
Position statement

Allergy pay for performance position statement

Joint Task Force for Quality and Performance Measures

We are the Joint Task Force for Quality and Performance Measures, appointed by the American Academy of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, and the Joint Council of Allergy, Asthma and Immunology to develop and provide expert advice to organizations attempting to develop allergy/immunology quality performance measures. In this regard and with the support of our parent organizations, we issue the following statement.

We support pay for performance as a means of improving the quality of health care in general, as long as the measures and the processes involved are valid, fair, and unobtrusive.

We specifically support the following concepts:

- Only those measures developed through the American Medical Association Physician Consortium for Performance Improvement and/or validated by the National Quality Forum (NQF) or other appropriate national validating bodies should be used in pay for performance programs.
- As of this writing, only 2 such current validated measures should be applied to the practice of allergist/immunologists, both in the area of asthma care:
 1. Percentage of patients who were evaluated during at least 1 office visit during the reporting year for the frequency (numeric) of daytime and nocturnal asthma symptoms.
 2. Percentage of patients with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
- The sole purpose of pay for performance quality measures should be for improvement of quality of care. Measuring the cost of service is not the same thing as measuring the quality of care. For example, assigning relative value to the services provided by individual or collective groups of physicians (tiering) based on the cost of services they provide is not an acceptable method for measuring the quality of care.
- Pay for performance programs, policies, and procedures should not create a conflict of interest that is detrimental to the patient's medical interest or otherwise adversely affects the patient-physician relationship.

- Physician risk management issues derived from adverse patient outcomes associated with involvement in pay for performance programs should be borne by the organizations initiating such programs and not by the physician.
- Most of the cost associated with the collection and reporting on performance measures should be borne by the organizations that require that the data be collected and reported, not by the practicing physician.
- There should be a fair process of appeals through which physicians who participate in performance measurement programs can request a reconsideration of their ratings. One example of such a process has been proposed by the American College of Physicians, and we support that process.
- The measures should be periodically reviewed for currency.

In addition, we support the following principles of the Ambulatory Care Quality Alliance (ACA) relative to measure development:

ACA Parameters for Selecting Measures for Physician Performance

- Measures should be reliable, valid, and based on sound scientific evidence.
- Measures should focus on areas that have the greatest impact in making care safe, effective, patient centered, timely, efficient, or equitable (the Institute of Medicine's 6 aims for improvement) and primarily, but not exclusively, where the most improvement can be made (80/20 rule).
- Measures should be selected based on a strong consensus among stakeholders and predictability of overall quality performance.
- Measures should reflect processes of care that physicians can influence or affect.
- Measures that have been endorsed by the NQF should be used when available. (This parameter reserves the right to use measures that have not been endorsed by the NQF. However, such measures should in the near future go through the NQF process.)
- Evidence-based quality measures should be evaluated in relation to cost of care; cost of care measures should be evaluated in relation to quality.
- Outcome measures should be appropriately risk adjusted and stratified.
- Measures should, as much as possible, be constructed to result in minimal or no unintended harmful consequences (eg, adversely affect access to care).

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- When relevant, physician-level measures should as much as possible complement measures in hospital and other health care settings.
 - The measurement set should include, but not be limited to, measures that are aligned with the Institute of Medicine's priority areas.
 - The measurement set should balance completeness and measurement burden and strive to include the minimum number of needed measures.
 - The set of measures should reflect a spectrum rather than a single dimension of care (eg, prevention and health promotion, chronic illness, acute care, and procedures [diagnostic and surgical]).
 - Implementation of measures should be as little burdensome as possible (ie, electronic data systems should be

considered whenever possible). (Although the working group acknowledges that administrative data should be considered as the logical starting point, there is interest in moving beyond claims and other administrative data as soon as is practical. As appropriate, measures derived from medical record review should not be excluded.)

- Performance measures should be developed, selected, and implemented through a transparent process.

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