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Quality of Care

Not so long ago, the aura that surrounded the medical profession could be summed up in one short phrase: “I’m a physician, trust me.” Practicing medicine in the twenty-first century, however, will require more than trust. Patients and society will say to physicians, “Yes, we trust you, but show us the data.”¹ Physicians will be expected to demonstrate the following core competencies: provision of patient care, knowledge, interpersonal and communication skills, professionalism, practice-based learning, and system-based practice. (Paul Miles, MD. Speech to Alice Aycock Poe Center for Health Education. May, 2005. Interview by author. July, 2005.) Every practicing physician must be able to ask and answer two important questions:

- 1 How do I know that what I’m doing works?
- 2 How can I improve what I do?

For most physicians, quality and quality improvement are not high priorities. A 2003 Commonwealth Fund Survey of Quality of Care covering more than 1800 physicians throughout the country confirmed this observation.² The study’s authors found that physicians’ adoption of measures, tools, and quality is moving slowly and is not where it should be to achieve a high performance. A major obstacle to physicians’ making quality improvement routine was lack of information about their own practices. The study also noted that physicians are uncomfortable sharing physician-specific performance data with the general public, with their patients, or with medical leadership. Finally, the study observed that practice size affects the likelihood that physicians receive and use data on quality of care. Those in practices with 50 or more physicians were more likely to be involved in quality improvement activities than those in smaller practices.

This chapter will address the following questions:

- ▶ What are quality and quality improvement?
- ▶ What quality and quality improvement initiatives already exist?
- ▶ How can you use measurement to compare your current status with post-improvement status?
- ▶ If you want to make quality of care and quality improvement a priority for your practice, what steps should you take?

Appendix H, which can be found on the website www.radcliffe-oxford.com/medicalpracticemanagement, contains additional information to help you implement a quality

improvement program: a glossary of terms related to quality; national public and private agencies, organizations, and associations that are focusing on healthcare quality and improvement; recommended books and articles; opportunities for continuing education on quality and quality improvement; online information related to the promotion of quality in healthcare; and Programs in the Centers for Medicare & Medicaid Services (CMS) Physician Focused Quality Initiative.

What Are Quality and Quality Improvement in Healthcare?

The Institute of Medicine (IOM) defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”³ The IOM’s important 1991 report, *Crossing the Quality Chasm. A New Health System for the 21st Century*,⁴ extends this concept a step further and comments: “Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge.” Quality is the difference between the care that is given now and the care that could be delivered, given what we already know. As the IOM report documents thoroughly, Americans don’t have that guarantee, and the difference between what exists now and the ideal is a chasm, not merely a gap.

The quality chasm in healthcare isn’t large because healthcare professionals don’t know enough or try hard enough. Even the major deficiency in the American healthcare financing system – payment for services, not for care – is not the primary culprit. Outmoded systems of work are the major barrier that prevents all Americans from receiving state-of-the-art healthcare. In setting an agenda to address this system malfunction, the Institute of Medicine calls for healthcare that is safe, effective, patient-centered, timely, efficient, and equitable.

The evaluation of quality of care should focus on structure, process, and outcomes.⁵ Structural quality refers to the health system capabilities of both large and small systems. Process quality looks at clinician/patient interactions. Outcomes evaluation refers to changes in health status. Although it is possible to measure the quality of structure, process, and outcome, most quality of care information is about appropriateness and professional standards.⁴

Just where does quality improvement fit in? Quality improvement is the method for closing the gap between the current state(s) and the desirable state(s), using measurement before, during, and after to track changes and results. Improvement science is a formal body of knowledge that applies the scientific method to improving complex systems. The principles of improvement science involve:⁶

- 1 Understanding healthcare as a system
- 2 Using a balanced set of process and outcome measures tracked over time to determine if change results in improvement
- 3 Using an explicit evidence base to determine which changes should be implemented and tested
- 4 Focusing on multidisciplinary teams to make change
- 5 Avoiding a focus only on poor performers.

