts strongly suggests the need for consensus on measurement approaches and the measures themselves.

### **Brief Overview of Presentations**

AHRQ launched the conference by presenting a draft typology developed by RAND to capture the diverse concepts and perspectives embedded in the term, “efficiency.” Ultimately AHRQ’s goal is to map existing efficiency measures to an agreed upon typology to help facilitate more meaningful discussions of efficiency across diverse groups.

According to RAND, a typology will help to understand and organize current activity in efficiency measurement (see Figure 1). Efficiency in health care is challenging to define for the following reasons:

- Efficiency is a relative term; perspective has a great influence on what elements of health care delivery are valued. Efficiency is defined differently by purchasers, payers, plans, consumers and providers all of whom have a different perspective on what constitutes quality and appropriate cost.
- There are many types of efficiency, including technical, productive and social efficiency. Technical and productive efficiency may not be aligned with social efficiency. Some types of efficiency may be viewed as contradictory to the values of health care practitioners; for example, many physicians perceive their obligation as prioritizing the needs of the individual over those of society.
- We have no definition of “true” efficiency. There is insufficient evidence to say with certainty what and how many health care service inputs will yield the greatest efficiency and with what risks and benefits. For example, a variety of imaging approaches can be used to make a diagnosis, each with varying risks, benefits, and acceptability to patient and provider.
- Financial rewards are often dissociated from actual health care outcomes. Health care is paid for, and generally measured by, unit of service (episode, visits, or hospital day), while the health care outcome is not factored into the purchasing equation. Rarely are health care purchasing and incentives based on efficiency, defined as a combination of cost and quality.

Many presenters highlighted the urgency of defining efficiency in order to measure it by nationally standardized metrics. Each organization presenting data at the conference used a working definition of efficiency, but no uniform definition is yet available. (A summary description of each presentation is found in Appendix 1.)

Conference presentations focused on two areas of efficiency measurement: hospital efficiency and physician efficiency. Much of the activity reported at the conference has been implemented by health plans, with the encouragement of purchasers. Health services researchers have participated in the process by providing guidance on measurement issues and by evaluating measurement and reporting strategies. Examples of hospital efficiency measurement initiatives presented at the conference include:

- **The Alliance** identifies efficient hospitals by measuring quality and re-pricing State of Wisconsin inpatient claims data sets based on Alliance terms for participating hospitals while adjusting for severity. The Alliance found that a hospital's quality varied from measure to measure and from clinical area to clinical area. The Alliance is working to apply an incentive program based on quality and severity adjusted cost.
- **Tufts Health Plan** developed a PPO product program to create preferential tiers of hospitals based on quality and efficiency measurement. The program used differential consumer co-pays for hospitals based on rankings of hospital cost and quality.
- **CIGNA Centers of Excellence** are designed to promote transparency of hospital quality and cost to consumers. CIGNA uses multi-payer data to rank hospitals in 29 clinical areas and provides the information to consumers to assist them in selecting care options. Ultimately incentives will be brought into alignment for both consumers and providers.

Examples of physician efficiency measurements presented at the conference include:

- **HealthPartners** has developed a methodology to implement and use composite measures reported at the group level. Each composite measure includes several care management elements necessary for quality care of the clinical condition. Performance is "all or none" on the measure – that is, the group must consistently provide all of the necessary elements of care. Information on quality and cost is provided to consumers.
- **DCG Physician Profiling** was a case study of a physician profiling initiative in a large IPA model health plan. The plan classified physicians into quartiles using a case mix adjusted methodology. The profiling effort was an early stage program and resulted in helpful findings that can guide future efforts, particularly in the areas of physician engagement and data management.
- **HEREIU Fund Las Vegas**, a union-sponsored health plan, implemented a network restructuring effort based on provider cost and quality. HEREIU first profiled all network physicians for efficiency (a combination of cost and quality). The Fund used software to capture encounter-specific quality indicators and cost for selected clinical conditions. Efficiency measurement was used to flag providers for further investigation. The Fund eventually reduced the size of its provider network by de-selecting the least efficient providers (those with higher costs not justified by higher quality). With the cost savings, it simultaneously implemented a bonus program for high quality providers and covered an increase in employee wages.

## Diverse Stakeholder Views

During the conference, presenters highlighted some of the divergent views of stakeholders and how those views might influence development and implementation of efficiency measures:

**Purchasers:** Public and private purchasers want to understand how to purchase health care benefits more responsibly, to get more “value” out of the dollars they spend. Purchasers tend to want to “get on with it – linking dollars to efficiency” given what is known now, instead of waiting for definitive research on efficiency measurement strategies.

**Plans and providers:** Plans and providers prefer to use a few, informative measures rather than numerous, possibly conflicting measures. However, there is little uniformity in the measures selected across providers. Many providers tend to want to be measured on processes they are already engaged in which differ across hospitals and physicians.

**Consumers:** Consumers tend to react negatively to the idea that care is being withheld or provided cheaply, as evidenced by the negative response to managed care. As purchasers and providers develop and report measures, there is a risk of consumers interpreting the term “efficiency” as “cheap.” This is one of the challenges in communicating the complex concepts of efficiency measurement and quality.

## Measurement Challenges

Performance measurement for cost and quality carries with it challenges and questions. Some specific technical issues highlighted at the conference include:

**Data access:** Data access and availability can be a measurement barrier. Effective efficiency measurement potentially requires data from multiple sources, which may not always be available. For example, episode grouping is an emerging technique used to evaluate care across multiple settings such as inpatient and outpatient services. As such, it requires access to large pools of accurate inpatient and outpatient claims data and ideally lab and pharmacy data as well.

**Pooling multiple payer data sets:** Pooling data (multi-payer data) can be a valuable approach to collecting information on provider performance. However, a number of technical adjustments must be used to standardize the information. For example, capitation and carve outs, reimbursement rates, product/benefit limits and benefit design differences affect what data are available for analysis. It is also necessary to standardize or map terms such as “charge,” “price” and “cost” to adjust for differences in the level of discounts offered to various payers and across product lines. NCQA is developing a standard pricing system that can be mapped to actual prices to compare costs for episodes of care.

**Attribution logic:** Attributing care to an accountable health care provider is a key process step to evaluating performance. This is particularly true when physician incentives are tied to performance. Attribution is particularly important in primary or specialty care physician

performance measurement. Options for creating attribution algorithms include creating a threshold number of visits or costs that identify the accountable physician.

