

# Performance Standards vs. Standardized Performance

## A Choice for Optimizing Quality of Care

**E**fforts to improve quality in healthcare have been eclipsed over the past year by the cost and access concerns of reform, but quality will be back in the spotlight again soon. Faced with rising insurance premiums and higher out-of-pocket payments for healthcare, employers and consumers will be less willing to pay for medical services that are unnecessarily or incompetently performed.

Purchasers' concerns with quality and value can be expected to intensify because persistent economic stagnation, now labeled as the Great Recession, is forcing them to spend every dollar more wisely. Will quality-conscious purchasers be impressed with providers' current steps toward improving the services they deliver? A fresh look at quality improvement methods suggests that the current approach might not meet the expectations of consumers who demand consistently good care from their providers.

### **THE LIMITS OF PERFORMANCE STANDARDS**

Leaders in quality improvement have developed excellent campaigns to reduce errors and save lives at provider organizations that implement the recommended programs. They all deserve credit for tackling a serious problem.

However, one of the most common mechanisms for promoting quality—meeting 80 percent performance standards in order to get maximum reimbursement—does not assure 100 percent of the

patients that they are getting the level of quality they have every right to expect. Indeed, couldn't a consumer reasonably interpret 80 percent performance as evidence that a provider's services might not be up to snuff 20 percent of the time? And why should he or she pay anything for care that falls in the 20 percent category of standards not met?

Under this plausible line of reasoning, today's basic pay-for-performance (P4P) mechanism could easily evolve to non-payment for non-performance. The recent CMS policy that refuses to pay for "never events" is a step in that direction. Providers can be justifiably proud if setting an 80 percent performance standard has caused quality to rise from a lower level, but they must not stop there. How can any health professional aspire to anything less than doing his or her job right all the time?

### **THE SUPERIORITY OF STANDARDIZED PERFORMANCE**

The key to meeting consumer expectations (and getting paid!) in the future is consistently doing the right thing—providing

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every service for every patient the way the organization's health professionals have determined that it ought to be provided. In addition, it means having a formal system to identify any unexplained variation from expected performance and a process to prevent the problem from happening again. The organization's employees are trained and empowered to make the necessary changes in operations, and they have the resources to get the job done.

The entire process is data-driven and information-intensive. HIT professionals must be key members of the team that develops, implements, and manages systems to improve performance throughout the organization. Today's approach to pay-for-performance appropriately recognizes that data are absolutely essential for quality improvement, but it does not take all the necessary steps to ensure quality across an enterprise. (The common reference to P4P as "pay-for-reporting" is a clear sign of this limitation.)

Fortunately, many proven programs already exist for achieving top quality in healthcare organizations. Six Sigma, ISO 9001, Zero Defects, total quality management/continuous quality improvement (TQM/CQI), and other performance improvement (PI) systems are available to pick up where P4P leaves off. Leaders must push for implementing a performance improvement system across their organizations, maximizing the ROI on HIT in pursuit of doing the right things 100% of the time. Meeting 80 percent performance standards on a few dozen quality indicators is not the same as providing top quality care.

### **CASE STUDY: ASPIRIN AS A QUALITY INDICATOR**

According to one common P4P indicator, a hospital meets quality standards if it gives aspirin within a specified time to 80 percent of all patients who present to the emergency department (ED) with heart attacks. Many hospitals have worked hard to increase aspirin administration in order to meet this standard and receive a modest financial reward. But is quality really higher if the hospitals had been giving aspirin less than 80 percent of the time before the standard was imposed? Are hospitals improving quality even more if they move toward 100 percent after passing an 80 percent threshold?

The answer is not what conventional wisdom would have us believe. Some heart attack patients should not receive aspirin. Indeed, the latest clinical research suggests that aspirin is overused in coronary care. A hospital that gives aspirin to all heart attack patients in its ED is doing harm to the patients who should not have it. Relative compliance with a standardized quality indicator is not necessarily proof of overall clinical quality.

On the other hand, absolute quality would be produced by a process that evaluates the timely appropriateness of aspirin for every heart attack patient after arrival at the ED. The process for standardizing performance would identify all patients who should not receive aspirin and make sure that it is not given to them. Aspirin would be given only when indicated. Adhering to this process 100 percent of the time is something significantly different than giving aspirin to 100 percent

of the patients, whether they should have it or not. In other words, quality should be measured by how many patients are treated according to an evidence-based care process, not by how many patients receive aspirin. Correctly using the treatment protocol on every patient would be the measure of top quality.

When process is standardized, hospitals' rates of aspirin administration would vary at any given point in time because patient populations vary widely from facility to facility. Also, the rates would vary over time because best practices are constantly changing due to new research findings and/or the discovery of new therapies (e.g., discovery of a drug better than aspirin).

### **FOCUSING HIT ON QUALITY**

Information systems must be managed differently when their purpose is shifted from measuring compliance with a minimum performance standard to ensuring evidence-based care for each individual patient. HIT leaders may need to restructure their information systems to target unexplained variations and promote responsive performance improvements—an outcome reasonably expected by 100 percent of the patients. **JHIM**

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**Jeffrey C. Bauer, PhD**, a nationally recognized medical economist and health futurist, is the Chicago-based Vice President of Forecasting and Strategy for Affiliated Computer Services, Inc. (ACS), a Xerox Company. Visit [www.jeffbauerphd.com](http://www.jeffbauerphd.com) or contact him at [jeff.bauer@acs-inc.com](mailto:jeff.bauer@acs-inc.com).