The IOM recommends six steps for bringing both the American healthcare system as a whole and its many components toward a place that will give every individual the care that he or she now lacks. Here is a list of the IOM’s recommendations and some questions that can help you relate their application to your own practice setting.

1 *Redesign processes of care to more effectively meet the needs of the chronically ill.* Whatever your specialty, you care for both individuals and groups of patients with chronic conditions. The patients with chronic conditions consume more time and resources than your other patients, so you want to be sure that you, your care team, and your patients themselves are managing care as well as possible. If you are part of a large healthcare system or belong to an IPA or Physician Association, process redesign may already be part of a larger organizational agenda into which your practice fits. If you are a private practitioner, redesign of processes of care is your responsibility. You have an opportunity to work smarter, not harder.

2 *Make efficient use of information technology* to automate clinical information and make access to that information easier for both patients and the care team. If you routinely collect demographic information about your patients and document the care that you provide, you have a head start in addressing quality of care. The important question is how well you can access the information that you have and use it along with information that is available from other sources to help you provide quality care.

Do you spend a lot of time looking for medical records that are piled high on someone's desk? Do you have a secure website? If the answer is yes, can and do you use it interactively to allow patients to communicate with your practice? If you have already purchased Electronic Health Records (EHR) or are thinking about introducing this application into your practice, are you focusing on ways in which the technology can help you better meet the needs of your patients and your care team or are you fretting about the price? Do your practice management system, your website, your EHR, and your e-prescribing application interface with each other so you have comprehensive information from all of these sources available at your fingertips? Are you aware of the Voluntary Consensus Standards for Ambulatory Care endorsed by the National Quality Forum in the summer of 2005? Can you readily measure the quality of the care that you and your practice deliver for both individual patients and for your practice as a whole?

3 *Manage your own and your workforce's knowledge base and skills.* Your medical school and subsequent training gave you a good knowledge base, but it didn't teach you enough to sustain you for the rest of your medical career. The base of knowledge continuously expands, so even the smartest physician can benefit from the availability of new information on diagnoses and treatment. In the future, maintaining board certification and state licensure will require a commitment to life-long learning and periodic self-assessment. The same high level of competency holds true for your clinical and administrative staff. Can each one of you access information on new findings, new treatments, new medications, new administrative requirements, new administrative solutions, and most importantly, on your patients themselves?

4 *Coordinate care across patient conditions, services, settings, and time.* If you are a primary care physician or medical specialist, the office visit is the way in which you interact most frequently with patients. If you are a surgeon or hospital-based physician, your main interaction with your patients may be in a hospital or ambulatory surgery center setting, with briefer interactions in your office. Are you able to coordinate care for your patients across settings, regardless of the time of

day or night that the patients or your medical colleagues contact you? Problems with handoffs and the management of transitions from one provider to another are major sources of medical error.

- 5 *Enhance the effectiveness of teams.* Although the physician/patient interaction is of the utmost importance, your patients interact with other people in your office and/or at the hospital. Does everybody who interacts with patients work as a team, or do they work as individuals with little coordination of efforts? Communication skills are critical, and there is a growing awareness of the need to understand cultural, language, and literacy issues in relating to patients.
- 6 *Improve performance by incorporating care processes and outcomes measurement into your daily work.* Do you understand, analyze, and improve the processes that affect patient care? Do you measure the impact of what you do, set goals, and take steps to improve? Does your practice have an ongoing plan to systematically improve care?

Appendix H, which can be found on the website www.radcliffe-oxford.com/medicalpracticemanagement, contains a glossary of terms that are commonly used in talking about quality and quality improvement.

Examples of National Healthcare Quality and Quality Improvement Programs

Quality of healthcare and quality improvement are not new subjects. You may be familiar with and/or participate in some of the programs that already exist. Many of the current initiatives are external to medical practices and feature financial incentives for quality improvement. Although each initiative listed here has contributed in some way toward better understanding of quality problems and ways to address them, many of the externally driven programs don't affect your structure and processes for delivering care. Only you can do that.