**Sample size:** Achieving a sufficient sample size is a challenge for many forms of measurement, especially individual provider performance evaluation. Specialty physicians often have a small case volume (especially when looking at a given procedure or condition), which presents profiling challenges for statistical reasons. Options for addressing low sample size include increasing the measurement time period to increase the number of events, profiling groups instead of individuals, and pooling payer data.

**Statistical validity:** Adequacy of sample size and adjustments for case mix has a great impact on validity of measurement. Statistical techniques can be used to adjust for both of these issues. Methods that could be applied include: use of z scores, weighting of component measures, ranking of providers/facilities, use of threshold sample size and statistical testing for significance. Software tools such as episode groupers are becoming more sophisticated to support measurement and attribution.

**Performance ranking:** Performance of hospitals and physicians is usually not consistent across all quality and cost measures. This makes it difficult to provide a simple ranking to guide consumer or purchaser choices and introduces challenges to reporting provider performance across multiple measures. This complexity means that purchasers must weigh conflicting information, apply value judgments, and make trade-offs based on price, quality, and preference, rather than using a simple ranking approach.

**Transparent measurement methods:** Physicians and hospitals often want to understand the approaches and methods underlying performance measurement. “Showing the math” and offering tools for various users to understand the information is an important goal. More purchasers and plans are creating ways to make their measurement and incentive programs transparent to providers.

**Unintended consequences:** Measurement of quality and cost may have unintended consequences. For example, inadequate severity adjustment may cause providers with more complex patient populations to be denoted as “inefficient.” Even when using appropriate severity adjustment methods, cost measures should be paired with indicators of quality, access, and patient-centeredness to avoid creating incentives for physicians and hospitals to solely focus on short term cost control.

### Issues for Further Discussion

There were numerous opportunities for comment and discussion during the conference. Some of the issues and themes requiring additional follow up include the following:

- Purchasers feel an urgency to increase efficiency of the health care system. There is a perception that lack of efficiency is driving unnecessary costs in the health care system.

This has a direct influence on their ability to provide coverage to beneficiaries and their willingness to “invest” in health care.

- There is concern whether efficiency measurement is being done correctly and about the potential consequences of incorrectly constructed or applied measures. Conference participants have adopted strategies to enhance the credibility of efficiency measures. These include increasing transparency of cost, utilization, measure specifications; requiring that providers be at the table; and providing detailed results that are actionable to providers.
- Collaboration, such as the AQA initiative, may be an effective approach to measure development. Performance measurement activities do not provide a competitive advantage to plans or payers. Plans are not differentiated on this element, and measurement is not a marketing advantage to reach consumers. The competitive advantage for plans lies in providing quality and cost information that consumers want and collaborating with physicians to improve efficiency, including both their quality and cost.
- There is an ongoing challenge of communicating efficiency information to stakeholders in a useful and fair manner. As noted above, providers, groups, and hospitals are not consistently high performers across conditions or across time. While simple rating systems or rankings present advantages in communicating complex information, they may provide inadequate information to support consumer choices and may unfairly reflect the performance of some providers.
- Many network physicians do not wholeheartedly support the reporting concept. It is critical to engage physician leaders and enlist their support to help improve quality of all practitioners. Outreach to physicians could be through local physician opinion leaders.
- Consumers have not yet been drivers of measurement or key users of measurement data. This may change with the growth of consumer directed health plans (CDHPs) and public reports that are more “consumer friendly.” In spite of lack of consumer demand, health plan measurement activities have been beneficial in that they changed provider behavior. As CDHPs evolve, there may be more demand for efficiency findings from consumers. Consumers in CDHPs will bear more cost and have more of an incentive to seek out efficient providers.

### **Research and Development Needs**

Conference presentations addressed diverse approaches to measuring hospital and physician efficiency. During the dialogue between presenters and the audience, a number of research and development needs and strategies were identified. The results of these activities would facilitate development of standard efficiency measures. These include:

**Measure development strategy:**

- Develop measures that relate to the desired output of health care: health care outcomes and the cost of the outcome. This is the preferred alternative to measuring units of service such as days of hospitalization or numbers of visits. This will create incentives for the delivery system to create superior health outcomes rather than to manage units.
- Use a mix of local and top down approaches in measure development. The value proposition is defined at the local level, based on local community needs. Local problems and solutions must be addressed in order to engage the providers.
- Continue to promote innovation in health care delivery. Recognize that a single standard measure of efficiency may not be the end goal. In fact, a suite of quality and cost measures may improve efficiency overall. Single quality or cost measures may drive providers to “teach to the test” and focus only on the subject being measured, to the detriment of other issues.
- Develop more explicit approaches to identifying the accountable unit for efficiency, for example, the physician, hospital, group, or plan. The most valuable measures will focus on the smallest unit of an organized entity accountable for care.
- Develop measures for non-physician and specialty providers to improve care and to promote their integration into mainstream health care processes.

**Methods:**

- Develop more transparent physician attribution algorithms for fee for service or loosely managed network environments.
- Create implementation rules for attribution and cost analysis so that all physician and hospital measures could be standardized to a common scale.
- Develop accepted, standard methods for addressing cost outliers.
- Develop a crosswalk of measures used by presenters at this conference, including the AQA endorsed measures, and the RAND typology.
- Develop composite measure methods that are more reflective of multi-dimensional care than are the current single stand alone item measures.
- Identify approaches to correlate reimbursement amounts to level of quality in a manner that is fair and equitable.

**Information Sharing and Decision Support:**

- Evaluate the effect of measurement and reporting techniques on consumer choices.
- Develop information on consumer weighting of clinical and non-clinical factors in health care decision-making. Identify decision-support tools with capability to integrate performance data with weighted consumer preferences for other factors such as provider experience, reputation, location, convenience, amenities, transportation, etc.
- Create public domain tools for presenting findings effectively to consumers, physicians, and other stakeholders.
- Develop a communications campaign and multi-faceted approach to promoting health care efficiency. This could be on the scale and scope of seat belt initiatives that transformed public thinking about this safety issue.

