Reference sources of meaningful measures of Operational, Service and Clinical Performance are provided in the
www.wiederholdassoc.com/images/blog/table-of-potential-data-analytics-sources
(*Table of Potential Data Analytics Sources) and expanded upon below.*

Operations/Financial Excellence:

Understanding the operations and financial performance of physician enterprise organizations is a good place to start when developing decision making processes. The ***Medical Group Management Association (MGMA)*** provides a comprehensive set of survey and benchmark information to evaluate and benchmark operational and financial performance. The ***American Medical Group Association (AMGA)*** provides a comprehensive set of survey and benchmark information to evaluate and benchmark operational and financial performance. ***Sullivan Cotter:*** Specializing in performance-based total rewards programs and workforce solutions for the health care industry and Not-for-Profit Sector. Compensation benchmark and survey information includes, but is not limited to:

- MGMA Provider Compensation Data, AMGA Compensation and Productivity Survey, Sullivan Cotter Physician Compensation and Productivity Survey:
    - Provider compensation data will help to attract and retain physicians, as well as evaluate benefits and performance measurements:
        - Total Compensation (by percentile)
        - Gross Professional Revenue (by percentile)
        - Work Relative Value Units (wRVU by percentile)
        - Compensation Conversion Factor (Compensation/wRVU by percentile)
- MGMA Cost and Revenue Data, AMGA Medical Group Operations and Finance Survey and MMGA Practice Operations Data: Cost, revenue, operations and finance data provides measure to benchmark and improve:
    - revenue cycle management,
    - operating expense (by category),
    - staffing models,
    - support staff salaries and benefits,
    - operational indicators:
        - access,
        - staffing standards, and
        - management costs,
        - hours of operations,
        - appointments,
        - wait times and

        - no-shows.
- MGMA Management and Staff Compensation Data, AMGA Executive, Leadership Compensation Survey and AMGA Physician Retention Survey, Sullivan Cotter Surveys provide information to attract and retain highly qualified:
    - physicians,
    - other providers,
    - leadership,
    - management and
    - support staff.

Service Excellence:

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The Centers for Medicare & Medicaid Services (CMS) develop, implement and administer several different patient experience surveys. These surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them. Patients are the best and/or only source of information for the information requested. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers. The acronym "CAHPS" is a registered trademark of and available through the *Agency for Healthcare Research and Quality (AHRQ).* CAHPS surveys are available across most types of healthcare: Hospitals, Home Health CAHPS, Medicare Advantage and Prescription Drug Plan, In-Center Hemodialysis, Hospice, Physician Practices, and others. The focus of this article will define the consumer assessment primarily in the physician practice setting.

Clinician & Group Survey (CG-CAHPS): Assesses patients' experiences with health care providers and staff in doctors' offices. Survey results can be used to: improve care provided by individual providers, sites of care, medical groups, or provider networks; and equip consumers with information they can use to choose physicians and other health care providers, physician practices, or medical groups. The survey provides in sections/categories for ease of interpretation:

- *Access to Care* (5 questions); *Provider Communication* (6 questions);
- *Test Results* (1 question);
- *Office Staff* (2 questions); and

- *Overall Provider Rating* (1 question).

CAHPS for PQRS: The CAHPS for PQRS survey was developed to collect information about patient experience and care within medical group practices participating in the Physician Quality Reporting System (PQRS). The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care they provide to Medicare.

CAHPS for MIPS Survey: The Merit-based Incentive Payment System (MIPS) is one track of the Quality Payment Program, where clinicians earn a performance-based payment adjustment to their Medicare payment. Clinicians participating in MIPS have the flexibility to choose the measures and activities that are most meaningful to their practice to demonstrate performance. The CAHPS for MIPS survey is an optional quality measure that groups participating in MIPS can elect to administer. It would count, in the quality performance category, as a patient experience measure. Additionally, a MIPS eligible clinician may also be awarded points under the improvement activities performance category for administering the survey.

Clinical Excellence:

The passage of the *Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act* (*MACRA*) supports an ongoing transformation of health care delivery by furthering the development of new Medicare payment and delivery models for physicians and other clinicians. Health and Human Services (HHS) has developed a plan for the development of quality measures for application under certain applicable provisions related to the new *Medicare Merit-based Incentive Payment System (MIPS)* and to eligible *Medicare alternative payment models (APMs).* MACRA provides both a mandate and an opportunity for CMS to leverage quality measure development as a key driver to further the aims of the CMS Quality Strategy:

- Better Care
- Smarter Spending
- Healthier People

The CMS Quality Measure Development Plan (MDP):

The *Quality Measure Development Plan (MDP),* required by *MACRA*, is a focused framework to help us build and improve quality measures for clinicians. These quality measures will support MIPS and advanced APMs. A link to the Quality Measure Development Plan is provided for ease of reference: final Quality Measure Development Plan. Initial Priorities for Measure Development by Quality Domain**:**

- **Clinical Care**
  - Measures incorporating patient preferences and shared decision-making
  - Cross-cutting measures that may apply to more than one specialty
  - Focused measures for specialties that have clear gaps
  - Outcome measures
- **Safety**
  - Measures of diagnostic accuracy
  - Medication safety related to important drug classes
- **Care Coordination**
  - Assessing team-based care (e.g., timely exchange of clinical information)
  - Effective use of new technologies, such as telehealth
- **Patient and Care Giver Experience**
  - Patient-reported outcome measures (PROMs)
  - Additional topics that are important to patients and families/caregivers (e.g., knowledge, skill, and confidence for self-management)
- **Population Health and Prevention**
  - Developing or adapting outcome measures at a population level, such as a community or other identified population, to assess the effectiveness of the health promotion and preventive services delivered by professionals
  - IOM Vital Signs topics (e.g., life expectancy, well-being, addictive behavior)
  - Detection or prevention of chronic disease (e.g., chronic kidney disease)
- **Affordable Care** (Overuse measures (e.g., overuse of clinical tests/procedures)

Measuring, monitoring, reporting, analyzing, improving and controlling clinical performance measures has proven to be a significant challenge across many organizations. Sample measure may be located within the CMS.gov website:

- Quality Measures: https://qpp.cms.gov/measures/quality
- Advancing Care Information: https://qpp.cms.gov/measures/aci
- Improvement Activities: https://qpp.cms.gov/measures/ia

Key Take Aways:

- *Knowledge management and transfer* through data analytics is an important element of a Performance Excellence Philosophy to achieve an *vision* of success in the ever-evolving healthcare industry of today.
- Healthcare providers are required and must report key measures of performance in order to maintain a competitive edge and to maximize reimbursement for services rendered.
- Measures of performance should focus on *Operations/Financial, Service and Clinical Excellence*.
- Sources of measures are provided.

Next Steps:

- *Process Management* through formal methodologies:
    - Determine the process management for the organization
    - Develop leadership, management and staff to focus on processes to:
        - achieve results,
        - standardize operating norms,
        - reduce variation, and
        - Hardwire best practices.