The following list includes: disease management, centers of excellence, evidence-based medicine, practice guidelines, National Committee for Quality Assurance (NCQA) HEDIS standards, Bridges to Excellence, the Leapfrog Group, and Pay-for-Performance.

- *Disease management:* a systematic and comprehensive approach to improving the management of a condition.⁷ The goal is to coordinate care and control costs by integrating components across the entire delivery system and by applying tools that are appropriate for the target population. One limitation of most disease management programs is that they focus on cost reduction and target the most severely ill patients. Patients do not always have a say in whether or not they can participate. Another shortcoming with disease management can be the exclusion of the primary care physician from the loop of care unless involvement of him/her is deliberately made part of the program. Although most disease management programs are not usually categorized as quality or quality improvement programs, there have been some successful efforts to improve the quality of care for chronic diseases using the Wagner Chronic Care Model and quality improvement (www.aamc.org/newsroom/pressrel/2005/050428.htm).
- *Centers of excellence:* the underlying premise is that there is a high correlation between volume and positive outcomes. Both the Centers for Medicare and Medicaid Services (CMS) and many managed care plans have established standards for centers of excellence.

These centers receive a single bundled fee for all services related to specific complex procedures. As with disease management, the major focus is on cost reduction, and patients do not always have input on whether or not they can seek care from a center of excellence. Again, these programs are not usually labeled as quality or QI programs, although some of them have achieved good results.

- ▶ *Evidence-based medicine (EBM)*: the concept of using research evidence to make decisions about the care of individual patients has existed since the 1950s and 1960s. Since that time, the standards for evidence have become more rigorous, and the tools for assembling evidence have become more powerful and widely available.⁸ Historically, one concern in using evidence-based medicine to improve the quality of care has been practicality. When information is widely scattered, busy independent physicians who are not researchers are unlikely to take the time to frame a research question, review available evidence, and select the best evidence as a guide in patient care. In order to address this issue, both the United Kingdom and the United States have made progress in synthesizing available evidence. The Cochrane Collaboration in England and the Agency for Healthcare Research and Quality's Evidence-Based Practice Centers have facilitated the organization of evidence-based medicine so that the results are easier to use. Another concern with EBM is that for a large part of medical care there is not yet solid evidence.
- ▶ *Practice guidelines*: the IOM defines clinical practice guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.”⁷ The guidelines take evidence and move a step ahead; they build conclusions or recommendations about appropriate and necessary care for specific types of patients.³ A problem with practice guidelines is that they depend on evidence, not all of which is reliable. A partnership of the Agency for Healthcare Research and Quality, the American Medical Association, and the American Association of Health Plans has created a National Guideline Clearinghouse that offers online access to a large and growing resource. But guidelines alone don't produce quality, particularly if there is no opportunity for physician judgment and patient feedback in their application. The real issue is that physicians do not know how to improve in a systematic and measurable way. Dissemination of evidence-based guidelines alone has not significantly changed practice performance.
- ▶ *National Committee for Quality Assurance (NCQA)*: this organization sets standards for health plans and makes available comparative quality data. Its Health Plan Employer Data and Information Set (HEDIS) indicators focus primarily on the occurrence of desired or undesired events in specific population groups. Some HEDIS measures such as rates of childhood immunization and mammography deal with illness prevention. Other measures, such as the percentage of diabetics who have had an annual eye exam, focus on caring for people who have been diagnosed with a chronic illness. Similar to practice guidelines, quality measures or indicators alone do not have a major impact unless physicians know how to improve in a systematic and measurable way.
- ▶ *The Leapfrog Group (www.leapfroggroup.org)*: this purchasing group was established in 2000 in order to drive “leaps” in quality and safety in hospitals by leveraging performance transparency at the provider level, consumer incentives, and provider rewards.⁹ The Group includes 150 public and private purchasers and represents more than 34 million lives. Hospital participation is voluntary, and almost half of the 3000 eligible institutions

have chosen to be included. Leapfrog sponsors 15 initiatives throughout the country, and its website contains the results. In a recent editorial, Dr Robert Galvin from General Electric, one of the founders of the Leapfrog Group, acknowledged that the initiative has not had the desired effect of significantly improving hospital safety.¹⁰