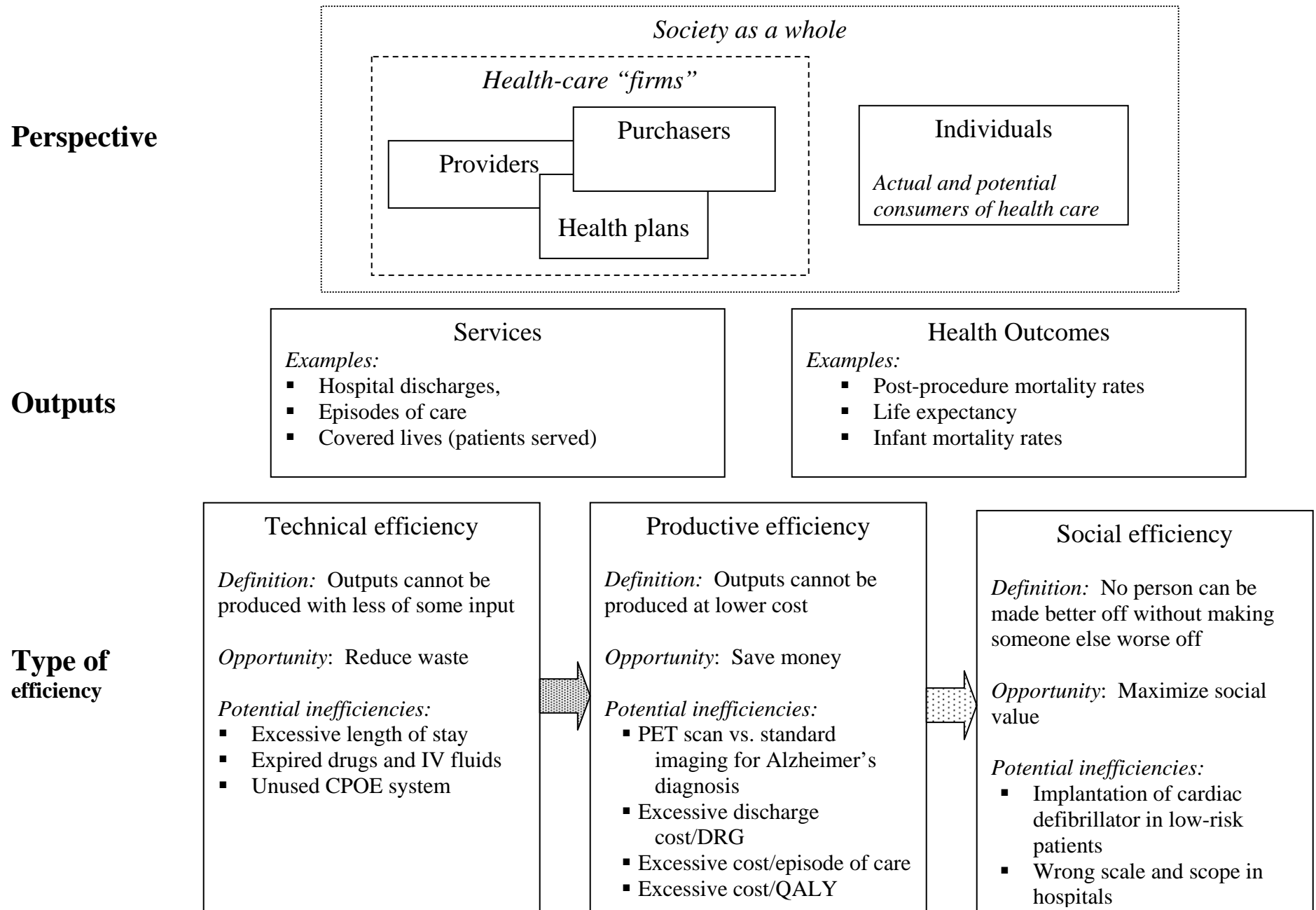
**Financial Outcomes:**

- Examine the correlation between increased efficiency and cost savings to consumers or payers (in direct cost savings, rebates, or decreased premium trend).
- Examine perverse incentives in the financing system and their effect on efficiency.
- Identify economic models for paying for well coordinated care.

**Conclusion**

Activities to measure and improve efficiency in health care are accelerating. Much of this work has been developed and implemented independently by health plans, purchasers, and providers. This conference provided a starting point in identifying a common framework for measurement, and classifying existing efficiency measurement activities. Ultimately this work may lead to greater consensus on a definition and measurement approach that will appropriately balance the need for higher quality and lower costs – in other words “efficiency.”

**Figure 1:  
A Typology of Efficiency in Health Care**



## **Appendix A: Summary of Presentations**

### **Opening Session**

#### **Welcome/Opening Remarks Carolyn Clancy, MD**

Carolyn Clancy (AHRQ) welcomed the group and noted that to improve quality we have to be able to measure it. AHRQ creates tools for improving quality: evidence reviews, quality of care reports, and conferences. In setting the stage for the conference, she noted that in *Crossing the Quality Chasm*, the IOM outlined 6 aims for improving the health care system. The aims include efficiency, but it has been underrepresented in research and literature. We know that the highest quality of care is not the most expensive. Cost of care has increased; we want to see quality of care increase at the same rate. We also need to control costs without sacrificing quality. At this point, efficiency is in the eye of the beholder and means different things to different stakeholders. We must clarify common definitions and develop a typology and framework that will allow us to discuss and move forward on measuring and improving efficiency.

#### **Efficiency In Health Care: Opening Remarks Cheryl DeMars, CEO**

Cheryl DeMars (The Alliance) outlined the goals for the conference and contrasted the current situation with where we want to be in measuring efficiency. We currently have no common language, definitions or perceptions of efficiency. From The Alliance perspective, employers want efficiency, which they include as a component of the term, “value.” Employers want more information on the relationship between what they spend and the costs of providers to deliver care. They also want a better understanding of the health outcomes that matter to productivity and quality of life, and how to create incentives that drive towards those outcomes. Employers are working towards a market that recognizes and rewards value and considers the longitudinal cost and quality of health promotion and management of chronic conditions.

### **Defining “Efficiency” in the Context of Purchasing: A Typology of Healthcare Efficiency Measures**

Herb Wong (AHRQ) moderated the session and provided an overview of AHRQ’s involvement. AHRQ has a research program related to efficiency, including developing the evidence for efficiency and supporting development of the typology. AHRQ commissioned the paper presented at the conference from RAND. RAND’s charge is to develop a typology and then to catalogue/evaluate existing efficiency measures.

#### **A Typology of Efficiency in Health Care: Implications for Measurement Elizabeth McGlynn, PhD**

Elizabeth McGlynn (RAND) noted that there is a pressure to measure efficiency, but a lack of information on the validity of measures and the consequences of applying imperfect measures. There is a need to develop strategies for conveying efficiency to consumers in a way that doesn’t imply “cheap” care, particularly since consumers equate spending more with better quality. In economic theory, efficiency is evaluated in terms of producing an outcome product; in health care, however, it has come to mean production of units of services such as a surgical procedure or hospital stay. This

may be an imperfect strategy, since we do not know the correlation between units of services and ultimate health outcomes. Efficiency is often viewed through different lenses by stakeholders, including individuals, purchasers, plans, providers and the greater society. The values and preferences of the stakeholder groups are quite varied. There are several types of efficiency, including technical efficiency, productive efficiency, and social efficiency. They are interrelated but not always aligned. Dr. McGlynn noted that for standardized measurement, we must be explicit about issues relating to perspective, outputs, and definitions of efficiency. In the current system outputs are driven by reimbursement, which may not be aligned with efficiency. RAND will be refining the draft typology presented at the conference, and will be enhancing it through an evaluation of existing efficiency measures. (See also Figure 1)

### **Reaction**

Andy Webber (National Business Coalition on Health (NBCH)) offered a purchaser reaction to the concept of efficiency measurement and to the draft typology. He noted that the NBCH mission is to introduce “value based purchasing” community by community. This means looking at the quality of what purchasers are paying for. Payers bear the cost of inefficiency in two ways: through increasing premium costs, and through decreased productivity rates. Efficiency increases competitive ability of employers globally. One challenge is in communicating complex concepts to consumers. Efficiency is a concept prone to misunderstanding, e.g. managed care became a discussion about cheap care, rather than a discussion of efficiency and quality. Purchasers want to understand how to pay for care more effectively. The bias of purchasers is “get on with it – linking dollars to efficiency” rather than continuing to diagnose the problem. Purchasers want appropriate care, provided in a technically efficient manner (at lowest resource use possible) and at the lowest cost possible. Reporting affects behavior, so reporting must be a component of the efficiency measurement strategy. Mr. Webber suggested that we begin the measurement process by looking at the points of convergence of stakeholder interests and beliefs.

### **Reaction**

Chris Queram (Wisconsin Collaborative for Healthcare Quality (WCHQ)), presented a reaction as a community collaborative for quality. Purchasers don’t want to delay the outcome because of lack of agreement on a framework. He noted that a lot of measurement experiments are under way even in the absence of consensus on a definition or approach. Examples include the WCHQ project, which is using the CMS Premier program methodology to examine the relationship between quality and costs. Consumer directed plans may interface with the efficiency typology since consumers will bear more cost and have more of an investment. He noted that ultimately, a typology must support various measurement initiatives. The product may strike at cultural norms of how we look at physician and hospital accountability.

## **Reaction**

Jon Kingsdale (Tufts Health Plan) presented a reaction from the plan perspective. Health plans define efficiency as their “per member per month” (PMPM) cost, but there is actually a much bigger picture. Many factors contribute to efficiency or lack thereof. For example, health care worker wages are a huge contribution to overall health care costs. Patient belief has a major effect on health care e.g. if the patient believes a diagnosis is better with PET scan vs. x-ray, that may have an effect. Coinsurance is another example of efficiency being in the eye of the beholder. Patient contributions are considered a positive from an insurance perspective, but are a poor risk for a consumer who can’t predict what their 20% will add up to. He concluded that ultimately the concept of efficiency must be well defined, and that consumer voices need to be incorporated into design of measurements.

## **Measuring Hospital Efficiency: Current Research**

### **Identifying High-Value Hospitals** Meredith Rosenthal, PhD

Meredith Rosenthal (Harvard University) began by observing that purchasers and plans want efficiency measures, but are struggling with little guidance on how to develop them. Her interest is in what information can be provided to consumers to guide them in choosing higher value providers. Pay for performance and “tiering” of networks based on quality may offer some leverage in encouraging both consumers and providers to take notice of efficiency. She presented data showing that cost and quality are not correlated, e.g. higher cost does not necessarily lead to higher quality. Even when high quality or low cost hospitals are identified, their performance is not consistent across conditions; in fact, most top hospitals for some conditions are very poor in managing some others. This variability is challenging to present in a meaningful way to consumers, and challenging for decision-making by purchasers. She presented several approaches to support decision-making, such as developing standard scores, weighting of information according to values, or establishing thresholds for selection based on cost and quality. From a purchaser perspective, decisions are made through tradeoffs based on the strengths of the various hospitals and needs within the purchasers’ covered population. Ideally we would make information transparent and allow the consumer to make the choice about tradeoffs, and they would have the skills to use that information effectively. Since we are far from such an ideal situation, however, more systematic efforts are needed to synthesize quality and cost data in ways that truly promote efficiency.

### **Benchmarking Hospital Longitudinal Efficiency** David Goodman, MD, MS

David Goodman (Dartmouth Medical School) presented information from a recent study of Medicare data published in the *Dartmouth Atlas*. The Atlas study concluded that there is regional variation in health care costs; higher cost does not improve outcomes. The study examined both price and volume; about one third of the higher cost is due to price and two thirds of costs are related to volume of services. Higher spending is associated with greater use of inpatient care, particularly intensive care, as well as more specialty consultations and imaging, all which may be the result of poor care coordination. The conclusion drawn by the Dartmouth researchers was that lower spending regions are more efficient and may be benchmarks for the country. Dr. Goodman observed that higher use regions for end-of-life tended to have the same high trend prior to the end of life timeframe, and have higher use for non Medicare patients. There are regional cost trends and trajectories that continue over time

and over population. He suggested that improvements could be made through organization of the health care system to create more coordination and thus greater efficiency.

## **Measuring Hospital Efficiency: Real World Approaches**

David Hopkins (PBGH) moderated the session. He provided context for the purchasers by noting that PBGH is part of the California Hospital Assessment and Reporting Taskforce (CHART) initiative in California, created to increase hospital value.

### **Measuring Hospital Efficiency: Employer Health Care Alliance Cooperative** John Bott, MSSW, MBA

John Bott (The Alliance) presented on an initiative developed by the purchasing alliance to measure hospital efficiency. The effort builds on previous work by The Alliance that demonstrated the effectiveness of public reporting of quality data. The Alliance examines efficiency by re-pricing State of Wisconsin inpatient claims data sets based on Alliance terms for participating hospitals, using adjustments for case mix and severity. The Alliance calculates the cost to serve the typical admission (in terms of relative weights) for a given hospital. As with other presenters, The Alliance found no correlation between quality and cost in the hospitals evaluated with this method. High quality does not necessarily cost more. They also found that a given hospital's performance varied from measure to measure across clinical areas. Quality in one area did not predict performance in another. The Alliance is working to apply an incentive program that factor in both performance in quality measures as well as severity adjusted cost.