- ◆ *Pay-for-Performance (P4P)*: Pay-for-performance programs offer financial incentives to physicians for achieving specific, measurable patient safety, quality, satisfaction, or efficiency objectives. These programs generally base a portion of physician payment on quantitative measures that may include patient care process measures, outcomes measures, or patient satisfaction scores.¹¹ Although pay-for-performance programs are relatively new, the programs in California and in Boston have already paid out financial rewards to physicians. Both the Medical Group Management Association (MGMA) and the American Medical Association (AMA) have developed specific standards to be met by any such programs.^{11,12}
- ◆ *Bridges to Excellence (BTE)* (www.bridgestoexcellence.org): Spearheaded by General Electric and six other large employers, and physician leaders, Bridges to Excellence (BTE) is a pay-for-performance program that rewards physicians for delivering high quality care to patients with diabetes (Diabetes Care Link), and coronary disease (Cardiac Care Link). There is also a financial reward for the use of office-based EHR (Physician Office Link). In the diabetes and cardiac care programs, both of which are administered by the National Committee on Quality Assurance (NCQA), physicians can receive certification by meeting process and outcome goals developed by the American Diabetes Association and the American Heart Association. Because BTE uses process and outcome measures, it avoids the problem of small sample size that can penalize practices. The number of patients required for certification in each of these three programs is 35. Right now, a major shortcoming of BTE is its availability only to physicians who provide care to the patients of participating employers. BTE is considering licensing the product so that large health plans can use it.¹⁰
- ◆ *Examples of quality in office-based settings*: Organizations that have taken a leading role in promoting quality and quality improvement in office-based settings are the Institute for Healthcare Improvement (IHI), the American Academy of Family Practice (AAFP), and the American Academy of Pediatrics (AAP). Their respective websites contain the details.

Importance of Measurement in the Quality of Medicine

If measurement is the key to understanding your current status and the improvements that you make, what do you measure? The Centers for Medicare & Medicaid Services (CMS) have been working with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance to measure the improvement of care for such clinical conditions as coronary artery disease and heart failure, diabetes, high blood pressure, osteoarthritis, asthma, behavioral health, prenatal care, and preventive care. In January 2005, the Performance Measurement Workgroup proposed a starter set of measures based on their ability to meet five criteria:

- ◆ Clinical importance and scientific validity
- ◆ Feasibility

- ▶ Relevance to physician performance
- ▶ Consumer relevance
- ▶ Purchaser relevance.

After an expedited review process, the National Quality Forum endorsed National Voluntary Consensus Standards for Ambulatory Care. These standards represent the consensus of more than 260 healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality improvement organizations. They are a standardized set of measures for gauging and publicly reporting the quality of ambulatory care. These approved measures are available online (www.qualityforum.org) and physicians can use them voluntarily.

Public and Private Initiatives in Quality of Care and Quality Improvement

The quality of healthcare as a national concern and priority is fairly recent. Following the occurrence and publicity around numerous errors and devastating consequences, the Institute of Medicine published its 1999 report, *To Err is Human: Building a Safer Health System*.¹³ That report was a wake-up call to the entire healthcare industry, and quality of care and quality improvement are now both high priorities at the national, state, and local levels. Appendix H, available on the website www.radcliffe-oxford.com/medicalpracticemanagement, lists many national public and private agencies, organizations, and associations that are concerned with both quality and quality improvement in healthcare. Check to see what is going on in your own state and local community.

Suggestions for Moving Ahead

Quality is a huge topic, and it is tempting to set it aside for another day. Rather than procrastinate about the inevitable, learn more about existing quality improvement initiatives. Use your research to gain a broad perspective so you can designate someone within your practice to organize your efforts, but remember that quality is everyone's responsibility. Then objectively assess your current situation, organize your findings, and decide what actions to take. Last but not least, document your quality efforts.