### **Leapfrog Hospital Rewards Program: Efficiency Measurement** Barbara Rudolph, PhD, MSSW

Barb Rudolph (The Leapfrog Group) reported on the Leapfrog Hospital Rewards Program (LFHRP), a program licensed by purchasers that provides incentives for both effectiveness and efficiency. Leapfrog program incentives are always an "add on" to baseline hospital reimbursement; there is never a financial penalty for low performers. Hospitals can participate in five clinical areas: CABG, AMI, PCI, CAP, and Deliveries/Newborn and are scored separately on each clinical condition. A "rolled up" score based on multiple measures, utilizes a two-level weighting scheme based on the importance of specific outcomes to employers and the potential for each measure's role in mortality reduction. Leapfrog's efficiency model utilizes average severity adjusted LOS for routine and specialty bed days, adjusted for readmissions. Hospitals are rewarded if they are in the top quartile for both quality and cost, or show persistent improvements. The Leapfrog Group is now in the second generation of the program, and has addressed a number of the measurement problems identified in the first version. Hospitals and plans are invited to suggest revisions that would streamline measurement and rewards.

### **Tufts Health Plan Jon Kingsdale, PhD**

Jon Kingsdale (Tufts Health Plan) presented a PPO product program intended to create preferential tiers of hospitals based on quality and efficiency measurement. The program used differential consumer co-pays for hospitals based on rankings of hospital cost and quality. Hospital costs are calculated from an all payer database in the state of Massachusetts. In the initial roll out, hospitals supported the program conceptually, but challenged the methodology used in the ranking. Tufts developed the program because a large purchaser wanted it – not because of consumer demand. Dr. Kingsdale observed that from the plan perspective, there is little market value in reporting on efficiency. It is complex to market a performance based program to consumers. While consumers were positive about the effort, there is no real demand from consumers seeking information to manage their care. Provider collaboration is needed or the providers may undermine the program by questioning the validity of the data. Ultimately measurement may improve quality, but may not provide a competitive advantage to plans that do it.

### **Measuring Hospital Efficiency: Blue Cross Blue Shield of Illinois Carol Wilhoit, MD, MS**

Carol Wilhoit (Blue Cross Blue Shield of Illinois) reported on the plan's effort to create a tiered network of high performing hospitals and the providers affiliated with them. The plan produces a "blue star" hospital report based on 5 indicators. The report addresses utilization efficiency and administrative efficiency. For utilization indicators, the plan has developed a methodology to adjust Milliman's expected length of stay guidelines to create standard measures. Administrative efficiency captures rates of electronic claims submission. According to Dr. Wilhoit, the consumer report is considered to be a starting point. She noted that administrative efficiency is one of few areas that is "win-win" financially – it costs money to send in a claim and to receive it, so both payer and hospital benefit by increasing number of electronic claims and reducing duplicate claims.

### **CIGNA Centers of Excellence Dick Salmon, MD, PhD**

Dick Salmon (CIGNA) addressed CIGNA's initiative to promote transparency of quality and cost to consumers. CIGNA uses all-payer data to rank hospitals in 29 clinical areas and provide the information to consumers to assist them in selecting care options. A CIGNA analysis revealed that if all patients went to Centers of Excellence (COE), they would experience a 30% reduction of complications and 40% reduction in costs. Currently about 15% of CIGNA contracted hospitals are ranked as COE. Information on COE is provided to members in the CIGNA provider directory. In the online version, members can drill down per hospitals to show the price range of hospitals, and the cost to patients if they have not yet met their deductible. No incentives or rewards are provided yet, but scores and patient outcomes are reported to the hospitals. Dr. Salmon concluded that consumers are not yet fully activated, but that plans can take steps to provide them with information and drill-down opportunities that will build capacity to select health care based on cost and quality. Ultimately incentives will be brought into alignment for both consumers and providers.

## **Summary of Day 1: Hospital Efficiency** Elizabeth McGlynn, PhD

Dr. McGlynn noted that much of the first day's presentation focused on the perspective of the purchaser. She noted that in discussing efficiency, the views of other stakeholders are likely to be somewhat different. She made a number of observations from the morning sessions, including: There is a disconnect in payment and measurement activities: we pay for services but are hoping to produce and measure outcomes. She pointed out that on a day to day basis, most stakeholders focus on technical and productive efficiency. Medicare has the greatest capability to transform social efficiency by changing payment strategies. We don't yet understand the implications of measuring efficiency, and what the consequences will be, intended and unintended. For example, there may be social implications – by measuring hospital efficiency we could drive hospitals to shift care into the ambulatory sector. From the consumer perspective, health care decision-making is a “multi-attribute problem.” Cost and quality are not the only factors considered by consumers. People weigh other factors such as location, convenience, amenities, transportation, etc. To influence decision-making, we must also develop weights for these things and have a dialogue about the effect of preferences on outcomes. We need to better understand the quality implications of measurement. This includes measuring the effect of quality reporting on the segment of consumer decision-making that is allocated to those issues. There is room for improvement in technical efficiency to improve how we organize and deliver care.

## **Physician-level Efficiency Measurement**

### **Update on AQA: Efficiency, Cost and Value of Care; Data Aggregation Pilot Projects** Mark Rattray, MD

Mark Rattray (United Healthcare) presented on behalf of AQA (formerly known as the Ambulatory Quality Alliance), a multi-stakeholder collaboration created to improve quality. The AQA was created by AAFP, ACP, AHIP, AHRQ and others to address physicians' concern about multiple measures, physician lack of involvement and the need for all-payer data (Medicare and commercial). AQA also was designed respond to purchaser demands. AQA is committed to measuring performance at the physician level, collecting and aggregating data in the least burdensome way, and reporting meaningful information to consumers, physicians, and other stakeholders to inform choice and improve outcomes. AQA defines “efficiency of care” as a measure of cost of care associated with a specified level of quality of care. “Value of care” is a measure of specified stakeholder's (such as an individual patients, consumer organizations, payers, providers, governments, or society) preference-weighted assessment of a particular combination of quality and cost of care performance. AQA is currently pilot testing measures in six pilot sites, with technical and financial support from members and federal agencies.

### **Measuring Physician Performance on Costs of Care: Formulating Initial, National Standards** Sally Turbyville, MA

Sally Turbyville (NCQA) described an initiative by NCQA, a national accreditation organization. NCQA is researching development of implementation standards for assessing costs of care at the physician level, using existing software tools. NCQA's goals are to link measures of cost and quality. The approach will build on existing HEDIS quality measures, with the addition of measures of cost of care. NCQA is committed to developing measures that are transparent and fair, beginning with what

can be measured now. NCQA recently completed a Commonwealth Fund-supported effort to develop methods to identify national, regional and local benchmarks of physician performance based on widely available electronic data. Through the project NCQA has developed an understanding of existing software capabilities and has developed preliminary implementation rules for data management. Under the implementation rules for attribution and cost analysis, all plans would use their own cost reimbursement systems but would measure physicians by mapping costs to a standard scale. NCQA is working to reduce variability in the measurement process – the next step is to address the actionability of findings. At the group level, medical directors will be responsible to determining what to do with information on efficiency of care.

### **HealthPartners: Efficiency in Health Care** Gail Amundson, MD, FACP

Gail Amundson (HealthPartners) reported on the HealthPartners methodology to develop and use composite measures reported at the group level. The initiative is based on the principles of: “Transparency is transformational, composites are critical for providing an idea of what happens at the patient level. Drive competition to group level rather than the plan level.” Each composite measure includes several care management elements necessary for quality care of the clinical condition. Cost is also measured. Clinical performance is “all or none” on the measure – that is, the group must consistently provide all of the necessary elements of care. The plan developed methodology for attribution of performance at the medical group level. There currently is wide variation in performance, particularly with newer measures and more challenging measures. Groups are not consistent performers across measures. For example, groups tend to be good on some measures and less good on others. HealthPartners expects performance to be more consistent as groups adopt infrastructure support tools such as electronic medical records (EMRs). Ultimately the plan would like to drill down to determine how individual physician performance is influencing group performance, and to help individual physicians improve the quality of care they deliver. HealthPartners has observed that the performance of the whole network is going up. The plan interprets this as an indicator that groups are not avoiding the risk of high risk patients. Performance information is reported to consumers in two domains, cost and quality. Consumer tools allow patients to review the performance of medical groups. Dr. Amundson reported that the HealthPartners approach is consistent with an ICSI position paper on public reporting of physician information [www.icsi.org](http://www.icsi.org).

### **DCG Physician Profiling Case Study** Stanley Hochberg, MD

Stanley Hochberg (MedVentive) presented a case study of a physician profiling initiative in a large IPA model health plan. The plan classified physicians into quartiles using a case mix adjusted methodology. The profiling effort was an early stage program, and resulted in helpful findings that can guide future efforts, particularly in the areas of physician engagement and data management. Dr. Hochberg reported that profiling necessitates a shift in thinking of physicians. Physicians are trained to look at the patient in front of them, while profiling challenges them to look at care across a group of patients. Health plan reports also have to aggregate and report data in a more meaningful fashion than they have thus far. Physicians have had recent experience with meaningless profiles from single payer data based on an insignificant number of patients. This has made them skeptical of future profiles. Multi-payer data aggregation is more effective for profile development. Plans using the data still need to be mindful of how the data are aggregated, and how the results are interpreted. Issues such as capitation, benefit differentials, and re-insurance limits may affect what cost data is captured and used.

For reporting, options include quartiles, thresholds, or scales. When dollars are linked to performance, there is no perfect approach; some providers will be rewarded and others not, even if their performance is closely clustered. A continuous scale may be a better way to present data than quartiles. Rank and file physicians in networks still do not uniformly support the reporting concept and need to be reached through their opinion leaders. If efficiency is part of contract obligations, there is a business case for measurement and investment in support infrastructure. A successful effort can engage leaders and have the model dispersed through the medical leadership.

## **Measuring Physician-Level Efficiency: Real World Approaches**

### **The Value of Physician Network Restructuring** Elizabeth B. Gilbertson

Elizabeth Gilbertson (HEREIU Fund Las Vegas) discussed a union-driven network restructuring effort based on provider efficiency and quality. The self-funded health plan covers a relatively low-wage population, and at the time of restructuring was experiencing unsustainable cost increases. They determined that a network restructuring could help the plan to reduce costs; this alternative was preferable to raising patient contributions. HEREIU profiled all physicians in the network for efficiency using software with clinical indicators to also capture encounter-specific quality indicators. Efficiency indicators were used to flag providers for further investigation but were not decision-making criteria. The restructuring took into account a combination of physician practice patterns, geographic and specialty distribution of physicians and language/culture. Ultimately the plan terminated 50 doctors while also designating selected “Gold Star” primary care doctors. These physicians were eligible for bonuses of up to 10% of prior 6-month reimbursement. The plan conducted consumer outreach and notification to members to inform them of changes; after an initial disruption, employee satisfaction has been high. After restructuring, the trend of cost increase went from 17% to 12% to 2% while the market continued at 12%. In this instance, health care spending is directly related to ability to provide health benefits and wage increases. As a result of the cost savings, wages of workers were increased between .55-.60 cents per hour.

### **Economic Profiling of Physicians** J. William Thomas, PhD

William Thomas (University of Southern Maine & University of Michigan) offered a technical overview of how profiles are created for primary and specialty providers and for medical groups. He noted that there are definitional issues as well as data analysis considerations in developing profiles. The raw material for physician profiles comes from health plan claims files, since claims are normally submitted whether a health plan ultimately pays for all, some, or none of the costs of services received by members. For profiling, claims are first processed through episode grouper software that ties together claims for services that are diagnostically and chronologically related to specific illness occurrences. Actual and expected costs associated with each episode are calculated, and responsibility for each episode is attributed to a physician. With these actual and expected costs, plans can calculate physicians’ cost efficiency scores, and can then compare physicians’ performance within their specialties. A number of methodological factors can influence the accuracy of an individual physician’s cost efficiency score, the most important of these being episode sample size, i.e., the number of episodes available for profile calculations. Measures calculated on small sample sizes can be inaccurate, and cost efficient physicians can be misclassified as being cost inefficient. But if a health plan sets too high a threshold for episode sample sizes, very few providers could be profiled.