It is essential to distinguish quality improvement efforts that originate within your practice from activities that you undertake in order to satisfy external standards. Both are important. Standards that are imposed by outside agencies and organizations are likely to impact your bottom line more than the way in which you deliver patient care. If you look only outside your practice and not at what is going on within it, you won't change the structures and processes that affect your clinical results.

Learn More about Quality and Quality Improvement

So much information on quality and quality improvement is available that the challenge is in knowing where to begin. A good starting place is the Institute of Medicine's *Crossing the Quality Chasm*.⁴ Although the book is long and detailed, it will give you an excellent framework, providing insights into what is wrong and how to fix it. The observations and recommendations are well documented, and you'll have the confidence of knowing that the material comes from a reliable source.

Other good places to begin your quality journey are the Dartmouth Microsystems website (www.clinicalmicrosystem.org) and *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, by Langley *et al.*¹⁴ The American Health Quality Association (AHQA) website (www.ahqa.org) contains both good information and links to other organizations and projects. AHQA's bi-monthly Quality Update summarizes the many quality activities and events occurring throughout the country, and its website has good information on patient safety. The Institute for Healthcare Improvement website (www.ihl.org) also has excellent information. Improvingchroniccare.org can also give you suggestions.

Quality and quality improvement are becoming an important component of the training, continuing education, and credentialing for healthcare professionals. Both the American Board of Medical Specialties and state licensure boards require physician competency in quality improvement and use of data to demonstrate that they can measure and improve the quality of care. Look at the American Board of Internal Medicine's new charter on professionalism (www.abim.org) to learn how that organization describes the quality imperative. The American Academy of Pediatrics (www.aap.org), the American Academy of Family Physicians (www.aafp.org), and the American College of Physicians (www.acponline.org) have been extremely proactive about quality, and their respective websites contain information that you might want to use in your practice. For example, the American Academy of Pediatrics EQIPP tool offers physicians assistance in managing patients with ADHD, asthma, and other conditions. The American Academy of Family Physicians Quality Initiative includes criteria for performance measures and a practice enhancement program.

The American College of Surgeons (www.facs.org) offers four programs directed toward quality improvement. These are the National Surgical Quality Improvement Program (ACS NSQIP) and accreditation of bariatric surgery, trauma, and cancer centers.¹⁵

If you would like to participate in training or continuing education that focuses on quality and quality improvement, investigate the programs offered by the American College of Physician Executives (www.acpe.org) and by the Institute for Healthcare Improvement (www.ihl.org). Both of these organizations have trained thousands of physicians, and their curricula are a good combination of theory and practice. Your own specialty society may also offer training.

Many of the organizations and associations that are referenced in this section hold regular meetings for which you can get CME credit. If you attend a meeting that is not limited to your specialty, you'll gain broad exposure to quality efforts throughout the country and/or state and enhance your ability to network with a wide variety of colleagues.

Designate Someone in Your Practice to be Responsible for Quality and Quality Improvement

Select one physician within your practice as the leader for your quality and quality improvement efforts. He/she will take a lead role in understanding the state-of-the-art, obtaining standards that are relevant for your practice, and in guiding your entire team to work with those standards to make systematic process improvement.

Take an Objective Look at Your Practice

A common lament from physicians is: “My practice is a mess. I need an operational audit to help me learn what is wrong and to guide me in correcting the problems.” The operational audit that so many of you mention has at least three components: analysis of structure, workflow, and outcomes. Let’s look at each one.

With respect to structure, two common problems have a definite impact on quality of care. One is the lack of a competent practice administrator or manager and the second is ambiguous physician responsibility for practice management. If you are one of those who say with a perfectly straight face that you “sort of have a practice manager,” you indeed have a problem – and it’s not your practice manager. If you “love seeing patients, hate practice management, and rotate the physician in charge so that nobody has to spend too much time doing the terrible job of managing the practice,” you also have a problem. Both of these common structural problems produce the same result: your practice doesn’t know what management entails, what steps you need to take, and who is responsible for each task. If you adjust and improve your structure, you’ll have a better chance of improving your processes and outcomes.