Options for addressing the sample size issue include increasing time periods to increase number of events, and profiling groups instead of individuals. Another approach is to consolidate data across multiple payers. Health plans need to adhere to accepted methodologies to guide definitions and data analysis decisions.

### **Measuring Physician Level Efficiency: Medicare Physician Group Practice Demonstration John Pilotte**

John Pilotte (CMS) reported on a CMS-sponsored care coordination pilot project for medical group practices. The pilot incorporates testing of care coordination approaches, increased efficiency through greater use of health information technology, and performance measurement. The program particularly focuses on improvements in chronic disease case management, high-cost, high-risk case management, and improving coordination of patient transitions and discharges. CMS has set both quality and financial targets. It is the first program to demonstrate performance measurement at the group practice level. CMS is testing 32 ambulatory care performance measures. Groups are not at risk for insurance, but they are at business risk. Groups must develop infrastructure to execute the program, and are expecting a return on investment that will generate their bonus. CMS will look at cost growth rate of the pilot group versus the control group and will bonus physicians out of the savings. Savings will accumulate over the 3 years of the program. Groups do not have to show savings every year, but must show savings over 3 years. The financial reconciliation methodology is on the CMS web site. Some challenges expected in the demonstration project are the claims lag, which slows calculation of savings and award of bonuses, defining comparison groups, and defining and reimbursing care coordination.

### **CMS Primary Group Practice Demonstration Project Theodore A. Praxel, MD**

Theodore Praxel (Marshfield Clinic) started by explaining that the Marshfield Clinic is a large medical group participating in the CMS care coordination demonstration project. The clinic has taken on the challenge of improving effectiveness and efficiency of care to a group of Medicare beneficiaries. Efficiency in the CMS project is defined as generating savings. Effectiveness is measured as high performance on quality indicators. The clinic has invested in significant information technology (IT) and care coordination infrastructure. One goal is to leverage informatics to improve care at the point of care and at the population level. For example, Dr. Praxel described investment in an anti-coagulation medication management clinic. Currently, reimbursement from insurers and CMS for the anticoagulation management is zero. If 5000 Medicare beneficiaries were enrolled savings to CMS would be about \$11.67 million, to patients \$2.5 million, at a cost to Marshfield of \$1.5 million. This type of investment puts the clinic at financial risk, since the clinic will not receive the bonus payment to recoup costs unless they are able to demonstrate savings relative to their comparison group. Some of the challenges they have experienced in measurement are: defining the accountable provider, the method for delivering incentive payments; obtaining Medicare data in a timely manner; and linking with other provider entities: providers, hospitals, nursing homes. They are hoping to develop and measure care coordination strategies that increase efficiency and thus reduce cost trends over time.

### **Summary of Day 2: Physician Level Efficiency John Freedman, MD, MBA**

John Freedman (Consultant) identified common themes from the conference. He commented that several presentations have illustrated lack of correlation between cost and quality, and substantial variation in both. The draft AHRQ typology may be helpful in understanding the diversity of measurement activity. Current measurement efforts address both technical and productive efficiency, and have outstripped our ability to describe efficiency in a standardized way. There is concern about the effect of measurement and whether it is being done right. He identified a number of strategies that have been implemented to address measurement concerns. These include increasing transparency, creating decision rules, requiring provider involvement, and ensuring there is detail behind the data. He noted that there is a corollary typology to the RAND draft. In this model, there is a public and a private typology. The public typology includes standards and publicly available information, along with outputs of various collaboratives. Outputs include a database of existing efforts and measures. There is also a private sector typology. This one embeds the measurement approach into the other incentives of the organization, e.g. surround it with education to improve results, and incentives to reward results. Reporting has to be integral to all aspects of the organization. An overarching question is, “Who is the accountable unit for efficiency? Provider? Group? Plan?” In an organized, interconnected group, it is the group that is measured. In a solo practice it is the individual. In an un-integrated group, that does not share policies and IT, the level of accountability is not clear. He concluded by noting that the conference has illustrated how many measures there are, and how people are using them in different ways. There is a need for efficiency measure development that will promote engagement, consensus building, and effective use of measurement to improve quality and reduce cost.

## Appendix B: Conference Overview and Agenda



### **Efficiency in Health Care: What Does it Mean? How is it Measured? How Can it be Used for Value-Based Purchasing?**

May 23-24, 2006

Alliant Energy Center · 1919 Alliant Energy Center Way · Madison, Wisconsin

#### **Overview**

---

Public and private purchasers of health care are using their market power both to drive quality improvements and keep their costs down. While great advances in quality measurement for value-based purchasing have been realized over the last several years, scientific evidence on efficiency measurement is lagging behind. Purchasers nationwide are looking for guidance on defining efficiency and how to measure it for the purposes of value-based purchasing, comparative reporting and tiering.

AHRQ and the Employer Health Care Alliance Cooperative are convening this May conference to discuss what it means to measure “efficiency” and how that understanding can be used to support value-based purchasing, comparative reporting and tiering.

#### **Who Should Attend:**

- Private and public purchasers
- Coalitions
- Health Plans
- Providers

#### **Why You Should Attend:**

This conference will assist you in understanding what you can do now toward evidence-based efficiency measurement. Specifically, you will:

- Learn how nationally recognized researchers and leading organizations define efficiency.
- Learn about AHRQ's new typology of efficiency measures.
- Learn what leading purchasers, plans and providers from across the country are doing now to measure quality and efficiency for pay-for-performance, comparative reporting and tiering.
- Learn of the most recent research and progressive work on efficiency measurement to shape future strategies to measure provider efficiency.
- Contribute to shaping future research needs and identifying tools to help you improve efficiency measurement.



## Efficiency in Health Care: What Does it Mean? How is it Measured? How Can it be Used for Value-Based Purchasing?

May 23-24, 2006

Alliant Energy Center · 1919 Alliant Energy Center Way · Madison, Wisconsin

### FINAL AGENDA

---

#### Tuesday, May 23, 2006

##### *Check-in*

7:00 a.m. – 9:00 a.m.

##### *Continental Breakfast:*

8:00 a.m. – 9:00 a.m.