Workflow process is a second issue, and it’s a big one. Many of you haven’t changed the way you run your practices in 30 or 40 years. If you introduce EHR into your practice before you improve your workflow, you’ll automate these bad habits, not fix them. Ask yourself about the processes that are currently in place for every aspect of your practice, including but not limited to appointment scheduling, check-in, collection of demographic information, review of systems, moving the patient into and out of the exam room, prescriptions (ordering and refill), check-out, ordering ancillary tests and routing the results to physicians and patients themselves, and billing and collections. Does every process that you now have contribute positively to the delivery of care to your patients in the way in which you would like it to do?

If your workflow analysis identifies many problems, measure them, correct them, and measure them again to see how you have changed. Here are some examples. How many patients did your practice turn away because you couldn’t book a convenient appointment? How many claims denials did you receive because information was incomplete and/or inaccurate? How many more patients could you have seen each day if you weren’t saddled with administrative work that could have been done by someone else or electronically? Would your nurse have treated more patients if she had been able to communicate with health plans and pharmacies electronically rather than by phone? How much money did you lose because you filed claims late? How much money do your patients and insurance companies owe you?

Finally, what about outcomes? Can you do a diagnostic test on your practice to see if you can improve a quality gap? Here are practical suggestions.

- ▶ Explore reliable national registries to which you can submit information on your patients and from which you can receive comparative information. For example, in January 2006 Medicare implemented its Physician Voluntary Reporting Program enabling physicians to voluntarily report information on 36 evidence-based measures to the Centers for Medicare & Medicaid Services (CMS).
- ▶ Select a nationally accepted quality measure and apply it to 20 consecutive patients to see how good a job you are doing. There are excellent evidence-based measures available for diabetes, asthma, congestive heart failure, and preventive care.

- ▶ Given the structure and workflow of your practice, extract useful information about the patients for whom you care from your practice management, electronic health records, and other systems. Organize the information to tell you about patients as individuals and about subsets of patients. Do you know patients' ages and where they live? If you are a primary care physician, do you know how many of your patients have chronic conditions such as asthma, diabetes, or heart disease? For these chronic patients, do you keep careful track of important measurements, medications, and other indicators? If you are a specialist physician, do you know your most common diagnoses or procedures? If you do, are you sure that the care that you and your partners provide to this group(s) of patients meets the standards that your specialty society promulgates? Do you know how to use evidence-based medicine at the point of care?
- ▶ Use satisfaction surveys for patients and medical colleagues to better understand their perception of the care you provide and the processes by which you deliver it. Correct problems that you identify and check to make sure that your quality improvement activities have a positive impact on measurable results.

Organize Your Findings

If you have done a thorough job at looking at your practice, you are likely to find many areas that need improvement. Make a list of issues and organize it in a way that makes sense to you. Here's an example from a pediatric practice that had a long and overwhelming list of structural and workflow issues. The practice considered the implications of each problem. Some issues had a direct impact on patient care (e.g., communications between front office and clinicians). Other issues had financial implications for the practice (e.g., absence of revenue cycle management process). Still others were related to compliance. Clearly, the practice couldn't address everything at once. Rather than work only on enhancing financial performance or improving patient care, it selected several issues from each category, first addressing those it could easily fix. With a well-organized work plan, the practice watched its list of tasks shrink. Clinical Microsystems (www.clinicalmicrosystem.org) has a step-by-step template that takes you through a meaningful process improvement effort.

Document Your Quality Efforts

Quality improvement should be an ongoing activity in your practice. Document exactly what you do so you can determine progress and self-correct your improvement processes as you continue to learn. Documentation will also help you with accountability – to yourself, to your practice, to professional organizations, to public and private payers, and to your patients.

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