##### **Session 1:**

**9:00 a.m. – 9:30 a.m.**

##### **Welcome, Opening Remarks and Conference Overview**

##### **Presenters:**

##### **Cheryl DeMars**

Employer Health Care Alliance Cooperative (The Alliance)

##### **Carolyn Clancy**

Agency for Healthcare Research and Quality (AHRQ)

##### **Session 2:**

**9:30 a.m. – 10:45 a.m.**

##### **Defining “Efficiency” in the Context of Purchasing: A Typology of Healthcare Efficiency Measures**

##### **Moderator:**

##### **Herbert Wong**

AHRQ

##### **Presenter:**

##### **Elizabeth McGlynn**

The RAND Corporation

##### **Reactor Panel:**

##### **Andrew Webber**

National Business Coalition on Health

##### **Christopher Queram**

Wisconsin Collaborative for Healthcare Quality

##### **Jon Kingsdale**

Tufts Health Plan

**Content:** AHRQ has commissioned RAND to develop a report that identifies and describes existing measures of health care efficiency and organizes them into a typology. A preliminary report on the typology will be presented at this session with reaction from a panel representing providers, plans and employer purchasers. Session includes discussion with audience participants.

*Break*  
10:45 a.m. – 11:00 a.m.

**Session 3:** **Measuring Hospital Efficiency: Current Research**  
**11:00 a.m. – 12:00 p.m.**

**Moderator:** **John Bott**  
The Alliance

**Presenters:** **Meredith Rosenthal**  
Harvard University  
  
**David Goodman**  
Dartmouth Medical School

**Content:** This session features noted researchers who are conducting studies in the area of efficiency measurement. Research will focus on current approaches used by health plans and purchasers to identify preferred hospitals using cost and quality information to create tiers of hospitals. Research will also focus on benchmarking hospital efficiency. The session will include discussion with audience participants.

*Lunch*  
12:00 p.m. – 1:15 p.m.

**Session 4:** **Measuring Hospital Efficiency: Real World Approaches**  
**1:15 p.m. – 2:45 p.m.**

**Moderator:** **David Hopkins**  
Pacific Business Group on Health (PBGH)

**Presenters:** **John Bott**  
The Alliance  
  
**Barbara Rudolph**  
The Leapfrog Group

**Jon Kingsdale**  
Tufts Health Plan

**Content:** During sessions 4 and 5, employer groups and health plans that are measuring hospital efficiency directly will share information about their experiences. This efficiency measurement may be used for various purposes, including public reporting, tiering, pay-for-performance, and other quality and efficiency improvement activities. The session will include discussion with audience participants.

*Break*  
2:45 p.m. – 3:00 p.m.

**Session 5:** **Measuring Hospital Efficiency: Real World Approaches (Continued)**  
3:00 p.m. – 4:30 p.m.

**Moderator:** **David Hopkins**  
PBGH

**Panel Faculty:** **Carol Wilhoit**  
Blue Cross/Blue Shield of Illinois

**Dick Salmon**  
CIGNA Healthcare

**Session 6:** **Summary of Day 1: Hospital Efficiency**  
4:30 p.m. – 5:00 p.m.

**Presenter:** **Elizabeth McGlynn**  
The RAND Corporation

*Reception:* 5:00 p.m. – 6:00 p.m.  
*Hors d'oeuvres and cash bar*

**Wednesday, May 24, 2006**

*Continental Breakfast*  
7:30 a.m. – 8:30 a.m.

**Session 7:** **Ambulatory Care Quality Alliance Efficiency Measurement**  
8:30 a.m. – 9:15 a.m.

**Moderator:** **Irene Fraser**  
AHRQ

**Presenter:** **Mark Rattray**  
UnitedHealthcare

**Content:** At this session, a member of the Ambulatory Care Quality Alliance will present information related to the AQA definition of efficiency, review their work to date,

and provide a brief update on pilot projects they have underway. The aspects of their work related to efficiency will be emphasized.

**Session 8:**  
**9:15 a.m. – 10:45 a.m.**

**Measuring Physician-Level Efficiency: Real World Approaches**

**Moderator:**

**Christopher Queram**  
Wisconsin Collaborative for Healthcare Quality

**Panel Faculty:**

**Sally Turbyville**  
National Committee for Quality Assurance (NCQA)

**Gail Amundson**  
HealthPartners

**Stanley Hochberg**  
MedVentive

**Content:**

During sessions 8 and 9, employers and health plans that are measuring physician efficiency directly will share information about their experiences. This efficiency measurement may be used for various purposes, including public reporting, tiering, pay-for-performance, and other quality and efficiency improvement activities. The discussion will include issues related to current data limitations as well as what can be done currently given those limitations and what is needed to improve measurement in the future. The session will include discussion with audience participants.

*Break*

*10:45 a.m. – 11:00 a.m.*

**Session 9:**  
**11:00 a.m. – 12:00 p.m.**

**Measuring Physician-Level Efficiency: Real World Approaches  
(Continued)**

**Moderator:**

**Christopher Queram**  
Wisconsin Collaborative for Healthcare Quality

**Panel Faculty:**

**Elizabeth Gilbertson**  
Hotel Employees and Restaurant Employees International Union Welfare Fund  
(HEREIU Fund)

**William Thomas**  
University of Southern Maine

*Lunch*

*12:00 p.m. – 1:00 p.m.*

**Session 10:**  
**1:00 p.m. – 2:00 p.m.**

**Measuring Physician-Level Efficiency: CMS Demonstration  
Program on Pay-for-Performance for Physician Groups**

**Moderator:**

**Irene Fraser**  
AHRQ

**Panel Faculty:**

**John Pilotte**

Centers for Medicare and Medicaid Services (CMS)

**Theodore Praxel**

Marshfield Clinic

**Content:**

The Centers for Medicare and Medicaid Services (CMS) has a demonstration to make higher payments for high quality and efficient care. Ten large physician groups across the country are participating in the first pay-for-performance initiative for physicians under Medicare. This session will feature a speaker from CMS to provide information about the project. In addition, a representative from one of the pilot physician groups will present on their experiences under the program. The session will include discussion with audience participants.

**Session 11:**

**2:00 p.m. – 2:30 p.m.**

**Summary of Day 2: Physician-Level Efficiency**

**Presenter:**

**John Freedman**

Health Care Consultant

**Session 12:**

**2:30 p.m. – 3:30 p.m.**

**Overall Discussion on Lessons Learned and Next Steps**

**Presenters:**

**Irene Fraser**

AHRQ

**Cheryl DeMars**

The Alliance

**Content:**

This final session invites audience participants to be interactive by contributing to shaping future research needs and identifying tools needed to help improve efficiency measurement in a way that will be most useful to rewarding, recognizing and incentivizing efficient health care.